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 _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/19/20 through 10/22/20. Event ID# PBO811 One of the 6 complaint allegations was substantiated.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and physician interview, the facility failed to assess a resident's bilateral leg wounds on admission for 1 of 2 residents reviewed for wounds (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/14/20 and discharged on 8/20/20 with diagnoses which included vascular dementia and end stage renal disease. Review of the Hospital discharge summary records dated 8/14/20 read in part that Resident #1 was discharged with a left lateral leg stasis ulcer, left medial leg diabetic ulcer, left toe stasis ulcer, right posterior leg stasis ulcer, and right medial leg diabetic ulcer. Review of Resident #1's facility admission observation assessment dated 8/14/20 at 4:32 PM by Nurse #1 revealed skin assessment	F 658	Resident #1 no longer resides at the facility. An audit of current residents was completed to ensure that nursing staff appropriately assessed other resident with wounds when they were admitted to ensure no additional assessments were missed. This was completed by the Senior Nurse Consultant on October 22, 2020. Licensed Nurses were re-educated by the Director of Health Services/Designee on providing a complete head to toe skin assessment upon admission. The Director of Health Services/Designee will audit the head to toe skin assessment of any resident admitted to ensure they are being completed. This will occur five times a week for four weeks then monthly	11/16/20

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

Electronically Signed | 11/02/2020

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F 658	Continued From page 1 comments in part "ulcer to right posterior leg". Review of facility observation assessment dated 8/14/20 at 9:24 PM by Nurse #2 revealed skin assessment comments of "left arm has fistula". Review of facility observation assessment dated 8/15/20 at 2:51 AM by Nurse #2 revealed skin assessment comments of "shunt on left arm". Review of facility observation assessment dated 8/15/20 at 4:08 AM by Nurse #3 revealed no comments related to skin assessment. Review of facility observation assessment dated 8/16/20 at 4:09 AM by Nurse #3 revealed skin assessment comments read in part "skin tear on right forearm due to fall". Review of facility observation assessment dated 8/16/20 at 7:51 PM by Nurse #4 revealed no comments related to skin assessment. Review of facility observation assessment dated 8/17/20 at 1:24 AM by Nurse #3 revealed skin assessment comments of "skin tear to right forearm". Review of facility observation assessment dated 8/19/20 at 1:56 AM by Nurse #5 revealed skin assessment comments of "see wound report". Review of facility observation assessment dated 8/20/20 at 3:29 AM by Nurse #3 revealed skin assessment comments of "skin tear to right arm and weeping from bilateral lower extremities". Review of Resident # 1's wound report from the dates of 8/14/20 to 8/20/20 revealed no	F 658	times one. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of compliance 11/16.2020	

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F 658	Continued From page 2 documentation of wounds including wound assessment, measurements, or treatment. Three attempts were made on 10/20/20 at 8:49 AM, 10/20/20 at 1:45 PM, and 10/21/20 at 7:53 AM to interview Nurse # 1 and the nurse could not be reached. An interview with the facility physician on 10/20/20 at 1:53 PM revealed he was unaware of Resident #1's bilateral leg ulcers and left toe ulcer. He further stated the facility should have performed a complete skin assessment on the resident upon her admission. An interview with the Director of Nursing (DON) on 10/22/20 at 11:00 AM revealed a head to toe skin assessment should have been performed on Resident #1 as part of the admission process. The DON validated this had not been done and did not know why this had not been done. An interview with the Administrator on 10/22/20 at 11:57 AM revealed she was unaware Resident #1 had not had a skin assessment on admission and did not know why it had not been done.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		11/16/20

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F 684	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and physician interview, the facility failed to initiate physician orders on admission for the treatment of bilateral leg ulcers and failed to provide physician ordered treatment for bilateral leg ulcers for 1 of 2 residents reviewed for wounds (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/14/20 with diagnoses which included vascular dementia and end stage renal disease. On 8/20/20 the resident was discharged home with hospice care after a decision was made to discontinue dialysis treatment for renal disease. Review of the Hospital discharge summary records dated 8/14/20 read in part that Resident #1 was discharged with a bilateral buttocks pressure ulcer, left upper arm skin tear, left lateral leg stasis ulcer, left medial leg diabetic ulcer, left toe stasis ulcer, right toe scab, right posterior leg stasis ulcer, and right medial leg diabetic ulcer. Review of physician's orders for August 2020 for Resident #1 revealed no treatment orders for left toe ulcer, right or left leg stasis or diabetic ulcers. Review of the Treatment Administration Record (TAR) for August 2020 for Resident #1 revealed no treatment orders for left toe ulcer, right or left leg stasis or diabetic ulcers. Review of the Care Plan for Resident #1 with approach start date of 8/15/20 revealed a problem category of pressure injuries and a goal	F 684	Resident # 1 no longer resides at the facility. An audit of current residents was completed to ensure that nursing staff-initiated physician orders for treatments on admission and that appropriate physician ordered treatments were provided to them. This was completed by the Senior Nurse Consultant on October 22, 2020. Licensed Nurses were re-educated by the Director of Health Services/Designee on complete treatment order transcription, order clarification and following physician ordered treatments. The Director of Health Services/Designee will audit treatment physician orders for any resident admitted to ensure they are initiated and being provided to the resident as ordered. This will occur five times a week for four weeks then monthly times one. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any needs for additional education. Date of compliance 11/16/2020	

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F 684	Continued From page 4	F 684		

of ulcers will show signs of healing with no signs and symptoms of infection or complications through the next review. The care plan approach was for treatment per orders and to see the TAR for most current treatment orders. There was no mention of the resident having diabetic or stasis ulcers to her lower extremities on the care plan.

An interview on 10/19/20 at 3:51 PM with Nurse #6 revealed she had entered Resident #1's admission orders and had not seen the wound care orders. She stated it was an oversight and the wound care orders had not been verified with the physician or entered into the resident's electronic medical record.

Nurse # 3 was assigned to care for Resident # 1 on 8/16/20 and 8/17/20. An interview on 10/21/20 at 9:14 AM with Nurse #3 revealed she had seen bilateral leg dressings on Resident #1's legs one shift and the resident did not have bilateral leg dressings the next shift she provided care for the resident. She also revealed she had not provided wound care for Resident #1's legs and did not review her TAR to see if wound care had been ordered.

Nurse #2 was assigned to care for Resident #1 on 8/14/20 and 8/15/20. An interview with Nurse #2 on 10/21/20 at 9:05 AM revealed she did not recall Resident #1 or changing dressings for Resident #1.

An interview on 10/20/20 at 8:53 AM with Nurse #7 revealed she was the nurse on duty when Resident #1 was discharged from the facility on 8/20/20. She further revealed Resident #1 had bilateral dressings on her legs which were wet, and she did change the dressings. Nurse #7

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F 684	Continued From page 5	F 684		

further stated she could not locate any orders for the bilateral leg ulcer wounds and she did not document the bilateral leg dressings she performed.

An interview with Resident # 1's responsible party (RP) was conducted on 10/20/20 at 11:26 AM. During the interview the RP reported the following. She was a health care professional who was familiar with the resident's leg wounds. The leg wounds were chronic in nature. She was afforded a compassionate care visit during the resident's seven-day facility stay. On the date of her visit she found the dressings to be soiled and wet and she was concerned the dressings were not being changed. She reported her concerns to the nurse on duty. The RP requested wound care supplies and did her mother's bilateral leg dressings herself. The RP expressed that although the resident's wounds were chronic in nature and not expected to heal, she was concerned with the lack of dressing changes for them.

An interview with the facility physician on 10/20/20 at 1:53 PM revealed he was unaware of Resident #1's bilateral leg ulcers and left toe ulcer. He further stated the facility should have performed wound care for the resident's leg and toe wounds.

An interview with the Director of Nursing (DON) on 10/22/20 at 11:00 AM validated Resident #1 had not received wound care and did not know why this had not been done. She stated the nurses should have followed up to ensure the resident was provided appropriate physician ordered wound care.

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F 684	Continued From page 6 An interview with the Administrator on 10/22/20 at 11:57 AM revealed she was unaware Resident #1 had not had received wound care and did not know why it had not been done.	F 684		