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	09/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 Based on observation, record review, and resident and staff interviews, the facility failed to provide a safe transfer for 1 of 1 resident (Resident #285) reviewed for supervision to prevent accidents. On 8/26/24 Resident #285 was assessed by Physical Therapist #1 to have required a mechanical lift transfer. The mode of transfer had not changed and on 9/5/24 Nursing Assistant (NA) #1 and NA #2 transferred Resident #285 from the bed to a chair without the use of a mechanical lift. Findings included: Resident #285 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure with hypoxia (low oxygen levels in the body), anxiety, muscle weakness, unsteady on feet, shortness of breath, and pneumonia. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #285 was moderately cognitively impaired. She was dependent on staff for transfers from bed to chair. She required the use of supplemental oxygen. Review of a care plan for Resident #285 dated 8/23/24 revealed she was at risk for falls related to cardiac dysrhythmia (abnormality of heart rhythm), and generalized weakness. Interventions included assist for toileting and transfers as needed. Review of the physical therapy initial evaluation and plan of treatment for Resident #285 dated 8/26/24 revealed Resident #285's baseline for sitting to standing was patient unable to stand despite max A +2 [maximum assistance of 2 persons]. The evaluation further revealed Resident #285 was unable to ambulate. In an interview with Physical Therapist (PT) #1 on 9/10/24 at 11:22 am she stated she had evaluated Resident #285 on 8/26/24 and had determined a mechanical lift was the safest mode of transfers because Resident #285 could not stand safely related to weakness and unsteadiness on her feet. She stated a two-person physical assist without the use of a mechanical lift put Resident #285 at a risk for falls related to poor physical strength. The interview further revealed NA #1 told PT #1 she transferred Resident #285 without the use of a mechanical lift on 9/5/24 and that concerned her because NA #1 should have used a mechanical lift. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #285 on 9/11/24 at 9:58 am she stated on 9/4/24 the therapist (not sure which one) told her she wanted Resident #285 out of bed for therapy on 9/5/24 and to let the Nursing Assistants (NAs) know when they came to get her up to use the mechanical lift. Resident #285 stated that on 9/5/24 NA#1 and NA #2 came to assist her out of bed, and she told them to use a mechanical lift for the transfer and NA #1 told her they (NA #1 and NA #2) were sent to get her out of bed and into the chair and that was what they were doing. She stated when NA #1 and NA #2 assisted her to stand up to transfer to the chair she could feel herself falling and staff grabbed her by her underarms and it hurt like hell and it scared her because she thought she was going to fall. The interview further revealed that Resident #285 had pneumonia and had difficulty breathing and the exertion from the transfer made her short of breath. In an interview with NA #1 on 9/10/24 at 11:12 am she stated she transferred Resident #285 from the bed to a chair without the use of a mechanical lift on 9/5/24 because she had not been aware at that time that Resident #285 required a mechanical lift. She stated Resident #285's care card had indicated that she was a two person assist for transfers. She indicated that NA #2 assisted her to transfer Resident #285. She stated Resident #285 held onto a walker during the transfer, became short of breath, could not pivot to turn, and sit in the chair. NA #1 explained she and NA #2 assisted Resident #285 to sit on the side of bed until she could regain her breath and then they continued with the transfer to the wheelchair. NA #1 indicated Resident # 285 did not tell her that she should have used a mechanical lift until after she had been transferred into the chair. She stated on 9/5/24, after the transfer had occurred, Physical Therapist (PT) #1 told her that Resident #285 should have been transferred using a mechanical lift. During an interview with NA #2 on 9/11/24 at 11:08 am she stated she assisted NA #1 on 9/5/24 to transfer Resident #285 from the bed to a wheelchair. She indicated they did not use a mechanical lift for the transfer because Resident #285's care card indicated she had been a two person assist for transfers and did not indicate a mechanical lift had been required. She stated when she arrived at Resident #285's room on 9/5/24 to assist NA #1 with the transfer that Resident #285 was sitting on the side of the bed with her legs over the edge of the bed and feet on the floor. She stated when they assisted the resident stand up the resident stated, I can't do it, I can't do it, so they assisted her to sit back down on the bed by holding her under each arm, on each side of the resident. She stated NA #1 told Resident #285 they were going to transfer her to the chair and asked if she was ready and Resident #285 agreed she was. She stated Resident #285 stood up and NA #1 and NA #2 assisted her to pivot to the chair and sat her down. They stated the resident was able to bear weight during the transfer, but they helped her maintain her balance. She stated after Resident #285 was seated in the wheelchair that she was short of breath and that concerned her, so she checked on her frequently afterward until she was no longer short of breath. In an interview with Certified Occupational Therapy Assistant (COTA) #1 on 9/11/24 at 10:05 am she stated that on 9/4/24 she told Resident #285 to tell the NA staff to use a mechanical lift when they got her up for therapy on 9/5/24. The COTA stated after Resident #285 was out of bed, the resident told her NA #1 and NA#2 had transferred her without the use of a mechanical lift. She stated Resident #285 could not bear weight to stand related to weakness so she should have been transferred with a mechanical lift. She stated Resident #285 had not had a change in her transfer status since she had been admitted . She stated if there had been a change in how Resident #285 transferred a therapist would have communicated that to the nursing staff verbally. The interview revealed there had not been a formal process in place for therapy to communicate modes of transfer to nursing staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow-up interview with PT #1 on 9/11/24 at 10:45 am she confirmed she documented in her physical therapy progress notes on 8/26/24 Resident #285 was not safe to bear weight and that she verbally notified the nurse on duty that day. She stated she did not recall which nurse she spoke to. In a follow-up interview with Nurse #6 on 9/11/24 at 11:51am she stated she worked on 8/26/24 when therapy did the initial evaluation on Resident #285, but she did not recall if a therapist told her to transfer Resident #285 with a mechanical lift. She further indicated therapists would tell the NAs how to transfer a resident and the NAs would tell the nurse so the nurse could update the care plan. She stated she was not told how Resident #285 should transfer at any time and had not updated the care plan. In an interview with the Director of Nursing (DON) on 9/11/24 at 8:21 am she stated if a resident required a mechanical lift for transfers that they should be transferred with a mechanical lift unless therapy changed the mode of transfer. She stated therapy communicated verbally to the nursing staff about how a resident should be transferred. In a follow up interview with the DON on 09/11/24 at 1:03 pm she stated that on admission a nurse assessed a resident to see how they would transfer until therapy assessed the resident. She stated therapy usually assessed residents the next day after admission and determined how the resident should be transferred and then therapy would tell the nurse. She stated that the safest mode of resident transfers was also discussed in morning meeting with the interdisciplinary team each day. She stated there was not a set system on how to communicate on how to transfer residents and without a system someone could be transferred incorrectly. She explained therapy initially assessed Resident #285 and assessed her mode of transfer to be a mechanical lift. She said the facility needed a process to communicate about transfers after a resident was assessed by therapy. She further indicated when NA #1 and NA #2 noticed Resident #285 became short of breath they should have reported the resident being short of breath to the nurse before they continued with the transfer. She stated when therapy notified Nurse #6 Resident #285 should be transferred with the use of a mechanical lift that Nurse #6 should have notified the DON or MDS nurse so they could have updated the care plan. During an interview with the Administrator on 9/11/24 at 1:32 pm she stated Resident #285 had been assessed by nursing when admitted and Resident #285 required two-person assistance to transfer out of bed, and that was put on the care plan. She stated therapy did not always make the determination on how a resident should be transferred.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48230 Based on observation, record review, staff and Physician interview the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41%, for Medication Administration. Both errors were for medications received by Resident #77. Findings included: a. A review of Resident #77's medication orders dated 7/29/24 revealed he was prescribe one 325 mg (milligram) aspirin by mouth once daily. Further review of the resident's orders revealed he was to be given medications whole in puree (meaning not to crush the medications and to place the medication in a food to help with administration such as applesauce). On 9/10/24 at 8:35 AM Nurse #1 was observed as she prepared and administered four medications to Resident #77. The medications administrated included one enteric coated aspirin 325 mg. All of the resident's medications were crushed and administered to the resident in applesauce. In an interview with Nurse #1 on 9/10/24 at 9:28 AM she stated she had been crushing Resident #77's medications as he had been having trouble swallowing them whole. Nurse #1 revealed she used an enteric coated aspirin instead of a regular aspirin as that was what she had in her cart, and she should have gone to the medication storage room for the correct aspirin. b. A review of Resident #77's medication orders dated 7/29/24 revealed he was prescribed one Metoprolol Succinate extended release tablet 50 mg by mouth once daily. Further review of the resident's orders revealed he was to be given medications whole in puree (meaning not to crush the medications and to place the medication in a food to help with administration such as applesauce). On 9/10/24 at 8:35 AM Nurse #1 was observed as she prepared and administered four medications to Resident #77. The medications administrated included one Metoprolol Succinate extended release tablet 50 mg to be given by mouth. All of the resident's medications were crushed and administered to the resident in applesauce. In an interview with Nurse #1 on 9/10/24 at 9:28 AM she stated she had been crushing Resident #77's medications as he had been having trouble swallowing them whole. She further stated she knew she should not have crushed Metoprolol Succinate extended release because that changes it from a long acting to a short acting medication. She further revealed she should have contacted the Physician or Nurse Practitioner to change his order from taking medication whole to crushed. An interview with the Pharmacist on 9/10/24 at 2:03 PM revealed Metoprolol Succinate extended release should not be crushed as it changes it to immediate release and can lower the residents blood pressure and/or pulse. He stated enteric coated aspirin should not be crushed as the enteric coating protects the stomach lining. He further revealed if a residents orders changed from taking medications whole to crushed, he would recommend an equivalent medication that can be crushed. He stated the pharmacy did not receive a request for recommendations for crushable medications for Resident #77. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 9/10/24 at 9:22 AM revealed Metoprolol Succinate extended release should not have been crushed as it changes it from a long-acting medication to a short acting one that could cause a drop in blood pressure or pulse for the resident. The DON stated the nurse should have known not to crush it. She further stated she expected nursing to follow the orders in the electronic medication administration record including how residents took their medications. If a resident needed a change from taking medications whole, to taking them crushed, nursing would contact the Physician or Nurse Practitioner for that order and any changes from medications that could not be crushed to an equivalent medication that could be crushed. In an interview with the Physician on 9/11/24 at 8:02 AM he stated Metoprolol Succinate extended release should not be crushed as it could cause the resident's blood pressure and/or pulse to drop. He further stated Resident #77 did not have an order for enteric coated aspirin and enteric coated aspirin should not be crushed if it was given. The Physician revealed Resident #77 did not have an order for medications to be crushed but had an order for them to given whole in puree.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 Based on record review, and staff, resident, family member, Pharmacist, Psychiatric Nurse Practitioner (NP), and Nurse Practitioner (NP) interviews the facility failed to administer prescribed medications for 1 of 1 resident (Resident # 45) reviewed for significant medication errors. Resident #45 was not administered 10 consecutive doses of lorazepam (anti-anxiety medication) during the time period of 7/29/24 through 8/01/24 when the order was erroneously discontinued on the Medication Administration Record (MAR) by the Director of Nursing (DON) which caused Resident #45 to experience increased anxiety. Resident #45 was assessed by the NP on 8/01/24 due to severe anxiety and noted the resident was crying and asking for his medication. Findings included: Resident #45 was admitted to the facility on [DATE] with a diagnosis that hypertension (high blood pressure), anxiety disorder, and asthma. Review of Physician orders dated 6/1/24 indicated Resident #45 had been prescribed lorazepam, 1 mg (milligram) tablet, take one tablet 4 times a day for anxiety disorder. Review of the Physician orders dated indicated Resident #45 had been prescribed lorazepam 1 mg per 1ml (milliliter) to be given orally in a syringe for anxiety as needed (PRN). Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was severely cognitively impaired and was coded to receive an anxiolytic (medication to treat anxiety). Review of the 2024 July and August Medication Administration Record (MAR) revealed Resident #45 was not administered a total of 10 doses of his prescribed lorazepam (a medication to treat anxiety) on 7/29/24 (2 doses), 7/30/24 (4 doses), 7/31/24 (4 doses), and 8/1/24 (2 doses). This was evidenced by the absence of nursing initials on the MAR for the dates of the missed doses. The order on the MAR had a discontinue date of 7/29/24. Additionally, the MAR revealed Resident #45 was not administered any doses of PRN lorazepam. Review of the Controlled Drug Record for Resident #45's lorazepam 1 mg tablet revealed that Nurse #7 signed on 7/29/24 at 8 pm and on 7/30/24 at 9 pm that 2 doses of lorazepam had been administered. These doses were not signed off as administered on the MAR. During an interview with Nurse #7 on 09/10/24 at 11:00 am he stated that he did not recall if he had administered lorazepam 1 mg tablet to Resident #45 on 7/29/24 or 7/30/24. He further indicated that if he did not have an order for it, he would not have administered it. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with Nurse # 5 on 9/10/24 at 2:47 pm she stated she had worked 7/31/24 and saw that Resident #45's lorazepam had been discontinued so she did not administer it because the order needed to be renewed. She stated she put in a request for the NP to see him and renew the lorazepam. She stated that she did not administer the PRN lorazepam on 7/31/24 because he had not been anxious. The interview further revealed that one day (date unknown) during the first part of July the family had asked that Resident #45's lorazepam dose be held so he would not be drowsy when the family visited that day, but they had not asked that it be stopped. During an interview with Nurse #4 on 9/10/24 at 3:53 pm she stated that when the pharmacy refill review request (a record of orders that are scheduled to be refilled) came electronically on 7/29/24 that it got messed up by someone (she did not know who), and Resident #45's scheduled lorazepam had been discontinued and had to be restarted. She stated when it had been brought to her attention by nursing staff that his lorazepam had been discontinued, she notified the NP to get it reordered on 8/1/24. She recalled that a hydroxyzine order had been received from the NP to be given until the scheduled lorazepam had been reordered. She further indicated that no one had reported to her that he had been overly anxious, and if he had been he had an order for PRN lorazepam that he could have received. In an interview with Resident #45 on 9/10/24 at 8:19 am he stated he recalled that he had not received his prescribed anxiety medication for several days one time but could not recall the name of the medication or the exact dates. He stated he went bezerk and that was what happened when staff forgot to give him his anxiety medication. He further clarified that it made him feel bad overall but could not further describe how he felt. He stated that the nurse (he could not recall her name) gave him some sort of a concoction and that made him feel better, and he had felt fine since. Review of a NP progress note written by the NP dated 8/1/24 read in part, I was called to see [Resident #45] due to his severe anxiety. [Resident #45] was crying and asking for his medications. [Resident #45] was given hydroxyzine [a non-narcotic medication that helped to reduce anxiety] 50 mg by mouth stat [immediately]. Apparently, his Ativan [lorazepam] has been abruptly discontinued. Initially I was told it was by his [family member's] desire but on further investigation it was discontinued from the MAR. The [lorazepam] was resumed as ordered. Review of Physician orders dated 8/1/24 indicated that Resident #45 was prescribed hydroxyzine 25 mg tablets, give 2 tablets 50 mg stat one time dose for anxiety. The order had a start and stop date of 8/1/24. A review of the August MAR revealed that lorazepam, 1 mg to be administered four times a day was reordered and transcribed to the MAR for Resident #45 on 8/1/24, and it was administered as ordered. An interview with Nurse #3 on 9/11/24 at 8:44 am she stated on 8/1/24 she was assigned to administer medications to Resident #45 and administered a dose of hydroxyzine 50 mg as a stat (immediately) as one time dose for anxiety, but could not remember what time she had given it. She stated Resident #45 had increased anxiety on 8/1/24 and she could not remember if he had been crying or what his behaviors had been on 8/1/24 because he often became anxious. She stated she did not recall if he had lorazepam ordered at that time or if she had administered it. She further indicated that she did not routinely work with Resident #45, so it was difficult to recall the exact details of the day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with the NP on 9/10/24 at 9:18 am she stated that Resident #45 sometimes became groggy when he took the lorazepam, and she was told by nursing staff that his family member wanted the lorazepam stopped. She further stated a nurse told her the facility had not renewed the lorazepam because Resident #45's family member had not wanted it renewed. She could not recall the name of the nurse. She stated that lorazepam should not have been abruptly stopped because it could have caused a rebound of anxiety. She further indicated that she had ordered hydroxyzine when she learned the lorazepam had been discontinued and reordered the lorazepam. An interview with the Director of Nursing (DON) on 9/11/24 at 8:04 am revealed that she had erroneously discontinued Resident #45's lorazepam on 7/29/24. She stated that the pharmacy sent an alert that Resident #45 had 2 lorazepam orders, so she had reviewed the orders and had not realized that one of the lorazepam orders had been for PRN lorazepam 1 mg per 1 milliliter (ml) to be given orally in a syringe, and she thought it was a duplicate lorazepam order and discontinued the scheduled lorazepam 1 mg to be given 4 times a day. She stated that on 8/1/24 a nurse (she did not recall the name) notified her that the order for Resident #45's scheduled lorazepam had been discontinued so she asked the Nurse #4 to notify the NP to reorder the lorazepam and she did. The interview further revealed that Resident #45's family had not contacted her to ask that the lorazepam order be discontinued. She further indicated that the lorazepam should not have been discontinued and Resident #45 should have received scheduled lorazepam on 7/29/24, 7/30/24, 7/31/24, and 8/1/24. She stated the lorazepam 1 mg tablets had been available for administration and had not yet been returned to the pharmacy. During an interview with Resident #45's family member on 9/11/24 at 9:26 am she stated that Nurse # 4 notified her on 8/1/24 that Resident #45 had become combative, yelled, cursed, and they could not get him to calm down and the doctor ordered a medication to calm him down. She stated she did not know what medication had been ordered. The interview further revealed that she had not asked the facility to stop his lorazepam and had only asked the facility to hold one dose around the 7/19/24 so family could visit. She stated that when he did not get his scheduled lorazepam that he became combative and upset. In an interview with the Psychiatric Nurse Practitioner on 9/10/24 at 12:09 pm she stated Resident #45 had been ordered lorazepam to be given on a routine scheduled basis, as well as lorazepam to be given on an as needed (PRN) basis, so he should not have missed any doses of his lorazepam. She further stated she would have expected that the nurses would have given him the PRN lorazepam if they did not have an order for the scheduled lorazepam. She stated that she did not discontinue the scheduled lorazepam, and was unaware it had been discontinued. She stated lorazepam should not have been stopped abruptly as it could have caused increased agitation for the resident. In an interview with the Pharmacist on 9/10/24 at 02:10 pm he stated that according to his records the order for lorazepam for Resident #45 had been discontinued by the Director of Nursing (DON) on 7/29/24 and it had been reordered on 8/1/24 by the Nurse Practitioner. He further stated that lorazepam should not have been stopped abruptly and should have been titrated (dose lowered by over a period of several days) to a lower dose and then tapered off before it had been stopped. He stated if it had been abruptly stopped that Resident #45 could have experienced irritability, tremors, sweating, panic attacks, headaches, and worsened anxiety. (continued on next page)

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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 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Administrator on 9/11/24 at 1:25 pm she stated Resident #45 should have received his medications as ordered and not missed doses. She stated that nurses administered medication according to the order on the MAR. She further indicated the error occurred because of the way the medication re-order system was set up and that the lorazepam had been restarted for Resident #45 when they became aware it had been stopped.