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	11/19/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, and staff and Responsible Party (RP) interviews, the facility failed to notify the RP of a change in condition when the fingerstick blood sugar (FSBS) levels exceeded 500 milligrams per deciliter (a normal blood glucose level is 80-130 milligrams per deciliter) for 1 of 3 residents reviewed for notification of change (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses which included diabetes, dementia, and femur fracture. The admission nursing note dated 9/27/24 at 5:52 pm revealed Resident #1 was alert with noted confusion. Resident #1 had a physician order dated 9/27/24 for insulin lispro (fast-acting insulin) per sliding scale with the following instructions: If Blood Sugar is less than 70, call MD. If Blood Sugar is 141 to 180, give 2 Units. If Blood Sugar is 181 to 220, give 2 Units. If Blood Sugar is 221 to 260, give 2 Units. If Blood Sugar is 261 to 300, give 4 Units. If Blood Sugar is 301 to 350, give 4 Units. If Blood Sugar is 351 to 400, give 6 Units. If Blood Sugar is greater than 400, give 6 Units. If Blood Sugar is greater than 400, call MD. The FSBS (fingerstick blood sugar) was to be checked at 6:30 am, 11:30 am, 4:30 pm, and 9:00 pm every day. The Medication Administration Record (MAR) for 10/01/24 revealed Resident #1's FSBS was 565 mg/dL at 9:00 pm as noted by Nurse #3. The nursing progress note dated 10/02/24 at 3:01 am by Nurse #3 revealed Resident #1's initial HS (hour of sleep or at bedtime) FSBS was 546 milligrams per deciliter (mg/dL). The on-call provider was notified, and Nurse #3 was instructed to administer an additional 3 units of insulin lispro along with the ordered dose of 6 units of insulin lispro. The progress note further noted that Resident #1's FSBS was rechecked in 2 hours and the FSBS was 428 mg/dL. The on-call provider was once again notified and gave instructions to administer an additional 6 units of insulin lispro and recheck Resident #1's FSBS in two hours. Resident #1's FSBS was noted to be 298 mg/dL after the additional insulin lispro dose was administered. Nurse #3 further noted Resident #1 was asymptomatic. The MAR for 10/02/24 revealed Resident #1's FSBS at 9:00 pm was noted by Nurse #3 to be 519 mg/dL. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note dated 10/03/24 at 2:20 am by Nurse #3 revealed Resident #1's FSBS at HS was 519 mg/dL. Nurse #3 administered the ordered rapid-acting insulin and notified the on-call provider. The on-call provider instructed Nurse #3 to administer an additional 8 units of rapid-acting insulin and recheck Resident #1's FSBS 2 hours after. Nurse #3 noted that Resident #1's FSBS after the additional 8 units of rapid-acting insulin was 364 mg/dL. Nurse #3 further noted Resident #1 was asymptomatic. The MAR for 10/03/24 revealed Resident #1's 9:00 pm FSBS was 515 mg/dL as recorded by Nurse #3. The nursing progress note dated 10/04/24 at 8:35 am by Nurse #3 revealed Resident #1's FSBS at HS was 515 mg/dL. Nurse #3 noted the on-call provider was notified and instructed Nurse #3 to administer an additional 8 units of insulin lispro and recheck Resident #1's FSBS in 2 hours. Nurse #3 further noted Resident #1's FSBS was rechecked and was 389 mg/dL and Resident #1 was asymptomatic. Review of the nursing progress notes from 10/01/24 through 10/04/24 revealed no documentation that Resident #1's RP was notified of the elevated blood glucose levels at 9:00 pm on 10/01/24, 10/02/24, or 10/03/24. A telephone interview was conducted with Resident #1's Responsible Party (RP) on 11/19/24 at 10:26 am who revealed she was not notified of Resident #1's elevated blood glucose levels on 10/01/24, 10/02/24, and 10/03/24. The RP stated she was notified by Nurse #3 on the morning of 10/05/24, when Resident #1 was transferred to the hospital unresponsive, that Resident #1 had experienced elevated blood glucose levels on several nights throughout the week. She stated she was not aware of how high Resident #1's blood glucose levels were during the week until she was at the hospital. The RP stated that had she been made aware of Resident #1's high blood glucose levels on the nights prior she would have requested Resident #1 be sent to the hospital. A telephone interview was conducted on 11/19/24 at 2:14 pm with Nurse #3 who revealed she did not notify Resident #1's RP of the elevated blood glucose levels when they occurred because it was the middle of the night, and it was not life threatening. She stated she would not have called the RP because the additional insulin that was administered did bring the blood glucose levels down. Nurse #3 stated she did notify Resident #1's RP about the elevated blood glucose levels throughout the week when she notified the RP that Resident #1 was sent to the hospital on the morning of 10/05/24. An interview was conducted on 11/19/24 at 2:40 pm with the Director of Nursing who revealed Nurse #3 should have notified Resident #1's RP of the elevated blood glucose levels.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, Pharmacist, Nurse Practitioner, and Medical Director telephone interviews, the facility failed to administer scheduled antibiotic medication which resulted in 3 doses of the antibiotic being missed for 1 of 3 residents reviewed for medication administration (Resident #1). The findings included: Review of the hospital visit summary dated 9/22/24 through 9/27/24 revealed Resident #1 was noted to have had a urine culture completed on 9/23/24 with a positive culture result of Escherichia Coli (E. coli, a common bacteria that causes urinary tract infections). Resident #1 had a discharge diagnosis which included urinary tract infection and was not prescribed antibiotic medication upon discharge. Resident #1 was admitted to the facility on [DATE] with diagnoses which included femur fracture, urinary tract infection, and diabetes. Resident #1 was transferred to the hospital on 10/05/24 for further evaluation of altered level of consciousness. The Nurse Practitioner (NP) visit note dated 10/02/24 revealed Resident #1 had a urinary tract infection (UTI) listed on hospital diagnosis list with unknown treatment. The NP noted to continue to monitor for symptoms and would consider treatment as indicated. The Medical Director's History and Physical progress note dated 10/03/24 revealed Resident #1 had reported increased urinary frequency without dysuria (discomfort upon urination). The Medical Director further noted Resident #1 was diagnosed with a urinary tract infection prior to admission however it was unclear if Resident #1 was treated during the hospital stay. The Medical Director's treatment plan included an empiric (based on observation and experience) course of ciprofloxacin antibiotic and to continue to monitor for symptoms. Resident #1 had a physician order dated 10/03/24 at 2:29 pm for ciprofloxacin (antibiotic medication) 250 milligram (mg) tablet, give 1 tablet twice a day for urinary tract infection (UTI). The order had a start date of 10/03/24 with an end date of 10/09/24. The medication was scheduled to be administered at 9:00 am and 5:00 pm. A review of Resident #1's Medication Administration Record (MAR) for October 2024 revealed ciprofloxacin was not administered on 10/03/24 at 5:00 pm or 10/04/24 at 9:00 am and 5:00 pm. An interview was conducted with Nurse #1 on 11/19/24 at 8:30 am who was assigned to Resident #1 on 10/03/24 for the 7:00 am through 7:00 pm shift. Nurse #1 stated she was not aware the physician wrote an order for ciprofloxacin for Resident #1 during her shift, so she did not administer the medication. She stated when a physician order was entered a yellow box would come across the resident screen stating an order was waiting to be verified, but she did not verify physician orders. She stated the Unit Manager normally verified the physician orders for the residents. Nurse #1 stated she did not recall the order for Resident #1's antibiotic. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to conduct a telephone interview with the Unit Manager on 11/19/24 at 8:54 am was unsuccessful. A telephone interview with Nurse #3 was conducted on 11/18/24 at 3:12 pm who was assigned to Resident #1 on 10/3/24 during the 7:00 pm through the 7:00 am shift and again on 10/04/24 during the 11:00 pm to 7:00 am shift. Nurse # 3 stated she was not sure when Resident #1's ciprofloxacin order was entered but she stated she verified the order on 10/04/24 at 10:02 pm when she saw the order. Nurse #3 stated she notified the on-call provider that the medication was delayed, and a new order was obtained to start the antibiotic on 10/05/24. Nurse #3 stated she was aware of how to verify physician orders, but she was unable to state why the order was not verified during her shift on 10/03/24. A telephone interview was conducted on 11/19/24 at 9:15 am with Nurse #2 who was assigned to Resident #1 on 10/04/24 from 7:00 am through 11:00 pm. Nurse #2 stated he often did not have time to review physician entered orders until the end of his shift, but he did know how to verify the orders. Nurse #2 stated he was not aware of an order for Resident #1 to receive ciprofloxacin at 9:00 am and 5:00 pm during his shift on 10/04/24. A telephone interview was conducted on 11/19/24 at 10:16 am with the Pharmacist who revealed Resident #1's ciprofloxacin order was not submitted by the facility to the pharmacy until 10/04/24 at 10:02 pm. The Pharmacist stated the pharmacy was unable to send the antibiotic medication for Resident #1 until the order was submitted by the facility. During a telephone interview on 11/19/24 at 10:41 am with the NP she revealed she and the Medical Director had discussed an antibiotic as treatment for a possible UTI that Resident #1 had prior to admission to the facility that may not have been treated fully. The NP stated she was not aware the ciprofloxacin was not administered to Resident #1 as ordered. A telephone interview was conducted on 11/19/24 at 10:53 am with the Medical Director who was assigned as the primary provider for Resident #1. The Medical Director reported that based on the hospital discharge summary Resident #1 had a UTI while hospitalized , but it was unclear if antibiotic therapy was completed. He stated Resident #1 had reported increased urinary frequency during his visit on 10/03/24 so he ordered an antibiotic in the event that the UTI was not treated in the hospital. The Medical Director stated he was not notified that Resident #1's ciprofloxacin was not administered as ordered. The Medical Director stated the medication should have been administered to Resident #1 as scheduled. An interview was conducted with the Director of Health Services on 11/19/24 at 9:36 am who revealed the nurses, or the Unit Manager were responsible to verify the physician orders. She stated when an order was entered into a resident's electronic record a notice would populate on the resident screen that a new order was pending verification. She stated to verify an order the nurse would have to review and confirm the order. The Director of Health Services stated that until the physician orders were verified the order would not be sent to pharmacy and would not show on the MAR to be administered. The Director of Health Services stated had Resident #1's ciprofloxacin order been verified when written the medication would have been available to be administered. The Director of Health Services stated she did not know why Resident #1's ciprofloxacin order was not verified by the nursing staff when ordered and she was unable to state how the order was missed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 11/19/24 at 1:30 pm who revealed the Director of Health Services was responsible to ensure physician orders were verified and the medications were available to be administered. The facility provided the following corrective action plan with a completion date of 10/09/2024. An Ad-Hoc (as needed) Quality Assurance and Performance Improvement (QAPI) meeting was held on 10/07/24 with the Administrator, Director of Health Services, Nurse Navigator, Unit Manager, and Corporate Clinical Director. The facility's corrective action plan was developed and implemented on 10/07/24. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 no longer resides in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected due to overlooked and unverified physician orders. An audit of all active resident physician orders was completed by the Director of Health Services on 10/08/24 to ensure all physician orders were verified (reviewed and confirmed) and accurately transcribed. No issues were identified. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. On 10/05/24 the Director of Health Services initiated education for licensed nurses regarding physician order verification. The education consisted of where to look for physician written orders, how to identify when orders were awaiting verification, and how to verify physician orders. The education was completed for 100% of the licensed nursing staff by 10/08/24. Education regarding physician order verification will be provided by the Director of Health Services or designee to all new hire licensed nurses in orientation or as indicated to ensure systems remain compliant. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nurse Navigator or designee will audit the Order Verification Reports for all resident physician orders to ensure verification and accuracy of the physician orders. The audits are to be conducted weekly for 12 weeks. The Director of Health Services or designee will report the findings to QAPI committee monthly for three months. The QAPI Committee will determine if sustained compliance has been achieved and if ongoing monitoring is needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The corrective action plan completion date was 10/09/2024. The facility's corrective action plan was verified on 11/19/2024 by the following: Review of the weekly order verification reports initiated on 10/07/24 and completed weekly to date. Record review of the resident order audit completed on 10/08/24 was completed and validated. Random review of resident orders was completed with no concerns identified. Interviews with licensed nursing staff revealed they were educated on where to look for physician orders, how to verify physician orders, and confirming all new orders are verified. The compliance date of 10/09/2024 was validated.