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Form Approved OMB
No. 0938-0391

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	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Neuse	1303 Health Drive New Bern, NC 28560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 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 [ROOM NUMBER]). Findings included: 1a. During an observation on 4/22/24 at 10:41 AM the 300 hallway and room [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] smelled strongly of urine. An observation on 4/23/24 at 2:23 PM revealed a strong smell of urine from room [ROOM NUMBER] and outside 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 [ROOM NUMBERS] 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 [ROOM NUMBERS] frequently had a strong urine odor. (continued on next page)

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.

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

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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 [ROOM NUMBERS] 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 [ROOM NUMBERS] refused 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 [ROOM NUMBERS] and the 300 hall. She stated that she would get room [ROOM NUMBER] 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 [ROOM NUMBERS] had behaviors and refused to have their rooms cleaned.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on record review and staff interviews, the 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 [DATE]. 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 dated dated [DATE] 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. 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48230 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 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.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on observations, record review, and resident and staff interviews, the facility's Quality Assessment and Assurance 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 the complaint investigation surveys of 8/30/23 and 2/21/24. This was for 3 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 [ROOM NUMBER]). 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 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. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40200 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. 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.