STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Trent	836 Hospital Drive New Bern, NC 28560

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on observations, record review, and resident, staff and Nurse Practitioner (NP) interviews, the facility failed to assess whether the self-administration of medication was clinically appropriate before leaving medication at the bedside. This was for 1 of 5 residents (Resident #87) reviewed for medication administration. Findings included: Resident #87 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breath). A review of Resident #87's medical record did not reveal a self-administration of medication assessment. A review of Resident #87's physician's orders did not reveal a physician's order to self-administer any medication. A physician's order dated 8/15/24 revealed Trelegy Ellipta (a long term medication to treat COPD) blister with device; 100-62.5-25 microgram (mcg) administer one puff inhalation once daily at 9:00 AM for COPD. A review of Resident #87's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. A review of Resident #87's comprehensive care plan dated last reviewed on 2/12/25 did not reveal any evidence Resident #87 self-administered medication. On 2/24/25 at 10:42 AM Resident #87 was observed in bed. She had her Trelegy Ellipta inhaler on her bedside table. An interview with Resident #87 at that time indicated she did not usually keep the medication at her bedside. She stated this medication was for her breathing and she took one inhalation daily each morning. She reported she must have been asleep when Nurse #3 brought the medication earlier and she had not taken the inhaler yet that morning. Resident #87 was then observed to administer one inhalation from the inhaler to herself. A review of Resident #87's February 2025 Medication Administration Record (MAR) revealed documentation by Nurse #3 on 2/24/25 indicating she administered one inhalation of Resident #87's Trelegy Ellipta inhaler to her at 9:00 AM that morning. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 12:05 PM an interview with Nurse #3 indicated she was assigned to care for Resident #87 on 2/24/25 from 7:00 AM to 3:00 PM. She stated she was familiar with Resident #87 and had cared for her before. She reported Resident #87 did not self-administer any medication. Nurse #3 stated she administered one inhalation of Resident #87's Trelegy Ellipta inhaler to her on 2/24/25 at 9:00 AM and then must have inadvertently left the inhaler at Resident #87's bedside. She reported that if Resident #87 had taken another dose of the medication on 2/24/25 at 10:42 AM, this would have been a medication error. On 2/27/25 at 9:01 AM an interview with the Director of Nursing (DON) indicated Resident #87 should not have any medication left at her bedside without a self-administration of medication assessment indicating this was appropriate for Resident #87, and a physician's order to self-administer the medication. On 2/27/25 at 9:51 AM an interview with Resident #87's NP #1 indicated that while taking an additional dose of Trelegy Ellipta inhaler medication on 2/24/25 would not have caused any harm to Resident #87, the medication should not have been left at her bedside. On 2/27/25 at 11:30 AM an interview with the Administrator indicated Nurse #3 was a very experienced nurse. She stated leaving medication at a resident's bedside would be very unusual for Nurse #3. The Administrator reported she felt this was just a one-time mistake.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff and Responsible Party (RP) interviews, the facility failed to ensure a copy of the resident's advanced directive was included in the resident's record and failed to honor the resident's wishes with regards to code status as expressed by the resident's RP on admission. This was for 1 of 11 residents (Resident #94) reviewed for advanced directives. Findings included: A review of Resident #94's hospital discharge summary dated [DATE] revealed his code status in the hospital was full code (a medical term that indicates a patient wants to receive all available measures to save their life in an emergency). It was initialed by Unit Manager #1 indicating she reviewed the document. Resident #94 was admitted to the facility on [DATE] with a diagnosis of dementia. A review of the facility's admission document titled NC Advanced Directive for Healthcare dated [DATE] and signed by Resident #94's RP and the facility's Admissions Director revealed documentation indicating Resident #94 had previously executed an advanced directive (Living Will or Healthcare Power of Attorney) and would provide a copy to the facility. A review of the facility admission document titled DNR (Do not Resuscitate is a legal order written to respect the wishes of a patient not to undergo cardiopulmonary resuscitation (CPR) if their heart stopped or they were to stop breathing) dated [DATE] and signed by Resident #94's RP and the facility's Admissions Director revealed documentation indicating Resident #94 had a DNR order or MOST (Medical Orders for Scope of Treatment) previously executed on his behalf and a copy would be provided to the healthcare center. A review of Resident #94's physician's orders revealed a code status order for full code dated [DATE] entered by Unit Manager #2. A review of Resident #94's comprehensive care plan revealed a focus area for advanced directives initiated on [DATE] indicating Resident #94's code status was full code. The goal was for Resident #94's wishes and directives to be carried out in accordance with his advanced directives on an ongoing basis. An intervention was to discuss advanced directives with Resident #94 and/or his appointed health care representative. A review of a Social Work (SW) progress note for Resident #94 dated [DATE] at 11:35 AM written Resident #94's SW revealed Resident #94's code status was DNR. A review of Resident #94's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. A review of Resident #94's medical record did not reveal a copy of his advanced directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:51 PM a telephone interview with Resident #94's RP indicated she completed the admissions paperwork for Resident #94 when he was admitted to the facility as he had not been capable of doing this. She stated Resident #94 had both a living will, and a healthcare power of attorney which listed her as his RP. She reported that she expressed that he had these things when she completed Resident #94's admission paperwork and also expressed that Resident #94's wish for code status was DNR. She stated she had provided the facility with a copy of these documents. She reported no one from the facility had ever let her know they did not have them, or she would have gladly provided them again. Resident #94's RP went on to say she participated in all Resident #94's care plan meetings, but she did not recall Resident #94's code status or advanced directives being discussed there. She stated she was not aware that Resident #94's code status in the facility had been full code since his admission, and this would not be what he wanted. On [DATE] at 2:52 PM an interview with the Admissions Director indicated she completed Resident #94's admission paperwork with his RP. She stated if a resident or RP indicated a resident had advanced directives she checked that box on the admission form. She stated if Resident #94's advanced directives were not in his record, it might be that his RP had not provided it to the facility. She reported she did not follow up after the initial admission paperwork was completed to ensure that the documents were received. The Admissions Director stated for code status, if a resident or RP expressed the wish to be a DNR, she checked that box on the admission form and also put a check in the box in the residents electronic record which caused a DNR flag to appear in the electronic record on the resident's face sheet for the nurses to see. She reported it would then be the nurse's responsibility to get the DNR order. On [DATE] at 8:10 AM an interview with Unit Manager #2 indicated she entered the full code order for Resident #94 into his electronic medical record on [DATE] based on the information she obtained from his hospital discharge summary. She stated Resident #94 was not residing on her unit, so she had not looked for any advanced directive paperwork, or a DNR or MOST form. She stated Unit Manager #1 would have been responsible for this. On [DATE] at 8:16 AM an interview with Unit Manager #1 indicated she did not follow up with residents or their RP's if they indicated the resident had advanced directives such as a living will or a health care power of attorney on admission to ensure a copy was obtained for the residents record. She reported she did recall on Resident #94's admission to the facility, the banner on his electronic record face sheet said DNR, and he had a full code order in place. She went on to say at some point the SW had been doing an audit to ensure resident's face sheet banner code status matched the code status order, and Resident #94's face sheet banner had been changed to full code. She stated she had checked with the SW, and the SW told her Resident #94 was a full code. She reported if a resident's admission paperwork indicated their wish was for a DNR code status, and the physician's order was for a full code status, she did try to clarify with the resident or their RP, but she had not done this for Resident #94. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:28 AM an interview with the SW indicated she did not recall why she documented Resident #94's code status was DNR in her progress note dated [DATE]. She stated if a resident had advanced directives paperwork such as a living will or a health care power of attorney, the Admissions Director would let her know and the Admissions Director would get copies of the documents and upload them into the residents medical record. She reported she had completed the audit for ensuring that residents code status physician's order and face sheet code status banner matched and recalled that Resident #94's banner indicated a DNR code status, but the physician's order was for full code. She stated when she didn't see any advanced directive paperwork such as a living will or a healthcare power of attorney in Resident #94's record she told Unit Manager #1 that Resident #94 was a full code. She stated she had not clarified the issue with Resident #94's RP. The SW stated Resident #94's RP did attend his care plan meetings, and she did not recall Resident #94's RP ever telling her he wanted to be a DNR code status. On [DATE] at 9:27 AM an interview with the Director of Nursing indicated if a resident or their RP indicated on admission that the resident had a living will or a health care power of attorney, the Admissions Director should be ensuring there were copies of the documents in the residents medical record. She went on to say if a resident's wishes were to be a DNR code status, that's what their code status should be, and the Unit Managers should be ensuring a goldenrod DNR form or a MOST form were obtained for the resident. On [DATE] at 11:30 AM an interview with the Administrator indicated the facility had a system in place where they asked on admission whether a resident had a living will or a health care power of attorney. She stated if Resident #94's RP indicated he had these, someone should have ensured a copy was obtained and included in Resident #94's medical record. The Administrator reported if a resident or a resident's RP expressed that the resident's wishes were to be a DNR code status, then that's what it should be.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls for 1 of 5 residents reviewed for accidents (Resident #87). Findings included: Resident #87 was admitted to the facility on [DATE]. A review of a nursing progress note for Resident #87 dated 1/25/25 at 4:45 PM written by Nurse #2 revealed Resident #87 had a fall from her bed. Resident #87 had no skin tears, limited range of motion or dizziness after her fall. Resident #87 was complaining of mild pain to her right hip and right knee. A review of Resident #87's quarterly MDS assessment dated [DATE] revealed she had no falls since her prior MDS assessment. On 2/26/25 at 12:46 PM an interview with Nurse #2 confirmed Resident #87 had a fall from her bed on 1/25/25. On 2/26/25 at 1:13 PM in an interview the MDS Coordinator stated she coded the falls section of Resident #87's MDS assessment dated [DATE]. She reported she normally looked at progress notes for information when coding this section. She went on to say the date of Resident #87's prior MDS assessment was 1/21/25, so the fall Resident #87 experienced on 1/25/25 should have been captured on Resident #87's 2/12/25 MDS assessment. She reported it was an oversight on her part. On 2/27/25 at 9:01 AM an interview with the Director of Nursing indicated resident's MDS assessments should accurately reflect their status. On 2/27/25 at 11:30 AM an interview with the Administrator indicated resident's MDS assessments should be coded accurately.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing side rails for 2 of 4 residents (Resident #18 and Resident #98) reviewed for side rails. Findings included: 1. Resident #18 was admitted to the facility on [DATE] with a diagnosis of diffuse traumatic brain injury. A review of Resident #18's record revealed an assessment titled restraint-adaptive equipment use dated 8/23/24 and completed by Unit Manager (UM) #1 indicated no answer was provided for the question have alternatives to restraint or adaptive equipment been tried in the past?. The choices were yes, no or not applicable. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #18 was moderately cognitively impaired. The MDS indicated Resident #18 required substantial to maximum assistance with bed mobility, transfers, and was non-ambulatory. The MDS revealed Resident #18 had no impairment of both upper and lower extremities. The MDS indicated Resident #18's siderails were not used as a restraint. A care plan with the latest review date of 1/17/25 revealed a problem of use of one quarter side rails for increasing or maintaining current bed mobility. The goal was Resident #18 would remain safe through the next review. The approach was for Resident #18 used one quarter side rails for turning and repositioning during incontinence care. An observation on 2/24/25 at 1:03 PM revealed Resident #18 lying in bed with bilateral one-quarter length side rails in the up position on the bed. An observation on 2/25/2025 at 12:09 PM revealed Resident #18 sitting in her bed with the head raised at a 45-degree angle. The side rails were observed to be in the raised position. An interview with Nurse #1 on 2/25/25 11:58 am revealed the Nurses completed the restraint-adaptive equipment use evaluation on admission and quarterly. Nurse #1 stated this form was used for side rail screening. She further stated she always answered no to the question Have alternatives to restraint or adaptive equipment been tried in the past?. Nurse #1 indicated side rails were on the beds on admission. She further indicated Nursing did not try alternatives to side rails before they were used, and she could not think of alternatives to try instead of using side rails. Nurse #1 was not aware alternatives needed to be tried before using side rails. In an interview with UM #1 on 2/25/25 at 12:03 PM she stated she recalled completing the restraint-adaptive equipment use evaluation for Resident #18. She further stated she was not aware of a time the facility tried alternative side rails. She was not aware alternatives to side rails needed to be attempted before using them, so she did not answer the question. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing (DON) on 2/25/25 at 12:09 PM she stated Nursing completed the restraint-adaptive equipment use evaluation on admission and quarterly. She further stated they did not try interventions before using side rails as she was not aware this was a requirement. The DON revealed side rails were always on the beds. If a resident did not need them, then they were kept in the down position. In an interview with the Administrator on 2/25/25 at 12:34 PM she stated alternative interventions to siderails were not tried before implementation as she was unaware that this was a requirement. 2. Resident #98 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) of left side of body following cerebral infarction (stroke). A review of Resident #98's record revealed an assessment titled restraint-adaptive equipment use evaluation dated 10/4/24 and completed by Nurse #1 indicated no alternatives to restraint or adaptive equipment been tried in the past. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #98 was cognitively intact and was dependent on staff for bed mobility. The MDS indicated Resident #98's siderails were not used as a restraint. A care plan with the latest review date 10/21/24 revealed a problem that Resident #98 had one quarter siderails to assist with bed mobility and transfers. The goal was Resident #98 would not obtain any injury from positioning/transfers. The approach stated Resident #98 and staff would use side rails to assist with bed mobility and transfers as needed. An observation on 2/24/25 at 11:15 AM revealed Resident #98 in bed with the one quarter length side rails in the raised position. An observation on 2/25/25 at 11:45 AM revealed Resident #98 in bed with bilateral one-quarter length siderails in the up position on the bed. An interview with Nurse #1 on 2/25/25 11:58 am revealed the Nurses completed the restraint-adaptive equipment use evaluation on admission and quarterly. Nurse #1 stated this form was used for side rail screening. She further stated she recalled completing the form for Resident #98 and she always answered no to the question Have alternatives to restraint or adaptive equipment been tried in the past?. Nurse #1 indicated side rails were on the beds on admission. She further indicated Nursing did not try alternatives to side rails before they were used. Nurse #1 was not aware alternatives were required before using side rails. In an interview with UM #1 on 2/25/25 at 12:03 PM she stated she was not aware of a time the facility tried alternatives to siderails. She was not aware alternatives to side rails needed to be attempted before using them. In an interview with the Director of Nursing (DON) on 2/25/25 at 12:09 PM she stated Nursing completed the restraint-adaptive equipment use evaluation on admission and quarterly. She further stated they did not try interventions before using side rails as she was not aware this was a requirement. The DON revealed side rails were always on the beds. If a resident did not need them, then they were kept in the down position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 2/25/25 at 12:34 PM she stated alternative interventions to siderails were not tried before implementation as she was unaware that this was a requirement.

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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. 48230 Based on observation, record review and staff interview, the facility failed to follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a hemodialysis catheter when Nurse Aide (NA) #1 and NA #2 provided a bed bath without wearing gowns for 2 of 20 staff observed for infection control (NA #1 and NA #2). Findings included: The facility policy titled Enhanced Barrier Precautions (EBP) dated 4/30/24 stated in part: EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gowns and gloves use during high contact resident care activities for residents with indwelling medical devices. The policy gave the example of bathing and dressing as a high contact activity. Observation of Resident #103's door on 2/26/25 at 9:03 AM revealed signage for EBP. The signage indicated that staff providing high contact care to Resident #103 were required to wear gowns and gloves. Further observation revealed a caddy outside Resident #103's room that contained Personal Protective Equipment (PPE) including gowns and gloves. An observation of NA #1 and NA #2 providing a bed bath and dressing Resident #103 was conducted on 2/26/25 at 9:05 AM. NA #1 and NA #2 were observed performing hand hygiene and donning gloves before providing the care. Resident #103 was observed to have a hemodialysis catheter (a tube with connectors) inserted in his right upper chest area. Neither NA #1 nor NA #2 donned gowns before providing high contact care to Resident #103. An interview was conducted with NA #1 and NA #2 on 2/26/25 at 9:30 AM. Both NAs stated they thought the EBP sign on the door was for Resident 103's roommate. When asked to give examples of who should be on EBP they stated residents with wounds, intravenous lines and urinary catheters. They could not recall other reasons a resident would require EBP for high contact care and did not think a hemodialysis catheter was included in reasons to require EBP. NA #1 and NA #2 both stated they had training on EBP at least one time. An interview was conducted with the Infection Preventionist on 2/26/25 at 9:34 AM. The Infection Preventionist stated all residents with an indwelling medical device, which included a hemodialysis catheter, would require EBP for high contact care such as bathing and dressing. The Director of Nursing (DON) was interviewed on 2/26/25 at 9:46 AM. The DON stated she was unaware a hemodialysis catheter required EBP for high contact care. Unit Manager (UM) #2 was interviewed on 2/26/25 at 10:05 AM. UM #2 stated a hemodialysis catheter did not require EBP for high contact care. In an interview with the Administrator on 2/26/25 at 10:38 AM she stated EBP was required for any resident with an indwelling medical device such as a hemodialysis catheter when staff were providing high contact care. She further stated staff were trained on EBP upon hire and annually.