PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED		
		345371	B. WING _			C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	É		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		EO	000			
F 000		3.73, Emergency t ID #RLQ311.	FO	000			
	the 18 complaint alleg	complaint survey was 5/21 through 11/3/21. 7 of gations were substantiated es. Immediate Jeopardy was					
	(K) CFR 483.12 at tag F6 (K) CFR 483.25 at tag F6 (K)	680 at a scope and severity 600 at a scope and severity 684 at a scope and severity 626 at a scope and severity					
F 580 SS=K	Quality of Care. Immediate Jeopardy removed on 10/29/21 and removed on 10/3 extended survey was	jury/Decline/Room, etc.)	F 5	580			12/3/21
AROPATORY	consult with the residence consistent with his or representative(s) when	ediately inform the resident; ent's physician; and notify, her authority, the resident		TITLE			(X6) DATE

Electronically Signed

11/23/2021

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.

AND BLAN OF CORRECTION LIDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	 	11/00/2021
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	results in injury and physician interventio (B) A significant chain mental, or psychoso deterioration in healt status in either life-th clinical complications (C) A need to alter traneed to discontinu treatment due to advocmmence a new fo (D) A decision to tranesident from the fact §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informatis available and proving physician. (iii) The facility must resident and the resimble when there is— (A) A change in room as specified in §483. (B) A change in resident and the resident and the resimble pertinent informatis available and proving the section (iv) The facility must update the address of phone number of the representative(s). §483.10(g)(15) Admission to a computation of the representative(s).	living the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of rerse consequences, or to rm of treatment); or nsfer or discharge the sility as specified in tification under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) rided upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph in. record and periodically (mailing and email) and	F 5	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
		345371	B. WING		11/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
DDIUTTUE	ALTH TOPAT		:	336 HOSPITAL DRIVE		
PRUITIHE	EALTH-TRENT			NEW BERN, NC 28560		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 580	Continued From page	÷ 2	F 580			
F 580	locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff, physically police officer interview facility failed to notify wound that progressive 9/24/20 through 1/10/20 the resident receiving the wound and no physically to the wound. Reside Emergency Medical Son 1/10/21 to have a his left arm at the time dressing present. The reviewed for wound collimited in the wound in the wound collimited in the wound in the wound collimited in the wound in the position of the wound in the wound in the wound in the wound in the position of the wound in the facility proving acceptable allegation removal. The facility real lower scope and set the potential for more	se the composite distinct by the policies that apply to sen its different locations. It is not met as evidenced sician, nurse practitioner, and we, and record review the the physician of an open wely deteriorated from 121. This failure resulted in no physician evaluation of sysician ordered treatments and #200 was identified by Services (EMS) and police large tunneling wound under the of death with no observed its was for 1 of 3 residents are (Resident #200). It began on 9/24/20 when and to his left axillary (armpit) and Care Nurse failed to refuse practitioner. Was removed on 10/29/21 and and implemented an of Immediate Jeopardy remains out of compliance at verity of "E" (no harm with than minimal harm that is ddy) to ensure monitoring	F 580	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pla correction does not constitute an admission or agreement by the provide truth of the facts alleged or the correction to the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. "Corrective action will be accomplished those residents found to have been affected by the deficient practice. Resident # 200 no longer resides in the facility. "How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Health Services initiate 100% body audits on all residents with the facility on 10/27/21. This audit reveno wounds without physician/physician extender notification.	er of loons d for e	
	Resident #200 was at 6/20/20 with diagnose contracture of the righ	dmitted to the facility on es that included anemia, nt and left knee, stage II e right and left buttock, and		"Measure ☐s facility put into place or systemic changes made to ensure that the deficient practice will not recur;	t	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
			A. DOILDING			С	
		345371	B. WING			11/03/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
DDIUTTU	ALTII TOENT			836 HOSPITAL DRIVE			
PRUITIHE	EALTH-TRENT			NEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 580	featuring skin lesions inflammation and inferent featuring skin lesions inflammation and inferent feature feat	iva (a chronic skin condition which develop because of ection of sweat glands). Interly minimum data set 0/22/20 revealed he was ely intact. He required with bed mobility and toilet ependent on staff for all hygiene. He had two stage esent upon admission. He in-surgical dressings, and a pressure reducing air. He also had application ments. It 200's Treatment Orders and atton Records from June by 10th, 2021 revealed on a ordered to have Resident oit cyst, related to did with normal saline and every day. This order was 1/20 by Physician #1 and was	F 58	,	tion on to ender skin ent orders izing the sment, a change in condition is en added ientation educated prior to their s and c Certified n checks acation se of any essing Certified body This the Certified ntation upon nts not educated		
	from September 2020 no mention of any wo armpit. Review of Resident #	and nurse practitioner notes 0 through 1/10/21 revealed bund to Resident #200's left #200's chart revealed 0/24/20 through 1/10/21 no		The Director of Health Service Managers are reviewing the reweekly skin review to ensure protification is completed for all impairments or deteriorating slimpairments. This will occur we four weeks then monthly there	esidents ohysician new skin kin eekly for		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING					
						1	C	
		345371	B. WING _			11/	03/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIIITTUE	ALTH-TRENT			8	36 HOSPITAL DRIVE			
PROTTINE	EALIH-IKENI			N	IEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 580	Continued From page	÷ 4	F 5	580				
	facility staff and Phys Practitioner #1 related #200's left armpit. The EMS record date was dispatched to the	d to a wound to Resident d 1/10/21 indicated EMS e facility for Resident #200. n a large gaping hole in his			The Director of Health Services / Nurse Managers are reviewing the Certified Nurse Aide skin checks completed dur resident s personal care, weekly to ensure physician has been notified by Licensed Nurse of new or worsening s impairment. This will occur weekly for tweeks then monthly thereafter.	ing the kin		
	The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced.				"How the facility plans to monitor its performance to make sure that solution are sustained. The Director of Health Services will present the analysis of the weekly Licensed Nurse skin review to ensure physician notification to the Quality Assurance and Performance Committe meeting monthly for three months, therefor the quarterly thereafter until six months of continued compliance is sustained. The Director of Health Services will present the analysis of the weekly Certified Nursing Assistant skin check completed during personal care review ensure physician notification to the Quality Assurance and Performance Committee	ealth Services will sis of the weekly kin review to ensure ion to the Quality erformance Committee for three months, then er until six months of ance is sustained. ealth Services will sis of the weekly Assistant skin check personal care review to notification to the Quality		
	dispatch that EMS harespond for an unatted He stated he arrived EMS informed him Roopen sores on his bowhen they took off his sore was to his left ar the area. The gown the	ed he was contacted by his d requested an officer anded death at the facility. The facility at 5:03 AM on 1/10/21 and desident #200 had several day that they discovered as gown. The most notable mpit. The officer observed that was around that area fluid. The wound was			meeting monthly for three months, there quarterly thereafter until six months of continued compliance is sustained. Date when corrective action will be completed: 12/3/2021			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	long. The wound corbody towards his he enough of a cavity the resident's body to approximately 4 inchand was approximate cavity ran along the ended at his collarboin the cavity was a wadditional smaller so wound. He was infordid not have any drearrived. He stated the wound was not complete the wound was not complete the wound was not complete the wound has formed the surface of the sk o'clock. The tunneling inches in diameter from the body) to poste body) edges of the textended up under he length as the end of the view of the came pale pink and the words approach to the came pale pink and the words are to the came pale pink and the words approach to the came pale pink and the came pale pink and the pale pink and the pale pink and t	ches wide and three inches intinued into Resident #200's ad which was open and large and the could visualize inside under his armpit. It was nes deep to his collarbone ely 1.5 inches wide. The outside of his rib cage and one. The flesh that was visible whitish pink. There were ores located around the red by EMS that this wound essing present when they are staff could not explain why cared for at that time. Teport photographs taken on at the time of Resident #200's are surveyor by Police Officer in #200 had an open wound. The wound could be oximately 1.5 inches wide funneling (Tunneling is when I passageways underneath tim.) could be observed at 12 are was approximately 0.5 from medial (towards the olateral (away from the edges of the tunneling and 1 in anterior (towards the back of the tunneling. This tunneling his armpit an indeterminant the tunneling was outside of era. The wound presented as ound bed had yellow slough the material in the wound bed; be dry. It generally has a soft	F	580		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	surface of the wound that accumulate in the that accumulate in the 10/26/21 at 9:43 AM Resident #200. She Care Nurse at the tirk he was on her casel 9/24/20 the treatmer wound in his left arm stated she informed Resident #200's wow was completing the and that the dressing wound would not staffrom the wound. This recollection and she timeframe she notified The Wound Care Nuinformed her (unable keep an eye on the wound with any chang any treatment. She notifying NP #1 at so that the wound contic Care Nurse reported #200's wound and put reatment to his left at (1/10/21) and it progindicated that a coup #200's death, his left developed an odors the size of a nickel at the wound contic care Nurse reported #200's death, his left developed an odors the size of a nickel at the wound contic case Nurse reported #200's death, his left developed an odors the size of a nickel at the wound contic case Nurse reported #200's death, his left developed an odors the size of a nickel at the wound contic case Nurse reported #200's death, his left developed an odors the size of a nickel at the wound case where the wound case w	in coating, or patchy over the d. It consists of dead cells he wound drainage.). The Wound Care Nurse on stated she remembered stated she was the Wound me he was at the facility, and load. She further stated on the was discontinued to the lipit. The Wound Care Nurse Nurse Practitioner (NP) #1 and was not healed, that she treatment without an order, go she was using on the lipit of this information. The wound information was from her could not recall the exact led NP #1 of this information. The wound and keep her up to lipit she had not ordered stated that she recalled lone point in December 2020 mued to not heal. The Wound lipit she observed Resident rovided the non-ordered larmpit up until his death ressively deteriorated. She oble of days before Resident that armpit wound had she indicated the wound was	F	580		
	the odor that had de concerning to her the	d NP #1 about the size and veloped. She stated it was at the wound had and developed an odor, yet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	She indicated she hawith any other staff at Care Nurse revealed of any communication Resident #200's left at through 1/10/21, and date of the last time so During an interview on Nurse Practitioner #1 Resident #200. She fremembered he had especially under his at #200 had been given different times when she further stated the open very much and small area that was distate in September 2 antibiotic treatment shad gotten better. The interview that indicate Practitioner #1 she without an order and and deteriorated was Practitioner #1. Nurse being notified after So Wound Care Nurse of facility that the wound armpit had opened, of treatments without or resident's wound und she should have been have ordered another treatment and possib treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment. She also so the should have been have ordered another treatment.	ed any care for the wound. If the facility. The Wound she had no documentation in with NP #1 related to armpit wound from 9/24/20 she was unable to provide a she visualized the wound. In 10/26/21 at 10:50 AM stated she remembered further stated she hidradenitis suppurativa arms. She stated Resident antibiotics a couple of the lesions were infected. See areas did not typically were usually raised with a draining. She continued to 020 at the conclusion of his he had been told the wounds are Wound Care Nurse's ed she informed Nurse as completing treatments that the wound had opened shared with Nurse are Practitioner #1 denied ever be the provided and she would in notified and she would	F 5	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag	ge 8	F 5	80		
	Nurse Practitioner # by any staff that [Re opened up or gotten of antibiotics in Sept During an interview Physician #1 stated condition of hidrader problem that was vefurther stated the and underarms would cleand drain. He furthe was open, he would the wound was open would order antibiotit treatment to the area area open to allow it was not made aware Resident #200's left	28/21 which again attested 1 "was not aware or notified sident #200's] wound had worse since the completion ember 2020." on 10/27/21 at 8:58 AM Resident #200 had a nitis which was a chronic ry difficult to control. He eas to Resident #200's ose and then would rupture r stated if one of the wounds want to be made aware that in. The physician indicated he cs to attempt to provide a and he would leave the et of any open areas to armpit and did not know o Resident #200's left armpit				
	During an interview Director of Nursing s required treatment the to the nurse practition stated if the Wound about wound treatment the nurse practitioner about wound care in Nurse could and shout Nursing and escalate wound in question. Since the wound in question wounds to his right to	on 10/27/21 at 1:35 PM the stated if a wound was open or ne wound should be reported oner or doctor. She further Care Nurse had concerns ents, lack of response from er or physician, or concerns general the Wound Care ould inform the Director of the her concerns with the She further stated to her to was admitted with underarm which eventually or of 2020. He also developed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345371	B. WING _		,	C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 836 HOSPITAL 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	her knowledge was a completed in Septem stated up until his demade aware of any a status of his left arms photographs of Reside local police departments stated a wound of the have been reported to physician or Nurse Permade aware of the properties of the propertie	tarm during his stay that to closed and treatment was ober of 2020. She further ath on 1/10/21 she was not concerns about the skin bit. Upon viewing the clent #200 supplied by the cent the Director of Nursing to severity pictured should to herself as well as the ractitioner and she was not resence of that wound. In 10/27/21 at 4:17 PM the she was not aware of any #200's left armpit. She und Care Nurse was to resence of new of the Wound Care Nurse had and was not receiving sysician or nurse practitioner, calated her concerns to the rector of Nursing. She stated see never shared such cented such concerns with the sentified of the immediate at 11:03 AM. On 10/29/21 by provided the following immediate jeopardy	F 5	80			

<u>OLIVILIX</u>	O I OIK MEDIO/ IIKE &	·				<u> </u>	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILE			، ا	2
		345371	B. WING				03/2021
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	03/2021
					36 HOSPITAL DRIVE		
PRUITTHE	ALTH-TRENT				IEW BERN, NC 28560		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
			+		7		
F 500	0 " 15	40	_				
F 580	Continued From page		F	580			
		ctor of Nursing was notified					
	-	r that Resident #200 (whom					
		2021) had a wound under his					
		at the Wound nurse stated					
		g without an order from					
	9/24/20 through 1/10/	21. The Wound nurse					
	stated that she notifie	d the Nurse Practitioner					
	regarding Resident #2	200's open axilla area and					
	the Nurse Practitione	r allegedly stated to the					
	Wound nurse to conti	nue treatments with no					
	order being provided for the treatments. The Wound nurse was unable to provide a date for						
	this notification. The	Nound nurse indicated she					
	provided wound treat	ments to Resident #200					
	without an order from	9/24/21 through 1/10/21.					
	The Nurse Practition	er stated that she was never					
	•	ation related to the open					
	axilla area by the faci						
	•	esident #200. When the					
	wound nurse was ask	ked where the					
		ding treatments and Nurse					
	Practitioner notification	ons were located the wound					
	nurse stated there wa						
		was not an order to treat					
	_	1/10/21. The wound Nurse					
	-	weekly body observations					
	that included wound a						
		wound status for this same					
	•	is no documentation that					
		fied the Nurse Practitioner					
		r treatment of the wound					
		rmpit area. The facility was					
		d nurse was providing					
	treatment without a P	~ ~					
		vare of the Wound nurse's					
	lack of documentation	•					
	measurements of the	wound progression, the					
	Wound nurse was pro	oviding treatments without					
	orders, and the lack of	of notification to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY 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
F 580	Continued From pag physician/nurse prac	ctitioner.	F 5	580		
	noted the resident's as a large open wou extended up inside he could see ribs an body that was not be expired on 1-10-202	e potential to suffer a serious				
	· Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be.					
	body audits on all re 10/27/21. This audit physician/physician of the Director of Heal Managers began ed regarding notification physician extender rimpairments and/or for wound treatment conditions (utilizing the Assessment, Recompange in skin impairs noted. This educationsed Nurse general consequences of the second to the	th Services and/or Nurse ucation on 10/27/21				
	Managers educated Assistants on daily s	th Services and Nurse the Certified Nursing kin checks during personal includes notification to the				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(XX	3) DATE SURVEY COMPLETED
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11700/2021
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580 F 600 SS=K	Nursing assistant will nurse notification. The to the Certified Nursing orientation upon hire. not educated by 10/2 their next scheduled at Alleged date of IJ Re. The credible allegation removal was validated the Immediate Jeopale evidenced by staff into reviews, and observational included information of about newly identified worsening of known with the facility's Immediated 10/29/21 was validated Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriational exploitation as desincludes but is not limic corporal punishment, any physical or chemister the resident's missister in the same statement of the facility of the facility of the facility of the composition of the facility	sident's skin. The Certified utilize a body diagram for is education has been addeding Assistant general Certified Nursing Assistants 8/21 will be educated prior to shift. Important 10/29/21 In for Immediate Jeopardy don 11/2/21 which removed rdy on 10/29/21, as erviews, in-service record tion. The in-services on notifying the physician diskin concerns and wounds. In the Jeopardy removal date of ed. Neglect In Abuse, Neglect, and In right to be free from abuse, atton of resident property, effined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to edical symptoms.	F 5			12/3/21

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTR		COMPL	
			D 14//NO				
NAME OF B	20/4252 02 01/22/452	345371	B. WING _	OTDEETAE		11/0	03/2021
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-TRENT				ITAL DRIVE RN, NC 28560		
				NEW DEI			
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	÷ 13	F 60	00			
	by:			"Cori	rective action will be accomplishe	d	
	(EMT) interviews, and neglected to provide it to a resident by failing monitor an open would	. •		affect Resid			
	failing to notify the ph that progressively det through 1/10/21. Res	or to treating the wound, and ysician of an open wound eriorated from 9/24/20 sident #200 was observed by		reside affect	the facility will identify other ents having the potential to be ted by the same deficient practice		
	with a large tunneling	Services (EMS) on 1/10/21 wound under his left arm at s was for 1 of 3 residents are (Resident #200).		100% the fa	Director of Health Services initiate body audits on all residents with acility on 10/27/21. This audit reveounds without orders or without ician/physician extender notification	in als	
	Wound Care Nurse fa	began on 9/24/20 when the hiled to notify the physician open wound to Resident mpit), administered a		1	sidents have the potential to be		
	to assess and docum Immediate jeopardy v	nt to the wound, and failed ent the status of the wound. was removed on 10/29/21 ded and implemented an		syste	at measures will be put into place of the changes made to ensure that efficient practice will not recur.		
	removal. The facility r a lower scope and se	of Immediate Jeopardy emains out of compliance at verity of "E" (no harm with		and/c	Clinical Competency Coordinator or Nurse Management began ation on 10/27/21 for Licensed	rith.	
		than minimal harm that is dy) to ensure monitoring are effective.		emph servio	es regarding abuse and neglect w nasis on provision of care and ces, wound care including ssment, measurement, and	101	
	Findings included:			notific exten	cation to physician/physician nder. This education included that	t	
	6/20/20 with diagnose	dmitted to the facility on es that included anemia, nt and left knee, stage II		witho	ments were not to be provided out a physician⊡s order and that a ded treatments were to be	II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345371	B. WING		C 11/03/2021
NAME OF PE	ROVIDER OR SUPPLIER	- 12111	 	STREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2021
TO UNIC OF TH	TO VIDEIX OIX OOI I EIEIX			836 HOSPITAL DRIVE	
PRUITTHE	ALTH-TRENT				
				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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 600	Continued From page	· 14	F 60	00	
	Hidradenitis suppurat featuring skin lesions inflammation and infe Resident #200's quar assessment dated 10 assessed as cognitive extensive assistance	with bed mobility and toilet		documented. This education include the failure of the facility, its employe service providers to provide the care necessary to avoid physical harm constitutes neglect. The Licensed N not educated by 10/28/21 will be ed prior to their next scheduled shift. T education has been added to the ge orientation upon hire.	es, or e urses ucated his
	Il pressure ulcers pre- had application of nor pressure ulcer care, a	il hygiene. He had two stage sent upon admission. He n-surgical dressings, and a pressure reducing air. He also had application		The Clinical Competency Coordinate and/or Nurse Managers began educe the Certified Nursing Assistants that failure of the facility, its employees, service providers to provide the care necessary to avoid physical harm constitutes neglect. The Certified Nu	eating the or
	ulcer to his sacral are right buttock. There w to his left armpit. He w resist wound treatmen included to reiterate the	plan dated 11/26/20 planned to have a pressure a, right axilla, and left and vas no mention of a wound vas also care planned to nt care. The interventions he purpose and advantages esident as well as assess his		Assistants not educated by 10/28/2′ be educated prior to their next sched shift. This education has been added the general orientation of certified N Assistants. The Director of Health Services and Nurse Managers have reviewed the wound audit conducted on 10/27/21	I will duled d to ursing
	Review of Resident # Treatment Administra 2020 through January 8/20/20 the physician #200's left inner armp hidradenitis, cleansed apply a dry dressing of were performed per of through 9/15 of 2020 9/24 of 2020. This ord	with normal saline and every day. The treatments rders and he refused on 9/9 and again on 9/17 through der was discontinued on #1 and was transcribed by		reviewed the documentation to ensuresidents with skin impairments had order for treatment to areas with notification to physician and/or physextender of any new /changed skin impairments. The Director of Health Services and Nurse Managers revieresidents with wounds to ensure we documentation including ongoing assessments with wound measuren are currently in place, documented accurately and physician / physician extender notification. Review of	ire an ician wed ekly

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		E SURVEY MPLETED
		345371	B. WING		4	C 1/ 03/2021
NAME OF P	ROVIDER OR SUPPLIER	1	-1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/03/2021
	10115211 011 001 1 21211			836 HOSPITAL DRIVE		
PRUITTHE	ALTH-TRENT					
				NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	e 15	F 60	0		
F 600	A physician note data revealed Resident #2 improved with a cour would resume antibid reoccurred. Review of physician from September 202 no mention of any wo armpit. Review of Resident # between the time of 9 communication was facility staff and Phys Practitioner #1 relate #200's left armpit. A review of Resident assessments from 9/(1/10/21) revealed not his left armpit. The skin check refusals dicheck assessments. A nursing note dated Nurse #5 was alerted change in Resident # immediately respond #200 in his usual (du position, shallow respond with a faint pulse. 91 Resident #200 was folife, cessation of bread Cardiopulmonary Reinitiated. EMS arrived	ed 9/9/20 by Physician #1 200's hidradenitis had se of antibiotics and they offics if the inflammation and nurse practitioner notes 0 through 1/10/21 revealed ound to Resident #200's left #200's chart revealed 2/24/20 through 1/10/21 no documented between the sician #1 or Nurse d to a wound to Resident #200's weekly skin 23/20 to his time of death of documentation of a wound are was no documentation of furing this time on the skin 1/10/21 revealed at 4:45 AM a by Nurse Aide #3 of a #200's breathing. The nurse ed and observed Resident e to contractures) fetal orizations, unresponsive, and 1 was notified by the nurse. ound to be without signs of athing, and no pulse. suscitation (CPR) was d at the facility and called	F 60	documentation identified no resignation without wound documentation at in time and the current wound observations are accurate. The of Health Services and Nurse Mieducated the Licensed Nurses reaccuracy of weekly body observinclude identification of any dress noted or skin impairment noted or resident body. This education has added the License Nurse generatorientation upon hire. License Nurseducated by 10/28/21 will be eduprior to their next scheduled shift. The Director of Health Services Nurse Managers began education 10/27/21 regarding notification to physician and/or physician exter regarding newly identified skin impairments for wound treatment. This education has been added License Nurse general orientation hire. License Nurses not educated 10/28/21 will be educated prior to next scheduled shift. The Director of Health Services Nurse Managers began education 10/27/21 regarding notification to responsible party regarding new identified skin impairments and/or worsening sk	this point Director anagers egarding ations to sing on the as been al urses not ucated t. and/or on on o oder kin at orders. the on upon ed by o their and/or on on o Resident ly or new ducation rse cense 1 will be	
	change in Resident # immediately respond #200 in his usual (du position, shallow respwith a faint pulse. 91 Resident #200 was fulfe, cessation of bread Cardiopulmonary Re	#200's breathing. The nurse ed and observed Resident e to contractures) fetal pirations, unresponsive, and 1 was notified by the nurse. Dound to be without signs of athing, and no pulse. Suscitation (CPR) was dat the facility and called		10/27/21 regarding notification to responsible party regarding new identified skin impairments and/o worsening skin impairments and wound treatment orders. This enhas been added the License Nurgeneral orientation upon hire. Lic Nurses not educated by 10/28/2	o Resident ly or new ducation rse cense 1 will be duled	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDI				С
		345371	B. WING			1	/03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021
					36 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT				IEW BERN, NC 28560		
	OUR MARRY OF	TITLIFUT OF DEFICIENCIES					T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 16	F	600			
		ed 1/10/21 indicated EMS		000	Nurse Managers educated the Certified	4	
		e facility and when they			Nursing Assistants on daily skin checks		
		they found Resident #200 in			during personal care. This education	,	
		oviding CPR. He was			includes notification to the nurse of any	,	
		(cessation of breathing) and			skin impairment and/or new dressing		
	1 -	ch. The nurse (Nurse #5)			noted on resident⊡s skin. The Certified	1	
		Resident #200 not breathing			Nursing assistant will utilize a body		
		e. She called another nurse			diagram for nurse notification. This		
		downstairs unit (the facility			education has been added to the Certif	fied	
	, ,	ay with Resident #200 while			Nursing Assistant general orientation u		
	,	to EMS arrival the resident			hire. Certified Nursing Assistants not	•	
		R was initiated by the staff.			educated by 10/28/21 will be educated		
	· ·	g hole in his left armpit that			prior to their next scheduled shift.		
		agreed by EMS personnel to					
	_	I call time of death in the			The Director of Health Services / Nurse	3	
	facility at 5:02 AM. Th	ne local police department			Managers are reviewing the residents		
	was notified.				weekly skin review to ensure physician	I	
					notification is completed for all new ski	n	
	During an interview of	on 10/28/21 at 1:03 PM			impairments or deteriorating skin		
	Emergency Medical ⁻	Technician (EMT) #1 stated			impairments and ensure the facility, its	;	
	he was at the facility	on 1/10/21 for Resident			employees, or service providers are		
	#200. EMT #1 further	r stated the resident had a			providing the care necessary to avoid		
		to his left underarm and			physical harm that constitutes neglect		
	chest which was abo	ut three inches in length and			This will occur weekly for four weeks the	ien	
	two inches in width. I	He stated there was some			monthly thereafter.		
		ound and it presented as an			The Director of Health Services / Nurse	•	
		I the wound was not a fresh			Managers are reviewing the Certified		
		e appearance of being a			Nurse Aide skin checks completed duri	•	
		present prior to the initiation			resident⊡s personal care, to ensure th		
		n present for some time. This			facility, its employees, or service provide		
		aged and was "wide open."			are providing the care necessary to ave	old	
		e even with Resident #200's			physical harm that constitutes neglect,		
	_	gainst his body the wound			weekly to ensure physician has been	o.r	
	would have been visi	bie to an observer.			notified by the Licensed Nurse of new		
	During on interview -	on 10/29/21 at 2:00 DM ENT			worsening skin impairment. This will on	cui	
		on 10/28/21 at 2:00 PM EMT			weekly for four weeks then monthly thereafter.		
		patched to the facility on arrest for Resident #200.			uicicallei.		
		arrest for Resident #200. a wound to his left armpit			"How the facility plans to monitor its		
		a would to the fell allible	1				1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345371	B. WING _			1	C 03/2021
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021
TO THE OT TH	TO VIDER OR GOLL ELER				6 HOSPITAL DRIVE		
PRUITTHE	ALTH-TRENT				EW BERN, NC 28560		
				141			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 17	F 6	800			
		a golf ball and baseball sized			performance to make sure that solution	าร	
		e did not remember the			are sustained	10	
		eling but that the tunneling					
		le stated at the very least			The Director of Health Services will		
		of depth to this wound's			present the analysis of the Licensed		
	tunneling and noted	some green pus drainage to			Nurse skin review to ensure the facility	, its	
	the wound as well as	bloody clear pink fluid that			employees, or service providers are		
		nat had covered the wound			providing the care necessary to avoid		
		ated the wound was not an			physical harm that constitutes neglect		
		did not present as having			the Quality Assurance and Performance	е	
		sult of CPR. He further			Committee meeting monthly for three		
		earance of a wound that had			months, then quarterly thereafter until s	SIX	
		e some time. He stated he y dressing being in place to			months of continued compliance is sustained.		
		armpit. He could not recall if			sustaineu.		
	there was an odor to				The Director of Health Services will		
	thoro was an oasi to	that Wound.			present the analysis of the weekly		
	During an interview of	on 10/28/21 at 2:00 PM EMT			Certified Nursing Assistant skin check		
		bered walking in Resident			completed during personal care review	to	
		norning of 1/10/21. EMT #3			ensure the facility, its employees, or		
	stated she recalled h	e had a wound to his left			service providers are providing the care	е	
		a. The EMT stated a golf ball			necessary to avoid physical harm that		
		ound due to the depth and			constitutes neglect to the Quality		
		ne further stated she did not			Assurance and Performance Committee		
		nd to the underarm was			meeting monthly for three months, ther	1	
	_	e stated the wound had			quarterly thereafter until six months of		
	~	the wound had some depth			continued compliance is sustained.		
		xactly how deep or the fany. EMT #3 concluded			The Clinical Competency Coordinator	azill	
		ance of the wound to his			present the analyses compliance of	/V 111	
		t believe the wound was a			employee attendance to the education		
		d the appearance of a			provided to the Quality Assurance and		
		present on Resident #200			Performance Committee meeting month	hly	
	for some time.				for three months, then quarterly therea	•	
					until six months of continued compliance		
	The police case narra	ative dated 1/11/21 revealed			is sustained.		
		ved at the facility in response					
		ity on 1/10/21. Police Officer as informed by EMS upon			Date when corrective action will be completed: 12/3/2021		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	I	11100/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 600	based on the decea personnel wanted to Resident #200 had on his left arm that was extended up inside I documented the open bandaged and show were additional sore were smaller but we photographed the brand sores under his as pronounced. During an interview Police Officer #1 standispatch that EMS has respond for an unate He stated he arrived EMS informed him fropen sores on his brand was to his left at the area. The gown was soaked in a pin approximately two ir long. The wound could body towards his he enough of a cavity the resident's body to approximately 4 inchand was approximately 4 inchand was approximately and the ended at his collarbe in the cavity was a very some the sident's was a very was a very some the sident's was a very some the sident was a very	ed to be a case of neglect sed's condition and EMS of ensure a report was on file. One large open wound under "several inches wide and his body." The officer en wound that was not red no signs of care. There is on the resident's side that the still noticeable. The officer ody. There were abrasions right arm as well though not sed no signs of care. There is on the resident's side that the still noticeable. The officer ody. There were abrasions right arm as well though not sed not	F 6	00		
	wound. He was info	ores located around the rmed by EMS that this wound essing present when they be staff could not explain why				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345371	B. WING _			11/0) 3/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 0 836 HOSPITAL DRIVE NEW BERN, NC 28560	CODE	1170	30,2021	
(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 APPROPRIA		(X5) COMPLETION DATE	
F 600	1/10/21 at 5:28 AM a death provided to the #1 revealed Resident under his left armpit. observed to be approand 2 inches long. To a wound has formed the surface of the ski o'clock. The tunneling inches in diameter from center of the body) to center of the body) to center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the total center of the body) to poster body) edges of the center of the body) to poster body) edges of the total center of the body) edges of	report photographs taken on the time of Resident #200's surveyor by Police Officer the #200 had an open wound The wound could be eximately 1.5 inches wide unneling (Tunneling is when passageways underneath in) could be observed at 12 gwas approximately 0.5 om medial (towards the plateral (away from the diges of the tunneling and 1 anterior (towards the front in it in the tunneling was outside of the unneling. This tunneling is armpit an indeterminant the tunneling was outside of the unneling was outsi	F6					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			X3) DATE SURVEY COMPLETED				
		345371	B. WING			44,0	
NAME OF P	ROVIDER OR SUPPLIER	0.001.		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	1 11/0	03/2021
PRUITTHI	EALTH-TRENT			836 HOSPITAL 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	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 600	Continued From page	≥ 20	F	600			
	During an interview of Nurse #5 stated she is the She further stated he who did not like to be stated she did not spepassing away on her (1/10/21). She further open wounds under he remember if it was be concluded she could appearance under his During an interview th 10/26/21 at 9:43 AM Resident #200. She so Care Nurse at the time he was on her caselor refused care at times allow them to do anylother days he would approvided. She indicated wound care to his left the treatment was dissible continued to provide without orders. She is documented this treatment was distincted in the medical through 1/10/21. The about the treatment is she cleaned the would cleanser and patted of dressing. She placed	remembered Resident #200. was a very quiet gentleman bothered. She further ecifically remember him shift or details of that night stated Resident #200 had his arm but could not oth arms or one arm. She not remember the wound's arm or arms. The Wound Care Nurse on stated she remembered stated she was the Wound he he was at the facility, and had. She indicated he he, explaining he would not ching on certain days and hallow treatment to be sted she was providing anderarm and on 9/24/20 continued. She revealed wide care to the wound She was unable to recall his discontinued by the Nurse bund had not improved and at time. She further revealed 100's death (1/10/21) she the discontinued treatment tated she had not timent to the left armpit record from 9/24/20 as Wound Care Nurse spoke the provided. She indicated had with skin integrity wound		500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345371	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER	343371	J	STREET	FADDRESS, CITY, STATE, ZIP CODE	11/	03/2021	
TVAINE OF T	TOVIDER OR GOLT EIER				SPITAL DRIVE			
PRUITTHE	ALTH-TRENT							
				NEWE	BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	e 21	F 6	600				
		ulent drainage and weeping						
		r his left arm. She further						
		ng would not stay on due to						
		wound. She revealed she						
	_	ny assessments or wound						
		left armpit wound for						
		9/24/20 through 1/10/21.						
	The Wound Care Nu	rse stated she informed						
	Nurse Practitioner (N	P) #1 Resident #200's						
	wound was not heale	d, that she was completing						
		an order, and that the						
	_	ng on the wound would not						
	_	ainage from the wound. This						
		her recollection and she						
		xact timeframe she notified						
		tion. The Wound Care						
		t1 informed her (unable to						
		to keep an eye on the						
		up to date with any changes,						
		red any treatment. She						
		ed notifying NP #1 at some						
	-	020 that the wound continued						
		orted NP #1 saw the resident ut had not visualized the						
		pit as it had a dressing over						
	· · · · · · · · · · · · · · · · · · ·	Nurse reported she						
		200's wound and provided						
		ment to his left armpit up						
		21) and it progressively						
	,	icated that a couple of days						
		0's death, his left armpit						
		d an odor. She indicated the						
		of a nickel and was about 0.1						
		e Wound Care Nurse						
		I NP #1 about the size and						
	•	reloped. She stated it was						
	concerning to her tha							
	_	nd developed an odor, yet						
		ed any care for the wound.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345371	B. WING				0
		345371	D. WING			11/	03/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-TRENT				6 HOSPITAL DRIVE EW BERN, NC 28560		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 22	F	600			
	with any other staff at Care Nurse revealed of any communication Resident #200's left at through 1/10/21, and date of the last time s. This interview with the (10/26/21 at 9:43 AM Care Nurse indicated through Friday and erfor the unit would downs not working. She was no physician's or Resident #200's oper) continued. The Wound she worked every Monday very other weekend. Nurses the wound care when she e revealed because there					
	she was not in the fact provided him with treat had not verbally gone them of the dressing	cility would not have atment. She explained she to the nurses and informed change she was doing for armpit wound that was not					
	Nurse Practitioner #1 Resident #200. She fremembered he had especially under his a #200 had been given different times when to She stated he had so believed had been from areas under his arm a for surgical intervention stated when he first a through September of odor from those wour	stated she remembered further stated she hidradenitis suppurativa farms. She stated Resident antibiotics a couple of the lesions were infected. The scarring which she form a past surgery for the fand she offered to refer him fons which he refused. She farrived at the facility in June of 2020, he always had an fads under his arms and the reduced she wounds,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG_		, ا	3
		345371	B. WING				03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-TRENT			8	36 HOSPITAL DRIVE		
				N	NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	had put him on antibreceived clindamycin had Bactrim 6/29/20 8/18/20 through 9/1/7/10/20. Keflex 8/18 further stated these very much and were area that was drainin order the wound treat to his refusals. She refused something estaff were offering the discontinue it. She of September 2020 at treatment she had be gotten better. The Withat indicated she in she was completing and that the wound was shared with Nur Practitioner #1 denies September 2020 by any other staff at the Resident #200's left deteriorated, or was orders. She stated in his left arm had open notified and she worround of antibiotic troto surgery for treatmeshould have been not being done without a Nurse Practitioner # statement dated 10/Nurse Practitioner # by any staff that [Re	She stated at those times she protices. She stated he in 6/26/20 through 7/9/20. He through 7/10/20. Bactrim 20. Keflex 6/26/20 through //20 through 9/1/20. She areas did not typically open a usually raised with a smalling. She stated she did not atment to be discontinued due stated even if a resident every day, she would ensure the treatment and would not continued to state in the conclusion of his antibiotic een told the wounds had found Care Nurse's interview formed Nurse Practitioner #1 treatments without an order thad opened and deteriorated rise Practitioner #1. Nurse and ever being notified after the Wound Care Nurse or a facility that the wound to armpit had opened, receiving treatments without if the resident's wound under med, she should have been all have ordered another eatment and possible referral tent. She also stated she otified the treatments were an order.	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′			(X3) DATE SURVEY COMPLETED	
	345371	B. WING			C	
	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
During an interview of Physician #1 stated F condition of hidraden problem that was ver further stated the are underarms would clo and drain. He further was open, he would the wound was open would order antibiotic treatment to the area area open to allow it was not made aware Resident #200's left at there was a wound to after September 2020 During a follow up int PM Physician #1 state photographs supplied department of the woarmpit that he or his have been made awas severity of such a wo could not say how quone in the photograp further stated he did Resident #200's orde wound on his left arm made the recomment treatment he would he recommendation. He have told the Wound administering a discontent was verified to the would administering a discontent would an ecommendation.	ember 2020." on 10/27/21 at 8:58 AM Resident #200 had a itis which was a chronic y difficult to control. He as to Resident #200's se and then would rupture stated if one of the wounds want to be made aware that . The physician indicated he es to attempt to provide and he would leave the to drain better. He stated he of any open areas to armpit and did not know o Resident #200's left armpit 0. terview on 10/27/21 at 12:33 ted upon review of the d by the local police bund to Resident #200's left nurse practitioner should are of the presence and bund. He further indicated he tickly a wound such as the h could take to develop. He not recall discontinuing ters for treatment to his not but if the nurse had dation to discontinue the lave signed off on their further stated he would not Care Nurse to continue ontinued treatment and did	F 60				
	OVIDER OR SUPPLIER ALTH-TRENT SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page of antibiotics in Septe During an interview of Physician #1 stated foodition of hidraden problem that was ver further stated the are underarms would clo and drain. He further was open, he would the wound was open would order antibiotic treatment to the area area open to allow it was not made aware Resident #200's left at there was a wound to after September 2020 During a follow up int PM Physician #1 stat photographs supplied department of the wo armpit that he or his in have been made awas severity of such a wo could not say how qu one in the photograp further stated he did Resident #200's orde wound on his left arm made the recommen- treatment he would he recommendation. He have told the Wound administering a disco- not believe Nurse Pra requested the Wound	OVIDER OR SUPPLIER	OVIDER OR SUPPLIER ALTH-TRENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 of antibiotics in September 2020." During an interview on 10/27/21 at 8:58 AM Physician #1 stated Resident #200 had a condition of hidradenitis which was a chronic problem that was very difficult to control. He further stated the areas to Resident #200's underarms would close and then would rupture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the area open to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left armpit and did not know there was a wound to Resident #200's left armpit after September 2020. During a follow up interview on 10/27/21 at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left armpit that he or his nurse practitioner should have been made aware of the presence and severity of such a wound. He further indicated he could not say how quickly a wound such as the one in the photograph could take to develop. He further stated he did not recall discontinuing Resident #200's orders for treatment to his wound on his left armpit but if the nurse had made the recommendation to discontinue the treatment he would have signed off on their recommendation. He further stated he would not have told the Wound Care Nurse to continue administering a discontinued treatment and did not believe Nurse Practitioner #1 would have requested the Wound Care Nurse to continue	OVIDER OR SUPPLIER ALTH-TRENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 24 of antibiotics in September 2020.* During an interview on 10/27/21 at 8:58 AM Physician #1 stated Resident #200's underarms would close and then would upture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the ware aopen to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left ampit and did not know there was a wound to Resident #200's left ampit after September 2020. During a follow up interview on 10/27/21 at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left ampit after September 2020. During a follow up interview on 10/27/21 at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left ampit after September 2020. During a follow up interview on 10/27/21 at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left ampit may be upon the photograph could take to develop. He further stated he did not recall discontinuing Resident #200's orders for treatment to his wound on his left ampit but if the nurse had made the recommendation. He further stated he would not have told the Wound Care Nurse to continue administering a discontinued treatment and did not believe Nurse Practitioner #1 would have requested the Wound Care Nurse to continue	OVIDER OR SUPPLIER ALTH-TRENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 Contlinued From page 24 Contlinued From page 24 Continued From page 24 F 600 Continued From pa	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 1/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 836 HOSPITAL DRIVE NEW BERN, NC 28560		1703/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Wound Care Nurse order for treatment He stated he was u developed after his have taken to devel Physician stated he appearance in the pwhy the Wound Cameasurements, trea wound assessment wound. He stated documentation it was when the wound was everity of the wound photographs by the wounds should be chim or the nurse profor wound treatment loss as to why the verquest an order for he nor the nurse proforder for a wound to would not disconting resident even if the treatment except in such as hospice and that criteria at the time. During an interview Nurse Aide #5 stated #200. She stated he did not speak much needs known when stated he would let living care, but he dof the time. She coropen wounds in one	e did not understand why the would not have gotten an of a wound if she had asked. Insure if the wound could have death or how long it would lop such a wound. The efelt the wound had a severe chotographs and did not know the Nurse did not have atment records, and weekly is if she was following the ue to the lack of as impossible to know if or as or was not present or the and until the time of the police department. He stated documented and reported to actitioner if there was a need it. He expressed he was at a Wound Care Nurse did not in treatment because neither actitioner would ever deny an obe treated. He concluded he ue wound treatment to a resident continually refused extenuating circumstances in deciding the wound treatment to a resident #200 did not meet	F	500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345371	B. WING				02/2024
NAME OF PI	ROVIDER OR SUPPLIER	040071	1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 11/0	03/2021
					66 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT			NI	EW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	⊋ 26	F	300			
	wounds because she cleansing around the	she was aware of those had to take care while wound area. She could not are ever dressings on his or not.					
	Nurse Aide #1 stated him leading up to his to one of his armpits like pus." The nurse a Nurse #5 on multiple specific dates) of the and looked at the woreported she had not	she remembered caring for death. She recalled a wound that was oozing "something aide reported she notified occasions (unable to recall oozing and the nurse went und when notified. She recalled seeing the left arm sing on it at any point in the his death.					
	Nurse Aide #2 stated #200 had a wound ur did not remember if the dressings to the would she stated the area with no depth and it had like "pus". This wound	n 10/27/21 at 11:56 AM she remembered Resident nder one of his arms. She nere were ever any nd she noted under his arm. was about the size of a dime nad some drainage that was d was present through the facility to her knowledge.					
	Director of Nursing st required treatment th to the nurse practition to sign off on all treat aware of treatments. treatment should not and if the Wound Car needed to have conti request the order be	n 10/27/21 at 1:35 PM the ated if a wound was open or e wound should be reported her or doctor. The doctor had ments so he would be made She further stated wound be done without an order to Nurse deemed a wound nued treatment, she should continued or changed lation. She further stated if					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTIDENTIFICATION NUMBER: A. BUILDING				DATE SURVEY	
			7 ti Boilebi	_		(C
		345371	B. WING			11/	03/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-TRENT				36 HOSPITAL DRIVE		
	1			N	IEW 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	wound treatments, lanurse practitioner or wound care in general could and should informand escalate her conquestion. She stated #200 was admitted wounderarm which ever of 2020. He also deveram during his stay the closed and treatment september of 2020. Septemb	se had concerns about ck of response from the physician, or concerns about al the Wound Care Nurse orm the Director of Nursing cerns with the wound in to her knowledge, Resident with wounds to his right intually closed in September eloped an area under his left mat to her knowledge was a was completed in She further stated up until his a was not made aware of any kin status of his left armpit. Ind Care Nurse according to continued the order to the left and did not document a	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345371	B. WING			1	02/2024
NAME OF P	ROVIDER OR SUPPLIER	040071		SI	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/0	03/2021
					36 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT				EW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 28	F	500			
	attention from the phy she should have esca Administrator and Dir the Wound Care Nurs	vsician or nurse practitioner, alated her concerns to the ector of Nursing. She stated					
	The Removal Plan: F600 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and						
	by the State Surveyor expired January 10, 2 axilla area (armpit) the she had been treating 9/24/20 through 1/10/stated that she notifier regarding Resident #3 the Nurse Practitione Wound nurse to contifure order being provided Wound nurse was unthis notification. The Nurse Practitione without an order from The Nurse Practitione notified of any informaxilla area by the facithrough 1/10/21 for Residual axilla area for the Nurse Practitioner axilla area by the facithrough 1/10/21 for Residual axilla area for the Nurse Practitioner axilla area by the facithrough 1/10/21 for Residual axilla area for the Nurse Practitioner axilla area by the facithrough 1/10/21 for Residual axilla area for Residual axilla ax	esident #200. When the					
	wound nurse was ask documentation regard	ked where the ding treatments and Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345371	B. WING		,	C I1/ 03/2021	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2321	
(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 E APPROPRIATE	(X5) COMPLETION DATE	
F 600	nurse stated there was document and there was document and there was from 9/24/20 through failed to complete the that included wound a measurements of the period of time. There the wound nurse noti related to the order of identified under the a unaware of the wound treatment without a Plassessments from 9/2 to identify Resident # axilla area. The facility was unawallack of documentation measurements of the Wound nurse was proorders, and the lack of physician/nurse pract unaware of the failure open wound during was from 9/24/20 through. Upon arrival to facility noted the resident's a as a large open wound extended up inside his he could see ribs and body that was not ball expired on 1-10-2021	ons were located the wound as none, she did not was not an order to treat 1/10/21. The wound Nurse weekly body observations assessments and wound status for this same is no documentation that fied the Nurse Practitioner or treatment of the wound rempit area. The facility was donurse was providing thysician order. Weekly skin 24/20 through 1/10/21 failed 200's open wound to the ware of the Wound nurse's not assessment, wound progression, the boxiding treatments without of notification to the ditioner. The facility was the of nurses to identify the weekly skin assessments 1/10/21. If on 1/10/21 the EMS /police axilla area wound condition and under left arm that was its body. Officer documented it collar bone through the indaged. Resident #200	F 6	00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345371	B. WING _			C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	E	11/03/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	process or system f	ne entity will take to alter the ailure to prevent a serious om occurring or recurring, and	F 6	00			
	the State Agency re when she was notifi the axilla (armpit) wo f same. The Wour pending investigation 10/28/21. The wo	completed a 24-hour report to garding neglect on 10/27/21 ed of the concern regarding cound and no documentation and Nurse was suspended on on 10/27/21 and terminated cound Nurse was reported to Board of Nursing on 10/28/21 and ards violations.					
	Nurse Management for Licensed Nurses with emphasis on property wound care including and notification to particular to be provided without all provided treat documented. This efailure of the facility, providers to provide physical harm constant Nurses not educate educated prior to the education has been orientation upon hire.	ducation included that the its employees, or service the care necessary to avoid itutes neglect. The Licensed d by 10/28/21 will be eir next scheduled shift. This added to the general e.					
	Nurse Managers be Nursing Assistants t its employees, or se care necessary to a	tency Coordinator and/or gan educating the Certified hat the failure of the facility, ervice providers to provide the void physical harm constitutes ed Nursing Assistants not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		1110012021
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	their next scheduled been added to the grand Nursing Assistants. The Director of Health body audits on all results or the second of the secon	1 will be educated prior to shift. This education has eneral orientation of certified th Services initiated 100% sidents within the facility on reveals no wounds without visician/physician extender sident is noted without an tin integrity the Director of agers and/or Licensed Nurse an and/or physician extender th Services and/or Nurse ewed the wound audit	Fé	600		
	education has been general orientation u	added the License Nurse pon hire. License Nurses 28/21 will be educated prior to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			
		345371	B. WING			С
	ROVIDER OR SUPPLIER	349371	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560	 E	11/03/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	their next scheduled some process of the Director of Health Managers began eduregarding notification physician extender reimpairments and/or work for wound treatment of been added the Licent orientation upon hire. educated by 10/28/21 their next scheduled some party regarding notification upon hire. educated by 10/28/21 their next scheduled some process of the Director of Health Managers educated the Assistants on daily sk care. This education in nurse of any skin imported on resonution assistant will nurse notification. This to the Certified Nursir orientation upon hire.	shift. In Services and/or Nurse cation on 10/27/21 to physician and/or garding newly identified skin orsening skin impairments orders. This education has see Nurse general License Nurses not will be educated prior to shift. In Services and/or Nurse cation on 10/27/21 to Resident responsible identified skin impairments in impairments and new ers. This education has see Nurse general License Nurses not will be educated prior to shift. In Services and Nurse he Certified Nursing in checks during personal includes notification to the airment and/or new dident's skin. The Certified utilize a body diagram for seeducation has been added by Assistant general Certified Nursing Assistants (3/21 will be educated prior to shift.	F6	600		

PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		0.45074				С	
		345371	B. WING _		11/0	03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 607 SS=D	removal was validated the Immediate Jeopan evidenced by staff into reviews, and observation included information cassessments, wound care treatments according wound assessments, notification of wounds physician or the physician or the physician of the physician	n for Immediate Jeopardy d on 11/2/21 which removed rdy on 10/29/21, as erviews, in-service record tion. The in-services on abuse and neglect, skin care documentation, wound rding to physician orders, wound measurements, and and skin conditions to the ician's extender. Ite Jeopardy removal date of ed. buse/Neglect Policies -(3)		607		12/3/21	
	§483.12(b)(1) Prohibit neglect, and exploitate misappropriation of results in the same of	t and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures		"How corrective action will be accomplished for those residents for have been affected by the deficient practice. Resident # 200 no longer resides in facility.			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ` '		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _		11/	03/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				836 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT			NEW BERN, NC 28560		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG	`	NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 607	Continued From pa	ge 34	F 60	07		
	Findings included:			The Administrator completed		
	A review of the abu	se prevention and reporting		report to the State Agency re neglect on 10/27/21 when sh		
		re of the facility dated 9/2012		notified of the concern regard		
		as the failure to provide goods		wound and no documentation	-	
		sary to avoid harm, mental		The Wound Nurse was susp		
		illness. Anyone witnessing,		pending investigation on 10/2		
	suspecting, or hearing an allegation of neglect of			terminated on 10/28/21. The		
		immediately report this to the		was reported to the North Ca	arolina Board	
	administrator wheth	ner the administrator was on		of Nursing on 10/28/2021 fo	r professional	
the premises or not. The Administrator would standards violations.						
		ion and implement measures				
	-	e the safety and protection of		"How the facility will identify o		
		the actual or alleged		residents having the potentia		
		event the administrator had		affected by the same deficier	nt practice.	
	_	resident had been neglected,		All	:-14- 6-	
		ould report to the department h and appropriate law		All residents have the potent affected.	iai to be	
		ry. A 24-hour report was to be		allected.		
	_	ed to the appropriate health		"What measures will be put i	nto place or	
		epartment complaint division.		systemic changes made to e		
	raomity rogalation at	oparament complaint arriolom		the deficient practice will not		
	Resident #200 was	admitted to the facility on				
		oses that included anemia,		The Clinical Competency Co	ordinator	
	contracture of the ri	ight and left knee, stage II		and/or Nurse Management b	egan	
	pressure ulcers of t	he right and left buttock, and		education on 10/27/21 for Lic		
	Hidradenitis suppur	rativa (a chronic skin condition		Nurses regarding abuse and		
	_	ns which develop because of		emphasis on provision of car		
	inflammation and in	nfection of sweat glands).		services, wound care including	-	
	D			assessment, measurement,		
		arterly minimum data set		notification to physician/phys		
		10/22/20 revealed he was		extender and notification to the		
		ively intact. He had two stage		Administrator. This education		
	n pressure dicers p	resent upon admission.		that treatments were not to b without a physician □s order	•	
	Review of Resident	t #200's Treatment Orders and		provided treatments were to		
		tration Records indicated		documented. This education		
		a treatment order for a left		the failure of the facility, its e		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		245274	B WING			С	
		345371	B. WING _			11/03/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
PRIJITTHE	ALTH-TRENT			836 HOSPITAL DRIVE			
FROITINE	ALIII-IIXLIII			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	: 35	F 6	507			
F 607	inner armpit cyst that 9/24/20. There were related to his left arm the medical record rethe wound to his left a 1/10/21. There were reasurements of the was made to the wou Practitioner (NP) note. A nursing note dated Nurse #5 was alerted change in Resident # immediately responde #200 in his usual (due position, shallow resp with a faint pulse. 911 Resident #200 was folife, cessation of brea Cardiopulmonary Resinitiated. EMS arrived time of death at 5:02 and the had a large gaping was bleeding. It was a discontinue CPR and facility at 5:02 AM. The was notified. During an interview of Emergency Medical The was at the facility of #200. EMT #1 further	was discontinued on no orders after 9/24/20 bit wound. Further review of wealed no documentation of armpit from 9/24/20 through no assessments or wound and no reference and in the physician or Nurse is. 1/10/21 revealed at 4:45 AM by Nurse Aide #3 of a 200's breathing. The nurse and observed Resident et to contractures) fetal irrations, unresponsive, and was notified by the nurse. Fund to be without signs of thing, and no pulse. Suscitation (CPR) was at the facility and called	F 6	service providers to provide to necessary to avoid physical hands to the Administrator. The Lice not educated by 11/30/21 will prior to their next scheduled education has been added to orientation upon hire. The Clinical Competency Coland/or Nurse Managers begathe Certified Nursing Assistant Nurses, and ancillary staff the facility, its employees, providers to provide the care avoid physical harm constitute and must be reported to the per policy. The Certified Nurse Assistants, Licensed Nurses staff not educated by 11/30/2 educated prior to their next shift. This education has been the general orientation of Cell Nursing Assistants. The Administrator maintains identifies allegations of abuse time reported to the Administic date and time reported to the Agency. This log is reviewed Corporate Consultant monthly accuracy in timely reporting. "How the facility plans to more performance to make sure the are sustained."	be reported ensed Nurses I be educated shift. This of the general cordinator an educating ants, Licensed at the failure or service necessary to be necessary t		
	two inches in width. H	ut three inches in length and le stated there was some und and it presented as an		The Clinical Competency Copresent the analysis of educa			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345371	R WING	B. WING		С	
		345371	B. WING _			11/03/2021	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
PRUITTHE	ALTH-TRENT			836 HOSPITAL DRIVE			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			NEW BERN, NC 28560			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From pag	e 36	F 6	507			
F 607	old wound. He stated laceration but had the wound that had beer of CPR and had beer wound was not band. He continued to state left arm being held a would have been vis. During an interview of #2 stated he was dis 1/10/21 for a cardiace. The EMTs identified that was in-between opening. He stated he diameter of the tunned could be observed. Here was two inchest tunneling and noted the wound as well as was on the blanket the as well. He further stacute laceration and acute trauma as a restated it had the app been present for quit did not remember and the wound on his left there was an odor to During an interview of #3 stated she remem #200's room on the restated she recalled he armpit and chest are would have fit the wo size of the wound. Si	d the wound was not a fresh e appearance of being a n present prior to the initiation n present for some time. This laged and was "wide open." e even with Resident #200's gainst his body the wound ible to an observer. on 10/28/21 at 2:00 PM EMT patched to the facility on a arrest for Resident #200. a wound to his left armpit a golf ball and baseball sized and did not remember the seling but that the tunneling he stated at the very least as of depth to this wound's some green pus drainage to a bloody clear pink fluid that mat had covered the wound atted the wound was not an did not present as having sell of CPR. He further earance of a wound that had the some time. He stated he my dressing being in place to a armpit. He could not recall if	F 6	compliance of the Licenser Certified Nursing Assistants Staff regarding abuse report Quality Assurance and Perf Committee monthly until the sustained compliance is made quarterly thereafter. The Corporate Consultant panalysis of timely reporting Quality Assurance and Perf Improvement Committee mathree months of sustained of maintained then quarterly in "Include dates when correct be completed. 12/3/2021	s, and ancillary rting to the formance ree months of aintained then presents their to the facilities formance conthly until compliance is thereafter.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345371	B. WING _	B. WING		C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 836 HOSPITAL DRIVE NEW BERN, NC 28560	CODE	11700/2021	
(X4) ID PREFIX TAG			ID PREFII TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 607	but could not recall e amount of tunneling based on the appear underarm she did no result of CPR and ha wound that had beer for some time. The police case narr Police Officer #1 arri to a death in the facil #1 documented he warrival that it appears based on the decease personnel wanted to Resident #200 had on his left arm that was extended up inside he documented the ope bandaged and show were additional sores were smaller but were photographed the boand sores under his as pronounced. During an interview of Police Officer #1 stated dispatch that EMS have respond for an unatter the stated he arrived EMS informed him Respond for manual treatment of the page of the page of the stated he arrived EMS informed him Respond for the stated he arrived EMS informed him	the wound had some depth exactly how deep or the if any. EMT #3 concluded rance of the wound to his it believe the wound was a red the appearance of a represent on Resident #200 rative dated 1/11/21 revealed red at the facility in response lity on 1/10/21. Police Officer ras informed by EMS uponed to be a case of neglect red's condition and EMS rensure a report was on file. The series of the	F	607			
	when they took off hi sore was to his left a the area. The gown t was soaked in a pink	s gown. The most notable rmpit. The officer observed that was around that area to fluid. The wound was ches wide and three inches					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
345371 B. WING		C 11/03/2021	
PRUITTHEALTH-TRENT 836	REET ADDRESS, CITY, STATE, ZIP CODE 6 HOSPITAL DRIVE EW BERN, NC 28560	11/03/2021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. Review of the police report photographs taken on 1/10/21 at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/00/2021
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	that accumulate in the During an interview Nurse #5 stated she She further stated she remember him pass details of that night. #200 had open woun not remember if it wo Nurse #5 could not rappearance under him present when he die concerns with negle came and asked for was not unusual for code and death. She of the EMT and police Resident #200. During an interview Nurse #6 stated she She further stated she She further stated she She further stated she wounds were. She came to the facility of and was not made a concerns of neglect During an interview Director of Nursing saware by EMS, police concerns of neglect death. She further streport and police phores.	d. It consists of dead cells he wound drainage.). on 10/26/21 at 3:17 PM remembered Resident #200. He did not specifically ing away on her shift or She further stated Resident hads under his arm but could as both arms or one arm. Hemember the wound is arm or arms or if they were ad, and she did not have ct. She concluded the police a few things and left and it police to be called following a de indicated she was unaware the concerns with neglect for the membered Resident #200. He did not really remember the initiated CPR on Resident away. She stated she could aving wounds under his arms visualize or see how deep the was unaware the police for 1/10/21 for Resident #200 ware the EMT and police for the resident.	Fé	907		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345371	B. WING		C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/00/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 607	open because she fereported something to police photograph. Something to police photograph. Some something to concerns of neglect for stated what the staff from the police reports on she believed the voto CPR. During an interview of Administrator stated and report abuse and made aware of Reside concerns identified by Department, her staff reported these concerns why staff did not have further stated based to her by the Director interview with the staff wound care nurse, we 24-hour report for residence in the control of the policy of the poli	#200's left armpit was not lt her staff would have of the severity pictured in the he stated this was the the staff did not report any or Resident #200. She saw versus what the photos it showed were very different, wound had not opened prior on 10/28/21 at 9:32 AM the staff were trained to identify it neglect and upon being lent #200's status and the y EMS and the Police if should have identified and erns and she did not know the concerns with neglect. She con the information provided it of Nursing, following her te, she had suspended the as currently submitting a sident neglect, and initiated a in audit on all residents. A gith of time untreated, not	F 6	07		
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation		F 6-	"How corrective action will be accomplished for those residents foun have been affected by the deficient	12/3/21 d to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345371	B. WING			C 11/03/2021		
NAME OF P	ROVIDER OR SUPPLIER	5.65.1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021	
TVAIVIL OF T	TOVIDER OR OUT FIER				36 HOSPITAL DRIVE			
PRUITTHE	ALTH-TRENT							
				IN	IEW BERN, NC 28560			
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENC REGULATORY OR	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 641	Continued From pag	e 41	F	641				
	areas of alarms (Res	sident #43), Pre-Admission			practice.			
	Screening Resident	Review (PASARR) (Resident						
	#65) and speech (Re	esident #3) for 3 of 25			Resident # 43 MDS assessment has b	een		
	residents whose MDS were reviewed.				updated to reflect the use of a wander			
					elopement alarm.			
	Findings included:				Resident # 3 no longer resides in the facility.			
	1. Resident #43 was	admitted to the facility on			Resident # 65 MDS assessment has b	een		
	06/29/2015 with a dia	agnoses of aphasia (loss of			updated to reflect the state level PASA	RR		
	ability to express or t	understand speech due to			2 process to have a serious mental hea	alth		
	brain damage).				illness or related condition.			
	A review of Resident #43's quarterly MDS							
	assessment dated 08/18/2021 revealed Resident				"How the facility will identify other			
	#43 had both short and long term memory				residents having the potential to be			
	problems. He demor				affected by the same deficient practice			
	-	physical behaviors directed						
		lays of the 7 day look back			On 11/18/2021 the Interdisciplinary Tea	ım		
	•	ment. Resident #43 had no			began reviewing 100% of the MDS			
	_	s during the assessment			assessments to validate accuracy of th			
		pendent with locomotion on			assessments, areas identified have be	en		
		staff set up. He used a mobility. Resident #43 did			corrected.			
	not use a wander/eld	•			"What measures will be put into place	or		
	not use a wander/eit	решеш ааш.			systemic changes made to ensure that			
	A review of the quart	terly elonement risk			the deficient practice will not recur.			
	•	dent #43 dated 8/18/2021			are denoted practice will not recul.			
		nigh risk for wandering and			The Interdisciplinary team will be			
	continued the wande				educated on 11/24/2021 by the Clinica	l		
		gaa.a p.og.a			Reimbursement Consultant regarding			
	A review of Resident	t #43's current care plan last			accuracy of MDS Assessments. This			
		21 revealed a focus area			education has been added to the gene	ral		
		15 of wandering. The goal			orientation for all newly hired			
		3 to wander safely within			Interdisciplinary Team members.			
		s. An intervention was wander						
	guard to right wrist.				The Case Mix Director and			
	-				Interdisciplinary team is reviewing all M	IDS		
	On 10/27/2021 at 2:2	28 PM an observation of			assessments for accuracy prior to sign			
	Resident #43 reveale	ed he had a wander			as correct and submitting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345371	B. WING_	B. WING		C 11/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021
					36 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT				EW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	Continued From page 42					
	guard/elopement alar right wrist. An attemp at that time was unsu	m bracelet present on his t to interview Resident #43 ccessful.			The Social Service Director with the Interdisciplinary team review admission readmission MDS□s to ensure the behaviors / changes in behavior are	ı /	
	MDS nurse indicated section of Resident # 08/18/2021 indicating wander/elopement al: #43 had been using a the time of the assess	9 PM an interview with the she completed the alarm 43's MDS assessment dated he did not use a arm. She stated Resident a wander/elopement alarm at sment and she completed ely. She went on to say she			accuracy assessed. The Clinical Reimbursement Consulta will review the new / readmission, quarterly, annual, significant change assessments for accuracy of coding weekly for four weeks, bi-weekly for tw months, and monthly for three months.	o	
	Director of Nursing (D	3 AM an interview with the DON) indicated resident's nould accurately reflect their ney were receiving.			"How the facility plans to monitor its performance to make sure that solutior are sustained.	ıs	
	09/19/2018 with diaground psychotic disorder with physiological condition disorder. Review of Resident # revealed he had a lever psychological condition of the provided he had a lever psychological	vel II Preadmission ent Review (PASARR) dated			The Case Mix Director will present the analysis of the Clinical Reimbursement Consultant review to the Quality Assurance and Performance Committee meeting monthly for review and revision as needed. The analysis will be present monthly until three months of sustained compliance then quarterly thereafter.	ee ns nted	
	for Resident #65 date was not currently con PASARR process to I or related condition. F moderately impaired. delusions, or behavio period for this assess				"Include dates when corrective action was be completed. 12/3/2021	vill	
	On 10/28/2021 at 1:3	8 PM an interview with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345371	B. WING	B. WING		C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	Resident #65 had be level II PASARR produmental illness or relation on 10/28/2021 at 1:4 MDS nurse stated ship section of Resident # indicating he was not state level II PASARF mental illness or relation say this was incorrective. On 10/29/2021 at 9:5 Director of Nursing (I MDS assessments ship status and the care the 3. Resident # 3 was a 3/4/21. Her diagnose subdural hemorrhage receptive-expressive. The quarterly Minimum 10/18/21 indicated Rewas understood and She was coded as mental illness or relation.	I worker (SW) indicated en determined by the state cess to have a serious ted condition on 07/02/2019. If PM in an interview the see completed the PASARR (65's MDS dated 07/30/2021 to currently considered by the R process to have a serious ted condition. She went on to set and she must have missed (33 AM an interview with the DON) indicated resident's hould accurately reflect their hey were receiving. Admitted to the facility on se included traumatic e and mixed language disorder. Im Data Set (MDS) dated esident #3 had clear speech, was able to understand.	F 6	·			
	Manager (CDM) date interviewed Resident dislikes, she can nod is she really understa A review if the dental	en by the Certified Dietary ed 3/8/21 reported the CDM : #3 on "3/5/21 for likes and I her head yes /no but unsure ands the question." exam documentation 1 read "Denies pain by					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	stated during the results assessment the Rest The SW said Resider and she pointed, but Resident #3 speak at On 10/28/2110:15 At she completed the completed the completed the completed the complete and the resident did softly. She added Fibut could not carry to On 10/28/21 from 10 MDS nurse was obstanded to speak at the complete and the resident #3 to speak agrunting noise, but is During the observation resident on different words but the resident the words. On 10/28/21 at 10:3 had worked with Rehad never heard her was on her assing Nurse #7 worked. In heard Resident #3 single Polymer Polyme	PM the Social Worker (SW) sident's quarterly sident #3 did not speak to her. ent #3 could nod her head a she had never heard a word. M the MDS nurse reported quarterly MDS dated 10/18/21 speak to her, but it was desident #3 could say words on a conversation. D:17 AM until 10:30 AM the erved to attempt to get k. Resident #3 made a she was not able to speak. On the MDS nurse asked the attempts to say 3 different ent was not able to say any of the sident #3 many times and a speak. O AM Nurse Aid #6 stated she sident #3 numerous times as gnment on the days when Nurse #7 said she had never	F 6	41		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345371	B. WING			C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 644 SS=E	CFR(s): 483.20(e)(1) §483.20(e) Coordinat A facility must coordin pre-admission screer (PASARR) program to of this part to the may avoid duplicative test includes: §483.20(e)(1)Incorpo from the PASARR lev PASARR evaluation to assessment, care placare. §483.20(e)(2) Referri all residents with new serious mental disord related condition for I a significant change i This REQUIREMENT by: Based on record rev physician interviews to follow-up psychiatric accordance with Pre- Resident Review (PA and evaluation report failed to incorporate to the resident's compre residents reviewed for #65) Findings included: Resident #65 was ad 09/19/2018 with diag	ion. In the assessments with the string and resident review ander Medicaid in subpart C kimum extent practicable to sing and effort. Coordination arating the recommendations are II determination and the report into a resident's nning, and transitions of all level II residents and are vigevident or possible ler, intellectual disability, or a level II resident review upon	F 6	"How corrective action will be accomplished for those reside have been affected by the depractice. Resident #65 was referred to Health for psychiatric service 65 stated he was feeling well psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric will identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021. Resident # 65 care plaupdated to identify the psychiatric services on Nove 2021.	ents found to efficient the Mental es. Resident # I and refused mber 2, in has been iatric refusal.	12/3/21	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDII	_			С
		345371	B. WING _			11/03/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIUTTU	ALTIL TOPNT			83	36 HOSPITAL DRIVE		
PRUITIHE	EALTH-TRENT			N	IEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 644	Continued From page	e 46	F	344			
		wn physiological condition			The Social Service Director and MDS		
	and paranoid persona				Coordinator have reviewed 100% of all		
	' '	,			PASARR level 2□s to ensure all		
	Review of Resident #	65's PASARR level II			recommendations have been followed		
		ation dated 07/02/2019			and corrected as indicated.		
		essed to be a PASARR level					
		evealed this PASARR level II			"What measures will be put into place of		
	determination had no	Resident #65 was to receive			systemic changes made to ensure that the deficient practice will not recur.		
		services by a psychiatrist.			the delicient practice will not recur.		
	lonon up poyoniamo	eervieee by a peyermanien			The Administrator educated the Social		
	A review of the annua	al Minimum Data Set (MDS)			Services Director and Case Mix		
	assessment for Resid	dent #65 dated 07/30/2021			Coordinator regarding PASARR □s Lev	el 2	
	revealed he was asse				and psychiatric service referrals and		
	PASARR. Resident #	_			comprehensive care plan reviews. Thi		
		He had no hallucinations,			education has been added to the gene		
		ors in the 7-day look back			orientation for newly hired Social works	ers	
	not receiving psychol	ment. He was assessed as			and the Interdisciplinary team. 11/23/2021		
	Hot receiving psychol	ogical therapy.			11/23/2021		
	A review of Resident	#65's current care plan			The Administrator is conducting weekly	1	
	dated 10/15/2021 rev	ealed he was not care			reviews of Level 2 PASARRS weekly for	or	
	planned for his level	II PASARR status.			four weeks then bi-weekly for four wee	ks	
		#051 P			then monthly until three months of		
	A review of Resident				sustained compliance is maintained, th	en	
		peen seen for psychiatric atrist during his stay in the			quarterly thereafter.		
	facility following the F	- ·					
		ation dated 07/02/2019.			"How the facility plans to monitor its		
					performance to make sure that solution	าร	
	On 10/29/2021 at 8:0	8 AM an interview with			are sustained.		
	Resident #65 indicated he recalled seeing a						
		ears ago but did not think he			The Administrator will present the analy	ysis	
		ist since his admission to the			of the Level 2 PASARR review to the		
	-	was feeling well and not			Quality Assurance and Performance		
	having any problems				Improvement Committee for review and		
	On 10/20/2021 at 0:1	7 AM an interview with			revisions, monthly until three months o sustained compliance is maintained the		
		worker (SW) indicated she			guarterly thereafter.	-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345371	B. WING			C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 644	Notification letter for 07/02/2019 with no eshe should have obta from Resident #65's peseen by a psychia reviewed Resident #6 could find no evidence been obtained for Resident and would do so now Resident #65's level recommendations shinto his comprehensive On 10/29/2021 at 9:50 Director of Nursing (Dexpect Resident #65' recommendations to comprehensive plane interview on 10/29/205 further indicated Resifollowed through with Resident #65 to be sepsychiatric services. On 10/29/2021 at 10: with Resident #65's fa #1) indicated if the Particular psychiatric than a referral for psychave been obtained. No history of self-harm further indicated he direceiving psychiatric	R level II Determination Resident #65 dated xpiration date. She stated ained a psychiatric referral chysician for Resident #65 to trist. She stated she 65's medical record and the a psychiatric referral had sident #65. She further know why she had not the referral for Resident #65 the SW reported II PASARR determination ould have been incorporated the plan of care. If AM in an interview the DON) indicated she would as level II PASAAR be incorporated into his of care. In a follow-up tident #65's SW should have to obtaining a referral for the short should have to obtaining a referral for the short should have to obtain the short short should have to obtain the short short short short short the short short short short short short the short short short short short short the short short short short short the short short short the short short short the short short short the short short	F 64	"Include dates when corrective be completed. 12/3/2021	e action will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245274	B. WING			С		
		345371	B. WING			11/	03/2021	
	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 36 HOSPITAL 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 644	Administrator indicate determination that Re		F	644				
F 656 SS=E	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each res- resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identifiassessment. The con- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483 provided due to the re under §483.10, include treatment under §483 (iii) Any specialized ser provide as a result of recommendations. If findings of the PASAF rationale in the reside	cility must develop and hensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive aprehensive care plan must great to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 8.10(c)(6). ervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its	F	656			12/3/21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345371		A. BUILDING	(X3) DATE SURVEY COMPLETED		
		B. WING		C 11/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/03/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETIO
F 656	desired outcomes. (B) The resident's properties of the resident of the requirements of the recurrent of the requirements of the resident of the requirements of the requirements of the requirements of the resident of the requirements of the requirements of the resident of the requirements of the resident of the requirements of the resident	reference and potential for cilities must document the desire to return to the dessed and any referrals to desire and/or other appropriate dose. In the comprehensive care, in accordance with the thin paragraph (c) of this This not met as evidenced dons, resident and stafford review the facility failed to desive individualized plans of advance directives (Resident disident #98), epilepsy/seizures distent #98), epilepsy/seizures desure ulcers (Resident #79), and contracture (Resident dents reviewed for deplans. Findings included: It admitted to the facility on desest that included acute dents is heard the loudest) and dobserve pacemaker site for pain as needed.	F 65	"How corrective action will be accomplished for those residents for have been affected by the deficient practice. The Interdisciplinary Team has updathe Comprehensive Care plans for resident #52, #98, #65, #95, #74,#75 to reflect the resident person-center care. "How the facility will identify other residents having the potential to be affected by the same deficient praction. The Interdisciplinary Team conducter review of 100% resident care plans to comprehensive person-centered care plans. Resident comprehensive care plans have been updated as indicated." What measures will be put into place systemic changes made to ensure the	ted 9, #80 ed ce. d a for e e ed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24F274 P. WINC				С		
		345371	B. WING _			11/	/03/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PRIJITTHE	EALTH-TRENT			83	36 HOSPITAL DRIVE			
1 10111111	-ALIII-IIILIII			N	EW BERN, NC 28560			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page 50 F #74 was severely cognitively impaired. Per MDS			356				
					the deficient practice will not recur.			
		gnosis of heart failure.			'			
					The Clinical Reimbursement Consulta	nt		
	The active care plan,	last reviewed on 8/29/2021,			has educated the Interdisciplinary tear	n on		
		o care plan that addressed			11/24/21 regarding comprehensive			
	Resident #74's pace	maker.			person-centered care plans. This			
					education has been added to the gene			
		cation Administration Record			orientation of newly hired Interdisciplin	ary		
		ober 2021 revealed Resident			Team members.			
	1	er for apical pulses remained			The Clinical Deimburgement Consults	n.t		
	active and were com	pieted as ordered.			The Clinical Reimbursement Consultar will review the baseline care plans of r			
	During an interview v	with the MDS Nurse on			admissions for development of a person			
	During an interview with the MDS Nurse on 10/28/2021 at 2:00 pm, she stated she was				center care plan and comprehensive c			
		had a pacemaker. The MDS			plans developed on admission, annual			
	I .	I Resident #74's pacemaker			and with significant changes.	,		
		n his care plan and that this						
	should have been ad	ldressed.			"How the facility plans to monitor its			
					performance to make sure that solution	าร		
		:14 am during an interview			are sustained.			
		ng (DON) stated Resident						
		ould have been addressed			The Clinical Reimbursement Consultar			
	on the care plan.				will provide the facility Quality Assuran			
	2 Resident #05 was	admitted on 9/23/2021 to the			and Performance Committee meeting analysis of their review of the baseline			
		s that included chronic			and initial / annual / significant change			
	obstructive pulmonar				person centered care plan review monthly			
	obstructive pullional	y disease (OOI D).			until three consecutive months of	uny		
	The admission Minim	num Data Set (MDS)			compliance is sustained then quarterly	,		
		0/14/2021 revealed Resident			thereafter.			
	#95 was severely co	gnitively impaired. He						
	required extensive as	ssistance of 1 with all						
	activities of daily livin				"Dates when corrective action will be			
	independent with me	als.			completed. 12/3/2021			
	The active care plan,	initiated on 9/29/2021,						
	revealed there was n							
	addressed Resident							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	10/28/2021 at 2:00 p	e 51 vith the MDS Nurse on m, she stated she thought for Resident #95' s ADL care.	F6	656		
	She stated it was an have been a care pla	oversite and there should n to address his needs.				
	Nursing stated the M for the care plans. She known how he was make further stated the	DS Nurse was responsible ne then stated she had not nissed for an ADL care plan. ere should have been a care dent #95's daily ADL needs.				
	3. Resident #80 was admitted to the facility on 11/01/2016 with diagnoses that included cerebrovascular disease affecting the left non-dominant side.					
	A record review rever contracture on 2/19/2	aled a diagnosis of left hand 2019.				
	severely cognitively in	om Data Set (MDS) 0/08/2021 revealed she was mpaired. Per MDS she had on one side of the upper				
		last reviewed on 8/29/2021, are that addressed Resident acture.				
	was resting in bed wi covers. Her left hand position. She stated s hand or use the left a	n and interview with 27/2021 at 10:00 am, she th her left arm outside of the was noted to be in a closed she could not open her left arm. She then stated her been in that condition for a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (836 HOSPITAL DRIVE NEW BERN, NC 28560	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	The state of the s	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	during an interview s had a left hand contr it was addressed on	ed on 10/28/2021 at 2:00 pm he was aware Resident #80 acture. She said she thought the care plan. The care plan	Fé	656		
	was reviewed with the MDS Nurse and she verified it was not on the care plan and that it should have been. During the interview with the Director of Nursing on 10/28/2021 at 11:14 am she stated the MDS Nurse was responsible for the care plans. She said Resident #80's care plan should have included her left hand contracture. 4. Resident #98 was admitted to the facility on 6/10/21 with diagnoses which included epilepsy disorder and schizophrenia.					
	(MDS) dated 10/15/2 cognitively intact and supervision for most	was independent or activities of daily living.				
	Resident #98 last rev	ehensive care plan for vised 10/15/21 revealed no n or focus for schizophrenia /.				
	MDS Nurse revealed entering the care pla Resident #98 should	7/21 at 8:13 AM with the she was responsible for n information. She stated have been care planned for tial for seizures and she had				
		9/21 at 11:51 AM with the ed it was her belief that care urate.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	•	11/03/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 656	9/30/21 with diagnorm Mellitus and a stage Mellitus and a stage Resident #79's adm (MDS) dated 9/30/2 cognitive impairment on staff for activities to have had a stage was present on administrator and Review of the compart Resident #79 last recare plan intervention ulcers. An interview on 10/MDS Nurse reveale entering the care plan intervention and pressure ulcers and An interview on 10/Administrator reveal plans should be accepted as should be accepted for the plans of the plans o	s admitted to the facility on bees which included Diabetes at 2 sacral pressure ulcer. Inission Minimum Data Set at 12 revealed he had severe at 12 and was totally dependent as of daily living. He was coded at 2 sacral pressure ulcer that 13 and 14 and 15 and 16 and	F 6	<u> </u>		
	The October 2021 Resident #52 had a The quarterly Minin 10/19/21 revealed I	Physician orders indicated no Not Resuscitate status. The Not Resuscitate status of the Not Resuscitate status of the Not Resuscitate status. The Not Resuscitate status of the Not Resuscitate status of the Not Resuscitate status of the Not Resuscitate status.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	'	11/00/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	total assistance with The current care platwo different code s been initiated on 6/5 "wishes to be a full which had been initi Resident #52 had "Nesuscitate), allow resuscitation." Both nurse on 9/4/21 and plans. On 10/28/21 the ME was a DNR and not added the care plan code problem shoul plan. She said the both DNR and full c 7. Resident #65 was 09/19/2018 a diagnormal medical milling and the complete should be a complete should be a complete should be should b	She required extensive or activities of daily living. In revealed Resident #52 had tatuses. One care plan had 5/19 and noted Resident #52 code." Another care plan ated on 7/22/21 noted vishes to be a DNR (Do Not natural death, do not attempt had been edited by the MDS I continued to be active care OS nurse stated Resident #52 a full code. The MDS nurse had an error because the full d not be on the current care care plan should not have ode. Is admitted to the facility on cosis of seizures. In Data Set assessment #65 dated 07/30/2021 on was moderately impaired. Pepilepsy was listed in the sician's orders for Resident ent order for levetiracetam (an cation to treat seizures) 500 a twice daily last initiated on the care plan for Resident #65 evealed no identification or	F6	56		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	345371		B. WING		C 11/03/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/00/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 677 SS=D	On 10/28/2021 1:13 MDS nurse indicate diagnosis of seizure have been incorpora plan of care. On 10/29/2021 at 9 Director of Nursing expect Resident #6 be incorporated in hocare. ADL Care Provided CFR(s): 483.24(a)(2) A resout activities of daily services to maintain personal and oral hymbolic tresident and staff in provide nail care for activities of daily living Resident #80) Findings included: 1. Resident #90 was 10/02/2020 with dia (paralysis on one sinon-traumatic intractint the brain), must (tightening of the mit joints to become versident value in the seident value in the seident value in the mit joints to become versident in to the seident value in the seident value v	a PM an interview with the d Resident #65 had a es. She stated this should ated in his comprehensive 251 AM an interview with the (DON) indicated she would es's diagnosis of seizures to ais comprehensive plan of for Dependent Residents 2) ident who is unable to carry a living receives the necessary a good nutrition, grooming, and a living receives the necessary a good nutrition, grooming, and a living receives the necessary and a living receives the facility failed to expect to a living receive and living the living failed to expect the living failed to expect the living failed to the facility on gnoses including hemiplegia de of the body) following cranial hemorrhage (bleeding cole weakness, contracture uscle and tendon that causes ry stiff and prevents normal lift hand and wrist, and	F 65		e. S □s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			c				
	345371 B. WING			11/	03/2021		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-TRENT				36 HOSPITAL 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	assessment for Residerevealed he was cognitude and behaviors or required the extensive for bathing and person functional limitation in upper and lower extremated and the second assistance due to here the goal was for Resident and the second and t	al Minimum Data Set (MDS) dent #90 dated 10/10/2021 nitively intact. Resident #90 ejection of care during the 7 of the assessment. He e assistance of one person nal hygiene. He had a range of motion to his emity on one side. At care plan for Resident #90 (2021 revealed a focus area ADL decline requires miplegia and hemiparesis. ident #90 to have his ADL equired assistance from was to set-up Resident #90 7 PM an observation of d his left hand was rnails of his left hand were #90's medical record from 0/25/2021 did not reveal any when Resident #90 had his ed. 5 PM an observation of d his left hand was rnails of his left hand were ew with Resident #90 at that eived his bath that morning. assistant (NA) washed his	F	677	"What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur. On 11/22/21 the Director of Nursing and/or Clinical Competency Coordinate began educating the Certified Nursing Assistants and Licensed Nurses on completion of nail care during daily personal grooming and notification to Licensed Nursing for nails they are unato trim. This education has been added the general orientation for all Certified Nursing Assistant sand Licensed Nurupon hire. The Director of Nursing and/or Clinical Competency Coordinator began educathe Licensed Nurses on 11/22/2021 regarding observing nails during their weekly skin checks and trimming nails required. The Director of Health Services and Nursing Leadership complete a weekly review of 25% resident nails to ensure nails are being trimmed and cleaned. The nail care review will occur weekly for foweeks then monthly until three months sustained compliance is met, then quarterly. "How the facility plans to monitor its performance to make sure that solution are sustained.	or able to ses ting as	
	had to do that. Reside	ls of his left hand as a nurse ent #90 went on to say his ed the fingernails of his right			The Director of Nursing will present the analysis of the nail care review to the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345371	1 B. WING		C 11/03/2021	
	ROVIDER OR SUPPLIER	0.0071		STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/03/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 677	hand because it was could not recall when hand had last been trindicated he was satisfingernails on his righ his left arm or hand a the fingernails of his I trimmed. On 10/26/2021 at 2:5 fingernails of Resider revealed they extenditip of each finger. An time indicated she as bath that morning, ha had noticed the finger trimming. She stated #90's fingernails becastated she would non resident's fingernails didn't usually work winotified his nurse that On 10/26/2021 at 3:0 fingernails of Resider conducted with Nurse Nurse #8 at that time Resident #90's left habeyond the tip of each trimmed. She further to care for Resident #regularly cared for hir Resident #90 had dia assistants were not a She stated she usual diabetic residents we trimming. She stated	m the fingernails of his left contracted. He stated he the fingernails of his left immed. Resident #90 further of sied with the length of the thand but he could not use and could not see whether eft hand needed to be 7 PM an observation of the at #90's left hand with NA #2 at that sisted Resident #90 with his divided washed his left hand, and mails of his left hand needed she could not trim Resident ause he had diabetes. NA #2 mally notify the nurse if a meeded trimming but she the Resident #90 and had not day. 9 PM an observation of the at #90's left hand was at #8. In an interview with she stated the fingernails of and extended ½ to ½ inch an finger and needed to be indicated she was assigned 190 that day. She stated she in. Nurse #8 went on to say betes and nursing llowed to trim his fingernails. By checked the fingernails of eakly to see if they needed	F 677	Quality Assurance and Performance Committee monthly for review and revision as needed. "Include dates when corrective action be completed. 12/3/2021	will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
345371		B. WING			C 11/03/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 58	F 6	77			
		could not recall when she rimmed Resident #90's					
	fingernails of Resident conducted with the Dian interview at that tirfingernails of Resident at least 1/4 inch beyon needed to be trimmed nursing assistants were Resident #90's finger She went on to say shall care to report to her if a resident needet the NA's were unable she trimmed resident stated she last trimmed about a month ago. 2. Resident #80 was a 11/01/2016 with diagrore cerebrovascular diseason-dominant side.	irector of Nursing (DON). In me the DON stated the at #90's left hand extended d the tip of each finger and d. She further indicated the ere not allowed to trim mails as he had diabetes. The expected NA's providing the resident's nurse or to led their nails trimmed and to do so. The DON stated its fingernails weekly. She led Resident #90's fingernails admitted to the facility on loses that included lase affecting the left					
	severely cognitively in extensive assistance total assistance with a coded no rejection of assessment period. Pfunctional range of moof the upper and lower A care plan last review	/08/2021 revealed she was mpaired. She required with personal hygiene, and pathing. The MDS was care for the 7 day look back for the MDS she had often limitations on one side er extremity. wed on 10/15/2021 revealed ocused on Resident #80's					

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , ,		' '	(X3) DATE SURVEY COMPLETED C 11/03/2021	
		345371					
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560	•	11/03/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	revealed Resident #8 position with the pink approximately one-hanalis were touching to the closed position. To closed tightly in her had been cut in tell the last time her for	20/26/2021 at 10:00 am 20's left hand was in a closed 29 and middle finger nails 29 alf inch in length. The finger 29 he palm of her hand while in 20 he rest of her fingers were 20 hand and could not be seen. 20 with Resident #80 on 21 am, she stated it have been 22 was able to open her hand. 23 ingernails on the left hand 23 a while. She was unable to 26 ingernails were cut. 26 28/2021 at 3:00 pm 27 singernails on her left 28 and touched the palm of her 28 pm during an interview 29 #7 she stated fingernail 29 are with the baths by the NAs. 20 and the nurses when a 20 care. The NA stated she was 26 80's nails needed cutting.	F 6				
	needed to be cut by	said the NAs usually when a resident fingernails a nurse. She stated she was NAs that Resident #80's					

		(X3) DATE SURVEY COMPLETED			
		345371	B. WING		C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11100/2021
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.75
F 677	Continued From page	e 60 ng stated on 10/29/2021 at	F 67	7	
	11:14 am during an ir #80's fingernails on h	nterview she heard Resident er contracted hand were d her fingernails should have			
	pm the facility had tw resident's fingernails the NAs should have	when needed. She stated been monitoring Resident informed the nurses when			
F 684 SS=K	Quality of Care CFR(s): 483.25		F 684	4	12/3/21
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profession, the comprehencare plan, and the residents.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure it treatment and care in essional standards of nensive person-centered			
	police officer and emo (EMT) interviews, and failed to obtain physic a wound and failed to monitor a wound to d	etermine the need for		"Identify those recipients who have suffered, or are likely to suffer, a seriou adverse outcome as a result of the noncompliance, and. Resident # 200 no longer resides in the	
	1/10/21. Resident #2 Emergency Medical	rated from 9/24/20 through		facility. "How the facility will identify other residents having the potential to be affected by the same deficient practice	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345371	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER	0.00.	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2021
NAME OF FI	NOVIDER OR SUFFLIER				
PRUITTHE	ALTH-TRENT			836 HOSPITAL 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 COMPLETION
F 684	84 Continued From page 61		F 68	34	
	under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on 9/24/20 when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse administered a discontinued treatment to the wound and failed to assess and document the status of the wound. During this time, staff failed to identify, report, and				
				The Administrator completed a 24	-hour
				report to the State Agency regardi	
				neglect on 10/27/21 when she wa	
				notified of the concern regarding t	he axilla
				wound and no documentation of s	ame.
				The Wound Nurse was suspended	b
				pending investigation on 10/27/21	and
				terminated on 10/28/21. The wour	nd Nurse
				was reported to the North Carolina	
				of Nursing on 10/28/2021 for prof	essional
	document this wound on weekly skin			standards violations.	
		iate jeopardy was removed		T. D	
	on 10/29/21 when the			The Director of Health Services in	
	implemented an acce	•		100% body audits on all residents	
	Immediate Jeopardy			the facility on 10/27/21. This audit	
		ance at a lower scope and m with the potential for		no wounds without physician/physextender notification. If any reside	
	,	irm that is not immediate		noted without an order for impaire	
		nonitoring systems put in		integrity the Director of Nursing, N	
	place are effective.	ionitoring systems put in		Managers and/or Licensed Nurse	
	place are effective.			notify the physician and/or physici	
	Findings included:			extender for orders.	
	J			All residents have the potential to	suffer a
	Resident #200 was a	dmitted to the facility on		serious adverse outcome as a res	
	6/20/20 with diagnose	es that included anemia,		this noncompliance.	
	contracture of the righ	nt and left knee, stage II			
	pressure ulcers of the	right and left buttock, and		"What measures will be put into pl	ace or
		va (a chronic skin condition		systemic changes made to ensure	that
	•	which develop because of		the deficient practice will not recur	:
	inflammation and infe	ction of sweat glands).			
				The Director of Health Services ar	
		terly minimum data set		Nurse Managers have reviewed th	
		/22/20 revealed he was		wound audit conducted on 10/27/2	
	assessed as cognitive			reviewed the documentation to en	
		with bed mobility and toilet		residents with skin impairments ha	
	use. He was totally de	-		order for treatment to areas. The I	
		ll hygiene. He had two stage sent upon admission. He		of Health Services and Nurse Mar reviewed residents with wounds to	_

PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345371	B. WING			1	C (03/2021	
NAME OF P	ROVIDER OR SUPPLIER	0.007.	1	9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021	
NAME OF T	TOVIDER OR GOLT EIER				36 HOSPITAL DRIVE			
PRUITTHE	ALTH-TRENT							
				r	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 62	F	684				
	had application of no	n-surgical dressings,			weekly documentation including ongoin	ng		
	pressure ulcer care, a	and a pressure reducing			assessments including wound			
	device to bed and ch	air. He also had application			measurements are currently in place a	nd		
	of ointment and treat	ments.			documented. Review of documentation	1		
					identified no residents without			
	Resident #200's care				documentation at this point in time.			
		e planned to have a pressure						
		ea, right axilla, and left and			The Director of Health Services and/or			
	_	vas no mention of a wound			Nurse Managers began education on			
to his left armpit. He was also care planne		· · · · · · · · · · · · · · · · · · ·			10/27/21 regarding weekly skin			
	resist wound treatment care. The interventions included to reiterate the purpose and advantages of treatment for the resident as well as assess his				observations and documentation in the			
					electronic health record of same. When	та		
	resistance to care.	esident as well as assess his			new skin impairment is noted, the Licensed nurse will complete the woun	nd		
	resistance to care.				documentation in the electronic medica			
	Review of Resident #	200's Treatment Orders and			record that includes description and	41		
		ation Records from June			measurement of area ,and contact the	ذ		
	2020 through Januar	y 10th, 2021 revealed he			physician/physician extender for orders			
	_	/2020 to have his left inner			regarding newly identified skin	•		
	armpit cyst, related to	hidradenitis, cleansed with			impairments and/or worsening skin			
	normal saline and ap	ply a dry dressing every day.			impairments for wound treatment order	rs.		
	This order was disco	ntinued on 9/24/2020. The			This includes that the assessments ar	ıd		
		ed by Physician #1 and			measurements were necessary as a			
	transcribed by the We	ound Care Nurse.			monitoring tool to determine if there are	е		
					any changes in the wound that would			
		cian and Nurse Practitioner			require a change in the treatment plan			
		/20 through 1/10/21 revealed			This education has been added to the			
		dent #200's left armpit			License Nurse general orientation upo	n		
	wound.				hire. Any Licensed Nurse will not be			
	Further review of the	modical record revealed no			allowed to work after 10/28/21 until the	•		
		medical record revealed no wound to his left armpit			receive the education. The new Wound Nurse and the Nurse Practitioner are	ı		
		1/10/21. There were no			meeting weekly to discuss and review	all		
	_	surements of the wound.			residents with wounds.	ип		
	association of filed	caremonia or ano wound.			The Director of Health Services and/or			
	A review of Resident	#200's weekly skin			Nurse Managers began education on			
		23/20 to his time of death			10/27/21 regarding completing weekly			
		documentation of a wound			skin observation and wound managem			
	,	re was no documentation of			notes including description and			

Facility ID: 923215

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDII			١ ,	c
		345371	B. WING _			1	03/2021
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
				83	86 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT			N	EW BERN, NC 28560		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	∋ 63	F 6	84			
	skin check refusals d	uring this time on the skin			measurements of skin impairments		
	check assessments.				weekly. This education has been adde	ed	
					the License Nurse general orientation		
		neck completed by Nurse #1			upon hire. Any Licensed Nurse will no		
		200 had alterations in skin.			allowed to work after 10/28/21 until the	У	
	There was no further	documentation.			receive the education.		
	On 12/26/20 a skin cl	neck completed by Nurse #3			The Director of Health Services and		
	I .	200 had alterations to his			Nurse Managers educated the Certified	d	
	skin. The comment n				Nursing Assistants on daily skin checks		
	alteration was to the	resident's sacrum.			during personal care. This education		
	includes notification to the nurse of a		/				
	On 1/2/21 a skin ched	ck completed by Nurse #4			skin impairment and/or new dressing		
	indicated Resident #2	200 had no alterations to his			noted on resident □s skin. The Certified	ł	
	skin.				Nursing assistant will utilize a body		
					diagram for nurse notification. This		
	_	1/10/21 revealed at 4:45 AM			education has been added to the Certi		
		by Nurse Aide #3 of a			Nursing Assistant general orientation u		
		200's breathing. The nurse ed and observed Resident			hire. Any Certified Nursing Assistant want be allowed to work after 10/28/21 u		
		e to contractures) fetal			they receive the education.	IIIIII	
	,	pirations, unresponsive, and			they receive the education.		
		I was notified by the nurse.			The Clinical Competency Coordinator/	RN	
		ound to be without signs of			is responsible for ensuring education is		
	life, cessation of brea				completed prior to the start of any		
		suscitation (CPR) was			Licensed Nurse and/or Certified Nursir	ıg	
	initiated. EMS arrived	l at the facility and called			Assistant working the floor after 10/28/	21.	
	time of death at 5:02	AM at the facility.			The Director of Health Services and/or		
					Nursing Leadership review the weekly		
		ed 1/10/21 indicated EMS			skin observations to validate all areas		
		e facility for Resident #200.			identified have physician notification,		
		g hole in his left armpit that			treatments orders are written, wound is	3	
		agreed by EMS personnel to			monitored for changes weekly for four		
		call time of death in the			weeks then monthly thereafter.		
	was notified.	ne local police department			"How the facility plane to manitor its		
	was nouned.				"How the facility plans to monitor its performance to make sure that solution	ne	
	During an interview o	n 10/28/21 at 1:03 PM			are sustained; and	13	
	_	Fechnician (EMT) #1 stated			a. o odotamou, and		

34	5371 B. WIN			
		IG		C 11/03/2021
NAME OF PROVIDER OR SUPPLIER		$\overline{\top}$	STREET ADDRESS, CITY, STATE, ZIP CODE	11/03/2021
			836 HOSPITAL DRIVE	
PRUITTHEALTH-TRENT				
			NEW BERN, NC 28560	
(X4) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDING TAG REGULATORY OR LSC IDENTIFYING INF	D BY FULL PR	ID EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684 Continued From page 64		F 684	1	
he was at the facility on 1/10/21 for Re #200. EMT #1 further stated the resid gaping, open wound to his left underathest which was about three inches in two inches in width. He stated there will drainage from the wound and it prese old wound. He stated the wound was laceration but had the appearance of wound that had been present for som wound was not bandaged and was "Wille He continued to state even with Resideft arm being held against his body the would have been visible to an observed. During an interview on 10/28/21 at 2:0 #2 stated he was dispatched to the fa 1/10/21 for a cardiac arrest for Reside The EMTs identified a wound to his let that was in-between a golf ball and be opening. He stated he did not remembered in the wound as well as bloody clear pin was on the blanket that had covered the wound as well as bloody clear pin was on the blanket that had covered the sawell. He further stated the wound wacute laceration and did not present a acute trauma as a result of CPR. He find stated it had the appearance of a wound been present for quite some time. He did not remember any dressing being the wound on his left armpit. He could there was an odor to that wound. During an interview on 10/28/21 at 2:0 #3 stated she remembered walking in	esident ent had a rm and a length and vas some inted as an not a fresh being a the initiation he time. This ride open." lent #200's he wound er. OO PM EMT cility on ent #200. ft armpit hiseball sized ber the tunneling ery least wound 's drainage to k fluid that he wound vas not an his having urther and that had stated he in place to I not recall if	F 684	Include dates when corrective action we be completed. The Director of Health Services will present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the Quality Assurance and Performance Committee monthly until three months sustained compliance is maintained the quarterly thereafter. The Clinical Competency Coordinator of present the analysis of education compliance of the Licensed Nurses regarding weekly skin observation and documentation in wound management notes including description and measurements and physician notification weekly to the Quality Assurance and Performance Committee monthly until three months of sustained compliance maintained then quarterly thereafter. The Clinical Competency Coordinator of present the analysis of education compliance of the Certified Nursing Assistants regarding on daily skin check during personal care to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarter thereafter. Date when corrective action will be completed: 12/3/2021	of en vill s vill ks

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING _			C 1/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 E APPROPRIATE	(X5) COMPLETION DATE	
F 684	armpit and chest are would have fit the wo size of the wound. Si remember if the wou bandaged or not. She some drainage, and but could not recall e amount of tunneling based on the appear underarm she did no result of CPR and ha wound that had been for some time. The police case name Police Officer #1 arrit to a death in the facil #1 documented he warrival that it appears based on the decease personnel wanted to Resident #200 had on his left arm that was extended up inside he documented the ope bandaged and show were additional sores were smaller but were photographed the boand sores under his as pronounced. During an interview of Police Officer #1 stated dispatch that EMS have respond for an unatter the size of the work of the police of the tated dispatch that EMS have respond for an unatter the work of the	e had a wound to his left a. The EMT stated a golf ball and due to the depth and the further stated she did not and to the underarm was the stated the wound had the wound had some depth the wound had some depth the wound to his the believe the wound was a the appearance of a the appearance of a the resident #200 attive dated 1/11/21 revealed the dated 1/11/21 revealed the dated at the facility in response the did to be a case of neglect the discondition and EMS the ensure a report was on file. The large open wound under the wound that was not the do signs of care. There the son the resident's side that the still noticeable. The officer dy. There were abrasions the region of the contacted by his the did requested an officer	F 6	84			
	his left arm that was extended up inside h documented the ope bandaged and show were additional sores were smaller but wer photographed the boand sores under his as pronounced. During an interview of Police Officer #1 stated dispatch that EMS have respond for an unatter He stated he arrived.	"several inches wide and is body." The officer in wound that was not ed no signs of care. There is on the resident's side that the still noticeable. The officer dy. There were abrasions right arm as well though not on 10/16/21 at 6:20 PM and he was contacted by his ad requested an officer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		345371	B. WING			C 1 1/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021	
(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 E APPROPRIATE	(X5) COMPLETION DATE	
F 684	when they took off his sore was to his left at the area. The gown the was soaked in a pink approximately two inclong. The wound conbody towards his heat enough of a cavity that he resident's body un approximately 4 inches and was approximated cavity ran along the conded at his collarbotin the cavity was a whadditional smaller soon wound. He was informed in the wound was not cavity and the wound has formed the wound has formed the surface of the skin o'clock. The tunneling inches in diameter from the body) to poster the body) edges of the tune the wounder his left armpit.	dy that they discovered is gown. The most notable impit. The officer observed that was around that area ifluid. The wound was ches wide and three inches itinued into Resident #200's and which was open and large at he could visualize inside inder his armpit. It was es deep to his collarbone of the flesh that was visible intish pink. There were resoluted around the med by EMS that this wound issing present when they estaff could not explain why ared for at that time. The flesh that this wound is staff could not explain why ared for at that time. The flesh that this wound is staff could not explain why ared for at that time. The flesh that this wound is staff could not explain why ared for at that time.	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345371	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	0.007.1	1	STREET ADDRESS, CITY, STATE, ZIP COD		11/03/2021
				836 HOSPITAL DRIVE		
PRUITTHE	EALTH-TRENT			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 E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	e 67	F 6	84		
F 684	pale pink and the worpresent (yellow/white usually wet but can be thick bed, present as a thir surface of the wound that accumulate in the During an interview of Wound Care Nurse's Resident #200. She's care nurse at that time caseload. She indicate to his cyst to his 9/24/20 the treatment continued to provide was open. She was used treatment was discorpractitioner on 9/24/2 improved and had not revealed that until his continued to provide without orders. She's documented this treatmedical record from the She indicated she has assessments or wound 9/24/20 through 1/10 wound and provided his left armpit up until progressively deterio 1/10/21. The Wound	ra. The wound presented as und bed had yellow slough material in the wound bed; e dry. It generally has a soft k and adhered to the wound n coating, or patchy over the . It consists of dead cells e wound drainage.). In 10/26/21 at 9:43 AM the tated she remembered stated she was the wound e, and he was on her ted she was providing wound left underarm and on t was discontinued but she care to the wound because it inable to recall why the stinued by the Nurse 20 as the wound had not the healed at that time. She is death (1/10/21) she the discontinued treatment tated she had not then to the wound in the 2/24/20 through 1/10/21. In do not completed any and measurements from 1/21. She visualized the the non-ordered treatment to this death and it was rating till his death on Care Nurse indicated she y through Friday and every	F 6	84		
	working. She stated to physician's order for	care when she was not because there was no the treatment the staff as not in the facility would not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE
F 684	armpit of Resident #3 verbally gone to the a the dressing change was not ordered by t couple of days before wound had develope concerning to her tha deteriorated in size a she notified Nurse Pr Nurse Practitioner #3 do anything for the w	e dressing change to the left 200. She stated she had not nurses and informed them of she was doing for him that he physician. She stated a e his death his left armpit d an odor. She stated it was	Fé	584		
	During an interview of Nurse Practitioner #7 Resident #200. She Resident #200 comp she had been told the She indicated she had #200's wound progreg 9/24/20 through 1/10 Wound Care Nurse without orders. She obtained prior to treat The Wound Care Nu she informed NP #1 treatments without an had opened and dete #1. She denied ever September 2020 by wound to Resident # deteriorated, or was orders. NP #1 was in assessments or mea were completed from despite the Wound Care Nurse informed NP #1 was in assessments or mea were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 was in assessments or mean were completed from despite the Wound Care Nurse NP #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1	on 10/26/21 at 10:50 AM I stated she remembered stated in September 2020 leted antibiotic treatment and wounds had gotten better. Id not known Resident essively deteriorated from I/21 nor had she known the was completing treatments stated that orders were to be tments being completed. It is interview that indicated she was completing In order and that the wound eriorated was shared with NP I being notified after staff at the facility that the 200's left armpit had opened, receiving treatments without				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
							C	
		345371	B. WING _			11/	03/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				83	6 HOSPITAL DRIVE			
PRUITTHE	EALTH-TRENT			NE	EW BERN, NC 28560			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE	
F 684	Continued From page	e 69	F 6	684				
	were to be assessed							
		umented assessments there						
		ain if there were changes in						
		require a change in the						
	treatment plan.							
	During an interview o	n 10/27/21 at 12:33 PM with						
	_	und Care Nurse's interview						
	in which she reported							
	treatments with no ph	ysician's order from 9/24/20						
	through 1/10/21 as w	ell as her statement that she						
	completed no assess	ments or measurement of						
	the wounds througho	ut this same time period						
	were reviewed with th	ne physician. He stated that						
	orders were to be obt	ained prior to treatments						
	being completed and	identified wounds were to						
	be assessed, monitor	ed, and documented. He						
	stated wound measur	rements were part of the						
	assessment. He indic	ated without assessments						
	and measurements th	nere was no way to						
	determine if there we	re changes in the wound						
	that would require a c	change in the treatment plan.						
	He further stated he v	vas unable to understand						
	why the Wound Care	Nurse would not have						
	gotten an order for tre	eatment of a wound and why						
	she would not have c	ompleted wound						
	assessments and me	asurements in order to						
	monitor the wound's	status. He indicated that						
		rse practitioner would ever						
	deny an order for a w	ound to be treatment. The						
	police report photogra							
		armpit (taken 1/10/21) were						
		ian #1 during interview. He						
		if the wound could have						
		eath or how long it would						
	have taken to develop							
	Physician stated he fe	elt the wound had a severe						
	appearance in the ph	otographs and had						
	reiterated he had not	known why the wound care						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP O 836 HOSPITAL DRIVE NEW BERN, NC 28560	CODE	11/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	•	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	or weekly wound assifollowing the wound documentation it was when the wound was severity of the woun photographs by the During an interview of Director of Nursing as should not be done wound care nurse do have continued treat order be continued treat order be continued to situation. Identified wound measurement assessments in order progress. During an interview of Nurse #1 stated she #200 but did not rem stated from Septemb 2020 Resident #200 weekly skin checks. remember why she alteration on 12/18/2 identify any wounds skin assessments of noted any wounds to documented it and no stated if he had refuse	arements, treatment records, seessments if she was. He stated due to the lack of is impossible to know if and is or was not present or the duntil the time of the police department. In 10/27/21 at 1:35 PM the stated wound treatment without and order and if the emed a wound needed to the total depending on the vounds were to be assessed, amented. She concluded this were part of the er to follow the wound In 10/27/21 at 10:32 AM did skin check for Resident member him very well. She per 2020 through December was on her assignment for She stated she did not checked yes for skin 20. She stated she did not under his arms during her if the resident and if she had on his armpits, she would have notified the wound nurse. She sed his weekly skin	F	684		
	assessment as refus refuse his weekly sk documented them as head to toe skin che	rould have documented the sed, therefore he did not in assessments as she had s completed. She stated a full ck included observing the m top to bottom and then				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE : COMPI					
		345371	B. WING _			11/0) 3/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 836 HOSPITAL DRIVE NEW BERN, NC 28560	, ZIP CODE	1170	7072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page		F	684			
		nt #200's case if she					
	Nurse #3 stated she #200. She stated she 12/26/20 and noted h wound to his sacrum raise his arms and shunder his left arm. Shidentified any alteratiarm and armpit she wher skin assessment nurse. The nurse starefused his skin check documented the skin	ne had a pressure ulcer . Resident #200 was able to ne did not identify any wound ne further stated had she ons to his skin under his left would have documented it on and notified the wound care ted if Resident #200 had sk she would have check as refused. She documented his skin check not refuse his skin					
	Nurse #4 stated she #200. She stated she date but if the documentat was when she di if she documented no meant that he did not She further stated she to his left underarm of documented the wou care nurse. She state there were dressings if she saw issues with documented them. S	did a skin check on Resident e could not remember the mented date was 1/2/21 then id the skin check. She stated to alterations in skin that thave any wounds present. The did not identify any wound or she would have and and notified the wound ed she could not remember if the on his left armpit or not but the his skin, she would have the stated he did not refuse to or she would not have					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345371	B. WING_			C
	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	l	11/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOWS CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 684	Director of Nursing sunder Resident #200 their skin assessment documented and repnurse and nurse on responsible for notify responsible for notify responsible party, ar wound was present checks she did not kethe wound. The Administrator was jeopardy on 10/28/2 12:51 PM the facility credible allegation or removal. The Removal Plan: I Identify those recipies are likely to suffer, as a result of the noncompart of the State Surveyor expired January 10, axilla area (armpit) to she had been treating 9/24/20 through 1/10 stated that she notified regarding Resident at the Nurse Practitions wound nurse to conforder being provided Wound nurse was unthis notification. The	on 10/28/21 at 9:55 AM The stated if a wound was present o's arm at the time they did nots, it should have been corted to the wound care the hall who would be ving the Physician, and Director of Nursing. If the at the time of these skin know why they did not identify as notified of the immediate 1 at 2:49 PM. On 10/29/21 at provided the following f immediate jeopardy	F 6	84		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
				-		(C
		345371	B. WING			11/	03/2021
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
DDIUTTUE	ALTIL TOPAT			8	836 HOSPITAL DRIVE		
PRUITIHE	EALTH-TRENT			ı	NEW BERN, NC 28560		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 73	F	684			
		9/24/21 through 1/10/21.	•	00 1			
		er stated that she was never					
		ation related to the open					
	axilla area by the faci	•					
	-	esident #200. When the					
	wound nurse was ask						
		ding treatments and Nurse					
	_	ons were located the wound					
	nurse stated there wa						
	document and there	was not an order to treat					
	from 9/24/20 through	1/10/21. The wound Nurse					
	failed to complete the	weekly body observations					
	that included wound a						
		wound status for this same					
	·	is no documentation that					
		fied the Nurse Practitioner					
		r treatment of the wound					
		rmpit area. The facility was					
		d nurse was providing					
	treatment without a P	vare of the Wound nurse's					
	lack of documentation						
		wound progression, the					
		oviding treatments without					
	orders, and the lack of	-					
	physician/nurse pract						
		on 1/10/21 the EMS /police					
		axilla area wound condition					
	as a large open wour	nd under left arm that was					
	extended up inside hi	is body. Officer documented					
	he could see ribs and	l collar bone through the					
	body that was not bar	ndaged. Resident #200					
	expired on 1-10-2021	l .					
		e potential to suffer a serious					
	adverse outcome as	a result of this				ĺ	
	noncompliance.						
	Specify the action the	e entity will take to alter the					
		ilure to prevent a serious					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				•		(c	
		345371	B. WING			11/	03/2021	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
				8	336 HOSPITAL DRIVE			
PRUITTH	EALTH-TRENT			ı	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	when the action will be The Administrator core the State Agency regard when she was notified the axilla wound and The Wound Nurse was investigation on 10/27 10/28/21. The wound North Carolina Board for professional stand The Director of Health body audits on all research 10/27/21. This audit of the physician/physician eresident is noted with skin integrity the Director of Health Managers and/or Lic physician and/or physician an	moccurring or recurring, and be complete Impleted a 24-hour report to arding neglect on 10/27/21 do f the concern regarding no documentation of same. It is suspended pending 7/21 and terminated on Nurse was reported to the of Nursing on 10/28/2021 lards violations. In Services initiated 100% idents within the facility on eveals no wounds without extender notification. If any out an order for impaired extor of Nursing, Nurse ensed Nurse will notify the sician extender for orders. In Services and/or Nurse wed the wound audit 21 and reviewed the sure residents with wounds to mentation including ongoing and wound measurements are a documented. Review of fied no residents without is point in time. In Services and/or Nurse cation on 10/27/21 in observations and electronic health record of kin impairment is noted, the	F	684				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345371	B. WING			C I 1/03/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	<u> </u>	1170072021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	that includes descrip area ,and contact the extender for orders, skin impairments an impairments for wou includes that the as measurements were tool to determine if the wound that would retreatment plan. This the License Nurse gany Licensed Nurse after 10/28/21 until table. The new Wound Nu Practitioner are meereview all residents and wound manager began ed regarding completing and wound manager description and meanimpairments weekly added the License Nupon hire. Any Lice	e electronic medical record oftion and measurement of the physician/physician regarding newly identified d/or worsening skin and treatment orders. This sessments and the necessary as a monitoring there are any changes in the quire a change in the education has been added to eneral orientation upon hire. Will not be allowed to work they receive the education. The energy are the work they receive the education. The energy are the work they receive the education. The energy are the work they receive the education. The energy are the works and the Nurse thing weekly to discuss and with wounds. The services and/or Nurse uccation on 10/27/21 and weekly skin observation ment notes including	F 68	<u>'</u>		
	Managers educated Assistants on daily scare. This education nurse of any skin im dressing noted on re Nursing assistant winurse notification. The Certified Nursorientation upon hire Assistant will not be	th Services and Nurse the Certified Nursing skin checks during personal includes notification to the pairment and/or new esident's skin. The Certified Il utilize a body diagram for nis education has been added ing Assistant general e. Any Certified Nursing allowed to work after esceive the education.				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED			
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11100/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 684	responsible for ensure prior to the start of an Certified Nursing Ass 10/28/21. Alleged date of IJ Research and considering the resident assessment and considering the rediagnoses of the faciliary with the rediagnoses of the faciliary must have diagnoses of the faciliary must here resident assessment and considering the rediagnoses of the faciliary must have diagnoses of the faciliary must here diagnoses of the faciliary must here.	ency Coordinator/RN is ring education is completed by Licensed Nurse and/or sistant working the floor after emoval 10/29/21 on for Immediate Jeopardy ed on 11/2/21 which removed ardy on 10/29/21, as terviews, in-service record ation. The in-services on providing wound care to physician orders, wound a measurements, and wounds and skin ate Jeopardy removal date of ed. Staff 10(4)(c) vices e sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care	F 6			12/3/21
	at §483.70(e).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345371	B. WING _			C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 726	licensed nurses had and skill sets necess needs, as identified assessments, and systems assessments, and systems assessments and systems assessing implementing resid to resident's needs systems assessments and systems as identified assessments, and this REQUIREMENT by: Based on staff, phypolice officer and e (EMT) interviews, a nursing staff failed and skill sets to effect wound and to report to the physician for progressively deter 3-month period of the identified by Emergy (EMT) and police of tunneling wound undeath with no obse was for 1 of 3 resid (Resident #200). Immediate Jeopard Resident #200's woopened and the Woopene	facility must ensure that we the specific competencies ssary to care for residents' I through resident described in the plan of care. Iding care includes but is not g, evaluating, planning and ent care plans and responding Incy of nurse aides. Issure that nurse aides are able inpetency in skills and ary to care for residents'	F 7	"How corrective action will be accomplished for those residents have been affected by the deficie practice. Resident # 200 no longer resider facility. The Administrator completed a 2 report to the State Agency regard neglect on 10/27/21 when she we notified of the concern regarding wound and no documentation of The Wound Nurse was suspending investigation on 10/27/2 terminated on 10/28/21. The work was reported to the North Carolin of Nursing on 10/29/2021 for prestandards violations.	ent 24-hour ding as the axilla same. ed 21 and und Nurse na Board	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45074	D MINO				C
		345371	B. WING _			11/0	03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTHE	ALTH-TRENT			83	36 HOSPITAL DRIVE		
1 10111111	ALIII-IKENI			N	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				(X5) COMPLETION DATE
F 726	Continued From page	÷ 78	F 7	'26			
	to assess and docum	ent the status of the wound			"How the facility will identify other		
		ing. During this time, staff			residents having the potential to be		
	_	sments failed to identify,			affected by the same deficient practice		
		this wound on weekly skin					
	assessments. Immed	iate jeopardy was removed			The Director of Health Services initiate	d	
	on 10/30/21 when the	facility provided and			100% body audits on all residents withi		
	implemented an acce	ptable allegation of			the facility on 10/27/21. This audit reve		
	Immediate Jeopardy				no wounds without physician/physician		
		ance at a lower scope and			extender notification. If any resident is		
	severity of "E" (no harm with the potential for				noted without an order for impaired skil		
		irm that is not immediate			integrity the Director of Nursing, Nurse	:	
		nonitoring systems put in			Managers and/or Licensed Nurse will		
	place are effective.				notify the physician and/or physician extender for orders. All residents have	tha	
	Findings included:				potential to be affected.	uie	
	i ilidiligs ilicidded.				potential to be allected.		
	This tag is cross refer	renced to:			The Director of Health Services and/or Nurse Managers have reviewed the		
	Tag F580 - Based on	staff, physician, nurse			wound audit conducted on 10/27/21 an	d	
		e officer interviews, and			reviewed the documentation to ensure		
	record review the faci	lity failed to notify the			residents with skin impairments had an		
	physician of an open	wound that progressively			order for treatment to areas with		
		4/20 through 1/10/21. This			notification to physician and/or physicia	ın	
	failure resulted in the	<u> </u>			extender of any new /changed skin		
	physician evaluation of				impairments. The Director of Health		
		atments to the wound.			Services and Nurse Managers reviewe		
		entified by Emergency			residents with wounds to ensure weekl	У	
	,	IS) and police on 1/10/21 to			documentation including ongoing	to	
		g wound under his left arm			assessments with wound measuremen	IS	
		ith no observed dressing 1 of 3 residents reviewed			are currently in place, documented accurately and physician / physician		
	for wound care (Resid				extender notification. Review of		
	ioi woulid care (incol	2011: 11200).			documentation identified no residents		
	Tag F600 - Based on	staff, physician, nurse			without wound documentation at this pe	oint	
		icer and emergency medical			in time and the current wound		
		rviews, and record review			observations are accurate.		
	, ,	to provide necessary care					
		dent by failing to effectively			"What measures will be put into place of	or	
		n open wound, failing to			systemic changes made to ensure that		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D. WILLO			1	С
		345371	B. WING			11/	03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIJITTUE	ALTU TOENT			83	36 HOSPITAL DRIVE		
PRUITINE	EALTH-TRENT			N	IEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 726	Continued From page	e 79	F	726			
	obtain physician 's orders prior to treating the wound, and failing to notify the physician of an				the deficient practice will not recur.		
		gressively deteriorated from			The Director of Health Services and		
	_	/21. Resident #200 was			Nurse Managers educated the License	∍d	
		ncy Medical Services (EMS)			Nurses regarding accuracy of weekly		
	_	ge tunneling wound under his			body observations to include identificat		
		death. This was for 1 of 3			of any dressing noted or skin impairme	nt	
		r wound care (Resident			noted on the resident body. This education has been added the License		
	#200).				Nurse general orientation upon hire.		
	Tag F684 - Based on	staff, physician, nurse			License Nurses not educated by 10/28.	/21	
		ficer and emergency medical			will be educated prior to their next	- 1	
	1 -	erviews, and record review			scheduled shift.		
	, ,	otain physician ' s orders					
		und and failed to identify,			The Director of Health Services and/or		
	assess, and monitor a	a wound to determine the			Nurse Managers began education on		
		tment for an open wound			10/27/21 regarding weekly skin		
		teriorated from 9/24/20			observations and documentation in the		
	_	ident #200 was identified by			electronic health record of same. Wher	ıa	
		Technicians (EMT) and			new skin impairment is noted, the	_	
		nave a large tunneling wound			Licensed nurse will complete the woun		
		he time of death with no			documentation in the electronic medica	แ	
		esent. This was for 1 of 3 or wound care (Resident			record that includes description and measurement of area ,and contact the		
	#200).	i would care (Nesidelii			physician/physician extender for orders		
	<i>π</i> 200).				regarding newly identified skin	' ,	
	During an interview o	n 10/28/21 at 3:26 PM			impairments and/or worsening skin		
	•	n she was hired, she was			impairments for wound treatment order	·s.	
		n checks. She further stated			This includes that the assessments an		
	•	ad-to-toe assessment. She			measurements were necessary as a		
		t with the resident ' s head			monitoring tool to determine if there are	e	
	and observe the integ	grity of the skin to the			any changes in the wound that would	ĺ	
		e stated while checking their			require a change in the treatment plan.		
		ate their neck to check their			This education has been added to the		
	_	nd then they would have the			License Nurse general orientation upor	1	
		ms and observe the skin			hire. Any Licensed Nurse will not be		
		en she would inspect their			allowed to work after 10/28/21 until the	-	
		rea and groin. Then she			receive the education. The new Wound	i	
	would check legs and	I feet. Then the resident			Nurse and the Nurse Practitioner are		

	DF DEFICIENCIES CORRECTION	I DENTIFICATION NITIMBED:		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				_		(С	
		345371	B. WING _			11/	03/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				8	36 HOSPITAL DRIVE			
PRUITIHE	EALTH-TRENT			N	IEW BERN, NC 28560			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 726	Continued From page	e 80	F 7	726				
	would be turned over	and they would check the			meeting weekly to discuss and review a	all		
	back and the gluteal fold and legs. She stated				residents with wounds.			
		in assessment on 12/26/20						
	and noted his skin iss	sue to Resident #200 ' s			The Director of Health Services and/or			
		informed of the wound care			Nurse Managers began education on			
		of the wound as well as the			10/27/21 regarding completing weekly			
		and EMT at the time of his			skin observation and wound managem	ent		
		did not recall identifying			notes including description and			
		urther stated she could not			measurements of skin impairments	ام		
	•	nd would not have been			weekly. This education has been adde the License Nurse general orientation	a		
		ssessment if it had been having any knowledge of the			upon hire. Any Licensed Nurse will not	he		
		ning of a wound to his left			allowed to work after 10/28/21 until the			
		assessment she completed			receive the education.	,		
	on 12/26/20.							
					The Director of Health Nursing and/or F	3N		
		n 10/28/21 at 4:42 PM			Nurse Managers have validated, (by			
		was trained how to complete			observation) the 10/27/21 skin			
		ssments. She further stated			observations completed by the License			
		observations of the head, front of the resident, then			Nurses for comprehensive assessment and accuracy. No discrepancies where			
		, then legs and feet, and			identified. The Clinical Competency			
		ls. She stated she would			Coordinator, Director of Health Service	•		
	-	Resident #200 refused to			and RN Managers are observing all			
		ne did not document refusal,			Licensed Nurse ☐s on 10/29/21 comple	te		
		rved under his arms for skin			skin observation to validate competence			
	integrity. She further	stated she had no idea how			of the comprehensive assessment and	•		
	she could have misse	ed a wound as it was			accuracy of the assessment. Licensed			
		nd care nurse, EMTs, and			Nurses not deemed competent will be			
		cer. She stated the only			re-educated and reevaluated to validate	-		
		Resident #200 with on			competency prior to completing further			
		d under his buttock which			skin assessments. Licensed Nurse will			
	she would not note th				not be allowed to work after 10/29/21 u			
		it was a pressure ulcer			they have been observed and validated	1		
		and it was up to the wound ent those measurements			for competency of the comprehensive			
	and treatments.	ราน แบระ เทอสรนเษาแยกไร			assessment and for accuracy of the assessment.			
	and irealinents.				assessment.			
	During an interview o	n 10/28/21 at 10:24 AM the			The Clinical Competency Coordinator/F	RN		

OLIVILIV	O T OTT MEDIO, THE G	MEDIO/ (ID OLI (VIOLO					3. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	\ · · /	SURVEY PLETED
				_			С
		345371	B. WING				/03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
DDIJITTU	ALTU TOENT			83	36 HOSPITAL DRIVE		
PRUITIHE	EALTH-TRENT			N	EW BERN, NC 28560		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 726	Continued From page	e 81	F	726			
		ndicated she began working		0	is responsible for ensuring education a	and	
		cility in June 2020. She			evaluation of competency is completed		
		d training at the facility on			prior to the start of any Licensed Nurse		
		ss, evaluate, monitor, and			and/or Certified Nursing Assistant wor		
		ions. This training was			the floor after 10/29/21.	3	
		6/2020 when she took the					
	position of wound car	e nurse. When asked why			"How the facility plans to monitor its		
	she had not implemented this training for				performance to make sure that solutio	ns	
	Resident #200 's left	arm pit wound she indicated			are sustained.		
she had no reason she chose not to. She							
	_	ne should have assessed			The Director of Health Services will		
	-	en wound to his left armpit,			present the analysis of the weekly skir	1	
		's status, and documented			observations to validate all areas		
		cord in accordance with her			identified have physician notification,		
	_	Care Nurse reported she			treatments orders are written, to the		
	-	e orders for wound care prior t. She stated she had no			Quality Assurance and Performance Committee monthly until three months	of	
		ided the treatment without an			sustained compliance is maintained th		
		she had not asked the			quarterly thereafter.	CII	
		actitioner for orders and that			The Clinical Competency Coordinator	will	
	· •	have. She stated she was			present the analysis of education		
		ve completed all these steps			compliance of the Licensed Nurses		
		the time it was happening			regarding weekly skin observation and	d	
		ne did not follow her training.			documentation in wound management		
	The skin assessment	s completed from the			notes including description and		
		/21 that all failed to identify			measurements and physician notification	ion	
	Resident #200 's left				weekly to the Quality Assurance and		
		ound Care Nurse. The			Performance Committee monthly until		
	Wound Care Nurse s				three months of sustained compliance	IS	
	identified a wound of				maintained then quarterly thereafter.		
		d not speak to how the other					
	nurses missed the wo	ound.			Date when corrective action will be completed: 12/3/2021		
	During an interview o	n 10/28/21 at 1:28 PM Staff			00111pleted: 12/0/2021		
	_	nator #1 stated she was the					
		oordinator (SDC) from 2019					
		020. When staff were hired,					
	they were provided e						
		mentation of treatments. She					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345371	B. WING			C I 1/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		11/03/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 726	skin assessments the orientation as well. Sonotification of change physician and resport incidents involving skin eeded basis. They aproviding treatments orders for needed skin on wound care documbasis. She stated she of these issues were was back in 2019 and immediately available had done some in-set the topic of wound cate a new policy that he corporate and did not any concerns identified the facility. During an interview of the policy that had been not have anything to identified with the call buring an interview of Administrator stated staff would follow the head to toe skin asset would identify, and reintegrity. During an interview of Director of Nursing stated staff would follow the head to toe skin asset would identify, and reintegrity.	Ils observation checkoff for at were done with staff upon taff were educated on as of residents to the asible party to include a concerns on an asialso educated staff on not without orders, not obtaining in treatments, and education mentation on an as needed a believed the last time any needed to be in-serviced ad did not have those records as She stated the new SDC ervices since 1/10/2021 on are. This in-service was due	F 73	26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345371	B. WING		1.	C 1/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560		1703/2021
(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 CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	and Nurse #4 received. She further stated if Resident #200 's are skin assessments, it documented and rep. Nurse and nurse on responsible for notify responsible party, ar wound was present a checks she did not ket the wound. The Woutrained that identified assessed, monitored was to be provided a orders. She did not to care nurse did not for the Administrator was jeopardy on 10/29/2 the facility provided the facility provided the facility provided the facility those recipies are likely to suffer, a a result of the noncoord on 10/27/21 the Direct by the State Surveyor expired January 10, axilla area (armpit) the stated that she notifier regarding Resident #4 the Nurse Practitione Wound nurse to conforder being provided	ed skin assessment training. a wound was present under m at the time they did their should have been borted to the Wound Care the hall who would be ying the Physician, nd Director of Nursing. If the at the time of these skin know why they did not identify and Care Nurse had been d wounds were to be d, documented, and treatment according to physician 's understand why the wound would wher training. as notified of the immediate first at 9:36 AM. On 10/29/21 the following credible ate jeopardy removal.	F 72	26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345371	B. WING _			C 1/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 836 HOSPITAL DRIVE NEW BERN, NC 28560	•	1700/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 726	provided wound tre without an order for The Nurse Practition notified of any infor axilla area by the fithrough 1/10/21 for wound nurse was a documentation reg Practitioner notifica nurse stated there document and ther from 9/24/20 throuf failed to complete that included woun measurements of the period of time. The the wound nurse in related to the order identified under the unaware of the wo treatment without a assessments from to identify Residen axilla area. The facility was ur lack of documental measurements of the Wound nurse was orders, and the lace physician/nurse pro unaware of the fail open wound during from 9/24/20 throuf Upon arrival to faci noted the resident as a large open wo extended up inside	the Wound nurse indicated she catments to Resident #200 om 9/24/21 through 1/10/21. Oner stated that she was never remation related to the open acility staff from 9/24/20 or Resident #200. When the asked where the arding treatments and Nurse ations were located the wound was none, she did not be was not an order to treat gh 1/10/21. The wound Nurse the weekly body observations did assessments and he wound status for this same are is no documentation that offied the Nurse Practitioner or or treatment of the wound armpit area. The facility was und nurse was providing a Physician order. Weekly skin 9/24/20 through 1/10/21 failed at #200 's open wound to the maware of the Wound nurse 's tion of assessment, he wound progression, the providing treatments without k of notification to the actitioner. The facility was the providing treatments without the greekly skin assessments	F	726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE C A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345371	B. WING		C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 726	expired on 1-10-202 All residents have the serious outcome as noncompliance. Specify the action the process or system from the action will The Administrator countries the State Agency residents.	andaged. Resident #200 1. e potential to have suffered a a result of this e entity will take to alter the allure to prevent a serious om occurring or recurring, and	F 72	,	
	the axilla wound and The Wound Nurse winvestigation on 10/2 10/28/21. The wound North Carolina Boar for professional stan The Director of Heal body audits on all re 10/27/21. This audit physician/physician resident is noted wit skin integrity the Director of Heal Managers and/or Liphysician and/or phy The Director of Heal Managers have revice conducted on 10/27/documentation to er impairments had an with notification to plo	I no documentation of same. Yas suspended pending 27/21 and terminated on Id Nurse was reported to the Id of Nursing on 10/29/2021 Idards violations. Ith Services initiated 100% Isidents within the facility on I reveals no wounds without I extender notification. If any I hout an order for impaired I ector of Nursing, Nurse I censed Nurse will notify the I visician extender for orders. Ith Services and/or Nurse I ewed the wound audit I and reviewed the I sure residents with skin I order for treatment to areas I nysician and/or physician			
	The Director of Heal Managers reviewed	/changed skin impairments. th Services and Nurse residents with wounds to mentation including ongoing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345371	B. WING			C 1/03/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 836 HOSPITAL DRIVE NEW BERN, NC 28560		1/03/2021	
(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	(X5) COMPLETION DATE	
F 726	currently in place, do physician / physician / physician Review of documenta without wound documental managers educated regarding accuracy of to include identification skin impairment note education has been a general orientation upeducated by 10/28/22 their next scheduled. The Director of Healt Managers began educated by 10/28/22 their next scheduled. The Director of Healt Managers began educated by 10/28/22 their next scheduled. The Director of Healt Managers began educated by 10/28/22 their next scheduled. The Director of Healt Managers began educated by 10/28/22 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Jirector of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled. The Director of Healt Managers began educated by 10/28/24 their next scheduled.	extender notification. ation identified no residents nentation at this point in time id observations are accurate. In Services and Nurse the Licensed Nurses of weekly body observations on of any dressing noted or id on the resident body. This added the License Nurse oon hire. License Nurses oon hire. License Nurses oon hire. License Nurses oon hire. License Nurses oon hire. License Nurse oon hire. This observations and electronic health record of kin impairment is noted, the omplete the wound electronic medical record tion and measurement of ophysician/physician regarding newly identified allor worsening skin ond treatment orders. This obsessments and onecessary as a monitoring ore are any changes in the optimize a change	F 7:	26			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345371	B. WING		_	1	03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 836 HOSPITAL DRIVE NEW BERN, NC 28560	- ATE, ZIP CODE	1 117	03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Managers began edu regarding completing and wound managen description and measimpairments weekly. added the License N upon hire. Any Licenallowed to work after the education. The Director of Healt Managers have valid 10/27/21 skin observ License Nurses for coand accuracy. No dis The Clinical Competer Health Services and all Licensed Nurse's observation to validat comprehensive asset the assessment. Lice competent will be revalidate competency skin assessments. Li allowed to work after been observed and v	h Services and/or Nurse reation on 10/27/21 weekly skin observation ment notes including surements of skin This education has been curse general orientation sed Nurse will not be 10/28/21 until they receive h Nursing and/or RN Nurse rated, (by observation) the rations completed by the comprehensive assessment crepancies where identified. Proceedings on 10/29/21 complete skin	F	726			
	responsible for ensur of competency is con any Licensed Nurse Assistant working the Alleged date of IJ Re						
	_	d on 11/2/21 which removed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(
		345371	B. WING _			11/	03/2021
	ROVIDER OR SUPPLIER			83	TREET ADDRESS, CITY, STATE, ZIP CODE 16 HOSPITAL DRIVE EW 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 B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 726	reviews, and observa included information of treatments according assessments, wound identification of new vassessments. The facility 's Immed of 10/30/21 was valid Food in Form to Meet CFR(s): 483.60(d)(3) §483.60(d) Food and Each resident receive §483.60(d)(3) Food p to meet individual neet individual neet in the facility staff and the called to provide the confailed to provide the confail	rdy on 10/29/21, as erviews, in-service record tion. The in-services on providing wound care to physician orders, wound measurements, and wounds and weekly skin related. Individual Needs drink as and the facility provides- repared in a form designed eds. Is not met as evidenced and interviews with consulting dietitian the facility orrect consistency of food to residents reviewed for it itted to the facility on 3/4/21. The dietition of the service of the facility or subdural eceptive-expressive		305	"How corrective action will be accomplished for those residents found have been affected by the deficient practice. Resident #3 no longer resides in the facility. "How the facility will identify other residents having the potential to be affected by the same deficient practice. The Dietary Supervisor monitored the table line to ensure all residents received the correct diet texture. All residents have the potential to be affected.	ray	12/3/21

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NITIMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345371	B. WING _				03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2021
					36 HOSPITAL DRIVE		
PRUITTHE	ALTH-TRENT				EW BERN, NC 28560		
					<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 805	Continued From pag	e 89	F 8	305			
	assistance with most	activities of daily living			"What measures will be put into place	or	
		endent on staff for toileting			systemic changes made to ensure that		
		n eating. She received a			the deficient practice will not recur.		
	mechanically altered				and demonstrate products than met recount		
	,,,				The Certified Dietary Manager began		
	The October 2021 Pl	hysician orders revealed the			educating the Certified Nursing Assista	nts	
		lent #3 was regular puree.			on 11/23/2021 regarding how to read a		
		5 1			meal card and how to know what the		
	A dietary note written	on 10/18/21 by the Dietary			consistency of the diet should look like	to	
	Manager revealed Re	esident #3 continued to			ensure resident is given correct		
	receive a regular pur	eed diet.			consistency. This education has been		
					added to the general orientation of nev	/ly	
	During a meal observ	vation on 10/25/21 at 12:25			hired Certified Nursing Assistants.		
	PM Resident #3 's lu	ınch meal tray was on her					
	over the bed table. F	Resident #3 was feeding			The Speech Therapist is conducting ar	1	
	herself. The meal tra	y ticket identified Resident			education to the dietary employees on		
	#3 was on a regular	puree diet. The meal tray			12/1/2021 regarding diet textures (regu	ılar,	
	included pureed okra	a. The pureed okra			chopped, pureed, mechanical soft, nec	tar	
	contained visible pied	ces of okra.			thick and honey liquids). This education will include the reason a resident may		
	On 10/25/21 at 12:35	5 PM Unit Manager stated			ordered an altered diet consistency. Th	nis	
	she observed Reside	ent #3 ' s lunch meal tray and			education has been added to the gene	ral	
	she could see the pie	eces of okra. She removed			orientation of newly hired dietary		
	the plate containing t	he okra.			employees.		
	On 10/25/21 at 12:40	PM the Administrator stated			The Certified Dietary Manager reviewe	d	
		ave visible pieces of okra in			the policy regarding diet textures with t	he	
	-	added Resident #3 was			dietary staff on 11/23/2021. This		
		hole pieces of food by taking			education has been added to the gene	ral	
		esident ' s trays or food			orientation of newly hired dietary		
	items brought in by h	er family.			employees.		
		PM the Dietary Manager			The Certified Dietary Manager began		
		ould not have visible pieces			education to the Dietary Staff on		
	of food if it was pure	ed correctly.			11/23/2021 regarding reading and		
					following the spreadsheet given per me	eal	
		st was interviewed on			to prevent the wrong texture of foods		
		She stated Resident # 3			being served to the resident. This		
	required a pureed die	et because she did not chew			education has been added to the gene	ral	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE COMP	SURVEY LETED
						(0
		345371	B. WING _			11/	03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-TRENT			83	36 HOSPITAL DRIVE		
T INOTITIE	JALIII-IIILIII			N	EW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 805	Continued From page	90	F	305			
	the foods even when swallowed foods who	instructed to do so. She le.			orientation of newly hired dietary employees.		
	on 10/28/21 at 9:00 A	with the consulting dietitian M she stated Resident #3 and the pureed foods pieces in them.			The Dietary Supervisor/Cook is monitoring the pureed food prior to placing on tray line for texture accuracy alternating meal times, four times per week for four weeks, then bi-weekly for two months, then monthly thereafter. The Certified Dietary Manager is performing spot checks of meal trays delivered to the units for texture and consistency daily for two meals per day for one week, then ten trays per week if four weeks, then 10 trays per month for three months. "How the facility plans to monitor its performance to make sure that solution are sustained.	/ for r	
					The Certified Dietary Manager will press the analysis of the spot checks performance to the Quality Assurance at Performance Committee monthly until three months of sustained compliance sustained then quarterly thereafter. The Certified Dietary Manager will press the analysis of the Dietary Supervisors tray line review to the Quality Assurance and Performance Committee monthly of three months of sustained compliance sustained then quarterly thereafter. Include dates when corrective action w	and is eent ee until	
					be completed. 12/3/2021	111	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45074		_			C
		345371	B. WING			11/	03/2021
	OVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 36 HOSPITAL 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842 SS=E S	CFR(s): 483.20(f)(5), 8483.20(f)(5) Resider (i) A facility may not resident-identifiable to resident to use or consecution of the extent the resident of the extent the resident resident and resident are- (i) Complete; (ii) Accurately docume (ii) Readily accessible (iii) Readily accessible (iii) Readily accessible (iii) Readily accessible (iii) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permittifiable to representative where (iii) Required by Law; (iii) For treatment, pay operations, as permittifiable to representative where (iii) Required by Law; (iii) For treatment, pay operations, as permittifiable to resident in the resident of the resident in the resident of the resident in the resident of the resident in the res	dentifiable Information 483.70(i)(1)-(5) Int-identifiable information. Delease information that is to the public. Delease information that is to an agent only in Intract under which the agent Deliase the information Delease information Delease information Delease information Delease the information Delease information Delease is and practices, the facility Delease is and practices on each resident Delease is and Delease i		842			12/3/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COMPLETED
		345371	B. WING		C 11/03/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 HOSPITAL DRIVE NEW BERN, NC 28560	11/03/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 842	medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The far record information at unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The medical formation of the record of the re	funeral directors, and to avert ealth or safety as permitted a with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or all records must be retained a required by State law; or need to discharge when ent in State law; or ears after a resident reaches a law. edical record must containtion to identify the resident; sident's assessments; sive plan of care and services by preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and ology and other diagnostic equired under §483.50. T is not met as evidenced wiews and record review the ment wound care treatments in 1 of 3 residents reviewed	F 84	"How corrective action will be accomplished for those residents fou have been affected by the deficient practice. Resident #200 no longer resides in the facility. "How the facility will identify other	

PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345371	B. WING			C 11/03/2021	
NAME OF P	ROVIDER OR SUPPLIER	0.001.		STREET ADDRESS, CITY, STATE, ZIP COD		11/03/2021	
NAME OF T	NOVIDER OR SOLT LIER			, , ,	_		
PRUITTHE	ALTH-TRENT			836 HOSPITAL DRIVE			
				NEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 93	F 84	2			
	contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and			residents having the potential affected by the same deficient			
	-	tiva (a chronic skin condition		anected by the same delicient	і ріаспсе.		
		which develop because of		The Director of Health Service			
	inflammation and infe	ection of sweat glands).		100% body audits on all resid			
				the facility on 10/27/21. This a			
	•	arterly minimum data set		no wounds without physician/	•		
	assessment dated 10/22/20 revealed he was assessed as cognitively intact. He required			extender notification. If any re noted without an order for imp			
		with bed mobility and toilet		integrity the Director of Nursi			
	use. He had two stage II pressure ulcers present			Managers and/or Licensed N	•		
	upon admission. He l			notify the physician and/or phy			
	•	gs, pressure ulcer care, and		extender for orders.			
	a pressure reducing	device to bed and chair.					
		#200's Treatment Orders and		"What measures will be put in			
		ation Records from June		systemic changes made to en			
	_	y 10th, 2021 revealed he /2020 to have his left inner		the deficient practice will not r	ecur.		
	armpit cyst, related to	o hidradenitis, cleansed with		"The Director of Health Service			
		ply a dry dressing every day.		Nurse Managers have review			
		ntinued on 9/24/2020. The		wound audit conducted on 10			
		ed by Physician #1 and		reviewed the documentation t			
		ound Care Nurse. There ments documented for his		residents with skin impairmen order for treatment to areas. 1			
	left armpit wound.			of Health Services and Nurse			
	icit ampit would.			reviewed residents with woun	•		
	A review of the physic	cian and Nurse Practitioner		weekly documentation includi			
		/20 through 1/10/21 revealed		assessments including wound			
	no reference to Resid	dent #200's left armpit		measurements are currently in			
	wound.			documented. Review of docu			
				identified no residents without			
		medical record revealed no		documentation at this point in	time.		
		wound to his left armpit		WThe Discrete CH W C			
	from 9/24/20 through 1/10/21. There were no assessments or measurements of the wound.			"The Director of Health Service			
	assessments or mea	surements of the wound.		Nurse Managers began educa 10/27/21 regarding weekly sk			
	A nursing note dated	1/10/21 revealed at 4:45 AM		observations and documentat			
		by Nurse Aide #3 of a		electronic health record of sar			

Facility ID: 923215

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDI	_		Ι,	С
		345371	B. WING				03/2021
NAME OF P	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00,2021
				8	36 HOSPITAL DRIVE		
PRUITTHI	EALTH-TRENT			N	IEW BERN, NC 28560		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 842	Continued From page	e 94	F	842			
	change in Resident#	200's breathing. The nurse			new skin impairment is noted, the		
		ed and observed Resident			Licensed nurse will complete the woun	d	
	#200 in his usual (du	e to contractures) fetal			documentation in the electronic medica	ıl	
	position, shallow resp	pirations, unresponsive, and			record that includes description and		
	with a faint pulse. 91	1 was notified by the nurse.			measurement of area ,and contact the		
		ound to be without signs of			physician/physician extender for orders	; ,	
	life, cessation of brea	- ·			regarding newly identified skin		
		suscitation (CPR) was			impairments and/or worsening skin		
		d at the facility and called			impairments for wound treatment order		
	time of death at 5:02	am at the facility.			This includes that the assessments an	a	
	The EMS record date	ed 1/10/21 indicated EMS			measurements were necessary as a monitoring tool to determine if there are	_	
		e facility for Resident #200.			any changes in the wound that would	,	
		g hole in his left armpit that			require a change in the treatment plan.		
		agreed by EMS personnel to			This education has been added to the		
	_	I call time of death in the			License Nurse general orientation upor	า	
		ne local police department			hire. Any Licensed Nurse will not be		
	was notified.	·			allowed to work after 10/28/21 until the	у	
					receive the education. The new Wound	i	
		ative dated 1/11/21 revealed			Nurse and the Nurse Practitioner are		
		ved at the facility in response			meeting weekly to discuss and review	all	
		ity on 1/10/21. Resident			residents with wounds.		
	_	ppen wound under his left					
		Il inches wide and extended			"The Director of Health Services and/o	ſ	
	1	The officer documented the			Nurse Managers began education on		
		s not bandaged and showed			10/27/21 regarding completing weekly	ont	
	no signs of care.				skin observation and wound managem notes including description and	EIIL	
	During an interview o	on 10/26/21 at 9:43 AM the			measurements of skin impairments		
		stated she remembered			weekly. This education has been adde	ed.	
		stated she was the wound			the License Nurse general orientation		
		ne, and he was on her			upon hire. Any Licensed Nurse will no	t be	
		ted she was providing wound			allowed to work after 10/28/21 until the		
		left underarm and on			receive the education.	-	
		t was discontinued but she					
	continued to provide	care to the wound because it			"The Director of Health Services and		
		unable to recall why the			Nurse Managers educated the Certified	Ł	
	treatment was discon				Nursing Assistants on daily skin checks	3	
	Practitioner on 9/24/2	20 as the wound had not			during personal care. This education		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(
		345371	B. WING _			11/	03/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-TRENT				86 HOSPITAL DRIVE		
1 1011 1111	- CALITI-III CIVI			N	EW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	revealed that until his continued to provide the without orders. She is documented this treat medical record from She indicated she has assessments or wour 9/24/20 through 1/10/20. During an interview on Physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with no physician #1 the Wood in which she reported treatments with the deresses which would she assessed, monitor stated wound measurements the determine if there we that would require a composition of the stated due to the limpossible to know if was not present or the time of the photogode partment. During an interview on Director of Nursing stassessed, monitored, care treatment was to the province of the photogode partment.	thealed at that time. She death (1/10/21) she the discontinued treatment tated she had not tree to the wound in the 2/24/20 through 1/10/21. In the discontinued treatment to the wound in the 2/24/20 through 1/10/21. In 10/27/21 at 12:33 PM with und Care Nurse's interview I that she completed anysician's order from 9/24/20 cell as her statement that she ments or measurement of ut this same time period the physician. He stated that trained prior to treatments identified wounds were to red, and documented. He rements were part of the stated without assessments there was no way to re changes in the treatment plan. It lack of documentation it was and when the wound until	F	342	includes notification to the nurse of any skin impairment and/or new dressing noted on resident skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certif Nursing Assistant general orientation uthire. Any Certified Nursing Assistant without be allowed to work after 10/28/21 uthey receive the education. "The Clinical Competency Coordinator/ is responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/28/2. "The Director of Health Services and/or Nursing Leadership review the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. "How the facility plans to monitor its performance to make sure that solution are sustained. The Director of Health Services will present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the Quality Assurance and Performance	ied pon rill ntil (RN 3 9 21.	
	During an interview o Director of Nursing st assessed, monitored, care treatment was to She concluded wound	ated wounds were to be , and documented. Wound o be documented as well.			present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the	of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	0.45074				С	
345371		B. WING			11/03/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHEALTH-TRENT			836 HOSPITAL DRIVE			
1 KOTT TILALITI-TKLKT			NEW BERN, NC 28560			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		COMPLETION	
F 842 Continued From page	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		quarterly thereafter. The Clinical Competency Coordin present the analysis of education compliance of the Licensed Nursi regarding weekly skin observation documentation in wound manager notes including description and measurements and physician not weekly to the Quality Assurance a Performance Committee monthly three months of sustained compliamaintained then quarterly thereaf. The Clinical Competency Coordin present the analysis of education compliance of the Certified Nursin Assistants regarding on daily skin during personal care to the Quality Assurance and Performance Commonthly until three months of sust compliance is maintained then quarterly thereafter. "Include dates when corrective active completed. 12/3/2021	es n and ment ification nd until ance is ter. ator will ng checks / mittee ained parterly		