STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Crystal Coast	2416 US Highway 70 East Beaufort, NC 28516

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Medical Director, and family member interviews, the facility failed to ensure Resident #1 received a mental health evaluation and monitoring, failed to implement suicide precautions and failed to heighten awareness amongst all staff after Resident #1 had disclosed suicidal ideations. On 6/8/26 at 10:00pm, Resident #1 was found in his bed with the cord to the bed control wrapped around his neck tight with no breath or pulse. Nurse #2 called a code blue (a facility wide announcement that a resident was not breathing and without a pulse) and began Cardiopulmonary Resuscitation (CPR) while Nurse Aide (NA) #1 called for emergency medical services. The Emergency Medical Services (EMS) arrived and after performing CPR for 45 minutes, pronounced Resident #1 deceased . This deficient practice was for 1 of 1 resident reviewed for mental health services (Resident #1). The findings included:The hospital admission dated 5/27/26 revealed Resident #1 had fallen at home and fractured his left prosthetic hip. The hospital records indicated Resident #1 had tested positive for opioids and fentanyl (pain medications). Resident #1 also had a blood alcohol level of 15 (8 and below are considered within normal limits).Resident #1 was admitted to a private room in the facility on 5/29/26 with multiple diagnoses that included non-operable fracture of the left hip, acute pain due to trauma, and moderate protein calorie malnutrition. Resident #1 did not have any mental health diagnoses. Resident #1's baseline care plan dated 5/29/26 revealed no goals or interventions for depression or mental health.Physician order dated 5/29/26 revealed an order for Resident #1 to have a pain evaluation every shift.Review of Resident #1's Medication Administration Record (MAR) from 5/29/26 to 6/8/26 revealed Resident #1's pain ranged from 0 (no pain) to a 10 (severe pain). On 6/8/26 during the 7:00am to 7:00pm shift Resident #1's pain was documented as an 8.Physician order dated 5/31/26 and discontinued on 6/4/26 revealed an order for Resident #1 to receive oxycodone (pain medication) 5 milligrams (mg) every 4 hours as needed.Physician order dated 6/3/26 revealed Resident #1 was to receive morphine (pain medication) 0.5 milliliters (ml) (10mg) every 2 hours as needed for pain greater than 6.Physician order dated 6/3/26 revealed an order for Resident #1 to receive morphine extended release 30mg twice a day for pain. Review of Resident #1's Medication Administration Record (MAR) from 5/29/26 to 6/8/26 revealed Resident #1had received his scheduled morphine as ordered and received his as needed morphine 4 times on 6/4/26, 3 times on 6/5/26 and 6/6/26, 1 time on 6/7/26, and 2 times on 6/8/26. Review of the Patient Health Questionaire-9 (PHQ9) for depression dated 5/31/26 completed by the Social Worker (SW) revealed Resident #1 (who was [AGE] years old) had thoughts over the last 2 weeks that he would be better off dead. There was also a written comment on the PHQ9 that Resident #1 had told the SW right now I'd be better off dead because of the amount of pain Resident #1 was experiencing. The PHQ9 score was a 10 which indicated moderate depression. There were no directions or guidance on the PHQ9 as to what should be done if a resident scored at a certain level. The Director of Nursing (DON) was interviewed on 6/17/26 at 3:11pm. She stated the SW never informed management of Resident #1's suicidal statements made on 5/31/26.The SW was (continued on next page)

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

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	most qualified because he had a background in mental health. She stated she was informed by the SW that Resident #1 was no longer feeling suicidal, so no further actions were taken. Another interview occurred with the SW on 6/17/26 at 1:45pm. The SW stated he attended the morning administration meetings Monday through Friday. The SW discussed on 6/5/26 he was informed to see Resident #1 after the administration had learned that Resident #1 had made suicidal statements. He stated he did not know when Resident #1 had made the statement, but he went to see Resident #1 on 6/5/26 and felt Resident #1 was doing well. The SW stated Resident #1 told him he was no longer intending to hurt himself. The SW explained he did not perform any type of assessment on 6/5/26. He also stated he was unaware of Resident #1's history of depression but was aware of the resident's history of alcohol abuse. The SW stated he informed administration that Resident #1 was no longer suicidal and was unaware of any follow up. He also stated he did not feel a referral to mental health was warranted because Resident #1 was no longer suicidal. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact and feeling depressed for 2-6 days. Resident #1 did not have any behaviors documented. During an interview with Nurse #4 on 6/17/26 at 3:51pm, Nurse #4 confirmed she had been assigned to Resident #1 on 6/6/26 during the 7:00pm-7:00am shift. The nurse stated Resident #1 took his medications, did not have any complaints of pain or suicidal ideations. Nurse #4 stated Resident #1 was not cheerful or unpleasant. The nurse stated she was unaware of Resident #1's previous suicidal statements.Nurse #3 was interviewed on 6/17/26 at 3:29pm. Nurse #3 confirmed she was assigned to Resident #1 during the 7:00am to 7:00pm shift on 6/8/26. The nurse stated that Resident #1 had gone to a follow up orthopedic appointment that morning (6/8/26) and upon return refused his medication. Nurse #3 explained while Resident #1 was at the orthopedic appointment, the resident became upset because the Physician wanted to perform an x-ray and Resident #1 had informed the Physician, he was in pain and did not want to complete the x-ray. Nurse #3 stated she was told by the nurse at the orthopedic office that Resident #1 attempted to bite the Physician when the Physician tried to make Resident #1 have the x-ray. Nurse #3 also stated Resident #1 was ordered a urinalysis the morning of 6/8/26 however could not be completed on her shift due to Resident #1 being in pain. Nurse #3 clarified Resident #1's pain was in his left hip from the fracture. The nurse stated Resident #1 was alert and oriented, never conveyed any suicidal thoughts on 6/8/26 but did complain of not being able to handle his pain. Nurse #3 stated she was unaware of Resident #1's previous suicidal ideations made on 5/31/26 and 6/1/26. An interview with Occupational Therapist (OT) #1 occurred on 6/18/26 at 9:42am. OT #1 stated she had seen Resident #1 on 6/8/26 after he had returned from his appointment. She stated Resident #1 was irritated and refused therapy. OT #1 indicated this was the first time she had ever seen Resident #1 and was not informed about his previous suicidal statements. She stated on 6/8/26 Resident #1 requested to speak with the SW about going home. OT #1 stated she informed the SW that Resident #1 would like to speak with him and that Resident #1 was wanting to be discharged . During an interview with the SW on 6/18/26 at 10:02am, the SW stated he had seen Resident #1 on 6/8/26 after OT #1 had informed him that Resident #1 wanted to speak with him. The SW stated he discussed with Resident #1 the safety and care concerns of him discharging before he was ready. He stated Resident #1 told him he would stay. The SW stated Resident #1 did not have any complaints and did not appear depressed to him. During an interview with Nurse Aide (NA) #2 on 6/18/26 at 9:45am, NA #2 confirmed she had been assigned to Resident #1 during the 7:00am-7:00pm on 6/8/26. NA #2 stated she was familiar with Resident #1 and on 6/8/26 the resident did not appear any different from previous encounters. The NA stated Resident #1 did not voice any suicidal ideations to her. NA #2 explained she had not been made aware of Resident #1's prior suicidal statements.An interview was conducted with NA #1 on 6/18/26 at 11:12am. NA #1 confirmed she had been assigned to Resident #1 from the 7:00pm to 7:00am shift on 6/8/26. NA #1 explained this was the first evening she had been assigned to Resident #1. NA #1stated she entered Resident #1's room around 7:30pm. She discussed the resident being irritated (short with his answers, not looking at her) and appeared uncomfortable (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	three residents with a score greater than 10 were immediately referred to psychiatric services per physician order on 6-10-26. The Psychiatric Services Provider was notified by the Infection Preventionist and Senior Care Partner via email or phone on 6/10/2026. All responsible parties were notified of the referral and reason for the referral on 6/10/2026. All Resident's records were reviewed for diagnosis of depression by Infection Preventionist and Senior Care Psychiatric services were provided on 6-10-26 to the one resident who agreed to receive services, no new medication ordered continue to monitor per psychiatric response. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?On 6/10/2026, the Interdisciplinary team(IDT) (Medical Provider, Administrator, Director of Health Services, Therapy Manager, Social Worker, Senior Care Partner, Infection Preventionist, Dietary Manager, Maintenance Director, Activities Director, Medical Records, Financial Counselor , Human Resources, Case Mix Director, Housekeeping Manager, Pharmacist and Unit Managers) reviewed the suicide risk management process to ensure timely identification, assessment, communication, and interventions for resident exhibiting depression and suicidal ideations. After the review it was determined the education would be initiated.Clinical Competency Coordinator educated 100% of staff to include dietary, housekeeping, nursing, administrative, maintenance, medical director, therapy, consultant pharmacist and activities on recognition and monitoring for suicidal warning signs, depression screening, PHQ-9 review, reporting requirements for suicidal ideation, Physician and IDT team notification, documentation expectation and referral process for psychiatric services. This education was completed by the Clinical Competency Coordinator on 6/15/2026. All new hires will be educated on this process in new hire orientation by the Clinical Competency Coordinator. On 6/10/2026 the IDT decided that all residents will receive a PHQ-9 questionnaire review a minimum of every quarter. On 6/10/2026 the Administrator directed the Social Worker, Senior Care Partner and all licensed nurses, that a questionnaire will be completed immediately if changes in depressive behaviors or suicidal behaviors as outlined below. Findings will be reported to the Charge Nurse who will then report to the Provider, Director of Health Services, Responsible Party and Administrator. Depressive or Suicidal BehaviorsDepressive symptoms:Disheveled appearance - poor personal hygieneIncreased anxietyLack of concentration Isolation from family or friendsUnexplained fatigueChange in sleep patternsChange in appetite Suicidal behaviors:Giving away personal itemsObsession with deathMaking suicidal remarksMaking a suicide planWriting a suicide noteAttempting suicide Suicide Risk:History of suicide attempt(s)Family history of suicideFamily history of child abuse or neglectHistory of domestic violence or sexual abuseHistory of mental disorders, particularly clinical depressionHistory of alcohol/drug abuse and/or addictionImpulsive/aggressive tendencies, limited self-regulation skillsExperiencing a traumatic, triggering event such as the death of a loved one or receiving a terminal diagnosisChronic illness or unmanage painAccess to lethal means to complete suicideThe Medical Director and Responsible Party will be notified.On 6/10/2026 the IDT determined all newly admitted residents with a PHQ-9 score greater than 10 will be referred to psychiatric services on admission or if they answer yes to the question of Life is not worth living, wishes for death, or attempts to harm- self - presence, the Medical Director/Provider will be notified immediately for further orders. The party responsible will be notified of the change in condition and any new orders by the Senior Care Partner, Director of Health Services, and Social Worker. On 6/10/2026 the Administrator directed the Social Worker and Senior Care Partner that will be responsible for all admission PHQ-9s. This Plan of Correction was discussed in our Ad Hoc QAPI meeting on 6-10-26. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?Effective 6/9/2026 The Director of Health Services was directed by the Administrator to complete an audit of residents with the diagnosis of depression, PHQ-9 screening questionnaire score of 10 and greater, and suicidal ideations. This audit will include monitoring for physician notification, social service follows up, psychiatric referrals, and care plan revision. This audit will be completed weekly x 4 weeks and then monthly x 3 months. All PHQ-9 will be reviewed during clinical meetings (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Crystal Coast	2416 US Highway 70 East Beaufort, NC 28516

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by the Director of Health Services. The Consultant Pharmacist in collaboration with the Medical Director will continue to do a monthly review of all residents' medications for a potential medication adjustment. This will be audited by The Director of Health Services monthly x 3 months or until a pattern of compliance is obtained.The Administrator will interview a sample of 10 staff mem[TRUNCATED]