	-	ID HUMAN SERVICES			FORM	APPROVED
		MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE S COMPL	ETED
		345357	B. WING		C 10/0	4/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	complaint investigation through 10/04/21. The compliance with 42 C		F 000			
	Control Survey and c conducted on 9/21/21 facility was found to b CFR §483.80 infectio	. ,				
	Two of the 4 complair substantiated resultin					
	Immediate Jeopardy	was identified at:				
		760 at a scope and severity J 835 at a scope and severity J				
	The tag F760 constitu Care.	ited Substandard Quality of				
	removed on 9/30/21. was conducted.	began on 9/03/21 and was A partial extended survey				
F 580 SS=D		jury/Decline/Room, etc.))(i)-(iv)(15)	F 580		· · · · · · · · · · · · · · · · · · ·	10/20/21
	§483.10(g)(14) Notific	cation of Changes.				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		X6) DATE
Electroni	cally Signed				1	10/19/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/04/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345357	B. WING			(10/	C 04/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
	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	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page (i) A facility must imme consult with the reside consistent with his or representative(s) whe (A) An accident involve results in injury and he physician intervention (B) A significant change mental, or psychosocid deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue treatment due to advec commence a new forr (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent informatic is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must r update the address (n phone number of the representative(s).	e 1 ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring ; ge in the resident's physical, al status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of erse consequences, or to n of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the ent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F 58				
	•	, oudon					

Facility ID: 923514

If continuation sheet Page 2 of 23

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/04/2021		
	345357	B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/04/2021	
			1303 HEALTH DRIVE			
PRUITTHEALTH-NEUSE			NEW BERN, NC 28560			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
 that is a composite of §483.5) must discloss its physical configural locations that comprise part, and must speciar room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record rew physician interview, of physician of a medic 2 residents (Resident (Resident (Resident #1 was addr 8/27/21 with diagnoss renal disease (ESRE (DM). A review of Resident dated 9/01/21 indicat cognitively intact and no injections of any to the Invest Director of Nursing (9/20/21. Attachments were a signed staten 9/15/21 and a signed dated 9/15/21. An interview on 9/23 indicated she was ur 	 a boosite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct for the policies that apply to be its different locations T is not met as evidenced a boost is a section of the facility failed to notify the facility failed to notify the facility failed to notify the facility failed for a mitted to the facility on est that included end stage of and Diabetes Mellitus a mitted the resident was was coded to have received 	F 58		ever, rection is cies exist or this Plan of t ederal and made n error. I for or of Health cist report errors for otified. This 2021. ated on rector of tered Nurse tor on s which		

Facility ID: 923514

		ID HUMAN SERVICES			FOR	ED: 11/04/202
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345357	B. WING		10	C)/04/2021
NAME OF PI	ROVIDER OR SUPPLIER	L		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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580 F 607 SS=D	unsubstantiated med comment. She did not the notification. An interview on 9/21/ facility Physician reve the allegation of a me #1. Another interview on facility Physician cont the DON telling him a receiving insulin or hi An interview on 9/23/ Administrator revealed the time of this invest completed the invest Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The faciliti implement written pol §483.12(b)(1) Prohibit neglect, and exploitat misappropriation of re §483.12(b)(2) Establit to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on record rev facility failed to implet	ication error and he had no at know the time or date of 21 at 3:30 PM with the ealed he was not aware of edication error for Resident 9/29/21 at 9:00 AM with the firmed he did not remember anything about Resident #1 s hypoglycemia. 21 at 2:15 PM with the ed she was on vacation at igation and that the DON gation. buse/Neglect Policies -(3) cy must develop and licies and procedures that: it and prevent abuse, tion of residents and esident property, sh policies and procedures	F 5	The Director of Health Services will review Medication Errors to that the physician was notified to This will occur five times a weel weeks then monthly times one. Audit results will be reported to Assurance Performance Improv Committee to identify trends an opportunities for quality improve any need for additional education Compliance Date October 20, 2	ensure imely. k for four the Quality vement d further ement and on. 2021	10/20/21

Facility ID: 923514

If continuation sheet Page 4 of 23

		MEDICAID SERVICES	(Y2) MI II TIO	LE CONSTRUCTION		10. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:			. ,	MPLETED	
				·		С	
		345357	B. WING		1	0/04/2021	
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, 2			
				1303 HEALTH DRIVE			
PRUITTH	EALTH-NEUSE			NEW BERN, NC 28560			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLA	N OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETION DATE	
F 607	Continued From page	e 4	F 60	7			
	neglect allegation for	1 of 1 resident (Resident		Exploitation, Mistreatm	ent and		
	#1) reviewed for a me			Misappropriation of Pro			
				10/9/2020 and Abuse F			
	Findings included:			Reporting dated Septer	mber 2012.		
				All residents have the p	otential to be		
	The facility's policy tit	tled Investigation of Patient		affected by this deficier			
		oitation, Mistreatment, and					
	Misappropriation of F	Property revised on 10/09/20		The Administrator and	the Director of		
	read in part 'Interview	vs should be conducted of all		Health Services were re	eeducated on		
		relevant information. Written		September 27, 2021 or			
	-	rm any involved parties		policy, Root Cause Ana	-		
		Statements should be		Systematic Approach to			
		lowing individuals: the		unexpected/unanticipat or outcomes.	ed process failures		
		making accusation, the able patients who may have		of outcomes.			
		nt, and any other persons		The Administrator will r	eview all		
	who may have inform			grievances and sign the			
				state reportable events			
	Review of the Initial A	Allegation Report signed by		complaints are thoroug			
	the Director of Nursir	ng (DON) revealed the facility		policy. This will occur w	eekly for four		
		incident on 9/15/21 at 12:00		weeks then monthly tim	nes one.		
		ation report was dated					
		The allegation/incident type		Audit results will be rep			
	had the box checked	for resident neglect.		Assurance Performanc			
	Review of the Investi	gation Report signed by the		Committee to identify tr opportunities for quality			
		d as 9/20/21. Attachments		any need for additional	-		
		Report were a signed					
		e #1 dated 9/15/21 and a		Compliance Date Octo	ber 20, 2021		
		m the DON dated 9/15/21.					
	An interview on 9/23	/21 at 8:00 AM with the					
	(DON) indicated she						
		9/15/21. She stated the					
		ceived notification from the					
		dent that a complaint had					
		complaint line by Resident					
	#1's family member.	The DON also stated she					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/04/20 FORM APPROVE OMB NO. 0938-039		
TATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		345357	B. WING		10/04/2021		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
PRUITTHE	ALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560			
		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE COMPLETION TE APPROPRIATE DATE		
F 607	Continued From page	e 5	F 6	07			
		e on 9/03/21 that the resident					
		ulin as none was ordered for 'didn't think anything about it'					
		resident had no order for					
		ed on 9/03/21 she reviewed					
		t medications with the					
	the ED was 'under th	ent (ED) and she was aware					
		they did not say how he had					
		stated she told the ED that					
		insulin on 9/03/21. The DON ontacted Resident #1 or the					
		#2 during this investigation.					
		y Physician was notified of an					
	unsubstantiated med	ication error.					
	An interview on 9/23/	/21 at 2:15 PM with the					
		ed she was first made aware					
		or allegation on 9/15/21 d by the Corporate Vice					
		plaint had been called into					
	-	he further stated she was on					
		of this investigation and that					
F 760	the DON completed t Residents are Free of	of Significant Med Errors	F 7	60	10/20/21		
SS=J	CFR(s): 483.45(f)(2)	r olgrinioant woo Enoro			10/20/21		
	The facility must ens						
	§483.45(f)(2) Reside medication errors.	nts are free of any significant					
		T is not met as evidenced					
	by:						
		iew, residents, family, facility		Resident #1 no longer resid	les at the		
		d physician interviews, the ent a significant medication		facility.			
		g insulin to the wrong		All residents have the poten	tial to be		
	resident for 1 of 2 res	sidents (Resident #1).		affected by medication error	rs. On 9/24/21		
		nave a physician's order for	1	the Clinical Competency Co			

Event ID: 7EKR11

Facility ID: 923514

If continuation sheet Page 6 of 23

			()(0)			O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345357	B. WING)/04/2021
	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP CODE	10	0/04/2021
	NONDER OR GOI T EIER			1303 HEALTH DRIVE		
PRUITTHE	EALTH-NEUSE			NEW BERN, NC 28560		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETIO
F 760	Continued From page	e 6	F 760			
	insulin and on 9/03/2	1 was administered insulin		completed a review of Matrix Ca	are	
	prescribed for Reside	ent #2 and as a result		electronic records to ensure all	residents	
		on for the treatment of		had a valid picture that correspo		
	hypoglycemia.			the resident for identification pu		
				The Senior Nurse Consultant va		
		began on 9/03/21 when the		9/27/21 that all current residents		
		ent a significant medication g insulin to the wrong		Care electronic medical record		
	-	sidents (Resident #1).		current picture for identification	purposes.	
		it to the dialysis center and		Licensed Nurses were reeducat	ed on	
		hospital for hypoglycemia.		September 23, 2021 by the Dire		
		ardy was removed on 9/30/21		Health Services and the Register		
	when the facility prov	vided and implemented an		Clinical Competency Coordinate	or on	
		allegation of immediate		resident identification utilizing th		
		ne facility will remain out of		medication administration; gene		
	-	er scope and severity level D		guidelines which states to utilize		
		potential for more than		forms of identification to identify		
		not immediate jeopardy) to		Education was also completed v		
		ation and the monitoring to remove the immediate		Licensed Nurses on September on the five rights of medication		
		e and to correct current		procedure, including Right Resi		
	deficient practice as			Medication, Right Route, Right	-	
				Right Time.		
	Findings included:			The Director of Health Services		
	Desident ///			Nurse managers began auditing	•	
		nitted to the facility on		Registered / Licensed Nurses d		
		es that included end stage) and Diabetes Mellitus		September 23, 2021 during med administration to ensure complia		
	(DM).			they are utilizing two points of		
				identification when administering	g	
	A review of Resident	#1's Minimum Data Set		medication to residents to validation	•	
	dated 9/01/21 indicat	ted the resident was		correct resident receives the co	rrect	
		was coded to have received		medication. This will occur five		
	no injections of any t	ype.		week for two weeks then weekly	y times	
	A review of Resident	#1's physician orders		two.		
		ordered any insulin or any		Audit results will be reported to	the Quality	
	oral diabetic medicat			Assurance Performance Improv		

Facility ID: 923514

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY PLETED
		345357				С
NAME OF P	ROVIDER OR SUPPLIER	545507		STREET ADDRESS, CITY, STATE, ZIP		0/04/2021
	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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 760	Resident #2 was adm 8/20/21 with diagnose renal disease (ESRD (DM). A review of Resident dated 8/27/21 indicate cognitively intact and insulin injections for 7 period. A review of Resident indicated he was orde units twice a day at 9 Novolin is a combinat administered to treat starts to work within 1 injection. It peaks in 2 work for as long as 24 An interview on 9/21/ #1 revealed he had b 9/03/21 around 9:00 / #1 told him was insuli entered the room with and a shot around 8:3 that Resident #2 told him and not Resident told the nurse he did gave him the injection stated that Nurse #1	hitted to the facility on es that included end stage) and Diabetes Mellitus #2's Minimum Data Set ed the resident was was coded to have received ' days during the look back #2's physician orders' ered Novolin 70/30 insulin 10 :00 AM and 5:00 PM. tion insulin medication Diabetes Mellitus which 10 to 20 minutes after 2 hours and continues to 4 hours. 21 at 2:24 PM with Resident een given an injection on AM which he stated Nurse in. He said the nurse n some medications in a cup 30 AM or 9:00 AM. He stated Nurse #1 the shot was for t #1. Resident #1 stated he not take insulin, but she n anyway in his right arm. He told him it was insulin. urse #1 also gave him oral cup at the same time.	F 76	0 Committee to identify trend opportunities for quality im any need for additional ed Compliance Date Octobe	provement and ucation.	

Facility ID: 923514

If continuation sheet Page 8 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345357	B. WING _				C / 04/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PRUITTHI	EALTH-NEUSE				1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	roommate's insulin sh An interview on 9/22/2 Resident #2 revealed scheduled insulin on 9 Resident #2 stated he Resident #1 talk to Nu a shot on 9/03/21. Re not talked to Residen #2 stated he told Nurs his morning insulin do didn't say anything, a insulin. Per record review, Re Novolin 70/30 insulin a day at 9:00 AM and Medication Administra signed as administere on 9/03/21. An interview on 9/21/2 revealed she had give scheduled insulin aro she stated she had mo She stated she verifier medication administra pictures and resident door. She stated she name on 9/03/21 to v stated Resident #2 di received his insulin on Another interview on Nurse #1 revealed she morning insulin in his stated Resident #2 ne	hot on 9/03/21. 21 at 10:41 AM with he had not received his 9/03/21 at 9:00 AM. had not seen or heard urse #1 about insulin or get sident #2 also stated he had t #1 about insulin. Resident se #1 he had not received ose on 9/03/21, but she nd he did not receive his esident #2 was ordered 10 units subcutaneous twice 5:00 PM and the ation Record (MAR) was ed by Nurse #1 at 9:00 AM 21 at 3:15 PM with Nurse #1 en Resident #2 his und 9:00 AM on 9/03/21 and ot given Resident #1 insulin. ed resident's identity for ation through the electronic names on the outside of the called the resident by his erify the resident. Nurse #1 d not tell her that he had not	F	760			

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 11/04/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345357	B. WING			_		C 04/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-NEUSE				303 HEALTH DRIVE IEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	reaffirmed she verified picture on the electron tags on the outside of Another interview on S Nurse #1 with the Dire the Administrator press believe she had made Resident #1's dialysis part that dialysis was blood sugar was cheo reading of 64. The ne at 4:00 PM with a rea order to transport Ress at 5:07 PM. An interview on 9/21/2 Nurse #1 revealed sh Resident #1 when he dialysis on 9/03/21. S report that his blood s been given an oral sh came up a little and h glucose. She stated th had been given insuli he did not take insulin dropped again and the order for him to be se evaluation and treatm dialysis nurse also sta signs or symptoms of care. An interview on 9/24/2 revealed Resident #1 given him a shot on 9 dialysis. She stated sh	d resident's identity by the nic record and by the name the door. 9/23/21 at 5:37 PM with ector of Nursing (DON) and sent revealed she did not e a medication error. records for 9/03/21 read in started at 10:50 AM and sked at 1:45 PM with a xt blood sugar reading was ding of 49. The physician's sident #1 to the hospital was 21 at 12:55 PM with Dialysis e had assumed care of was halfway through his he stated she received in rugar was low, and he had ake. Then his blood sugar e was given an oral nat Resident #1 told her he n at the facility even though b. She stated his blood sugar e nephrologist gave an	F	760				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/04/2021 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION			LETED
		345357	B. WING _			_		C 04/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-NEUSE				303 HEALTH DRIVE IEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	DON informed the Dia resident did not receiv investigate. Resident #1's hospita (ED) records dated 9/ chief complaint was re- the roommates insulir and became hypoglyo Resident #1's arrival 1 was 170. The record 7 #1 was having labile b hypoglycemia and he 5% with half-normal s glucose readings wer and 68. Another para nursing staff call the f difficulty finding out w was, but they were ab An interview on 9/23/2 revealed Resident #2 9/03/21 that he had n insulin. She stated sh happened, and she re- next day. An interview on 9/21/2 facility Physician rever Resident #1's blood s not received insulin. H know of another reased drop that low and he l resident got a dose of #1 was alert and orien if he voluntarily told th	he had received a shot. The alysis Nurse that the ve insulin and she would I Emergency Department 03/21 read in part that the esident stated he was given in this morning at the facility cemic at dialysis. On to the ED his blood sugar further read that Resident blood glucose readings and was started on Dextrose aline. Some of his blood e: 69, 118, 99, 106, 67, 86 graph read "Did have acility they had some hat his roommate's insulin ble to find out it was 70/30". 21 at 3:04 PM with Nurse #2 had told her the night of ot received his morning e was not sure what eported it to Nurse #1 the 21 at 3:30 PM with the aled he did not know why ugar would be low if he had he also stated he did not on for his blood sugar to believed it was likely that the f insulin. He stated Resident thed with some dementia but he dialysis staff and the got an insulin injection he	F	760				

Facility ID: 923514

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/04/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE	
		345357	B. WING			_		C 04/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DDUUTTUE	ALTH-NEUSE			1:	303 HEALTH DRIVE			
PRUITINE	ALTH-NEUSE			N	IEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 760	episodes, but he did r He stated his hypogly related to dialysis but since it had not happe stated he got an insul Another interview on 9 facility Physician conf the DON telling him a receiving insulin or his An interview on 9/25/2 Dialysis Center Nepho dialysate used for dial help prevent hypoglyc at that dialysis center hypoglycemic issues. hypoglycemia was hig dialysis even if the res bit prior to dialysis. An interview on 9/23/2 Director of Nursing (D unaware of the medic She stated she talked when she went to pac belongings and Resid had not received his r "I can't say if it did or stated she told the dia the resident had not r ordered for him. She s anything about it' at th had no order for insuli Another interview on 9 DON revealed she did	 #1 having any hypoglycemia un low normal blood sugars. cemia could have been did not think it was likely ened before, and resident in injection. 9/29/21 at 9:00 AM with the irmed he did not remember nything about Resident #1 is hypoglycemia. 21 at 8:58 AM with the rologist revealed that the lysis contains glucose to cemia. Resident #1 was only a few times but had no He stated he thought the ghly unlikely a result of sident had only eaten a little 21 at 2:22 PM with the ON) indicated she was ation error until 9/15/21. to Resident #2 on 9/03/21 ex up Resident #1's lent #2 did not tell her he norming insulin. She stated, didn't happen". The DON alysis nurse on 9/03/21 that eccived insulin as none was stated she 'didn't think he time since the resident in. 9/23/21 at 5:37 PM with d not believe that Nurse #1 	F	760				
	had no order for insuli Another interview on 9 DON revealed she did	in. 9/23/21 at 5:37 PM with						

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		345357	B. WING			10/04/2021		
NAME OF P	ROVIDER OR SUPPLIER	L		:	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 SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 760	couldn't say exactly w conversation with Dia also stated she did no thought Resident #1 r An interview on 9/23/2 Administrator reveale the time of this invest completed the invest another interview on DON and Administrat did not believe Nurse error. Neither the DO explain why Resident shot and Resident #2 his insulin on 9/03/21 that Nurse #1 story has believed her. In the absence of the notified of immediate PM. the facility provid allegation of immediate Credible Allegation fo immediate jeopardy c " Identify those rec or are likely to suffer, as a result of the non Resident #1 was adm 8/27/21 from the hosp mean blood glucose of	 what was said during her lysis Nurse #2. The DON of know why the hospital received 70/30 insulin. 21 at 2:15 PM with the d she was on vacation at igation and that the DON gation. 9/23/21 at 5:37 PM with the or revealed that the DON #1 had made a medication N nor the Administrator can #1 stated he received a stated he had not received. The DON further stated ad never changed, and she Administrator, the DON was jeopardy on 9/27/21 at 4:00 led the following credible te jeopardy removal. r F760 for removal of completed on 9/30/21. cipients who have suffered, a serious adverse outcome compliance; and nitted to the facility on bital with an AIC of 4.2 and a of 68.7 per hospital records. 1 consumed 50% of his 	F	760				

If continuation sheet Page 13 of 23

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/04/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE	
		345357	B. WING			_		C 04/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	ALTH-NEUSE				303 HEALTH DRIVE			
				N	EW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	dialysis and was place residents blood sugar #1 was removed from blood sugar was rech results of 49. The Dia Resident #1 told her h the facility even thoug The dialysis center that to the hospital emerge sugar was 170 upon e room. The emergency 09/03/21 noted Resid dialysis he was given #2) insulin prior to ser The dialysis center ca with the Director of He requested to know wh received, the Director he was not on insulin medication either. The Director of Health Ser know what type of ins that morning, the Dire stated that Resident # insulin. The Director co with the Nurse who act to resident #1, stated his medications and d resident #1.	rese per medication Resident #1 was ysis center for scheduled ed on dialysis at 10:47am, at 1:45pm was 64, resident dialysis at 2:51pm, and ecked at 4:00pm with lysis Nurse stated that he had been given insulin at the did not take insulin. en transferred the resident ency room where his blood entrance to the emergency y department records dated ent #1 told the nurse at his roommate's (Resident hding him to dialysis. alled on 9/3/21 and spoke eatth Services and hat insulin resident # 1 of Health Services stated and was not on oral diabetic e hospital contacted the vices and requested to ulin resident #1 received totor of Health services f1 did not receive any of Health Services interview diministered the medication she only gave Resident #1 id not administer insulin to potential to be affected by ation errors.	F	760)SEFICIENCY)		
	the process or system	n the entity will take to alter n failure to prevent a serious n occurring or recurring, and						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/04/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345357	B. WING			_		C 04/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
				13	303 HEALTH DRIVE			
PRUITTHE	ALTH-NEUSE				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	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page when the action will b	e complete.	F 7	'60				
	On 9/23/21 the Direct Clinical Competency of education to the Regi Staff and Certified Nu identification utilizing administration; genera to utilize two forms of picture of residents, c utilize other healthcar identification. As of 9/ Licensed Nurse and/o not educated will be r until the education reg administration (identific completed. The educa administration: general added to the general of / Licensed Nurses and / Licensed Nurses and added to the general of practices. The Director responsible for trackin all Registered / License Nursing Assistants has and will maintain an e	or of Health Services and Coordinator began stered / Licensed Nursing rsing Assistants on resident the policy "medication al guidelines" which states identification; the Matrix all resident by name or e personnel for 27/21 any Registered / or Certified Nursing Assistant emoved from the schedule garding medication ication of residents) is ation regarding medication al guidelines has been orientation for all Registered d Certified Nursing resident identification or of Health Services is ng, trending, and ensuring sed Nurses and Certified ve completed the education employee roster identifying						
	Nurse Managers bega and Licensed Nurses medication pass proc Resident, Right Medic Dose, and Right Time Licensed Nurse who I education by 9/29/21 from the schedule unt medication administra medication pass is co	or of Health Services and/or an educating the Registered on the five rights of edure, including Right cation, Right Route, Right a. Any Registered / has not completed this 11:59pm will be removed il the education regarding tion and the five rights of						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY PLETED	
		345357	B. WING			C 10/04/2021		
NAME OF P	ROVIDER OR SUPPLIER		I.		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>		
PRUITTHI	EALTH-NEUSE				1303 HEALTH DRIVE NEW BERN, NC 28560			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 760	tracking to ensure all Nurses have complet maintain an employed completion of educati of Health Services an made aware 9/29/21 educating any Regist didn't receive the edu medication pass proc The education regard administration and the pass has been added for all Registered / Lic On 9/24/21 the Clinic: completed a review o records to ensure all that corresponded to purposes. The Senior on 9/27/21 that all cu Care electronic medic picture for identification The Director of Health managers began aud Licensed Nurses daily medication administra- to the policy. This inc Director of Health Sen that Registered / Lice points of identification medication to residen resident receives the Alleged date of IJ rem The credible allegatio as evidence by record	Registered / Licensed ed the education and will e roster identifying on provided. The Director d/or Nurse Managers were that they are responsible for ered / Licensed Nurse if they cation for five rights of edure by 9/29/21. ing medication e five rights of medication to the general orientation censed Nurses. al Competency Coordinator f Matrix Care electronic residents had a valid picture the resident for identification to rurse Consultant validated rrent residents in Matrix cal record have a current on purposes. In Services and Nurse iting the Registered / y on 9/23/21 during ation to ensure compliance cludes observations from the rvices and Nurse Managers nse Nurses are utilizing two of when administering ts to validate the correct correct medication. hoval 9/30/21. m was verified on 10/04/21 d review and staff interviews.	F	760				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345357	B. WING		C 10/04/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	ALTH-NEUSE			1303 HEALTH DRIVE	
FROMM	ALIII-NEUSE			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	N (X5) BE COMPLETION RIATE DATE	
F 760	Continued From page 16		F 760		
	administration.				
	Documentation of in- reviewed.	service records were			
	An observation of me conducted.	dication administration was			
	All of the evidence indicated the facility had removed the immediate jeopardy by 9/30/21.				
	Administration CFR(s): 483.70		F 835	5	10/20/21
	enables it to use its r efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by:	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. Γ is not met as evidenced			
	facility's administratic allegation of a signific to determine the valid medication error alleg	cant medication error, failed dity of the significant gation, and failed to identify urther medication errors for		Resident #1 no longer resides at the facility. All residents have the potential to be affected by medication administration errors and facility investigations The Facility Administrator and Director	1
	Immediate jeopardy began on 9/03/21 when the facility failed to determine the validity of the significant medication error allegation which occurred on 9/03/21 and did not identify the need for preventative measures. The immediate jeopardy was removed on 9/30/21 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance			Nursing were educated by the Senior Nurse Consultant on 9/27/21 on the grievance policy; specific to prompt e to resolve the grievance, in addition t taking immediate action to prevent fu potential violations of any patients r while the violation is being investigate and the Quality Assurance and	r o rther ights

Event ID: 7EKR11

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				PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · · ·	MPLETED	
						С	
		345357	B. WING		1	0/04/2021	
NAME OF P	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 835	Continued From page	e 17	F 83	35			
		severity level D (no actual		to Systematic Analysis and Sys	temic		
		or more than minimal harm		Action - using a systemic appr			
	that is not immediate	jeopardy) to ensure that the		determine when in-depth analy	sis is		
		onitoring systems put in		needed for identifying contribut	-		
		mmediate jeopardy are		factors that underlie variations i			
		ct current deficient practice		performance. This approach ca			
	as identified.			the 5 why approach or the Fish approach to identify root cause			
	Findings included:			why an event occurred.	analysis of		
	This tag was cross re	eferenced to:		The Administrator will review, a	-		
	1a E760 Based on r	ecord review, residents,		the grievance log and state rep events weekly to ensure compl			
	facility staff, dialysis s			thoroughly investigated per poli			
	interviews, the facility			Senior Nurse Consultant will re			
	-	n error by administering		facility Administrators findings of	of the		
		esident for 1 of 2 residents		grievance and state reportable			
	(Resident #1). Reside			investigations to ensure a thoro			
		insulin and was administered		investigation has been complet	ed monthly		
		Resident #2 and as a result on for the treatment of		times two.			
	hypoglycemia.			Audit results will be reported to	the Quality		
	nypogiyoonna.			Assurance Performance Improv	•		
	Review of the Initial A	Allegation Report signed by		Committee to identify trends an			
		g (DON) revealed the facility		opportunities for quality improve			
		incident on 9/15/21 at 12:00		any need for additional education	on.		
		ation report was dated			0004		
	9/15/21 at 4:37 PM.			Compliance Date October 20,	2021		
		gation Report signed by the					
		as 9/20/21. Attachments					
	for the Investigation F						
		e #1 dated 9/15/21 and a m the DON dated 9/15/21.					
		/21 at 8:00 AM with the					
		DON) indicated she was					
		cation error until 9/15/21.					
		told the dialysis nurse on					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEF AND PLAN OF CORF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345357	B. WING				C 04/2021
NAME OF PROVID					STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX S	E ATE	(X5) COMPLETION DATE	
9/03 as r 'didu resi on S med (ED imp not she on S con Res the uns An i Adm of th furth this inve In th noti PM alle Cre imm g or a as a Res 8/27	none was ordered n't think anything a ident had no order 9/03/21 she review dications with the f 9/03/21 she review dications with the f 9/03/21 she was aw ression he had rec say how he had rec sident #2 during th facility Physician w interview on 9/23/2 ninistrator revealed he medication error her stated she was investigation and estigation. he absence of the fied of immediate sident geopardy c sident #1 was adm 7/21 from the hosp	ent had not received insulin for him. She stated she about it' at the time since the for insulin. She also stated ved Resident #1's current Emergency Department are the ED was 'under the ceived insulin, but they did eceived it'. She also stated he had not received insulin stated she had not 1 or the roommate, is investigation. She stated was notified of an cation error. 21 at 2:15 PM with the d she was first made aware or allegation on 9/15/21. She is on vacation at the time of that the DON completed the Administrator, the DON was jeopardy on 9/27/21 at 4:00 ded the following credible te jeopardy removal. r F835 for removal of ompleted on 9/30/21.	F	83	5		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED	
		345357	B. WING			С	
		545557		STREET ADDRESS, CITY, STATE, ZIP C		04/2021	
NAME OF P	ROVIDER OR SUPPLIER			1303 HEALTH DRIVE	CODE		
PRUITTHE	EALTH-NEUSE			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 (CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 835	Continued From page	- 10		005			
F 033			F 8	335			
		1 consumed 50% of their					
	per the medication a	is medication by Nurse #1					
		sferred to the dialysis center					
		s and was placed on dialysis					
	-	s blood sugar at 1:45pm was					
		removed from dialysis at					
		ugar was rechecked at					
	4:00pm with results c	of 49. The Dialysis Nurse					
	stated that Resident	#1 told her he had been					
		cility even though he did not					
		ysis center then transferred					
		spital emergency room					
		ar was 170 upon entrance to . The emergency department					
		21 noted Resident #1's told					
		he was given his roommate's					
		prior to sending him to					
	dialysis.						
		alled on 9/3/21 and spoke					
	with the Director of H	ealth Services and					
	requested to know w	hat insulin Resident # 1					
		r of Health Services stated					
		and was not on oral diabetic					
		e hospital contacted the					
		rvices and requested to					
		sulin resident #1 received					
		ector of Health services #1 did not receive any					
		of Health Services interview					
		#1 who administered the					
		nt #1 on 09/03/21, stated she					
		1 his medications and did					
	not administer insulin						
		h Services received a call on					
		gency room nurse asking					
		sident #1 received of the					
	roommate, Resident Services replied to th	#2. The Director of Health					

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		MEDICAID SERVICES		E CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		ECONSTRUCTION	· · ·	IE SURVEY MPLETED
			A. BOILDING			С
		345357	B. WING		10/04/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		0/04/2021
				1303 HEALTH DRIVE	-	
PRUITTHE	ALTH-NEUSE			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
E 025		- 00		_		
	Continued From page		F 835			
		not receive resident #2				
	medications.	m Resident #1's family				
	-	il to the Area Vice President				
		a formal complaint of				
		tor on call there in the				
		the facility (dialysis center)				
	reported he was acci	dently given wrong				
	medication that was i	nsulin which belonged to his				
	roommate."					
		ent forwarded the email to				
	•	tor on 9/15/21 at 3:40 pm.				
		m the Director of Health				
	State Agency and be	e allegation of neglect to the				
		on of Resident #1 receiving				
		ion on 9/3/21. Upon the				
	Director of Health Se	rvices review and interview				
	with the assigned Nu	urse #1, it was documented				
		the correct medication and				
		gave the correct medication				
		lent #1 and Resident #2				
		the facility on 9/15/21. The				
		ttempted to contact Resident er the phone and the voice				
		you are trying to reach is				
		sician was notified on				
		or of Health Services of the				
		ysician did not have a				
	•	shift 11:00 PM to 7:00 AM				
		eduled on 9/3/21 were				
		rector of Nursing on 9/15/21				
		had not given resident #1				
	-	#1 was not interviewed				
	during the investigation					
		n The Director of Health he investigation of alleged				
	-					
	neglect and reported	the findings and submitted				

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	-	D HUMAN SERVICES					FORM): 11/04/2021 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		STRUCTION		(X3) DATE COMP	LETED
		345357	B. WING			-	(10/	C 04/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STA	ATE, ZIP CODE		
				1303 H	EALTH DRIVE			
PRUITTHE	ALTH-NEUSE			NEW E	BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 835	Continued From page #1, resident # 1 media and statement from D to the State Agency. All residents have the medication administra investigations. "Specify the action the process or system adverse outcome from when the action will b The Facility Administr were educated by the 9/27/21 on the curren date 1/1/1997 and rev prompt efforts to reso addition to taking imm further potential violat while the violation is to Grievances can be from members, staff memb concerns and/or any or related to resident car concerns and compla entity. The Quality Ass Improvement Plan spo Analysis is needed for causal factors that un performance, this app approach", which drill by asking why the even	221 cation administration record irector of Health Services) potential to be affected by tion errors and facility the entity will take to alter failure to prevent a serious noccurring or recurring, and e complete. ator and Director of Nursing Senior Nurse Consultant on t "grievance" policy effective rised 3/25/2019; specific to twe the grievance, in rediate action to prevent ions of any patients' rights being investigated. om residents, family ers related to resident entity that has a concern the and wellbeing, including ints called to any corporate surance and Performance ecific to "Systematic c Action" - using a determine when in-depth i dentifying contributing derlie variations in roach can utilize the "5 why is down to causative factor	F 8	35				
	illustrate the relations outcome and all the fa							

Facility ID: 923514

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345357	B. WING				C 04/2021
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	K (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	culture, human factors communication factor factors, care plan and factors, policy and pro- environmental factors The initiation of the gr investigation and the "systemic analysis an Administrator will be u appropriate investigat criteria starting 9/27/2 On 9/27/21 The Admi grievances and sign t reportable events wea are thoroughly investi Senior Nurse Consult Administrator's finding state reportable invest thorough investigation monthly. Alleged date of IJ rem The credible allegatio as evidence by record Interviews were cond members to verify edu all employees regardi investigation procedu Documentation of in-s reviewed. All of the evidence ind	s, information and s, training and competency assessment, equipment ocedure factors and ievance policy with timely utilization of the QAPI - d systemic action" by the utilized to determine ion efforts and reporting 1. nistrator will review all he grievance log and state ekly to ensure complaints gated per policy. The ant will review the facility gs of the grievance and tigations to ensure a n has been completed hoval 9/30/21 n was verified on 10/04/21 d review and staff interviews. ucted with a sample of staff ucation was conducted for ng the grievance and res.	F	835	5		

Event ID: 7EKR11

Facility ID: 923514

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