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 10/04/2021

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
E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 9/21/21 through 10/04/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 7EKR11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 9/21/21 through 10/04/21. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Two of the 4 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.45 at tag F760 at a scope and severity J CFR 483.70 at tag F835 at a scope and severity J The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/03/21 and was removed on 9/30/21. A partial extended survey was conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		10/20/21

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

Electronically Signed | 10/19/2021

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 10/04/2021

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 580	Continued From page 1 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580		

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 10/04/2021

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 580	Continued From page 2 Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to notify the physician of a medication error allegation for 1 of 2 residents (Resident #1) reviewed for notification. Findings included: Resident #1 was admitted to the facility on 8/27/21 with diagnoses that included end stage renal disease (ESRD) and Diabetes Mellitus (DM). A review of Resident #1's Minimum Data Set dated 9/01/21 indicated the resident was cognitively intact and was coded to have received no injections of any type. Review of the Investigation Report signed by the Director of Nursing (DON) was hand dated as 9/20/21. Attachments for the Investigation Report were a signed statement from Nurse #1 dated 9/15/21 and a signed statement from the DON dated 9/15/21. An interview on 9/23/21 at 8:00 AM with the DON indicated she was unaware of the medication error until 9/15/21. She stated she verbally notified the facility Physician of an	F 580	This Plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that deficiencies exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by Federal and State Law. The physician has since been made aware of an alleged medication error. An audit was completed by the pharmacist on October 7, 2021 for medication errors. The Director of Health Services reviewed the pharmacist report which showed no medication errors for which the physician needed notified. This was completed on October 7, 2021. Licensed Nurses were reeducated on September 23, 2021 by the Director of Health Services and the Registered Nurse Clinical Competency Coordinator on Procedure □ Medication Errors which contains date and time of physician notification.	

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 10/04/2021

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 580	Continued From page 3 unsubstantiated medication error and he had no comment. She did not know the time or date of the notification. An interview on 9/21/21 at 3:30 PM with the facility Physician revealed he was not aware of the allegation of a medication error for Resident #1. Another interview on 9/29/21 at 9:00 AM with the facility Physician confirmed he did not remember the DON telling him anything about Resident #1 receiving insulin or his hypoglycemia. An interview on 9/23/21 at 2:15 PM with the Administrator revealed she was on vacation at the time of this investigation and that the DON completed the investigation.	F 580	The Director of Health Services/Designee will review Medication Errors to ensure that the physician was notified timely. 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 need for additional education. Compliance Date October 20, 2021	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement the neglect policy with the requirement to thoroughly investigate a	F 607	The Director of Health Services immediately reviewed the facilities Investigation of Patient Abuse, Neglect,	10/20/21

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 10/04/2021

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 607	Continued From page 4 neglect allegation for 1 of 1 resident (Resident #1) reviewed for a medication error. Findings included: The facility's policy titled Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property revised on 10/09/20 read in part 'Interviews should be conducted of all individuals who have relevant information. Written signed statements form any involved parties should be obtained. Statements should be gathered from the following individuals: the suspect; the person making accusation, the patient involved, reliable patients who may have witnessed the incident, and any other persons who may have information.' Review of the Initial Allegation Report signed by the Director of Nursing (DON) revealed the facility became aware of the incident on 9/15/21 at 12:00 AM. The fax confirmation report was dated 9/15/21 at 4:37 PM. The allegation/incident type had the box checked for resident neglect. Review of the Investigation Report signed by the DON was hand dated as 9/20/21. Attachments for the Investigation Report were a signed statement from Nurse #1 dated 9/15/21 and a signed statement from the DON dated 9/15/21. An interview on 9/23/21 at 8:00 AM with the (DON) indicated she was unaware of the medication error until 9/15/21. She stated the Administrator had received notification from the Corporate Vice President that a complaint had been called into the complaint line by Resident #1's family member. The DON also stated she	F 607	Exploitation, Mistreatment and Misappropriation of Property dated 10/9/2020 and Abuse Prevention and Reporting dated September 2012. All residents have the potential to be affected by this deficient practice. The Administrator and the Director of Health Services were reeducated on September 27, 2021 on the grievance policy, Root Cause Analysis and Systematic Approach to unexpected/unanticipated process failures or outcomes. The Administrator will review all grievances and sign the grievance log and state reportable events weekly to ensure complaints are thoroughly investigated per policy. This will occur weekly 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 need for additional education. Compliance Date October 20, 2021	

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 10/04/2021

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 607	Continued From page 5 told the dialysis nurse on 9/03/21 that the resident had not received insulin as none was ordered for him. She stated she 'didn't think anything about it' at the time since the resident had no order for insulin. She also stated on 9/03/21 she reviewed Resident #1's current medications with the Emergency Department (ED) and she was aware the ED was 'under the impression he had received insulin, but they did not say how he had received it'. She also stated she told the ED that he had not received insulin on 9/03/21. The DON stated she had not contacted Resident #1 or the roommate, Resident #2 during this investigation. She stated the facility Physician was notified of an unsubstantiated medication error. An interview on 9/23/21 at 2:15 PM with the Administrator revealed she was first made aware of the medication error allegation on 9/15/21 when she was notified by the Corporate Vice President that a complaint had been called into the complaint line. She further stated she was on vacation at the time of this investigation and that the DON completed the investigation.	F 607		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, residents, family, facility staff, dialysis staff and physician interviews, the facility failed to prevent a significant medication error by administering insulin to the wrong resident for 1 of 2 residents (Resident #1). Resident #1 did not have a physician's order for	F 760	Resident #1 no longer resides at the facility. All residents have the potential to be affected by medication errors. On 9/24/21 the Clinical Competency Coordinator	10/20/21

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 10/04/2021

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 760	Continued From page 6 insulin and on 9/03/21 was administered insulin prescribed for Resident #2 and as a result required hospitalization for the treatment of hypoglycemia. Immediate jeopardy began on 9/03/21 when the facility failed to prevent a significant medication error by administering insulin to the wrong resident for 1 of 2 residents (Resident #1). Resident #1 was sent to the dialysis center and they sent him to the hospital for hypoglycemia. The immediate jeopardy was removed on 9/30/21 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the education and the monitoring systems put in place to remove the immediate jeopardy are effective and to correct current deficient practice as identified. Findings included: Resident #1 was admitted to the facility on 8/27/21 with diagnoses that included end stage renal disease (ESRD) and Diabetes Mellitus (DM). A review of Resident #1's Minimum Data Set dated 9/01/21 indicated the resident was cognitively intact and was coded to have received no injections of any type. A review of Resident #1's physician orders indicated he was not ordered any insulin or any oral diabetic medications.	F 760	completed a review of Matrix Care electronic records to ensure all residents had a valid picture that corresponded to the resident for identification purposes. The Senior Nurse Consultant validated on 9/27/21 that all current residents in Matrix Care electronic medical record have a current picture for identification purposes. Licensed Nurses were reeducated on September 23, 2021 by the Director of Health Services and the Registered Nurse Clinical Competency Coordinator on resident identification utilizing the policy medication administration; general guidelines which states to utilize two forms of identification to identify residents. Education was also completed with Licensed Nurses on September 28, 2021 on the five rights of medication pass procedure, including Right Resident, Right Medication, Right Route, Right Dose, and Right Time. The Director of Health Services and Nurse managers began auditing the Registered / Licensed Nurses daily on September 23, 2021 during medication administration to ensure compliance that they are utilizing two points of identification when administering medication to residents to validate the correct resident receives the correct medication. This will occur five times a week for two weeks then weekly times two. Audit results will be reported to the Quality Assurance Performance Improvement	

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 10/04/2021

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 760	Continued From page 7 Resident #2 was admitted to the facility on 8/20/21 with diagnoses that included end stage renal disease (ESRD) and Diabetes Mellitus (DM). A review of Resident #2's Minimum Data Set dated 8/27/21 indicated the resident was cognitively intact and was coded to have received insulin injections for 7 days during the look back period. A review of Resident #2's physician orders' indicated he was ordered Novolin 70/30 insulin 10 units twice a day at 9:00 AM and 5:00 PM. Novolin is a combination insulin medication administered to treat Diabetes Mellitus which starts to work within 10 to 20 minutes after injection. It peaks in 2 hours and continues to work for as long as 24 hours. An interview on 9/21/21 at 2:24 PM with Resident #1 revealed he had been given an injection on 9/03/21 around 9:00 AM which he stated Nurse #1 told him was insulin. He said the nurse entered the room with some medications in a cup and a shot around 8:30 AM or 9:00 AM. He stated that Resident #2 told Nurse #1 the shot was for him and not Resident #1. Resident #1 stated he told the nurse he did not take insulin, but she gave him the injection anyway in his right arm. He stated that Nurse #1 told him it was insulin. Resident #1 stated Nurse #1 also gave him oral medication pills in a cup at the same time. An interview on 9/21/21 at 12:32 PM with Resident #1's family member revealed he had told her that Nurse #1 had given him his	F 760	Committee to identify trends and further opportunities for quality improvement and any need for additional education. Compliance Date October 20, 2021	

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 10/04/2021

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 760	Continued From page 8	F 760		

roommate's insulin shot on 9/03/21.

An interview on 9/22/21 at 10:41 AM with Resident #2 revealed he had not received his scheduled insulin on 9/03/21 at 9:00 AM. Resident #2 stated he had not seen or heard Resident #1 talk to Nurse #1 about insulin or get a shot on 9/03/21. Resident #2 also stated he had not talked to Resident #1 about insulin. Resident #2 stated he told Nurse #1 he had not received his morning insulin dose on 9/03/21, but she didn't say anything, and he did not receive his insulin.

Per record review, Resident #2 was ordered Novolin 70/30 insulin 10 units subcutaneous twice a day at 9:00 AM and 5:00 PM and the Medication Administration Record (MAR) was signed as administered by Nurse #1 at 9:00 AM on 9/03/21.

An interview on 9/21/21 at 3:15 PM with Nurse #1 revealed she had given Resident #2 his scheduled insulin around 9:00 AM on 9/03/21 and she stated she had not given Resident #1 insulin. She stated she verified resident's identity for medication administration through the electronic pictures and resident names on the outside of the door. She stated she called the resident by his name on 9/03/21 to verify the resident. Nurse #1 stated Resident #2 did not tell her that he had not received his insulin on 9/03/21.

Another interview on 9/23/21 at 4:30 PM with Nurse #1 revealed she had given Resident #2 his morning insulin in his right arm on 9/03/21. She stated Resident #2 never said anything to her about not getting his insulin that morning. She

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 10/04/2021

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 760	Continued From page 9	F 760		

reaffirmed she verified resident's identity by the picture on the electronic record and by the name tags on the outside of the door.

Another interview on 9/23/21 at 5:37 PM with Nurse #1 with the Director of Nursing (DON) and the Administrator present revealed she did not believe she had made a medication error.

Resident #1's dialysis records for 9/03/21 read in part that dialysis was started at 10:50 AM and blood sugar was checked at 1:45 PM with a reading of 64. The next blood sugar reading was at 4:00 PM with a reading of 49. The physician's order to transport Resident #1 to the hospital was at 5:07 PM.

An interview on 9/21/21 at 12:55 PM with Dialysis Nurse #1 revealed she had assumed care of Resident #1 when he was halfway through his dialysis on 9/03/21. She stated she received in report that his blood sugar was low, and he had been given an oral shake. Then his blood sugar came up a little and he was given an oral glucose. She stated that Resident #1 told her he had been given insulin at the facility even though he did not take insulin. She stated his blood sugar dropped again and the nephrologist gave an order for him to be sent to the hospital for evaluation and treatment for hypoglycemia. The dialysis nurse also stated Resident #1 had no signs or symptoms of hypoglycemia while in her care.

An interview on 9/24/21 with Dialysis Nurse #2 revealed Resident #1 told her a facility nurse had given him a shot on 9/03/21 before he went to dialysis. She stated she called the facility Director of Nursing (DON) on 9/03/21 and told her that

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 10/04/2021

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 760	Continued From page 10	F 760		

Resident #1 reported he had received a shot. The DON informed the Dialysis Nurse that the resident did not receive insulin and she would investigate.

Resident #1's hospital Emergency Department (ED) records dated 9/03/21 read in part that the chief complaint was resident stated he was given the roommates insulin this morning at the facility and became hypoglycemic at dialysis. On Resident #1's arrival to the ED his blood sugar was 170. The record further read that Resident #1 was having labile blood glucose readings and hypoglycemia and he was started on Dextrose 5% with half-normal saline. Some of his blood glucose readings were: 69, 118, 99, 106, 67, 86 and 68. Another paragraph read "Did have nursing staff call the facility they had some difficulty finding out what his roommate's insulin was, but they were able to find out it was 70/30".

An interview on 9/23/21 at 3:04 PM with Nurse #2 revealed Resident #2 had told her the night of 9/03/21 that he had not received his morning insulin. She stated she was not sure what happened, and she reported it to Nurse #1 the next day.

An interview on 9/21/21 at 3:30 PM with the facility Physician revealed he did not know why Resident #1's blood sugar would be low if he had not received insulin. He also stated he did not know of another reason for his blood sugar to drop that low and he believed it was likely that the resident got a dose of insulin. He stated Resident #1 was alert and oriented with some dementia but if he voluntarily told the dialysis staff and the hospital staff that he got an insulin injection he believed him. The Physician stated he was

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 10/04/2021

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 760	Continued From page 11	F 760		

unaware of Resident #1 having any hypoglycemia episodes, but he did run low normal blood sugars. He stated his hypoglycemia could have been related to dialysis but did not think it was likely since it had not happened before, and resident stated he got an insulin injection.

Another interview on 9/29/21 at 9:00 AM with the facility Physician confirmed he did not remember the DON telling him anything about Resident #1 receiving insulin or his hypoglycemia.

An interview on 9/25/21 at 8:58 AM with the Dialysis Center Nephrologist revealed that the dialysate used for dialysis contains glucose to help prevent hypoglycemia. Resident #1 was only at that dialysis center a few times but had no hypoglycemic issues. He stated he thought the hypoglycemia was highly unlikely a result of dialysis even if the resident had only eaten a little bit prior to dialysis.

An interview on 9/23/21 at 2:22 PM with the Director of Nursing (DON) indicated she was unaware of the medication error until 9/15/21. She stated she talked to Resident #2 on 9/03/21 when she went to pack up Resident #1's belongings and Resident #2 did not tell her he had not received his morning insulin. She stated, "I can't say if it did or didn't happen". The DON stated she told the dialysis nurse on 9/03/21 that the resident had not received insulin as none was ordered for him. She stated she 'didn't think anything about it' at the time since the resident had no order for insulin.

Another interview on 9/23/21 at 5:37 PM with DON revealed she did not believe that Nurse #1 made a medication error. She also stated she

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 10/04/2021

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 760	Continued From page 12	F 760		

couldn't say exactly what was said during her conversation with Dialysis Nurse #2.The DON also stated she did not know why the hospital thought Resident #1 received 70/30 insulin.

An interview on 9/23/21 at 2:15 PM with the Administrator revealed she was on vacation at the time of this investigation and that the DON completed the investigation.

Another interview on 9/23/21 at 5:37 PM with the DON and Administrator revealed that the DON did not believe Nurse #1 had made a medication error. Neither the DON nor the Administrator can explain why Resident #1 stated he received a shot and Resident #2 stated he had not received his insulin on 9/03/21. The DON further stated that Nurse #1 story had never changed, and she believed her.

In the absence of the Administrator, the DON was notified of immediate jeopardy on 9/27/21 at 4:00 PM. the facility provided the following credible allegation of immediate jeopardy removal.

Credible Allegation for F760 for removal of immediate jeopardy completed on 9/30/21.

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

Resident #1 was admitted to the facility on 8/27/21 from the hospital with an AIC of 4.2 and a mean blood glucose of 68.7 per hospital records. On 9/3/21 Resident #1 consumed 50% of his breakfast, received his medication by the

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 10/04/2021

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 760	Continued From page 13	F 760		

Licensed Practical Nurse per medication administration record. Resident #1 was transferred to the dialysis center for scheduled dialysis and was placed on dialysis at 10:47am, residents blood sugar at 1:45pm was 64, resident #1 was removed from dialysis at 2:51pm, and blood sugar was rechecked at 4:00pm with results of 49. The Dialysis Nurse stated that Resident #1 told her he had been given insulin at the facility even though he did not take insulin. The dialysis center then transferred the resident to the hospital emergency room where his blood sugar was 170 upon entrance to the emergency room. The emergency department records dated 09/03/21 noted Resident #1 told the nurse at dialysis he was given his roommate's (Resident #2) insulin prior to sending him to dialysis.
The dialysis center called on 9/3/21 and spoke with the Director of Health Services and requested to know what insulin resident # 1 received, the Director of Health Services stated he was not on insulin and was not on oral diabetic medication either. The hospital contacted the Director of Health Services and requested to know what type of insulin resident #1 received that morning, the Director of Health services stated that Resident #1 did not receive any insulin. The Director of Health Services interview with the Nurse who administered the medication to resident #1, stated she only gave Resident #1 his medications and did not administer insulin to resident #1.

All residents have the potential to be affected by medication administration errors.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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 10/04/2021

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 760	Continued From page 14	F 760		

when the action will be complete.

On 9/23/21 the Director of Health Services and Clinical Competency Coordinator began education to the Registered / Licensed Nursing Staff and Certified Nursing Assistants on resident identification utilizing the policy "medication administration; general guidelines" which states to utilize two forms of identification; the Matrix picture of residents, call resident by name or utilize other healthcare personnel for identification. As of 9/27/21 any Registered / Licensed Nurse and/or Certified Nursing Assistant not educated will be removed from the schedule until the education regarding medication administration (identification of residents) is completed. The education regarding medication administration: general guidelines has been added to the general orientation for all Registered / Licensed Nurses and Certified Nursing Assistants regarding resident identification practices. The Director of Health Services is responsible for tracking, trending, and ensuring all Registered / Licensed Nurses and Certified Nursing Assistants have completed the education and will maintain an employee roster identifying completion of education provided.
On 9/28/21 the Director of Health Services and/or Nurse Managers began educating the Registered and Licensed Nurses on the five rights of medication pass procedure, including Right Resident, Right Medication, Right Route, Right Dose, and Right Time. Any Registered / Licensed Nurse who has not completed this education by 9/29/21 11:59pm will be removed from the schedule until the education regarding medication administration and the five rights of medication pass is completed.
The Director of Health Services is responsible for

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 10/04/2021

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 760	Continued From page 15	F 760		

tracking to ensure all Registered / Licensed Nurses have completed the education and will maintain an employee roster identifying completion of education provided. The Director of Health Services and/or Nurse Managers were made aware 9/29/21 that they are responsible for educating any Registered / Licensed Nurse if they didn't receive the education for five rights of medication pass procedure by 9/29/21.
The education regarding medication administration and the five rights of medication pass has been added to the general orientation for all Registered / Licensed Nurses.
On 9/24/21 the Clinical Competency Coordinator completed a review of Matrix Care electronic records to ensure all residents had a valid picture that corresponded to the resident for identification purposes. The Senior Nurse Consultant validated on 9/27/21 that all current residents in Matrix Care electronic medical record have a current picture for identification purposes.
The Director of Health Services and Nurse managers began auditing the Registered / Licensed Nurses daily on 9/23/21 during medication administration to ensure compliance to the policy. This includes observations from the Director of Health Services and Nurse Managers that Registered / License Nurses are utilizing two points of identification when administering medication to residents to validate the correct resident receives the correct medication.
Alleged date of IJ removal 9/30/21.

The credible allegation was verified on 10/04/21 as evidence by record review and staff interviews.

Interviews were conducted with a sample of staff members to verify education was conducted for all employees regarding medication

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 10/04/2021

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 760	Continued From page 16 administration. Documentation of in-service records were reviewed. An observation of medication administration was conducted. All of the evidence indicated the facility had removed the immediate jeopardy by 9/30/21.	F 760		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's administration failed to act on an allegation of a significant medication error, failed to determine the validity of the significant medication error allegation, and failed to identify the need to prevent further medication errors for 1 of 2 residents (Resident #1). Immediate jeopardy began on 9/03/21 when the facility failed to determine the validity of the significant medication error allegation which occurred on 9/03/21 and did not identify the need for preventative measures. The immediate jeopardy was removed on 9/30/21 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance	F 835	Resident #1 no longer resides at the facility. All residents have the potential to be affected by medication administration errors and facility investigations The Facility Administrator and Director of Nursing were educated by the Senior Nurse Consultant on 9/27/21 on the grievance policy; specific to prompt efforts to resolve the grievance, in addition to taking immediate action to prevent further potential violations of any patients□ rights while the violation is being investigated, and the Quality Assurance and Performance Improvement Plan specific	10/20/21

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 10/04/2021

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 835	Continued From page 17 at a lower scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the education and the monitoring systems put in place to remove the immediate jeopardy are effective and to correct current deficient practice as identified. Findings included: This tag was cross referenced to: 1a. F760. Based on record review, residents, facility staff, dialysis staff and physician interviews, the facility failed to prevent a significant medication error by administering insulin to the wrong resident for 1 of 2 residents (Resident #1). Resident #1 did not have a physician's order for insulin and was administered insulin prescribed for Resident #2 and as a result required hospitalization for the treatment of hypoglycemia. Review of the Initial Allegation Report signed by the Director of Nursing (DON) revealed the facility became aware of the incident on 9/15/21 at 12:00 AM. The fax confirmation report was dated 9/15/21 at 4:37 PM. Review of the Investigation Report signed by the DON was hand dated as 9/20/21. Attachments for the Investigation Report were a signed statement from Nurse #1 dated 9/15/21 and a signed statement from the DON dated 9/15/21. An interview on 9/23/21 at 8:00 AM with the Director of Nursing (DON) indicated she was unaware of the medication error until 9/15/21. The DON stated she told the dialysis nurse on	F 835	to Systematic Analysis and Systemic Action - using a systemic approach to determine when in-depth analysis is needed for identifying contributing casual factors that underlie variations in performance. This approach can utilize the 5 why approach or the Fishbone approach to identify root cause analysis of why an event occurred. The Administrator will review, and sign, the grievance log and state reportable events weekly to ensure complaints are thoroughly investigated per policy. The Senior Nurse Consultant will review the facility Administrators findings of the grievance and state reportable investigations to ensure a thorough investigation has been completed monthly times two. Audit results will be reported to the Quality Assurance Performance Improvement Committee to identify trends and further opportunities for quality improvement and any need for additional education. Compliance Date October 20, 2021	

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 10/04/2021

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 835	Continued From page 18	F 835		

9/03/21 that the resident had not received insulin as none was ordered for him. She stated she 'didn't think anything about it' at the time since the resident had no order for insulin. She also stated on 9/03/21 she reviewed Resident #1's current medications with the Emergency Department (ED) and she was aware the ED was 'under the impression he had received insulin, but they did not say how he had received it'. She also stated she told the ED that he had not received insulin on 9/03/21. The DON stated she had not contacted Resident #1 or the roommate, Resident #2 during this investigation. She stated the facility Physician was notified of an unsubstantiated medication error.

An interview on 9/23/21 at 2:15 PM with the Administrator revealed she was first made aware of the medication error allegation on 9/15/21. She further stated she was on vacation at the time of this investigation and that the DON completed the investigation.

In the absence of the Administrator, the DON was notified of immediate jeopardy on 9/27/21 at 4:00 PM. The facility provided the following credible allegation of immediate jeopardy removal.

Credible Allegation for F835 for removal of immediate jeopardy completed on 9/30/21.

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

Resident #1 was admitted to the facility on 8/27/21 from the hospital with an AIC of 4.2 and a mean blood glucose of 68.7 per hospital records.

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 10/04/2021

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 835	Continued From page 19	F 835		

On 9/3/21 Resident #1 consumed 50% of their breakfast, received his medication by Nurse #1 per the medication administration record. Resident #1 was transferred to the dialysis center for scheduled dialysis and was placed on dialysis at 10:47am, residents blood sugar at 1:45pm was 64, resident #1 was removed from dialysis at 2:51pm, and blood sugar was rechecked at 4:00pm with results of 49. The Dialysis Nurse stated that Resident #1 told her he had been given insulin at the facility even though he did not take insulin. The dialysis center then transferred the resident to the hospital emergency room where his blood sugar was 170 upon entrance to the emergency room. The emergency department records dated 09/03/21 noted Resident #1's told the nurse at dialysis he was given his roommate's (Resident #2) insulin prior to sending him to dialysis.

The dialysis center called on 9/3/21 and spoke with the Director of Health Services and requested to know what insulin Resident # 1 received, the Director of Health Services stated he was not on insulin and was not on oral diabetic medication either. The hospital contacted the Director of Health Services and requested to know what type of insulin resident #1 received that morning, the Director of Health services stated that Resident #1 did not receive any insulin. The Director of Health Services interview on 9/3/21 with Nurse #1 who administered the medication to resident #1 on 09/03/21, stated she only gave Resident #1 his medications and did not administer insulin to resident #1.

The Director of Health Services received a call on 9/3/21 from the emergency room nurse asking what medications Resident #1 received of the roommate, Resident #2. The Director of Health Services replied to the Emergency Room Nurse

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 10/04/2021

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 835	Continued From page 20	F 835		

that Resident #1 did not receive resident #2 medications.
On 9/15/21 at 3:33 pm Resident #1's family member sent an email to the Area Vice President of the facility making a formal complaint of "negligence - the doctor on call there in the emergency room said the facility (dialysis center) reported he was accidently given wrong medication that was insulin which belonged to his roommate."
The Area Vice President forwarded the email to the facility Administrator on 9/15/21 at 3:40 pm.
On 9/15/21 at 4:37 pm the Director of Health Services reported the allegation of neglect to the State Agency and began her investigation regarding the allegation of Resident #1 receiving the incorrect medication on 9/3/21. Upon the Director of Health Services review and interview with the assigned Nurse #1, it was documented that resident received the correct medication and Nurse #1 stated she gave the correct medication to Resident #1. Resident #1 and Resident #2 were not residents of the facility on 9/15/21. The Director of Nursing attempted to contact Resident #2 who did not answer the phone and the voice mail stated the party you are trying to reach is unavailable. The Physician was notified on 9/15/21 by the Director of Health Services of the allegation and the physician did not have a comment. The Night shift 11:00 PM to 7:00 AM nurses who were scheduled on 9/3/21 were interviewed by the Director of Nursing on 9/15/21 and both stated they had not given resident #1 any insulin. Resident #1 was not interviewed during the investigation.
On 9/20/21 at 2:59pm The Director of Health Services completed the investigation of alleged neglect and reported the findings and submitted supporting documentation (statement from Nurse

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 10/04/2021

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 835	Continued From page 21	F 835		

#1, resident # 1 medication administration record and statement from Director of Health Services) to the State Agency.
All residents have the potential to be affected by medication administration errors and facility investigations.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The Facility Administrator and Director of Nursing were educated by the Senior Nurse Consultant on 9/27/21 on the current "grievance" policy effective date 1/1/1997 and revised 3/25/2019; specific to prompt efforts to resolve the grievance, in addition to taking immediate action to prevent further potential violations of any patients' rights while the violation is being investigated. Grievances can be from residents, family members, staff members related to resident concerns and/or any entity that has a concern related to resident care and wellbeing, including concerns and complaints called to any corporate entity. The Quality Assurance and Performance Improvement Plan specific to "Systematic Analysis and Systemic Action" - using a systemic approach to determine when in-depth analysis is needed for identifying contributing causal factors that underlie variations in performance, this approach can utilize the "5 why approach", which drills down to causative factor by asking why the event occurred until a causative root cause analysis is identified. The "Fishbone" approach is a visual drill down to illustrate the relationship between a given outcome and all the factors that may influence that outcome, this reviews the organizational

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 10/04/2021

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 835	Continued From page 22	F 835		

culture, human factors, information and communication factors, training and competency factors, care plan and assessment, equipment factors, policy and procedure factors and environmental factors.
The initiation of the grievance policy with timely investigation and the utilization of the QAPI - "systemic analysis and systemic action" by the Administrator will be utilized to determine appropriate investigation efforts and reporting criteria starting 9/27/21.
On 9/27/21 The Administrator will review all grievances and sign the grievance log and state reportable events weekly to ensure complaints are thoroughly investigated per policy. The Senior Nurse Consultant will review the facility Administrator's findings of the grievance and state reportable investigations to ensure a thorough investigation has been completed monthly.
Alleged date of IJ removal 9/30/21

The credible allegation was verified on 10/04/21 as evidence by record review and staff interviews.

Interviews were conducted with a sample of staff members to verify education was conducted for all employees regarding the grievance and investigation procedures.

Documentation of in-service records were reviewed.

All of the evidence indicated the facility had removed the immediate jeopardy by 9/30/21.