STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/22/24 through 4/24/24. Event ID# 7CVT11. The following intakes were investigated NC00215453, NC00215651, NC00215662, NC00216093 and NC00216104. 6 of the 30 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		5/17/24

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

Electronically Signed | 05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide a room free of a strong smell of urine which reached out into the hallway. This was evident in 2 of 3 rooms reviewed for a safe, clean, homelike environment (Rooms 307 and Room 314). Findings included: 1a. During an observation on 4/22/24 at 10:41 AM the 300 hallway and Room 307 smelled strongly of urine. No soiled briefs or linens were observed in the room, and the resident was not visibly soiled. An observation and interview on 4/23/24 at 2:23 PM with Resident #22 revealed a strong smell of urine from the resident in Room 307 and outside the room in the 300 hall. 1b. During an observation on 4/22/24 at 10:41 AM the 300 hallway and Room 314 smelled strongly of urine. An observation on 4/23/24 at 2:23 PM revealed a strong smell of urine from Room 314 and outside	F 584	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 22 and # 23 rooms were stripped, deep cleaned and rewaxed/ resealed by 4/30/24. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 4/24/24 the Management team toured all rooms in the facility to identify any odors, this tour identified one room that required stripping, deep cleaning and rewaxing/ resealing of the floor, this was completed on 5/2/24. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 5/10/2024 the Administrator and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 the room in the 300 hall. Resident #23 was not able to be interviewed. No soiled briefs or linens were observed inside the room, and the resident was not visibly soiled. An interview on 4/23/24 at 1:38 PM with the Housekeeping Director revealed she was aware of the strong smell of urine in the facility on 4/22/24 and on the 300 hall on 4/23/24. She stated the residents in rooms 307 and 314 refused to allow housekeeping to clean their rooms. She also stated that Resident #23 urinated in trashcans and on the furniture. She stated some days the urine smell in the facility was worse than others. An interview on 4/23/24 at 2:23 PM with Nursing Assistant (NA) #1 revealed that she worked on the 300 hall frequently. She stated that the urine smell was really bad on 4/22/24 especially on 300 hall. She stated that Resident #23 refused care frequently and urinated in trashcans and cups. An interview on 4/23/24 at 2:46 pm with NA #2 revealed that she worked on the 300 hall at times. She stated that Rooms 307 and 314 frequently had a strong urine odor. An interview on 4/23/24 at 3:02 PM with Nurse #7 revealed she worked on the 400 hall which was adjacent to the 300 hall. She stated that the residents in rooms 307 and 314 were resistive to care and their rooms usually had a strong urine odor. An interview on 4/24/24 at 8:05 AM with the Maintenance Director revealed he was aware of the strong urine odor on the 300 hall. He stated that the residents in Rooms 307 and 314 refused	F 584	management team educated all staff related to when a resident room has odors to notify in writing the Administrator, Administrator in Training, Environmental Supervisor and/or Director of Nursing. Any staff not educated by 5/14/24 will be removed from the schedule. This education has been added to the general orientation for all staff. The department managers will complete room rounds for odors five days per week for four weeks, weekly for four weeks then monthly thereafter. When an odor is identified the department manager will notify in writing the Administrator, Administrator in Training, Environmental Supervisor and/or Director of Nursing. The Administrator, Administrator in Training, Environmental Supervisor and Director of Health Services will determine what the odor is from and ensure the odor is resolved. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Environmental Service Director will present the analysis of the room odor audits to the Quality Assurance and Performance Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 5/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 to allow housekeeping to clean their rooms. He stated that the floor tiles probably needed to be replaced to get the odor out. An interview on 4/24/24 at 9:39 AM with Nurse #8 revealed he usually worked at the 300 hall nurses' station and the resident in rooms 314 refused care so the 300 hall frequently had a strong urine odor. An interview on 4/24/24 at 10:05 AM with the Administrator revealed that she was aware of the strong odor of urine in Rooms 307 and 314 and the 300 hall. She stated that she would get Room 314 floor retiled to see if that would help. She stated that the facility had made multiple attempts to get the residents to permit their rooms to be cleaned. An interview on 4/24/24 at 11:10 AM with the Director of Nursing revealed that she was aware the urine odors on the 300 hall. She stated the residents in rooms 307 and 314 had behaviors and refused to have their rooms cleaned.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 602	"Address how corrective action will be	5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 4 facility failed to protect the resident's right to be free from misappropriation of a controlled medication, (30 Oxycodone 5 milligram (mg) pills), which were prescribed by the Physician for pain for 1 of 3 residents reviewed for misappropriation of property (Resident #10). The findings included: The resident was admitted to the facility on 1/9/23. The Physicians order for Resident #10 dated 8/8/23 was one tablet of Oxycodone 5mg every four hours as needed for moderate to severe pain. Review of a quarterly Minimum Data Set dated 4/1/24 revealed Resident #10 was moderately cognitively impaired. A review of the facility internal investigation report dated 9/15/23 revealed the Director of Nursing (DON) received a phone call from Nurse #6 on 9/7/23 at 7:33 AM and she stated they were counting narcotics at change of shift and there was a card of narcotic medication unaccounted for. The medication belonged to Resident #10. The DON stated she notified the Administrator and Nurse Consultant. She further revealed the facility notified law enforcement and Pharmacy on 9/13/23. In an interview with Resident #10 on 4/23/24 at 4:15 PM he stated he was not aware that any of his medication had been missing in September. He further stated he did not recall going without narcotic medication at any time, nor did he recall being charged for any medication.	F 602	accomplished for those residents found to have been affected by the deficient practice. Resident # 10 medication was replaced at the facility expense on 9/23/24. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 9/8/2024 the Director of Nursing reviewed all narcotics within the facility to ensure that no other medication was missing, all medication accounted for. On 9/13/2023 the Pharmacist also completed a count for all narcotics and did not identify any other missing medications. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/10/2024 the Director of Health Services and Nurse Managers began educating all Nurses on completing a proper medication count to ensure all narcotics and narcotic cards are accounted for and the Director of Nursing is notified immediately of any discrepancies. This education will be completed by 5/14/2024, any Nurse not educated will be removed from the schedule until the education is completed. The education has been added to the general orientation for all Nurses, The Director of Nursing was educated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 5 In an interview with the DON on 4/23/24 at 10:44 AM she stated all narcotics are kept double locked. In this case the Nurse would have two keys, one to unlock the cart and one to unlock the narcotic drawer. She further stated Nurse #4 and an orientee (Nurse #5) were working on that cart that night, and they both passed voluntary drug screening tests during the investigation by the facility. The DON revealed staff searched all medication carts and med rooms for the missing medication. Nurses #4, #5 and #6 could not be reached for interviews. The law enforcement officer was unavailable for interview. Observations during the survey revealed medication carts to be locked when not in use. An interview with the Pharmacist on 4/23/24 at 1:12 PM revealed he was notified of missing narcotic medication belonging to Resident #10 on 9/13/23. He came to the facility the same day to help staff investigate the incident. The Pharmacist further stated he was unable to locate the medication. In an interview with the Administrator on 4/24/24 at 2:15 PM, she stated she was made aware of the missing narcotic medication on 9/7/23 and helped staff search for it. She further stated the narcotic count sheet had been moved to the back of the three-ring binder but was unable to determine who had moved it. She had reviewed facility camera recordings, and the cart was parked out of view for some of the shift. The	F 602	the Senior Nurse Consultant on 5/10/2024 that medication discrepancies (missing medications) are reportable to the Division of Health Services Regulation. The Director of Health Services and/or Nurse Managers will validate the narcotic count sheets with the narcotics as well as the card count form with the number of cards in the narcotic boxes daily for 5 days then weekly for four weeks then monthly thereafter. The Administrator / Administrator in Training will validate any misappropriated medication that has been reported to Division of Health Services Regulation, Adult Protective Services and Law Enforcement per regulation, weekly for four weeks then monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will present the analysis of the narcotic count audits to the Quality Assurance and Performance Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. The Administrator / Administrator in Training will present the analysis of the misappropriation of medications reported to Division of Health Services Regulation, Adult Protective Services and Law Enforcement per regulation, to the Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 6 Administrator revealed the narcotic count should always be correct. She stated the facility covered the cost to replace the medication. The Administrator revealed they completed trainings that included misappropriation upon hire.	F 602	Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 5/17/2024	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit an initial or investigation (5 day) report to the state regulatory agency and did not notify Adult Protective Services (APS) regarding an allegation of misappropriation of resident property. They further failed to report to Law Enforcement within 24 hours of discovery of misappropriation of resident property for 1 of 3 residents (Resident #10) reviewed. Findings included: A review of the facility internal investigation report dated 9/15/23 revealed the Director of Nursing (DON) received a phone call from Nurse #6 on 9/7/23 at 7:33 AM and she stated they were counting narcotics at change of shift and there was a card of narcotic medication unaccounted for. The medication belonged to Resident #10. The DON further revealed the facility notified law enforcement on 9/13/23. The report did not indicate if APS was notified. An interview with the DON on 4/23/24 at 10:44 AM revealed she received a phone call from Nurse #6 on 9/7/23 who stated a card of a narcotic medication was missing during the shift change medication count. The DON stated she notified the Administrator. In a follow up interview with the DON on 4/24/24 at 11:09 AM she stated she did not send an initial report or 5-day investigation report to the state regulatory agency as she did not realize it was a reportable incident. She stated she did not report it to APS for the same reason. The DON revealed she did not think about the incident as being classified as misappropriation of resident	F 609	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Initial submission of misappropriation to Division of Health Services Regulation and notification to Adult Protective Services was completed on 5/10/2024. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Senior Nurse Consultant began education on 5/10/2024 with the Administrator, Administrator in Training and Director of Nursing related to notification to the Division of Health Service Regulations of all alleged misappropriation of resident medications. This education has been added to the general orientation of any new Administrator, Administrator in Training and/or Director of Health Services. The Director of Health Services and/or Nurse Managers will validate the narcotic count sheets with the narcotics as well as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 8 property. She further stated she did not notify law enforcement for 5 days because she spent that time looking for the missing medication. In an interview with the Administrator on 4/24/24 at 2:15 PM she stated she did not report the misappropriation to the state regulatory agency by sending an initial report or a 5-day investigation report. She further stated she did not notify APS. The Administrator revealed she did not think to categorize the missing medication as misappropriation as she was thinking more of diversion. She indicated that the delay in notification to law enforcement was because they were searching for the missing medication.	F 609	the card count form with the number of cards in the narcotic boxes daily for 5 days then weekly for four weeks then monthly thereafter. The Administrator / Administrator in Training will validate any misappropriated medication has been reported to Division of Health Services Regulation, Adult Protective Services and Law Enforcement per regulation, weekly for four weeks then monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Health Services will present the analysis of the narcotic count audits to the Quality Assurance and Performance Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. The Administrator / Administrator in Training will present the analysis of the misappropriation of medications reported to Division of Health Services Regulation, Adult Protective Services and Law Enforcement per regulation to the Quality Assurance and Performance Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 5/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 9	F 867		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 10	F 867		

facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 11 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, Nurse Practitioner, and staff interview the facility's Quality Assessment and Assurance	F 867	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 12 Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation surveys of 4/21/22 and 7/13/23 and the complaint investigation surveys of 8/30/23 and 2/21/24. This was for 4 recited deficiencies in the areas of Safe/Clean/Comfortable/Homelike Environment (F584), Reporting of Alleged Violations (F609), and Infection Control (F880). The continued failure during 2 or more federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The tag is cross-referenced to: F584: Based on observations, resident and staff interviews, the facility failed to provide a room free of a strong smell of urine which reached out into the hallway. This was evident in 2 of 3 rooms reviewed for a safe, clean, homelike environment (Rooms 307 and Room 314). During a recertification and complaint investigation survey of 4/21/22 the facility was cited for failing to keep walls, resident furniture and sinks in good condition. During a complaint investigation survey of 8/30/23 the facility was cited for failing to: clean and repair water damage to resident vanities; prevent leaking plumbing in resident hand sinks and toilets; clean a flat, black substance on resident walls near toilet plumbing and behind raised wallpaper; and repair wallpaper that was wet to touch and separated from the wall behind toilets. F609: Based on record review and staff interviews, the facility failed to report an allegation of misappropriation of resident property to the	F 867	practice. F 584 the two resident rooms with strong odors where stripped, deep cleaned and rewaxed by 4/30/2024 F 609 The facility reported the event to the Department of Health Service Division 5/10/24. F 880 Education was started on 4/23/24 related to enhanced barrier precautions. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/9/2024 the Facility Management team was assigned an electronic educational tool course Quality Assurance and Performance Improvement Developing and Sustaining a Quality Culture. This education will be completed by 5/16/2024 or the department manager will be removed from the schedule until the course has been completed. This education has been added to the general orientation of all the Facility Management team. The Administrator will lead the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 13 state regulatory agency and Adult Protective Services (APS). They further failed to report to Law Enforcement within 24 hours of discovery of misappropriation of resident property for 1 of 3 residents (Resident #10) reviewed. During a complaint investigation survey of 2/21/24 the facility was cited for failing to report an allegation of staff to resident abuse within the required time frame of 2 hours. F880: Based on observations, and staff interviews, the facility failed to implement their policies and procedures for wearing Personal Protective Equipment (PPE) when 3 of 3 Nursing staff members (Nurse #1, Nurse #2, and Nurse #3) were observed not wearing (PPE) when providing care to 1 of 1 resident (Resident #21). During a recertification and complaint investigation survey of 4/21/22 the facility was cited for not following isolation precautions for a resident who had orders to be on isolation enteric precautions. During an interview with the Administrator on 4/24/24 at 2:05 PM she stated the QA (Quality Assurance) committee met monthly and consisted of the Administrator, Director of Nursing, Medical Director and the Directors of the facility's departments. When an area of concern was identified during an IDT (Interdisciplinary Team) meeting, a PIP (performance improvement project), including audits with results was submitted to the QA committee every month until the concern was resolved. She further stated that as oversight, the corporate consultants also have access to this information to audit, submit recommendations, and follow-up to the QA	F 867	Assurance and Performance Improvement meetings with emphasis and focus on the areas that lead to the deficiencies and/or citations. This will ensure the facility has identified areas of noncompliance and that the areas of noncompliance have been addressed to prevent further deficient practices related to environment of facility, reporting of allegations of misappropriation, documentation, and infection control. At least one member of the Region Team that includes the Area Vice President, Senior Nurse Consultant, and/or Clinical Reimbursement will attend the monthly Quality Assurance and Performance Improvement Committee meeting monthly for three months then quarterly to ensure that the areas leading to deficient practices identified are addressed by the facility according to the Quality Assurance and Performance Improvement process. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained, The Administrator / Administrator in Training will present the analysis of the any new areas of non-compliance to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 5/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 14 Committee. The Administrator revealed that overcoming certain citations such Environment and Infection Control are difficult as they encompass so many potential issues. She further stated that the facility must ask permission from corporate for the funds to fix walls and replace resident furniture. The Administrator revealed they received a citation for failure to report on 2/21/24 and it was because the fax would not go through for several hours. They have since found that sending a fax from Human Resources works faster.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to implement their enhanced barrier precautions policies and procedures for wearing Personal Protective Equipment (PPE) when 3 of 3 Nursing staff members (Nurse #1, Nurse #2, and Nurse #3) were observed not wearing (PPE) when providing care to 1 of 1 resident (Resident #21). Findings included: The facility's enhanced barrier precautions guidelines effective date 4/01/24 read in part that enhanced barrier precautions were in effect for chronic wounds, internal devices, and lines. Infection Control signage posted on Resident #21's room door read in part 'Enhanced Barrier Precautions. Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities.' The high contact resident care activities list included device care or use: urinary catheter, feeding tube, tracheostomy; wound care: any skin opening requiring a dressing. During an observation on 4/23/24 at 8:59 AM, Nurse # 1 and Nurse #2 were observed to provide wound care on Resident #21's right and left buttock, suprapubic (above the pubic bone) urinary catheter care, gastrointestinal tube care, and tracheostomy care. Nurse #1 and Nurse #2 did not don a gown for any observed resident care.	F 880	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 21 no longer resides in the facility. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/23/24 the Director of Health Services, Clinical Competency Coordinator and Nurse Managers began education on Infection Control practices related to Enhanced Barrier Precautions to all staff. This education included when to utilize appropriate personal protective equipment with residents on enhanced barrier precautions. Staff members not educated by 5/14/24 will be removed from the schedule until the education is completed. This education has been added to the general orientation of all staff members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 An interview on 4/23/24 at 9:33 AM with Nurse #1 and Nurse #2 revealed they had had enhanced barrier training. They stated they had not donned a gown for any of Resident #21's observed care. They stated they had not done so due to nervousness about being observed. During an observation on 4/23/24 at 10:22 AM, Nurse #3 was observed to provide a tube feeding with water flushes for Resident #21. She did not don a gown for any observed resident care. She stated that she had not because 'people don't really' and she had fallen out of practice with wearing a gown for residents with enhanced barrier precautions. She stated she was aware that Resident #21 had an enhanced barrier precautions sign on his door but did not realize that it included tube feeding. An interview on 4/24/24 at 10:05 AM with the Administrator revealed the staff have had enhanced barrier precautions training and she thought they were just nervous, and it was human error they had not worn a gown during resident care. An interview on 4/24/24 at 11:10 AM with the Director of Nursing revealed that the staff have had enhanced barrier precautions training, and she did not know why they had not worn gowns during resident care.	F 880	The Director of Health Services, Clinical Competency Coordinator, Infection Preventionist, and Nurse Managers are monitoring for appropriate Personal Protective equipment utilization with residents on enhanced barrier precautions daily for five days, then weekly for four weeks, then monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Infection Preventionist will report the analysis of the appropriate Personal Protective equipment utilization reviews with residents on enhanced barrier precautions to the Quality Assurance and Performance Improvement monthly until three consecutive months of compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 5/17/2024	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345357	A. BUILDING: _____ B. WING _____	4/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff and nurse practitioner (NP) interviews the facility failed to accurately document a fall with injury on the discharge summary for 1 of 3 residents reviewed for supervision to prevent accidents. (Resident #1) Findings included: Resident #1 was admitted to the facility on 3/20/24 with a diagnosis of generalized weakness. A review of a nursing progress note for Resident #1 dated 3/22/24 at 1:50 AM revealed in part Resident #1 was found lying face down in her bathroom. Resident #1 reported she had lost her balance and had fallen. Resident #1 was noted to have a 3-4-millimeter (mm) laceration (cut) to the fifth metatarsal (pinky finger) of her left hand. Emergency Medical Services (EMS) was called, and Resident #1 was transported to the hospital. A review of the hospital record for Resident #1 dated 3/22/24 revealed in part she was seen in the hospital Emergency Room (ER). It further revealed 6 sutures (stiches) were placed to the laceration of Resident #1's left pinky finger. A review of Resident #1's admission Minimum Data Set (MDS) assessment dated 3/27/24 revealed in part she was moderately cognitively impaired. It further revealed she had one fall with injury since her admission to the facility.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345357	A. BUILDING: _____ B. WING _____	4/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Continued From Page 1

A review of the NP discharge summary for Resident #1 dated 4/5/24 written by NP #1 revealed in part Resident #1 had done well at the facility and was being discharged home with her family. It further revealed Resident #1 had one fall with no injury on 3/22/24 when she tried to go to the bathroom by herself without calling for help.

In a telephone interview 4/24/24 at 1:27 PM NP #1 stated she had not looked back at the documentation indicating Resident #1's fall on 3/22/24 resulted in a finger laceration requiring sutures when she completed Resident #1's discharge summary on 4/5/24. She went on to say her documentation on the discharge summary that Resident #1 had a fall with no injury on 3/22/24 was not accurate.

On 4/24/24 at 1:33 PM an interview with the Administrator indicated NP #1's documentation on resident's discharge summaries should be accurate.