

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/18/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>PruittHealth-Neuse</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1303 Health Drive , New Bern, North Carolina, 28560</b>	
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E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted on 12/15/2025 through 12/18/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DE176-HI.	E0000		01/04/2026
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 12/15/2025 through 12/18/2025. Event ID 1DE176-H1.  The following intakes were investigated: 2613083, 2589393, 2565677, and 864634.  15 of the 15 complaints allegations did not result in deficiency.	F0000		01/04/2026
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils  CFR(s): 483.60(g)  §483.60(g) Assistive devices  The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.  This REQUIREMENT is NOT MET as evidenced by:  Based on observation, record review, and staff and resident interviews, the facility failed to provide a prescribed assistive device, a spouted cup with handle, for 1 of 1 resident reviewed for assistive devices (Resident #65).  Findings included:  Resident #65 was admitted to the facility on 3/8/24 with diagnoses that included hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a nontraumatic intracranial (brain) hemorrhage affecting arm and leg of left side.	F0810	Corrective action for the residents found to be affected by the deficient practice.  The certified nursing assistant who delivered Resident #65's tray on 12/15/2025 was educated on 12/15/2025 regarding tray accuracy and assistive dining equipment immediately upon the facility being made aware of the occurrence by the Director of Health Services. The certified nursing assistant was placed back into orientation and training on 12/16/2025.  Corrective action for other residents having the potential to be affected by the same deficient practice.  All residents with assistive dining devices have the potential to be affected.  On 1/5/2026 the Director of Health Services implemented a tray accuracy audit for residents who receive assistive equipment with meals.	01/19/2026

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0810 SS = D	<p>Continued from page 1 A review of Resident #65's physician orders revealed an order dated 7/31/25 for the Resident to have a spouted cup with handle with all meals.</p> <p>Review of Resident #65's care plan last reviewed 9/25/25 revealed a problem of the Resident being at nutrition/hydration risk. The goal was for Resident #65 to remain adequately hydrated through the next review. Approaches included providing adaptive equipment with meal trays as ordered: spouted cup with handle.</p> <p>Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated 10/16/25 revealed she was moderately cognitively impaired, had impairment to one upper and one lower extremity and was independent with eating after the meal tray was set up.</p> <p>On 12/15/25 at 11:28 AM, Resident #65 was observed lying in her bed, her breakfast tray was still on the overbed table next to her. The diet slip on her breakfast tray indicated she should have a spouted cup with handle. Instead, her tray contained regular cups with lids and straws. She appeared not to have drunk any of the beverages on her tray.</p> <p>During an interview and observation on 12/15/25 at 12:42 PM, Nurse Aide (NA) #4 carried the lunch tray into Resident #65's room. NA #4 placed the lunch tray on the overbed table, removed the plate lid and began to walk away. When interviewed at the bedside, NA #4 was asked if she checked the diet slip to assure the lunch tray was correct. NA #4 stated she had not, explaining, "they didn't really say anything." NA #4 was then asked to look at Resident #65's diet slip. She looked at it but did not notice that it indicated Resident #65 was supposed to have a spouted cup with handle. When asked if Resident #65 was supposed to have a spouted cup with handle, she said "no." Then NA #4 looked again and said "yes." When asked what was on the tray, NA #4 stated a "regular cup". When asked what she did when a resident's tray did not match the diet slip, NA #4 stated she just leaves it and hopes for the best. NA #4 indicated she was trained on passing meal trays upon hire.</p> <p>In an interview with Resident #65 on 12/16/25 at 8:15 AM she indicated she sometimes spilled her drinks when they were in a regular cup with a lid and a straw and that it was easier for her to drink from the spouted cup with a handle.</p> <p>In an interview with the Director of Nursing (DON) on 12/16/25 at 2:03 PM she stated staff who were passing meal trays to residents were responsible for checking</p>	F0810	<p>Continued from page 1 Systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 12/15/2025 the certified nursing assistant who delivered Resident #65's tray was educated on tray accuracy and assistive dining equipment. The certified nursing assistant was placed back into orientation and training on 12/16/2025. On 1/5/2026 the Administrator, Director of Health Services, Clinical Competency Coordinator, and Certified Dietary Manager began education with all staff members regarding tray accuracy pertaining to assistive dining equipment. All staff members will be educated on this by 1/16/2026. Any staff member not educated by 1/16/2026 will be educated prior to the start of their next shift or removed from the schedule until the education is completed. This education has been added to the general new hire orientation and will be completed by the Clinical Competency Coordinator.</p> <p>The Director of Health Services or Nurse Managers will monitor this process for three meals daily for seven days, two meals daily for three weeks, one meal daily for four weeks, then randomly for one month until three months of compliance is maintained.</p> <p>Plans to monitor its performance to make sure that the solutions are sustained.</p> <p>The Director of Health Services will present the audit findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained.</p> <p>Administrator is responsible for POC.</p> <p>Date of compliance: 1/19/2026</p>	

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F0810 SS = D	Continued from page 2 the diet slip against what was on the resident's tray to assure accuracy. The DON indicated that if the meal tray was incorrect, staff were to take the tray to the Dietary Manager to have it corrected.  In an interview with the Dietary Manager on 12/16/25 at 3:01 PM, she stated that two dietary aides and the cook observed and checked trays before placing them on the meal cart, so she did not know why Resident #65 was served breakfast and lunch on 12/15/25 without spouted cups with handles. The Dietary Manager further stated she had many spouted cups with handles in the kitchen, so it was not a matter of low stock on those items.  An interview was conducted on 12/18/25 at 9:08 AM with the Administrator. She stated NAs were trained to check a resident's diet slip against the meal tray before serving it to the resident as they were the last to see the tray before it was served.	F0810		
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ  CFR(s): 483.90(i)  §483.90(i) Other Environmental Conditions  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is NOT MET as evidenced by:  Based on observation, record reviews, and interviews with the resident, staff, Medical Director and North Carolina Poison Control, the facility failed to ensure the environment was free of hazards when Resident #85 was observed with multipurpose cleaner on her bedside table. This occurred for 1 of 2 residents reviewed for supervision to prevent accidents (Resident #85).  The findings included:  Resident #85 was admitted to the facility on 6/27/24. Her diagnoses included diabetes, depression, and chronic kidney disease.  Review of the quarterly Minimum Data Set (MDS) assessment dated 10/3/25 revealed Resident #85 was moderately cognitively impaired. She used a wheelchair for mobility and needed assistance with all Activities of Daily Living (ADL).  An observation on 12/15/25 at 12:10 PM revealed a 40-ounce bottle of multipurpose cleaner, approximately	F0921	F0921  Corrective action for the residents found to be affected by the deficient practice.  On 12/15/2025 the multipurpose cleaner was removed from Resident #85's room and she was immediately educated by the Director of Health Services and again on 12/18/2025 about not being able to keep multipurpose cleaner in her room.  Corrective action for other residents having the potential to be affected by the same deficient practice.  All residents have the potential to be affected.  On 1/5/2026 the Administrator developed and implemented an audit tool to be completed to ensure residents do not have multipurpose cleaner in their rooms.  Systemic changes made to ensure that the deficient practice will not recur.  On 12/15/2025 and 12/18/25 Resident #85 was educated about not being able to keep multipurpose cleaner in her room. On 1/5/2026 the Administrator, Director of Health Services, and Clinical Competency Coordinator initiated education to all staff members regarding residents not being able to keep multipurpose cleaning products in their rooms. If observed, staff members are	01/17/2026

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F0921 SS = D	<p>Continued from page 3 half full, on Resident #85's bedside table.</p> <p>The warning label on the bottle of multipurpose cleaner stated that it could cause moderate to serious eye irritation, skin irritation, and respiratory tract infection from vapors. It warned users to avoid eye and skin contact, wear gloves and eye protection, and wash their hands thoroughly after use. Key warnings also stated that eye contact caused moderate to serious irritation; skin contact caused irritation and required washing thoroughly with soap and water after use; inhaling vapor or mist irritated the nose, throat, and lungs; and ingesting the cleaner caused stomach distress, nausea, and vomiting.</p> <p>An interview with Resident #85 was conducted on 12/15/25 at 12:15 PM. She stated she used the multipurpose cleaner to clean spills in her room and ordered it from a local retailer who delivered it to her room at the facility.</p> <p>An interview with Nurse Aide #2 was held on 12/15/25 at 12:30 PM. She stated she was not aware Resident #85 had a bottle of multipurpose cleaner and added the resident should not have had the cleaner in her room as it could have caused harm to this resident or any resident if it was consumed or splatter got in the eye.</p> <p>An interview with Nurse #1 was held on 12/15/25 at 12:35 PM. She stated she did not recall seeing the multipurpose cleaner in Resident #85's room. She also stated if the aides, housekeepers, or nurses saw it, they should have removed it immediately.</p> <p>An interview with a representative from the North Carolina Poison Control Center was held on 12/17/25 at 11:45 AM. She stated ingestion of the multipurpose cleaner could have caused side effects depending on the amount consumed. She added that if the cleaner contacted the eyes, it would cause irritation, and the eyes would need irrigation and further evaluation based on exposure.</p> <p>An interview was held with the Medical Director on 12/16/25 at 11:30 AM. She stated she had no concerns about the resident's exposure to the cleaner because she did not believe the resident would ingest it. She added that if ingestion occurred, she would call poison control for treatment instructions.</p> <p>An interview with the Director of Nursing (DON) was held on 12/15/25 at 12:32 PM. She stated the resident should not have had the multipurpose cleaner at the bedside because it could have been harmful to any</p>	F0921	<p>Continued from page 3 to immediately remove the products and report the occurrence to the Administrator and/or Director of Health Services. All staff members will be educated on this by 1/16/2026. Any staff member not educated by 1/16/2026 will be educated prior to their next shift or removed from the schedule until the education is completed. This education has been added to the general new hire orientation and will be completed by the Clinical Competency Coordinator.</p> <p>The Director of Health Services or Nurse Managers will monitor this process daily for seven days, then weekly for three weeks, then randomly for two months until three months of compliance is maintained.</p> <p>Plans to monitor its performance to make sure that the solutions are sustained.</p> <p>The Director of Health Services will present the audit findings to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained.</p> <p>Administrator is responsible for POC.</p>	

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F0921 SS = D	Continued from page 4 resident if ingested or splatter got in the eyes. She added Resident #85 ordered several items to be delivered to her room. The DON indicated Resident #85's roommate was non-ambulatory, did not self-propel in a wheelchair and was severely cognitively impaired.  An interview with the Administrator was held on 12/16/25 at 11:20 AM. She stated Resident #85 had a history of ordering items to be delivered to her room. She added she was not aware Resident #85 had multipurpose cleaner on her bedside table and expected any staff member who saw it to remove it immediately as it could cause harm to a resident if ingested or if there was exposure to the eyes of a resident. She indicated that if staff observed the multipurpose cleaner in a room, they should remove it and report finding the multipurpose cleaner to the DON and Administrator.	F0921		