STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/24/2025 through 02/27/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MW8B11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/24/2025 through 02/27/2025. Event ID# MW8B11. The following intakes were investigated NC00225167, NC00222085, NC00225875, NC00227397, NC00221846 and NC00221188. 14 of the14 complaint allegations did not result deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff and Nurse Practitioner (NP) interviews, the facility failed to assess whether the self-administration of medication was clinically appropriate before leaving medication at the bedside. This was for 1 of 5 residents (Resident #87) reviewed for medication administration. Findings included: Resident #87 was admitted to the facility on	F 554	Corrective action for the residents found to be affected by the deficient practice. Resident #87 was affected by the deficient practice. The medication was removed from the bedside of resident #87 immediately. Nurse #3 was provided 1:1 education by the facility, BSN, Staff Educator related to not leaving meds at bedside on 2-25-2025. An audit was conducted by DHS, Unit	3/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/12/2025

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.

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F 554

Continued From page 1

8/15/24 with a diagnosis of chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath).

A review of Resident #87's medical record did not reveal a self-administration of medication assessment.

A review of Resident #87's physician's orders did not reveal a physician's order to self-administer any medication. A physician's order dated 8/15/24 revealed Trelegy Ellipta (a long term medication to treat COPD) blister with device; 100-62.5-25 microgram (mcg) administer one puff inhalation once daily at 9:00 AM for COPD.

A review of Resident #87's quarterly Minimum Data Set (MDS) assessment dated 2/12/25 revealed she was cognitively intact.

A review of Resident #87's comprehensive care plan dated last reviewed on 2/12/25 did not reveal any evidence Resident #87 self-administered medication.

On 2/24/25 at 10:42 AM Resident #87 was observed in bed. She had her Trelegy Ellipta inhaler on her bedside table. An interview with Resident #87 at that time indicated she did not usually keep the medication at her bedside. She stated this medication was for her breathing and she took one inhalation daily each morning. She reported she must have been asleep when Nurse #3 brought the medication earlier and she had not taken the inhaler yet that morning. Resident #87 was then observed to administer one inhalation from the inhaler to herself.

F 554

Managers, and Treatment nurses on 2-25-2025 no other areas of concern were identified.

Corrective action for other residents having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this practice.
100% in-service was provided to all nurses by the Staff Educator/Infection Preventionist, related to not leaving residents□ medication at bedside on 2-25 -2025.

Systemic changes are made to ensure that the deficient practice will not recur.
Staff Educator/Infection Preventionist, Unit Managers, DHS, will audit and document to ensure that meds are not left at bedside. Staff Educator/Infection Preventionist, Unit Managers, DHS will perform walking rounds to observe that no medications at left at bedside.
New Nurses will be educated related to not leaving meds at bedside during orientation.

Plans to monitor its performance to make sure that the solutions are sustained.
A weekly audit will be performed and documented Director of Health Services and Unit Managers 5x a week x 4 weeks, 3 times a week bi-weekly and weekly x 1 month then randomly x 3 months. Until deficient practice is corrected Any area found to be out of compliance will be correct through 1:1 education related to PruittHealth Policy and taken to QAPI for

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 554	Continued From page 2 A review of Resident #87's February 2025 Medication Administration Record (MAR) revealed documentation by Nurse #3 on 2/24/25 indicating she administered one inhalation of Resident #87's Trelegy Ellipta inhaler to her at 9:00 AM that morning. On 2/25/25 at 12:05 PM an interview with Nurse #3 indicated she was assigned to care for Resident #87 on 2/24/25 from 7:00 AM to 3:00 PM. She stated she was familiar with Resident #87 and had cared for her before. She reported Resident #87 did not self-administer any medication. Nurse #3 stated she administered one inhalation of Resident #87's Trelegy Ellipta inhaler to her on 2/24/25 at 9:00 AM and then must have inadvertently left the inhaler at Resident #87's bedside. She reported that if Resident #87 had taken another dose of the medication on 2/24/25 at 10:42 AM, this would have been a medication error. On 2/27/25 at 9:01 AM an interview with the Director of Nursing (DON) indicated Resident #87 should not have any medication left at her bedside without a self-administration of medication assessment indicating this was appropriate for Resident #87, and a physician's order to self-administer the medication. On 2/27/25 at 9:51 AM an interview with Resident #87's NP #1 indicated that while taking an additional dose of Trelegy Ellipta inhaler medication on 2/24/25 would not have caused any harm to Resident #87, the medication should not have been left at her bedside. On 2/27/25 at 11:30 AM an interview with the Administrator indicated Nurse #3 was a very	F 554	plan review. These audits will be taken to QAPI by the DHS/Administrator and discussed during monthly QAPI meetings to ensure continued compliance. The systems will be reviewed during quarterly Executive QAPI, and systems updated as indicated. Date of compliance:3-14-2025	

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F 554	Continued From page 3 experienced nurse. She stated leaving medication at a resident's bedside would be very unusual for Nurse #3. The Administrator reported she felt this was just a one-time mistake.	F 554		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		3/14/25

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	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

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F 578	Continued From page 4 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Responsible Party (RP) interviews, the facility failed to ensure a copy of the resident's advanced directive was included in the resident's record and failed to honor the resident's wishes with regards to code status as expressed by the resident's RP on admission. This was for 1 of 11 residents (Resident #94) reviewed for advanced directives. Findings included: A review of Resident #94's hospital discharge summary dated 2/28/24 revealed his code status in the hospital was full code (a medical term that indicates a patient wants to receive all available measures to save their life in an emergency). It was initialed by Unit Manager #1 indicating she reviewed the document. Resident #94 was admitted to the facility on 2/28/24 with a diagnosis of dementia. A review of the facility's admission document titled "NC Advanced Directive for Healthcare" dated 2/28/24 and signed by Resident #94's RP and the facility's Admissions Director revealed documentation indicating Resident #94 had previously executed an advanced directive (Living Will or Healthcare Power of Attorney) and would	F 578	Corrective action for the residents found to be affected by the deficient practice. Resident #94 was affected by the deficient practice. Resident #94 code status has been reviewed and corrected to reflect his Advanced Directive for Healthcare which indicated a previously executed (Living Will or Healthcare Power of Attorney) on 2/25/2025. The daughter, (POA/HCPOA), has supplied the facility with a copy. The resident code status is a DNR. Corrective action for other residents having the potential to be affected by the same deficient practice. 41 residents had the potential to be affected by the deficient practice. A 100% audit has been completed by the Unit Managers to ensure all residents code status is current and updated per their wishes on 2/26/2025. Audit of the Golden Rods was completed by the Unit Managers to ensure they matched the submitted code status on 2/26/2025. Systemic changes are made to ensure that the deficient practice will not recur. Social Worker and Unit managers have	

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F 578	Continued From page 5 provide a copy to the facility. A review of the facility admission document titled "DNR" (Do not Resuscitate is a legal order written to respect the wishes of a patient not to undergo cardiopulmonary resuscitation (CPR) if their heart stopped or they were to stop breathing) dated 2/28/24 and signed by Resident #94's RP and the facility's Admissions Director revealed documentation indicating Resident #94 had a DNR order or MOST (Medical Orders for Scope of Treatment) previously executed on his behalf and a copy would be provided to the healthcare center. A review of Resident #94's physician's orders revealed a code status order for full code dated 2/28/24 entered by Unit Manager #2. A review of Resident #94's comprehensive care plan revealed a focus area for advanced directives initiated on 2/28/24 indicating Resident #94's code status was full code. The goal was for Resident #94's wishes and directives to be carried out in accordance with his advanced directives on an ongoing basis. An intervention was to discuss advanced directives with Resident #94 and/or his appointed health care representative. A review of a Social Work (SW) progress note for Resident #94 dated 3/12/24 at 11:35 AM written Resident #94's SW revealed Resident #94's code status was DNR. A review of Resident #94's annual Minimum Data Set (MDS) assessment dated 1/8/25 revealed he was severely cognitively impaired.	F 578	been educated by the DHS on 2-26-2025, verifying resident code status. The facility Unit Managers will be responsible for confirming with residents, resident family, and/or POA code status on admission. Audits will be completed and documented after each new admission during the 72-hour PAC meeting by the Social Worker or Nurse Navigator to ensure any Health Care documents have been received and code status is correct. The Advanced Directives will be added to new employees (job specific) orientation. Plans to monitor its performance to make sure that the solutions are sustained. Weekly Audit will be conducted x 4 weeks by the Administrator/Social Worker/Unit Managers. Bi- weekly Audit will be conducted x 2 weeks By the Administrator/Social Worker/Unit Managers Monthly audit will be conducted x 2 months by the Administrator/Social Worker/ Unit Managers or until deficient practice is maintained. These audits will go to the Administrator/Social worker to be taken to QAPI to ensure the facility remains in compliance. Date of compliance: 3-14-2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 578	Continued From page 6	F 578		

A review of Resident #94's medical record did not reveal a copy of his advanced directives.

On 2/26/25 at 1:51 PM a telephone interview with Resident #94's RP indicated she completed the admissions paperwork for Resident #94 when he was admitted to the facility as he had not been capable of doing this. She stated Resident #94 had both a living will, and a healthcare power of attorney which listed her as his RP. She reported that she expressed that he had these things when she completed Resident #94's admission paperwork and also expressed that Resident #94's wish for code status was DNR. She stated she had provided the facility with a copy of these documents. She reported no one from the facility had ever let her know they did not have them, or she would have gladly provided them again. Resident #94's RP went on to say she participated in all Resident #94's care plan meetings, but she did not recall Resident #94's code status or advanced directives being discussed there. She stated she was not aware that Resident #94's code status in the facility had been full code since his admission, and this would not be what he wanted.

On 2/26/25 at 2:52 PM an interview with the Admissions Director indicated she completed Resident #94's admission paperwork with his RP. She stated if a resident or RP indicated a resident had advanced directives she checked that box on the admission form. She stated if Resident #94's advanced directives were not in his record, it might be that his RP had not provided it to the facility. She reported she did not follow up after the initial admission paperwork was completed to ensure that the documents were received. The Admissions Director stated for code status, if a

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F 578		F 578		

Continued From page 7
resident or RP expressed the wish to be a DNR, she checked that box on the admission form and also put a check in the box in the residents electronic record which caused a DNR flag to appear in the electronic record on the resident's face sheet for the nurses to see. She reported it would then be the nurse's responsibility to get the DNR order.

On 2/27/25 at 8:10 AM an interview with Unit Manager #2 indicated she entered the full code order for Resident #94 into his electronic medical record on 2/28/24 based on the information she obtained from his hospital discharge summary. She stated Resident #94 was not residing on her unit, so she had not looked for any advanced directive paperwork, or a DNR or MOST form. She stated Unit Manager #1 would have been responsible for this.

On 2/27/25 at 8:16 AM an interview with Unit Manager #1 indicated she did not follow up with residents or their RP's if they indicated the resident had advanced directives such as a living will or a health care power of attorney on admission to ensure a copy was obtained for the residents record. She reported she did recall on Resident #94's admission to the facility, the banner on his electronic record face sheet said DNR, and he had a full code order in place. She went on to say at some point the SW had been doing an audit to ensure resident's face sheet banner code status matched the code status order, and Resident #94's face sheet banner had been changed to full code. She stated she had checked with the SW, and the SW told her Resident #94 was a full code. She reported if a resident's admission paperwork indicated their wish was for a DNR code status, and the

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F 578	Continued From page 8	F 578		

physician's order was for a full code status, she did try to clarify with the resident or their RP, but she had not done this for Resident #94.

On 2/27/25 at 8:28 AM an interview with the SW indicated she did not recall why she documented Resident #94's code status was DNR in her progress note dated 3/12/24. She stated if a resident had advanced directives paperwork such as a living will or a health care power of attorney, the Admissions Director would let her know and the Admissions Director would get copies of the documents and upload them into the residents medical record. She reported she had completed the audit for ensuring that residents code status physician's order and face sheet code status banner matched and recalled that Resident #94's banner indicated a DNR code status, but the physician's order was for full code. She stated when she didn't see any advanced directive paperwork such as a living will or a healthcare power of attorney in Resident #94's record she told Unit Manager #1 that Resident #94 was a full code. She stated she had not clarified the issue with Resident #94's RP. The SW stated Resident #94's RP did attend his care plan meetings, and she did not recall Resident #94's RP ever telling her he wanted to be a DNR code status.

On 2/27/25 at 9:27 AM an interview with the Director of Nursing indicated if a resident or their RP indicated on admission that the resident had a living will or a health care power of attorney, the Admissions Director should be ensuring there were copies of the documents in the residents medical record. She went on to say if a resident's wishes were to be a DNR code status, that's what their code status should be, and the Unit Managers should be ensuring a goldenrod DNR

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F 578	Continued From page 9 form or a MOST form were obtained for the resident. On 2/27/25 at 11:30 AM an interview with the Administrator indicated the facility had a system in place where they asked on admission whether a resident had a living will or a health care power of attorney. She stated if Resident #94's RP indicated he had these, someone should have ensured a copy was obtained and included in Resident #94's medical record. The Administrator reported if a resident or a resident's RP expressed that the resident's wishes were to be a DNR code status, then that's what it should be.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls for 1 of 5 residents reviewed for accidents (Resident #87). Findings included: Resident #87 was admitted to the facility on 8/15/24. A review of a nursing progress note for Resident #87 dated 1/25/25 at 4:45 PM written by Nurse #2 revealed Resident #87 had a fall from her bed. Resident #87 had no skin tears, limited range of motion or dizziness after her fall. Resident #87	F 641	Corrective action for the residents found to be affected by the deficient practice. Resident #87 was affected by the deficient practice. The MDS for resident #87 has been modified and resubmitted on 2-26-2025. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents with falls have the potential to be affected by the deficient practice. MDS sections J1700- J1900 will be reviewed by the Case Mix Director, prior to submission to ensure assessment is accurate. Resident falls for the last 30	3/14/25

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F 641	Continued From page 10 was complaining of mild pain to her right hip and right knee. A review of Resident #87's quarterly MDS assessment dated 2/12/25 revealed she had no falls since her prior MDS assessment. On 2/26/25 at 12:46 PM an interview with Nurse #2 confirmed Resident #87 had a fall from her bed on 1/25/25. On 2/26/25 at 1:13 PM in an interview the MDS Coordinator stated she coded the falls section of Resident #87's MDS assessment dated 2/12/25. She reported she normally looked at progress notes for information when coding this section. She went on to say the date of Resident #87's prior MDS assessment was 1/21/25, so the fall Resident #87 experienced on 1/25/25 should have been captured on Resident #87's 2/12/25 MDS assessment. She reported it was an oversight on her part. On 2/27/25 at 9:01 AM an interview with the Director of Nursing indicated resident's MDS assessments should accurately reflect their status. On 2/27/25 at 11:30 AM an interview with the Administrator indicated resident's MDS assessments should be coded accurately.	F 641	days have been reviewed and cross-checked by the Case Mix Director to ensure accuracy. Systemic changes are made to ensure that the deficient practice will not recur. Case Mix Director educated on MDS accuracy by Clinical Reimbursement Consultant, RN on 3-12-2025. The Case Mix Director will review all falls and document to ensure accurate coding in sections J1700-J1900 prior to submission of the MDS. Any new Case Mix employees will be educated during orientation. Plans to monitor its performance to make sure that the solutions are sustained. This information will be reviewed with any new MDS employees during the orientation process. Weekly audit of all falls will be performed weekly x 4 weeks, then Bi- weekly x 1 month and monthly x 3 Months. Audit will be performed by the Case Mix Director, until deficient practice has been maintained. The Director of Health Services/Administrator will take these audits to be reviewed during weekly Patient at Risk meetings, Case Mix Meetings and monthly QAPI to ensure assessments accuracy and any errors will be reviewed in QAPI and plan reviewed These will be reviewed during Quarterly Executive QAPI to ensure systems remain compliant.	

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	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11	F 641	Date of compliance:3-14-2024	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing side rails for 2 of 4 residents (Resident #18 and Resident #98) reviewed for side rails. Findings included: 1. Resident #18 was admitted to the facility on 10/16/20 with a diagnosis of diffuse traumatic brain injury.	F 700	Corrective action for the residents found to be affected by the deficient practice. Resident #18 and #98 were affected by the deficient practice. Resident #18 side rails were removed and were assessed for bed in the lowest position. Resident #98 was discharged on 2-26-2025 and did not return. Corrective action for other residents	3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 700

Continued From page 12

A review of Resident #18's record revealed an assessment titled "restraint-adaptive equipment use" dated 8/23/24 and completed by Unit Manager (UM) #1 indicated no answer was provided for the question "have alternatives to restraint or adaptive equipment been tried in the past?". The choices were yes, no or not applicable.

A quarterly Minimum Data Set (MDS) dated 1/13/25 revealed Resident #18 was moderately cognitively impaired. The MDS indicated Resident #18 required substantial to maximum assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #18 had no impairment of both upper and lower extremities. The MDS indicated Resident #18's siderails were not used as a restraint.

A care plan with the latest review date of 1/17/25 revealed a problem of use of one quarter side rails for increasing or maintaining current bed mobility. The goal was Resident #18 would remain safe through the next review. The approach was for Resident #18 used one quarter side rails for turning and repositioning during incontinence care.

An observation on 2/24/25 at 1:03 PM revealed Resident #18 lying in bed with bilateral one-quarter length side rails in the up position on the bed.

An observation on 2/25/2025 at 12:09 PM revealed Resident #18 sitting in her bed with the head raised at a 45-degree angle. The side rails were observed to be in the raised position.

F 700

having the potential to be affected by the same deficient practice.
All residents have the potential to be affected by this practice.
100% side rail audit was completed on 2-26-2025.
"All Residents were assessed for an alternative intervention and those that were appropriate for side rail use were care planned accordingly.
"All Nurses have been educated on the use of side rails by the Nurse Educator on 2-25-26-2025
"All new employees will be educated on the use of siderails by the Nurse Educator during orientation.

Systemic changes made to ensure that the deficient practice will not recur.
"All new admissions and readmissions will have alternative intervention documentation prior to using side rails if appropriate.
"Director of Health Services/Unit Managers will audit each new admission for the need of alternative intervention prior to use of side rails and any resident based off of change of ability.
"All new employees will be educated on the use of siderails by the Nurse Educator during orientation.

Plans to monitor its performance to make sure that the solutions are sustained.
"DHS, Unit Managers, and Nurse Educator will monitor and document weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months until sustained compliance is maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

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F 700	Continued From page 13	F 700		

An interview with Nurse #1 on 2/25/25 11:58 am revealed the Nurses completed the restraint-adaptive equipment use evaluation on admission and quarterly. Nurse #1 stated this form was used for side rail screening. She further stated she always answered no to the question "Have alternatives to restraint or adaptive equipment been tried in the past?". Nurse #1 indicated side rails were on the beds on admission. She further indicated Nursing did not try alternatives to side rails before they were used, and she could not think of alternatives to try instead of using side rails. Nurse #1 was not aware alternatives needed to be tried before using side rails.

In an interview with UM #1 on 2/25/25 at 12:03 PM she stated she recalled completing the restraint-adaptive equipment use evaluation for Resident #18. She further stated she was not aware of a time the facility tried alternative side rails. She was not aware alternatives to side rails needed to be attempted before using them, so she did not answer the question.

In an interview with the Director of Nursing (DON) on 2/25/25 at 12:09 PM she stated Nursing completed the restraint-adaptive equipment use evaluation on admission and quarterly. She further stated they did not try interventions before using side rails as she was not aware this was a requirement. The DON revealed side rails were always on the beds. If a resident did not need them, then they were kept in the down position.

In an interview with the Administrator on 2/25/25 at 12:34 PM she stated alternative interventions to siderails were not tried before implementation as she was unaware that this was a requirement.

Provider's Plan of Correction (F 700):

"Administrator, will take these audit tools to be discussed during monthly QAPI meetings to ensure continued compliance.

Date of compliance:3-14-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 700	Continued From page 14	F 700		

2. Resident #98 was admitted to the facility on 10/4/24 with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) of left side of body following cerebral infarction (stroke).

A review of Resident #98's record revealed an assessment titled "restraint-adaptive equipment use evaluation" dated 10/4/24 and completed by Nurse #1 indicated no alternatives to restraint or adaptive equipment been tried in the past.

A quarterly Minimum Data Set (MDS) dated 1/9/25 revealed Resident #98 was cognitively intact and was dependent on staff for bed mobility. The MDS indicated Resident #98's siderails were not used as a restraint.

A care plan with the latest review date 10/21/24 revealed a problem that Resident #98 had one quarter siderails to assist with bed mobility and transfers. The goal was Resident #98 would not obtain any injury from positioning/transfers. The approach stated Resident #98 and staff would use side rails to assist with bed mobility and transfers as needed.

An observation on 2/24/25 at 11:15 AM revealed Resident #98 in bed with the one quarter length side rails in the raised position.

An observation on 2/25/25 at 11:45 AM revealed Resident #98 in bed with bilateral one-quarter length siderails in the up position on the bed.

An interview with Nurse #1 on 2/25/25 11:58 am revealed the Nurses completed the restraint-adaptive equipment use evaluation on admission and quarterly. Nurse #1 stated this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

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F 700	Continued From page 15 form was used for side rail screening. She further stated she recalled completing the form for Resident #98 and she always answered no to the question "Have alternatives to restraint or adaptive equipment been tried in the past?". Nurse #1 indicated side rails were on the beds on admission. She further indicated Nursing did not try alternatives to side rails before they were used. Nurse #1 was not aware alternatives were required before using side rails. In an interview with UM #1 on 2/25/25 at 12:03 PM she stated she was not aware of a time the facility tried alternatives to siderails. She was not aware alternatives to side rails needed to be attempted before using them. In an interview with the Director of Nursing (DON) on 2/25/25 at 12:09 PM she stated Nursing completed the restraint-adaptive equipment use evaluation on admission and quarterly. She further stated they did not try interventions before using side rails as she was not aware this was a requirement. The DON revealed side rails were always on the beds. If a resident did not need them, then they were kept in the down position. In an interview with the Administrator on 2/25/25 at 12:34 PM she stated alternative interventions to siderails were not tried before implementation as she was unaware that this was a requirement.	F 700		
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	F 880		3/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 16	F 880		

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 §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(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

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F 880 Continued From page 17

circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a hemodialysis catheter when Nurse Aide (NA) #1 and NA #2 provided a bed bath without wearing gowns for 2 of 20 staff observed for infection control (NA #1 and NA #2).

Findings included:

The facility policy titled Enhanced Barrier Precautions (EBP) dated 4/30/24 stated in part: EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs

F 880

Corrective action for the residents found to be affected by the deficient practice. Who was the resident affected. It should read Resident # 103 was affected by the deficient practice. Resident expired on 2-26-2025

Corrective action for other residents having the potential to be affected by the same deficient practice.2 patients had the potential to be affected.

100% audit of all dialysis patients was completed on date 2-26-2026.
"All dialysis patients with permcath were identified and added to our EBP program

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F 880	Continued From page 18 targeted gowns and gloves use during high contact resident care activities for residents with indwelling medical devices. The policy gave the example of bathing and dressing as a high contact activity. Observation of Resident #103's door on 2/26/25 at 9:03 AM revealed signage for EBP. The signage indicated that staff providing high contact care to Resident #103 were required to wear gowns and gloves. Further observation revealed a caddy outside Resident #103's room that contained Personal Protective Equipment (PPE) including gowns and gloves. An observation of NA #1 and NA #2 providing a bed bath and dressing Resident #103 was conducted on 2/26/25 at 9:05 AM. NA #1 and NA #2 were observed performing hand hygiene and donning gloves before providing the care. Resident #103 was observed to have a hemodialysis catheter (a tube with connectors) inserted in his right upper chest area. Neither NA #1 nor NA #2 donned gowns before providing high contact care to Resident #103. An interview was conducted with NA #1 and NA #2 on 2/26/25 at 9:30 AM. Both NAs stated they thought the EBP sign on the door was for Resident 103's roommate. When asked to give examples of who should be on EBP they stated residents with wounds, intravenous lines and urinary catheters. They could not recall other reasons a resident would require EBP for high contact care and did not think a hemodialysis catheter was included in reasons to require EBP. NA #1 and NA #2 both stated they had training on EBP at least one time.	F 880	with appropriate PPE available per Pruitt policy. Systemic changes made to ensure that the deficient practice will not recur. "100% in-service provided to all clinical staff by the Infection Preventionist/Clinical Competency Coordinator to review EBP policy and the inclusion of dialysis patients for enhanced barrier precautions 2/26/2025. "All Dialysis admission will be reviewed by Unit Managers to ensure EBP policy is implemented if indicated. "Director of Health Services/Unit Managers/Infection Prevention Nurse will randomly audit and document that appropriate residents will have EBP protocol in place weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months until sustained compliance is maintained. Plans to monitor its performance to make sure that the solutions are sustained. "Director of Health Services/Unit Managers/Infection Prevention Nurse will audit all dialysis with permcath and documents that appropriate residents will have EBP protocol in place weekly x 4 weeks, bi-weekly x 1 month, and monthly x 3 months until sustained compliance is maintained. "Audits will be discussed during monthly QAPI meetings to ensure continued compliance. Date of compliance: 3-14-2025	

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	345371	A. BUILDING ______ B. WING ______	C 02/27/2025

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F 880	Continued From page 19	F 880		

An interview was conducted with the Infection Preventionist on 2/26/25 at 9:34 AM. The Infection Preventionist stated all residents with an indwelling medical device, which included a hemodialysis catheter, would require EBP for high contact care such as bathing and dressing.

The Director of Nursing (DON) was interviewed on 2/26/25 at 9:46 AM. The DON stated she was unaware a hemodialysis catheter required EBP for high contact care.

Unit Manager (UM) #2 was interviewed on 2/26/25 at 10:05 AM. UM #2 stated a hemodialysis catheter did not require EBP for high contact care.

In an interview with the Administrator on 2/26/25 at 10:38 AM she stated EBP was required for any resident with an indwelling medical device such as a hemodialysis catheter when staff were providing high contact care. She further stated staff were trained on EBP upon hire and annually.