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	12/18/2025

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility failed to provide a prescribed assistive device, a spouted cup with handle, for 1 of 1 resident reviewed for assistive devices (Resident #65). Findings included: Resident #65 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a nontraumatic intracranial (brain) hemorrhage affecting arm and leg of left side. A review of Resident #65's physician orders revealed an order dated 7/31/25 for the Resident to have a spouted cup with handle with all meals.Review of Resident #65's care plan last reviewed 9/25/25 revealed a problem of the Resident being at nutrition/hydration risk. The goal was for Resident #65 to remain adequately hydrated through the next review. Approaches included providing adaptive equipment with meal trays as ordered: spouted cup with handle. Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired, had impairment to one upper and one lower extremity and was independent with eating after the meal tray was set up. On 12/15/25 at 11:28 AM, Resident #65 was observed lying in her bed, her breakfast tray was still on the overbed table next to her. The diet slip on her breakfast tray indicated she should have a spouted cup with handle. Instead, her tray contained regular cups with lids and straws. She appeared not to have drunk any of the beverages on her tray. During an interview and observation on 12/15/25 at 12:42 PM, Nurse Aide (NA) #4 carried the lunch tray into Resident #65's room. NA #4 placed the lunch tray on the overbed table, removed the plate lid and began to walk away. When interviewed at the bedside, NA #4 was asked if she checked the diet slip to assure the lunch tray was correct. NA #4 stated she had not, explaining, they didn't really say anything. NA #4 was then asked to look at Resident #65's diet slip. She looked at it but did not notice that it indicated Resident #65 was supposed to have a spouted cup with handle. When asked if Resident #65 was supposed to have a spouted cup with handle, she said no. Then NA #4 looked again and said yes. When asked what was on the tray, NA #4 stated a regular cup. When asked what she did when a resident's tray did not match the diet slip, NA #4 stated she just leaves it and hopes for the best. NA #4 indicated she was trained on passing meal trays upon hire. In an interview with Resident #65 on 12/16/25 at 8:15 AM she indicated she sometimes spilled her drinks when they were in a regular cup with a lid and a straw and that it was easier for her to drink from the spouted cup with a handle. In an interview with the Director of Nursing (DON) on 12/16/25 at 2:03 PM she stated staff who were passing meal trays to residents were responsible for checking the diet slip against what was on the resident's tray to assure accuracy. The DON indicated that if the meal tray was incorrect, staff were to take the tray to the Dietary Manager to have it corrected. In an interview with the Dietary Manager on 12/16/25 at 3:01 PM, she stated that two dietary aides and the cook observed and checked trays before placing them on the meal cart, so she did not know why Resident #65 was served breakfast and lunch on 12/15/25 without spouted cups with handles. The (continued on next page)

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

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dietary Manager further stated she had many spouted cups with handles in the kitchen, so it was not a matter of low stock on those items. An interview was conducted on 12/18/25 at 9:08 AM with the Administrator. She stated NAs were trained to check a resident's diet slip against the meal tray before serving it to the resident as they were the last to see the tray before it was served.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews with the resident, staff, Medical Director and North Carolina Poison Control, the facility failed to ensure the environment was free of hazards when Resident #85 was observed with multipurpose cleaner on her bedside table. This occurred for 1 of 2 residents reviewed for supervision to prevent accidents (Resident #85).The findings included:Resident #85 was admitted to the facility on [DATE]. Her diagnoses included diabetes, depression, and chronic kidney disease.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 was moderately cognitively impaired. She used a wheelchair for mobility and needed assistance with all Activities of Daily Living (ADL). An observation on 12/15/25 at 12:10 PM revealed a 40-ounce bottle of multipurpose cleaner, approximately half full, on Resident #85's bedside table.The warning label on the bottle of multipurpose cleaner stated that it could cause moderate to serious eye irritation, skin irritation, and respiratory tract infection from vapors. It warned users to avoid eye and skin contact, wear gloves and eye protection, and wash their hands thoroughly after use. Key warnings also stated that eye contact caused moderate to serious irritation; skin contact caused irritation and required washing thoroughly with soap and water after use; inhaling vapor or mist irritated the nose, throat, and lungs; and ingesting the cleaner caused stomach distress, nausea, and vomiting.An interview with Resident #85 was conducted on 12/15/25 at 12:15 PM. She stated she used the multipurpose cleaner to clean spills in her room and ordered it from a local retailer who delivered it to her room at the facility.An interview with Nurse Aide #2 was held on 12/15/25 at 12:30 PM. She stated she was not aware Resident #85 had a bottle of multipurpose cleaner and added the resident should not have had the cleaner in her room as it could have caused harm to this resident or any resident if it was consumed or splatter got in the eye. An interview with Nurse #1 was held on 12/15/25 at 12:35 PM. She stated she did not recall seeing the multipurpose cleaner in Resident #85's room. She also stated if the aides, housekeepers, or nurses saw it, they should have removed it immediately.An interview with a representative from the North Carolina Poison Control Center was held on 12/17/25 at 11:45 AM. She stated ingestion of the multipurpose cleaner could have caused side effects depending on the amount consumed. She added that if the cleaner contacted the eyes, it would cause irritation, and the eyes would need irrigation and further evaluation based on exposure. An interview was held with the Medical Director on 12/16/25 at 11:30 AM. She stated she had no concerns about the resident's exposure to the cleaner because she did not believe the resident would ingest it. She added that if ingestion occurred, she would call poison control for treatment instructions. An interview with the Director of Nursing (DON) was held on 12/15/25 at 12:32 PM. She stated the resident should not have had the multipurpose cleaner at the bedside because it could have been harmful to any resident if ingested or splatter got in the eyes. She added Resident #85 ordered several items to be delivered to her room. The DON indicated Resident #85's roommate was non-ambulatory, did not self-propel in a wheelchair and was severely cognitively impaired.An interview with the Administrator was held on 12/16/25 at 11:20 AM. She stated Resident #85 had a history of ordering items to be delivered to her room. She added she was not aware Resident #85 had multipurpose cleaner on her bedside table and expected any staff member who saw it to remove it immediately as it could cause harm to a resident if ingested or if there was exposure to the eyes of a resident. She indicated that if staff observed the multipurpose cleaner in a room, they should remove it and report finding the multipurpose cleaner to the DON and Administrator.