STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PruittHealth-Trent	**836 Hospital Drive , New Bern, North Carolina, 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
F0000	INITIAL COMMENTS The surveyor entered the facility on 1/28/26 survey to conduct a complaint investigation. The survey team was onsite 1/28/26 through 1/30/26. Additional information was obtained offsite from 1/31/26 through 2/6/26. Therefore, the exit date was 2/6/26. The following intakes were investigated: 2724865, 2721300, 2651822, 2642114, and 2638308. Three of the nine complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/15/26 for F684 and on 1/21/26 for F580. Immediate Jeopardy was removed on 2/1/26. A partial extended survey was conducted.	F0000		
F0580 SS = J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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	F0580		

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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F0580 SS = J	Continued from page 1 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) 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, and interviews with staff, Nurse Practitioner, and Physician for Resident # 1, who had a critical blood glucose level the week prior to 1/21/26 without a documented long term plan to address the resident's diabetes after that date, the facility failed to notify the physician regarding all changes in condition observed on 1/21/26 and consult with the physician to determine if an alternate plan of	F0580		

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F0580 SS = J	Continued from page 2 treatment needed to commence to address all the resident's symptoms so that nursing staff would receive physician orders for monitoring the resident's change in condition, monitoring blood glucose, monitoring oxygen saturations, monitoring vital signs and other orders to treat her condition. Interviews with Nurse Practitioner # 2 and Nurse # 2 revealed the provider was notified regarding Resident # 1 having a cough on the morning of 1/21/26, a chest x-ray was requested, and an order was given for the chest x-ray. This was the only communication that day with the medical provider. On 1/21/26 when staff were aware after three consecutive meals the resident had eaten only one bite of food, was not pulling up fluid through a straw when assisted by a Nurse Aide, was observed by multiple staff not responding to staff per her normal baseline, and was observed by a 1/21/26 evening shift Nurse Aide to need total staff assistance to turn in bed which was not her baseline; there was no notification to the physician of the additional symptoms or a consultation with the physician regarding if more diagnostic tests, monitoring, or treatment other than just the x-ray was needed. On 1/22/26 at 5:44 AM Emergency Medical Services (EMS) was dispatched to the resident who was identified by EMS to have a blood sugar reading of "high." The resident was transferred to the hospital where she was noted by the Emergency Department (ED) physician to be obtunded (a state of reduced alertness and reduced consciousness), dehydrated, and experiencing agonal breathing (shallow, gasping, irregular breathing pattern which is considered critical). ED labs revealed a blood glucose level result of 882 (life threatening condition that requires immediate medical attention) along with other lab abnormalities. The resident's temperature was 41.7 Celsius (107.06) degrees Fahrenheit). Resident # 1 coded at 6:53 AM on 1/22/26 and expired after unsuccessful attempts were made to resuscitate her. This was for 1 of 3 residents reviewed for notification of physician regarding needed medical care (Resident # 1). Immediate jeopardy began on 1/21/26 when the facility failed to notify the physician that Resident # 1 was not responding to staff per her baseline, eaten one bite in three consecutive meals, a day shift Nurse Aide noted that she could not pull up fluid via way of a straw when she normally ate and drank independently, and an evening shift Nurse Aide observed that she needed total assistance to turn in bed and was no longer talking. Immediate jeopardy was removed on 2/1/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and	F0580		

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F0580 SS = J	Continued from page 3 severity level D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place. The findings included: Record review revealed Resident # 1 resided at the facility from 6/19/20 until 1/22/26. Resident # 1 had diagnoses which included diabetes, epilepsy, schizophrenia, schizoaffective disorder, hypertension, muscle weakness, intellectual disability, muscle weakness, a history of metabolic encephalopathy and feeding difficulties in June 2022, hyperlipidemia, vitamin D deficiency, depressive disorder, a history of insomnia, extrapyramidal and movement disorder, kidney disease, and a history of dysphagia. Orders, which originated on 6/19/20 and were in effect until Resident # 1's discharge date, were for Resident # 1 to be a full code. On 1/14/26 at 6:10 PM Nurse # 1 documented the following information in a progress note. She had received a critical blood sugar level of 466 (For adults with diabetes, normal blood sugar targets range from 80 to 130). The nurse rechecked the blood sugar and found it to be currently 496. The resident's vital signs were stable and registered 143/85 blood pressure, 93 heart rate, 16 respirations, and 98.1 temperature. The resident reported she felt sleepy all day. The providers' triage line was consulted and orders received for 10 units of Novolog insulin times one dose and then to recheck the blood sugar in one hour. Review of transcribed communication between Nurse # 1 and the provider via way of their electronic triage communication application revealed the following documentation was sent to the on-call provider on 1/14/26 at 5:54 PM regarding Resident # 1. "Received a critical lab of a 466 blood sugar level. I rechecked it and it now shows a reading of 496. Resident just eating dinner that has a hefty amount of carbs (carbohydrates) and sugars. Vitals signs remain stable 143/85 (blood pressure) 93 HR (heart rate) 16 RR (respirations) 98.1 T (temperature). Patient reports feeling sleepy all day. May I have insulin orders? According to the transcribed communication, the rendering provider signed on 1/14/26 at 7:51 PM that the following orders were communicated back. "Order Novolog 10 Units SQ (Subcutaneous) X 1 dose now. Recheck glucose in 1 hour. Notify if greater than 450. Place in acute book for PCP FU (primary care provider follow up On 1/14/26 at 8:06 PM, Nurse # 1 documented a recheck	F0580		

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F0580 SS = J	Continued from page 4 of the resident's blood sugar had been done and the reading was 386. The resident would be monitored for changes. Review of Resident # 1's record revealed no further documented blood sugar checks after the date of 1/14/26 through the resident's discharge and there were no further orders which addressed the resident's blood sugars or other abnormal labs after the orders on 1/14/26. According to staffing sheets, Nurse # 5 had cared for Resident # 1 from 7:00 AM to 11:00 PM on 1/19/26 (Monday) and again on 1/20/26 (Tuesday) from 7:00 AM to 5:00 PM. Nurse # 5 was interviewed on 1/28/26 at 3:00 PM and reported the following information. She routinely cared for Resident # 1 and the resident was normally alert, verbal, and had minimal confusion. Resident # 1 particularly liked a certain type of soft drink and when she (Nurse # 5) entered the room, Resident # 1 would speak up and ask her if she had that particular type of drink for her. The resident had been at her baseline on both days on 1/19/26 and 1/20/26 while she (Nurse # 5) took care of her. According to staffing records, Nurse Aide (NA # 3) had cared for Resident # 1 on the 7:00 AM to 7:00 PM shift on 1/19/26 (Monday) and on the 7:00 AM to 3:00 PM shift on 1/20/26 (Tuesday). NA # 3 was interviewed on 1/29/26 at 11:33 AM and reported the following information. Resident # 1 was usually upbeat, happy, and talkative. She loved a particular type of soft drink, and she would eat and drink independently without any problems. Resident # 1 knew her (NA # 3) by name when she cared for her. She had been fine without any complaints. According to staffing records, NA # 6 had cared for Resident # 1 on 1/20/26 (Tuesday) from 3:00 PM till 7:00 AM on 1/21/26 (Tuesday). NA # 6 was interviewed on 1/28/26 at 4:35 PM and reported the following information. The resident was able to help roll and turn in bed per her normal activity. She normally would talk and was alert enough to remember things that had been in previous conversations. On the evening of 1/20/26 Resident # 1 talked to her (NA # 6) and reported she thought she was getting a cold. She (NA # 6) noticed Resident # 1's voice was deep as if she was getting a cold. She also appeared dark under her eyes and her eyes looked sunken. The resident did not feel warm to the touch as if she might have a fever. She was sleepy but at times she would be in and out. She would routinely drink independently and did not need help that evening drinking fluids. She was able to drink from a straw that evening. Usually, the resident ate	F0580		

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F0580 SS = J	Continued from page 5 well. She (NA #6) thought she had told a nurse about the resident sounding like she was getting a cold, but she could not recall who she had told. Review of nursing progress notes revealed no nursing progress notes for 1/21/26 noting that the physician was notified of any change in condition. There was one order dated 1/21/26 and this was for a chest x-ray which was ordered by NP # 2, verified by Nurse # 2, and placed in the resident's electronic record on 1/21/26 at 11:23 AM by Nurse # 2. On 1/21/26 at 11:07 AM the facility Social Worker noted Resident # 1 had been seen by the psychiatric Nurse Practitioner that morning for medication management. Review of the Psychiatric Nurse Practitioner's note on 1/21/26 revealed in entirety the following documentation: "ASSESSMENT AND PLAN 1. Schizoaffective disorder, bipolar type: Chronic and stable. No associated behavioral or psychotic disturbances. Currently on Ingrezza 40mg (milligrams) qd (every day), Oxcarbazepine 300mg twice a day, and Risperidone 1.5mg twice a day. Plan: Continue current medication regimen. Will follow up and continue to monitor patient for changes in cognitive function. (Ingrezza treats movement disorders. Oxcarbazepine is used for mood disorders, and Risperidone is used to treat psychosis.) 2. Extrapyramidal and movement disorder: Chronic and mild. Involuntary movement occasional. Plan: Will continue Ingrezza 40mg qd (every day). Will monitor for any changes in EPS or other side effects. Will follow up to reassess condition and medication efficacy. 3. Depression: Chronic and stable. No associated behavioral or psychotic disturbances. This can indicate current medication of Venlafaxine ER 75 mg daily is managing symptoms. Plan: Continue current medication regimen. Will follow up and continue to monitor patient for changes in cognitive function. GENERAL Note Medications were reviewed for possible GDR (Gradual Dose Reduction) of psychotropics. Any reduction in regimen is likely to risk decompensation and is not recommended. At this time benefits outweigh risks and there is no clinical indication for any GDR of psychiatric medications. ORDERS Orders (as written)	F0580		

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F0580 SS = J	Continued from page 6 for this Visit no new orders." The Psychiatric NP was interviewed on 1/30/26 at 12:12 PM and reported she did not recall what time of morning she saw Resident # 1. She saw a lot of people and the resident was receiving patient care when she was there. She did not recall any specifics of a conversation with her. The Psychiatric NP explained she sometimes jotted down things that were different about residents, but she did not see anything in her note that she had jotted down that was not ordinary for Resident # 1. NA # 1 had cared for Resident # 1 from 7:00 AM to 7:00 PM on 1/21/26 (Wednesday). NA # 1 was interviewed on 1/28/26 at 4:05 PM and reported the following information. Prior to 1/21/26, she recalled last caring for Resident # 1 on the previous Friday. There was a significant change in Resident # 1 from the previous Friday to the Wednesday of 1/21/26. All day on 1/21/26 she did not "pep up" and she was sleepy. It was unusual that she would not pep up during the whole shift. She did not eat breakfast, lunch, or her supper meal. It was not unusual for her to not eat breakfast, but she typically ate other meals, and she routinely would feed herself and drink. Usually, Resident # 1 would talk a lot, but that day she did not converse like she usually did. She seemed out of it. If she asked her a question, the resident would answer with a sentence and then not keep talking. Her color also looked darker. She could not get the resident to pull up fluid with a straw which was unusual for her. During the day, the total she was able to get the resident to drink was about one cup of fluid by giving her sips. She recalled she had told Nurse # 2 that the resident did not eat breakfast or lunch, and Nurse # 2 knew she did not feel well. Nurse # 2 had told her (NA #1) that she was going to get a chest x-ray ordered. Nurse # 5 (who took over care of Resident # 1 at 3:00 PM) also knew that Resident # 1 did not eat her supper. Nurse # 2 cared for Resident # 1 on 1/21/26 from 7:00 AM to 3:00 PM. Nurse # 2 was interviewed on 1/29/26 at 8:52 AM and reported the following information. She did not normally care for Resident #1, and it had been about 2 months since she had been assigned to her. The resident "looked a little funny" to her and she also had a bad cough. Nurses #2 stated she listened to the resident's lungs, and they were coarse (abnormal breath sounds while listening with a stethoscope which can indicate fluid or mucous). She thought something respiratory was going on with the resident. In the morning when she tried to give her medications she was "half asleep" and she could not get the resident to take medications. She tried at lunch and she was able	F0580		

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F0580 SS = J	Continued from page 7 to get Resident #1 to take the medications at lunch time. The resident said she did not feel good and Nurse #2 asked her what was wrong and she just said she didn't know. Nurse #2 indicated she was able to get one bite of food in Resident # 1 at lunch, and she drank a "little bit." She did not see outward signs of dehydration. Given that she had not cared for the resident recently, she talked to Unit Manager # 1 and Nurse Aides to see what was going on with the resident. She looked at Resident # 1's chart and saw that the resident had a high blood sugar the previous week. She thought to herself that she had not even known the resident was a diabetic and as she recalled she had mentioned to Unit Manager # 1 that the resident's "blood sugar was crazy days ago." When she was with the resident, the resident did pull up from the straw and NA # 1 had not reported to her at any part of the day that the resident would not pull up fluid through a straw for her (NA #1). She did send a message to a Nurse Practitioner and thought it was NP # 2 that she texted a message to. She let the NP know the resident had a cough and asked if they could get a chest x-ray. The provider responded "yes." Nurse #2 explained the information that the resident had a cough and she was requesting a chest x-ray was the only information provided to the NP. She put the order for the chest x-ray into the computer which would have automatically generated the order going to the mobile x-ray company. She also called to verify that they had received it. The mobile x-ray company did not come on her shift, and she passed along to the next nurse that the resident was due for a chest x-ray. During her shift, she (Nurse # 2) took the resident's temperature and may or may not have written it down but as she recalled it was 98.5. She did not take the rest of the resident's vital signs or check her blood sugar. Nurse #2 stated it had been a "crazy" day with a lot of things going on and she had been very busy all day long. NP # 2 was interviewed on 1/29/26 at 12:05 PM and reported if a resident did not eat for three consecutive meals and had a change from their baseline responsiveness to staff, this was information that should be communicated to the provider. The only notification she was aware that took place on 1/21/26 was in regard to Resident #1's cough and a request for the x-ray. According to the assignments, Nurse # 5 cared for Resident # 1 during the first part of the 3:00 PM to 11:00 PM shift on 1/21/26. During the interview with Nurse # 5 on 1/28/26 at 3:00 PM Nurse # 5 reported the following information. On 1/21/26 during the change of shift report at 3:00 PM she was told that Resident # 5	F0580		

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F0580 SS = J	Continued from page 8 was not feeling well and that a chest x-ray was ordered. Nurse #5 could not recall the reason that was told in report for why the chest x-ray was ordered. She knew the resident had recently had her COVID vaccine. When she checked on Resident # 1 she was alert and she could tell the resident did not feel well. Resident # 1 did not carry on a conversation in the way she usually did. She (Nurse # 5) asked Resident # 1 if she would like the soft drink that she usually asked for, and the resident said no. She did not want anything. Resident #1 did not eat her supper meal while she (Nurse # 5) was there, and Nurse # 5 did not know if Resident # 1 ate anything after she left that night. Nurse #5 recalled she took the resident's temperature, and it was okay. She did not take the rest of the resident's vital signs or check her blood sugar. She was aware the resident had been put in the physician's book about blood sugars earlier in the month but there had been no order to check her blood sugars. Nurse #5 indicated she only cared for Resident # 1 for a few hours and left around 6:30 PM. During an interview on 1/29/26 at 1:55 PM with Nurse # 5, Nurse # 5 reported she did not notify or consult with the physician on 1/21/26 regarding Resident #1. According to assignment sheets, NA # 5 had cared for Resident # 1 on 1/21/26 (Wednesday) from 7:00 PM to 11:00 PM. NA # 5 was interviewed on 2/3/26 at 2:15 PM and reported the following information. Normally the resident was confused but would talk and converse when a staff member cared for her. The resident was normally very active and would help turn when care was provided during rounds. That night she (NA # 5) changed the resident one time while caring for her and the resident just laid in bed and did not help turn. Therefore, she had to get assistance from NA # 2. The resident did not talk at all. She briefly opened her eyes partially and then closed them again. She did not recall the resident's skin being warm. She knew the resident had recently had a shot and she thought that was why she was different and therefore she did not report it to anyone. Nurse # 4 cared for Resident # 1 on the second half of the 3:00 to 11:00 PM shift on 1/21/26 (Wednesday). Nurse # 4 was interviewed on 1/29/26 at 8:23 AM and reported the following information. One of the Nurse Aides had reported that Resident # 1 seemed "a little off." She thought it was NA # 4 who had told her that. She went to check on the resident who appeared to be sleeping. She asked the resident if she was okay and the resident replied "yea" and the resident opened her eyes some. She (Nurse # 4) touched Resident # 1, and she opened her eyes more. She (Nurse # 4) asked	F0580		

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F0580 SS = J	Continued from page 9 Resident #1 if she was sleeping good and the resident responded with a murmur which indicated yes. To her, it appeared the resident seemed to be getting an attitude about being bothered and it seemed to her (Nurse # 4) that the resident was just sleeping well. Therefore, she did not bother her further. She did call and talk to the nurse before her (Nurse # 5) and Nurse # 5 said that the resident had had a COVID vaccine, had some chest congestion, and there was an x-ray ordered. Nurse # 5 had told her (Nurse # 4) that if the x-ray company did not come by in the morning, then she (Nurse # 5) would follow up with them in the morning. Nurse # 5 also mentioned the resident was not eating as good. She (Nurse # 4) did not check Resident # 1's vital signs or blood sugar and she did not call an update the resident's physician about the resident. NA # 2 had cared for Resident # 1 on 1/21/26 from 11:00 PM to 7:00 AM on 1/22/26 until the time of her discharge. NA # 2 was interviewed on 1/28/26 at 6:58 PM and reported the following information. Prior to 1/21/26, she had last worked with Resident # 1 on the weekend of 1/17/26 and 1/18/26. When she left work on 1/19/26 (Monday) morning at 7:00 AM, Resident # 1 was okay and was watching television and laughing. She came back to work on 1/21/26 at 7:00 PM and learned that the resident was not doing well. Although she did not have her on her assignment starting at 7:00 PM, she looked in on her and the resident was sleeping and not responding as she usually did. If you called her name, the resident would not say anything. Resident #1 would open her eyes "a little" and then go back to sleep. NA #2 indicated she was assigned to the resident at 11:00 PM and knew she had just recently been changed so she did not change her at that time. At 2:00 PM rounds, she did not need changing. During the next rounds at around 4:00 to 4:30 AM the resident felt warm to the touch and she got the nurse. She took the resident's vital signs, and the nurse (Nurse # 3) wrote them down. She recalled the resident had a high fever and the nurse called EMS (Emergency Medical Services) right away. Nurse # 3 had cared for Resident # 1 on the shift which began at 11:00 PM on 1/21/26 until the resident's discharge to the hospital. Nurse # 3 was interviewed on 1/28/26 at 8:27 PM and again on 2/4/26 at 4:44 PM and reported the following information. Nurse #3 recalled Nurse # 4 had given her report at change of shift at 11:00 PM and there was nothing critical shared with her about Resident # 1. It was passed along in report that Resident # 1 was not eating, and she was due for a chest x-ray. She went in and looked at the resident at the beginning of her shift, and she appeared to be sleeping and breathing okay. She did not awaken the	F0580		

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F0580 SS = J	Continued from page 10 resident to do vital signs or check her blood sugar. Nurse #3 stated she was not aware that anyone had noticed Resident #1 had a change in responsiveness as this had not been reported to her. Later, as she was passing medications around 5:00 AM the assigned Nurse Aide (NA # 2) came to get her and said something was wrong. She went to check on the resident, and her skin was “fire hot.” Nurse #3 stated she had never felt someone’s skin to have ever been as hot as the resident’s skin was that night. Her breathing was labored and slow as if she was about to pass away. She told the Nurse Aide to get the resident’s vital signs, and she called EMS right away. On 1/22/26 at 5:53 AM Nurse # 3 documented a focused observation note under assessments in the resident’s electronic record. Nurse # 3 documented the resident was observed to have labored breathing with a temperature reading of 104.6. The resident was warm, clammy, flushed, with skin turgor slow to return to normal position. The resident was unable to answer related to any pain she might have. On 1/22/26 at 6:00 AM Nurse # 3 completed a Nursing Home to Hospital transfer form and noted the resident was observed with short, labored, breathing, diaphoretic skin (heavy perspiration) and temperature of 104.6. On 1/23/26 at 10:11 AM Nurse # 3 entered a late entry which noted the following information. “CNA (certified nursing assistant) assigned alerted nurse to resident’s change in condition. Upon entry into resident’s room, writer observed her respiratory status as labored and slow. Writer attempted to assess heart rate, but upon touching resident, she was extremely hot. Writer instructed the CNA to get resident’s vitals while she contacted EMS for transport to the ER for evaluation. VS: BP 57/32 (hypotension), P-131 (normal range 60 to 100), R-12, T-104.6, O2 (Oxygen saturation) = 89 RA (room air). (Readings below 90% to 92 % are considered low.) EMS arrived shortly after contact, and resident was transported to the [name of hospital] ER.” Nurse # 3 also noted she contacted the resident’s Responsible party and the DON. Review of EMS notes revealed they were dispatched on 1/22/26 at 5:44 AM and were on the scene at 5:47 AM. The paramedic noted they arrived to find the resident altered with two staff members at the bedside who were unsure how long the resident had been that way and were not able to provide an accurate last known well time. The paramedic did not note in the narrative note portion of the EMS report a further description of	F0580		

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F0580 SS = J	Continued from page 11 "altered." In another portion of the EMS report, the paramedic noted the resident was alert. The paramedic further documented the following information in the narrative. The staff reported the resident had a temperature of 104 prior to calling. EMS noted the resident's blood sugar was taken by them (the EMS crew) and that the reading was "H" (high). The resident's temperature was 103 axillary. (An axillary temperature is taken in the armpit, and the reading is generally one degree less than an oral temperature reading). The resident's first blood pressure registered 154/98 (hypertension), first pulse 120, first oxygen saturation 89 %, and first respirations 18. Oxygen was started and the resident was transported to the hospital and transferred to hospital care at 6:10 AM. Review of hospital 1/22/26 ED records revealed the following information. The physician noted the resident was obtunded upon exam. Her temperature was 41.7 Celsius and blood pressure was 64/31 with tachycardia. She had agonal respirations and was extremely warm to touch. The staff were unable to perform ultrasound guided peripheral access (a technique used to place an intravenous catheter in an arm) due to the severity of her volume status depletion and a central line (an intravenous catheter inserted in a large vein and which goes near the heart) was placed. Large volumes of fluids were infused. Labs drawn at 6:21 AM revealed a blood glucose level of 882, a BUN of 38 (normal 9-23), a Creatinine of 4.58 (normal .55-1.02), a sodium level of 156 (normal 136-145) along with other abnormal lab values. The resident's white blood count was 4.3 (normal 4.8-10.8). Soon after the central line was placed the physician was notified that the resident was becoming bradycardic (low heart rate) and she went into cardiac arrest. CPR (cardiopulmonary resuscitation) was initiated at 6:53 AM but efforts to resuscitate the resident were unsuccessful, and the resident expired. Review of Resident # 1's death certificate reflected the first cause of death was listed as advanced adult failure to thrive which the resident had for "weeks" and Type 2 diabetes which the resident had for "years." The ED physician was interviewed on 1/28/26 at 5:31 PM and reported the following information. The resident arrested very quickly in the ED, and they did not have much time to render treatment before this occurred. She had been very dehydrated when she arrived. He recognized that blood sugars can rise quickly but felt it had taken a couple of days to become as dehydrated as she was. He reported that she was approximately 6 liters of fluid in deficit. The ED physician also reported he felt the resident would not have expired if	F0580		

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F0580 SS = J	Continued from page 12 she had received medical attention sooner. The Director of Nursing was interviewed on 1/29/26 at 9:35 AM. The DON reported the following information. Nurse # 3 had called her on 1/22/26 when Resident # 1 was sent to the hospital, but she did not recall staff mentioned anything to her that Resident # 1 was experiencing any acute problems on 1/21/26 or about communication to the provider prior to her transfer. The facility Administrator was interviewed on 1/29/26 at 10:30 AM and reported the following information. She usually checked on all her residents often, and the facility staff were very good to check on residents as well. They had been very good about communicating with the previous provider and the new providers that had started in January 2026. Resident # 1's physician, who served as the facility's Medical Director, was interviewed on 1/29/26 at 1:40 PM and again 2/2/26 at 3:25 PM and reported the following information. He had not personally seen Resident # 1 since the new providers had assumed care of the resident in January 2026. When NP # 1 saw Resident # 1 on 1/5/26 as a new provider, she was supposed to do a broad overview and he had not seen the resident. Details from interviews which were relayed to the surveyor from staff who had cared for Resident # 1 on 1/20/26 through her transfer on 1/22/26 were shared with the physician. The physician reported that the staff had notified the provider of the chest congestion. The physician was interviewed regarding the importance of the provider knowing that the resident, excluding one bite, had not eaten three consecutive meals, reportedly was not responding to staff per her baseline, and was not able to suction fluid through a straw when assisted by a Nurse Aide. The physician acknowledged that this would have been good information for the provider to have had. As the resident's physician he had not been made aware of any problems with the resident prior to transfer. The physician further reported the following. A resident's blood sugar can rise even though they are not eating when there is a stress response in their body, and this in turn can also lead to dehydration when the individual goes into a hyperosmolar state. Given that facility staff were reporting that the resident had cold symptoms on 1/20/26 and respiratory symptoms on 1/21/26, it appeared the resident had developed an acute rapid onset of respiratory sepsis syndrome which also resulted in the resident having a hyperosmolar syndrome. Therefore, after hearing and reviewing details on 2/2/26 regarding staff reports of the resident having respiratory symptoms prior to the	F0580		

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F0580 SS = J	Continued from page 13 resident's hospital transfer, her death may have not been avoidable. It appeared she had rapidly declined in a 24-hour period's time. In reviewing the resident's hospital BUN and creatinine level results, her elevated levels may have been because there was an insult to her kidneys from an infection. On 1/29/26 at 5:05 PM the Administrator was informed of Immediate Jeopardy. The Administrator presented the following Immediate Jeopardy Removal Plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of noncompliance: Resident #1 was a long-term care resident of the facility who was admitted on 6/19/20 and discharged on 1/22/2026. She had medical diagnoses to include but not limited to Schizophrenia, Epilepsy, and Type 2 Diabetes. On 1/21/2026 Nurse Aide (NA) #1, per surveyor interview, reported that Resident #1 appeared sleepy, did not respond to conversation per baseline, and did not eat her breakfast, lunch, or dinner. Per Nurse #2's interview on 1/29/2026 by the facility Director of Nursing (DON), NA #1 did not communicate this to her (Nurse #2). NA #1 did not verbalize these concerns to the nurse managers, DON, or Administrator either. The facility became aware of NA #1's statement when the surveyor relayed this information to the facility on 1/28/2026. The facility was unable to validate this information due to NA #1 refusing to discuss her interview with the surveyor with the DON on 1/28/2026. This information was not in Resident #1's medical record. On 1/29/2026 one to one education was given to NA #1 on the importance of communicating change(s) of condition timely to the charge nurse by the DON. On 1/21/2026 at approximately 11:00am Nurse #2 assessed the resident for congestion. Nurse #2 was in the room and asked Resident #1 how she was feeling. Nurse #2 identified the congestion independently. Per interview with Nurse #2 by the DON on 1/29/2026, this assessment revealed a moist non-productive cough with coarse breath sounds. Nurse #2 notified the provider of changes and received an order for a chest x-ray. Nurse #2 did not find any signs and symptoms of any other changes in Resident #1's condition. Surveyor interviewed Nurse #2 and she reported she saw the blood sugar in the chart on 1/21/2026. She also reported the Resident #1 did not take her medication at breakfast,	F0580		

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F0580 SS = J	Continued from page 14 but she did take them at lunch. Per Nurse #2's interview, Resident #1's temperature at the time was 98.5 degrees and no blood glucose level was obtained. The x-ray was scheduled for 1/21/2026; however, it was not completed on this date. The x-ray technician arrived at the facility on 1/22/2026 and Resident #1 had already been discharged to the hospital. On 1/22/2026 at approximately 4:00am, NA #2 alerted Nurse #3 that Resident #1 felt extremely hot. Nurse #3 immediately assessed Resident #1 and observed Resident #1 to be in respiratory distress. Abnormal vital signs were obtained and EMS was called. EMS arrived shortly after calling and transferred Resident #1 to hospital. The facility called the hospital for an update on Resident #1's status and was told Resident #1 had coded and expired. On 1/29/2026 after conversation with the surveyor, the surveyor indicated a breakdown in the nurse to provider notification process related to a resident change in condition. Resident #1 experienced an acute change in condition. Nurse # 2 assessed Resident #1 and communicated her findings to the provider (on 1/21/2026) without knowledge of NA #1's observation of Resident #1. On 1/29/2026 an ad hoc Quality Assurance Performance Improvement meeting to include the Medical Director, Administrator, DON, Social Worker, Unit Managers, Treatment Nurse, Assistant Dietary Manager, Maintenance, Nurse Navigator and Housekeeping Supervisor was held to discuss the system breakdown between the nurse to provider notification based on the surveyor's report. The facility identified opportunities to strengthen these processes through a root cause analysis (RCA). On 1/29/2026 the RCA highlighted a need for better communication between NAs and Nurses that will lead to better provider notification. Although Resident #1 no longer resides in the facility, effective immediately on 1/30/2026 the facility implemented actions to remove the immediate jeopardy related to NA to Nurse communication related to a resident change in condition which would have led to provider notification. On 1/29/2026 the DON, Unit Managers, Wound Nurse, and Charge Nurses initiated an assessment on all residents in the facility for any change in condition to include altered mental status, abnormal vital signs that are outside of resident baseline, blood glucose levels, and any concerns identified by staff, resident, or family	F0580		

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F0580 SS = J	Continued from page 15 member as a change in condition. Any change in condition was communicated to provider for follow up. Six residents were identified through the review process with a new change in condition and were reported to the provider immediately. In addition, a 100% seven-day chart review of current residents was completed by the DON to identify any resident changes in condition and ensure notification to the provider was made. There were ten residents with change in conditions identified on 1/31/2026. These changes were reported to the Medical Director for further guidance. This was completed on 1/31/2026. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring Specify or recurring, and when the action will be complete: On 1/29/2026 education was initiated by the Clinical Competency Coordinator to all licensed nurses on tag F580 requirements of provider notification for residents with changes in condition via physician communication application which is provided by the provider group. This communication is available on facility tablets and desktops. The communication is automatically saved and time stamped when a new chat is opened by staff. Once communication is started the name of the provider is put into the chat and automatically saved within the application system. Once communication is completed with the provider, a copy of the chat is then emailed to Unit Managers and DON. 100% of nurses have been educated as of 1/30/2026. This education will be included in the new hire orientation for all licensed nurses. The Clinical Competency Coordinator will ensure that all education is completed. The Administrator will track this education provided to all nurses hired after 1/29/2026. Additionally, 100% of NAs were re-educated on communicating resident changes in condition to the nurse utilizing the Stop and Watch tool, which is used to identify and communicate a change in condition. This education included NA #1. The Stop and Watch tool is a paper tool the facility uses in-house for the NAs to communicate with nurses. This education was given by the Clinical Competency Coordinator. This education will be included in the new hire orientation for all nursing staff. The Clinical Competency Coordinator will ensure that all education is completed. The Administrator will track this education provided to all nursing staff hired after 1/29/2026. On 1/29/2026 the DON and Clinical Competency Coordinator educated all licensed nurses and implemented an escalation protocol requiring nurses to	F0580		

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F0580 SS = J	Continued from page 16 communicate any change in condition to the medical provider, nurse to nurse, and to the DON. If the interventions ordered by the provider are not satisfactory, the next step in the escalation process will be to notify the DON or the Administrator who will discuss further with the provider or the Medical Director for guidance. Nurses will be in-serviced prior to the next scheduled shift. The DON will track this education. This will be added to the orientation for all new nurses hired after 1/29/2026. Alleged date of the immediate jeopardy removal: 2/01/2026 Onsite validation of the immediate jeopardy removal plan was completed on 2/4/25. The ad hoc Quality Assurance Performance Improvement meeting conducted on 1/29/26 as well as the initial audits and assessments of all residents completed between 1/29/26 through 1/31/26 were verified. The physician was notified for residents identified with a change of condition through the audit and/or assessment. Interviews with licensed nurses confirmed they were educated on the following: requirements of F580; immediately notifying the physician or physician extender of resident change in conditions via the physician communication application; and the escalation protocol. Interviews with NAs revealed they were educated on communicating resident changes in condition to the nurse utilizing the Stop and Watch tool in addition to education on verbally notifying nurses of any emergent conditions such as falls, breathing difficulties and injuries. All education was added to new hire orientation. The immediate jeopardy removal date of 2/1/26 was validated.	F0580		
F0684 SS = SQC-J	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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, Nurse Practitioner, Physician, and Consultant	F0684		

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F0684 SS = SQC-J	Continued from page 17 Pharmacist, for Resident # 1, the facility failed to 1) ensure comprehensive assessment, monitoring, and treatment of the resident's diabetes and 2) ensure acute monitoring, assessment, and treatment when the resident further developed respiratory symptoms in conjunction with untreated diabetes. On 10/14/25 Resident # 1 had a Hemoglobin A1C collected which showed a result of 8.1 % with a normal range noted on the lab report to be less than or equal to 5.7. (A Hemoglobin A1C measures average blood sugar levels over the past 2–3 months). There was no documented plan to address the resident's elevated Hemoglobin A1C. On 1/14/26 facility staff were made aware of a critically high serum blood glucose level of 466 which had been drawn on 1/13/26. (For adults with diabetes, normal blood sugar targets range from 80 to 130). Upon notification to staff by the lab, a finger stick blood sugar was done on 1/14/26 and revealed a result of 496. Per order, the resident received a one-time order of insulin and one documented repeat finger stick blood sugar check on 1/14/26, which showed a result of 386. Resident # 1 was seen on 1/15/26 by the Nurse Practitioner with no orders or established plan of care for the resident's diabetes initiated. No further blood sugar checks were documented following the result of 386 through the resident's discharge date. On 1/20/26 the resident reported she felt as if she was getting a cold. On 1/21/26 staff reported the following observations and symptoms 1) excluding one bite at lunch, the resident did not eat three consecutive meals 2) the resident appeared sleepy and did not converse and respond to the staff per her baseline 3) she was unable to suction fluid through a straw when a Nurse Aide assisted her although she reportedly normally ate and drank independently 4) she had developed a cough and coarse breath sounds and 5) she did not assist to turn in bed as she usually did during the evening of 1/21/26. Interviews with four nurses who had cared for Resident # 1 beginning at 7:00 AM on 1/21/26 revealed no complete sets of vital signs or blood sugar levels were obtained. On 1/22/26 at 5:44 AM EMS (Emergency Medical Services) was dispatched to the resident who was identified to have a blood sugar reading by paramedics of "high." The resident was transferred to the hospital where she was noted by the ED (Emergency Department) physician to be obtunded (a state of reduced alertness and reduced consciousness) and dehydrated. ED labs revealed a glucose result of 882 (life threatening condition that requires immediate medical attention) along with other lab abnormalities. The resident's temperature was 41.7 Celsius (107.06 degrees Fahrenheit). Resident # 1 coded (a medical emergency which is typically a cardiopulmonary arrest) at 6:53 AM and expired after unsuccessful attempts were	F0684		

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F0684 SS = SQC-J	Continued from page 18 made to resuscitate her. This was for 1 of 3 residents reviewed for professional standards of practice to address medical conditions (Resident #1). Immediate jeopardy began on 1/15/26 when the facility failed to ensure monitoring and a treatment plan was initiated for Resident # 1, who had a critically high elevated blood glucose level on 1/14/26 after already having an elevated HgBA1C in October 2025. Immediate jeopardy was removed on 2/1/26 when the facility implemented a 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 a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place. Findings included: Record review revealed Resident # 1 resided at the facility from 6/19/20 until 1/22/26. At time of discharge Resident # 1 was 73 years of age. Resident # 1 had diagnoses which included diabetes, epilepsy, schizophrenia, schizoaffective disorder, hypertension, muscle weakness, intellectual disability, muscle weakness, a history of metabolic encephalopathy (a disturbance of the brain's functioning from disease) and feeding difficulties in June 2022, hyperlipidemia, vitamin D deficiency, depressive disorder, a history of insomnia, extrapyramidal (problems with muscle tone and muscle movements often caused by antipsychotic medications) and movement disorder, kidney disease, and a history of dysphagia. Orders, which originated on 6/19/20 and were in effect until Resident # 1's discharge date, were for Resident # 1 to be a full code. Orders, which originated on 10/4/22 and were in effect through the resident's discharge date, included that Resident # 1 was to be on a CCHO (Consistent Carbohydrate) /Liberalized diabetic diet. Review of labs revealed Resident # 1 had a HgbA1C (Hemoglobin A1C), which was ordered on 10/14/25, by Nurse Practitioner # 1. The lab report included that the lab was drawn on 10/14/25 at 7:18 AM and the results on 10/15/25 showed a result of 8.1 % with a normal range noted on the lab report to be less than or equal to 5.7. The electronic copy of the lab showed the results were signed by Nurse Practitioner # 1 on 11/5/25. During a 1/29/26 1:40 PM interview with the facility's current Medical Director, who began in his position in	F0684		

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PruittHealth-Trent	836 Hospital Drive , New Bern, North Carolina, 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
F0684 SS = SQC-J	Continued from page 19 January 2026, the Medical Director reported that a goal for diabetic residents was to have a HgbA1C of less than 7.0. On 11/5/25 the Facility's Consultant Pharmacist created a communication sheet to the physician regarding the elevated HgBA1C level and noted the following information and question to the physician in the communication sheet. Resident # 1's Hgb1AC had been elevated in October, and the resident was not receiving any treatment. The pharmacist questioned the provider whether the resident would benefit from either Metformin 500 mg (milligrams) twice per day or Jardiance 10 mg every day. The communication sheet was written by the pharmacist in a way that the provider could check to begin either the Metformin or the Jardiance and sign she agreed and that the order could be written. The provider could also check an alternative response on the form indicating not to start the resident on medication by checking a box titled "other" and noting a rationale on the form about the provider's response not to start treatment. NP # 1's initials appeared on the form on 11/20/25 with a notation of no change. There was no further documentation by NP # 1 on the form and there was no corresponding progress note on that date. A review of the record revealed no orders for diabetic medication were initiated following 11/5/25 through the resident's discharge date. On 12/15/25 Resident # 1's care plan was reviewed and revised. The care plan included that the resident had suspected intellectual disability. A problem, which originated on 6/19/20 and which noted that Resident # 1 felt tired and had little energy related to her diabetes, remained as an active problem as of the review date of 12/15/25. One of the interventions was to encourage the resident to avoid daytime napping. There were no directions about blood sugar monitoring or a plan for the resident's diabetes. A problem, which originated on 1/29/22 and remained active on 12/15/25, noted Resident # 1 had experienced weight loss/gain secondary to diuretic usage and fluctuating appetite. Directions on the care plan included to provide set up assistance for the resident's meals and assist if needed. Staff were to encourage oral intake of food and fluids and monitor and record the resident's intake of food. On 12/18/25 NP # 1 noted she was seeing Resident # 1 for a regulatory visit and follow-up to chronic medical conditions. NP # 1 documented Resident # 1 reported she felt "okay" and did not offer any complaints. Under	F0684		

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F0684 SS = SQC-J	Continued from page 20 "plan" for "Type 2 Diabetes Mellitus with diabetic chronic kidney disease," NP # 1 did not reference and address the 10/14/25 elevated HgbA1C of 8.1. Instead, NP # 1 documented that the resident's HgbA1C was 6.5 on 9/1/24 and was diet controlled. The plan was to continue a healthy diet. The resident's chronic kidney disease was documented to be mild and as Stage 2 with a glomerular filtration rate of 64 on 7/6/25. (Glomerular filtration rate is a measure of kidney function, which measures how many milliliters of blood the kidneys filter per minute with a normal rate equal to or greater than 90 ml (milliliters per minute). NP # 1 also included within her progress note labs from 7/10/25 which noted that the resident's BUN (Blood Urea Nitrogen) and Creatinine were normal. The resident's BUN was 10 (normal 9-23) and the resident's creatinine was .94 (normal .55-1.02). (Elevated BUN and Creatinine levels can at times signify kidney problems or dehydration.) NP # 1 was interviewed on 1/30/26 at 11:46 AM and reported the following information. She had spoken to Resident # 1 about doing checks of her blood sugar more often and treating her diabetes after the result of the HgBA1C was returned. NP #1 explained the result of 8.1 would have correlated to a daily blood sugar of around 200. NP # 1 indicated the resident was not interested in doing that and wanted to control her blood sugar with diet only. Given the result, she thought that it would be reasonable and then have another evaluation after three months. NP #1 indicated she should have placed the information in her December note that she had talked to the resident but had not done so. The interview further revealed after December NP # 1 did not see Resident # 1 again. On 1/5/26 NP # 2 saw Resident # 1. NP # 2 noted Resident # 1 was being seen for a routine evaluation and management visit of chronic health issues such as hyperlipidemia, hypertension, and vitamin D deficiency. NP # 2 noted the following information. The resident was alert, awake, and cooperative and oriented times three (indicating the resident was oriented to person, place, and time). Within the progress note, NP # 2 included lab values from July 2025. She did not reference the elevated HGBA1C, which had been drawn on 10/14/25. At the bottom of her progress note she addressed three diagnoses with a plan. The three diagnoses were hyperlipidemia, hypertension, and vitamin D deficiency. The progress note did not address a plan of care for the resident's diabetes. NP # 2 noted there was one order for the visit which was for a Vitamin D level.	F0684		

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F0684 SS = SQC-J	Continued from page 21 NP # 2 was interviewed on 1/29/26 at 12:05 PM and reported the following information. The date of 1/5/26 was her first visit with Resident # 1 as a provider in a new group of providers that had assumed care at the first of January 2026 for the facility's residents. On 1/5/26 she saw Resident # 1 for chronic problems and to establish the resident with their group. She had picked three diagnoses to concentrate on, and her plan was to pick three more the next month. NP # 2 was interviewed regarding why she picked only three and had not reviewed all of the resident's diagnoses and responded that if she had reviewed all of the diagnoses then it would take forever. She also said that her future plan was to see residents' monthly, which was more often than regulatory and hopefully would provide better resident care since more frequent routine visits would be conducted. NP #2 stated she had not addressed the resident's diabetes on 1/5/26 but planned to do so during a future visit. On 1/9/26 Resident # 1 had a quarterly MDS assessment completed which showed the resident had a Brief Interview for Mental Status Score of 7. (A score of 0 to 7 indicates severe cognitive impairment and a score of 8 to 12 indicates moderate cognitive impairment). She required set-up assistance for eating. Review of orders revealed an order, which originated on 7/9/24, for a CMP (Comprehensive Metabolic Panel) to be done every twelve months. Review of a CMP dated as collected on 1/13/26 at 2:00 AM revealed that the result was reported on 1/14/26 at 5:31 PM. The results showed the following: Glucose 466; noted to be critically high; (normal 74-106) Creatinine 1.15; noted to be high; (normal .55-1.02) Potassium 3.2; noted to be low; (normal 3.5-5.1) Chloride 89; noted to be low; (normal 98-107) Carbon dioxide 31; noted to be high; (normal 20-30) Estimated Glomerular filtration rate 50 noted to be low (normal equal to or greater to 90) Review of transcribed communication between Nurse # 1 and the provider via the facility's electronic triage communication application revealed the following documentation was sent to the on-call provider on 1/14/26 at 5:54 PM regarding Resident # 1. "Received a	F0684		

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F0684 SS = SQC-J	Continued from page 22 critical lab of a 466 blood sugar level. I rechecked it and it now shows a reading of 496. Resident just eating dinner that has a hefty amount of carbs (carbohydrates) and sugars. Vitals signs remain stable 143/85 (blood pressure) 93 HR (heart rate) 16 RR (respirations) 98.1 T (temperature). Patient reports feeling sleepy all day. May I have insulin orders? According to the transcribed communication, the rendering provider signed on 1/14/26 at 7:51 PM that the following orders were communicated back. “Order Novolog 10 Units SQ (Subcutaneous) X 1 dose now. Recheck glucose in 1 hour. Notify if greater than 450. Place in acute book for PCP FU (primary care provider follow up).” On 1/14/26 at 6:10 PM Nurse # 1 documented the following information in a nursing progress note. She had received a critical blood sugar level of 466. The nurse rechecked the blood sugar and found it to be currently 496. The resident’s vital signs were stable and registered 143/85 blood pressure, 93 heart rate, 16 respirations, and 98.1 temperature. The resident reported she felt sleepy all day. The providers’ triage line was consulted and orders received for 10 units of Novolog insulin times one dose and then to recheck the blood sugar in on hour. On 1/14/26 on the “3:00PM to 11:00 PM” shift, Resident # 1’s Medication Administration Record reflected that Nurse # 4 administered the 10 Units of Novolog Insulin. The MAR reflected the Novolog insulin was administered on the 3:00 to 11:00 PM shift and did not note a specific time of administration. On 1/14/26 at 8:06 PM, Nurse # 1 documented a recheck of the resident’s blood sugar had been done and the reading was 386 and that the resident would be monitored for changes. Nurse # 1 was interviewed on 1/28/26 at 4:02 PM and reported the following information. She had not been assigned to the resident that day but was working on the floor and received the call from the lab noting that the resident’s blood glucose was high. She went to check the resident who was alert and eating. She reported she had been sleepy that day. She (Nurse # 1) notified the provider. The resident received a dose of insulin, and her blood glucose came down below the parameter set by the provider. The information was placed in the communication book for the provider to review in the morning. On 2/4/26 at 4:44 PM Nurse # 3, who had cared for Resident # 1 beginning at 11:00 PM on 1/14/26, was interviewed. Nurse # 3 could not recall if it was told	F0684		

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F0684 SS = SQC-J	Continued from page 23 to her that Resident # 1's blood sugar was high or if she had seen the elevated blood sugar on a written report. Review of Resident # 1's record revealed no further documented blood sugar checks after the date of 1/14/26 through the resident's discharge and there were no further orders which addressed the resident's blood sugars or other abnormal labs after the orders on 1/14/26. On 1/29/26 at 12:40 PM the DON (Director of Nursing) provided a progress note from NP # 2 for a service date of 1/15/26. The DON reported they had not received the progress note when the service visit was completed. It had been received by them that day (1/29/26). Review of the progress note revealed on 1/28/26 NP # 2 signed a progress note which was dated for a service date of 1/15/26. NP # 2 documented the following information in the note. She was seeing Resident # 1 for an acute visit for elevated blood glucose on her labs. Within the note, NP # 2 noted that all the resident's lab work had shown that her labs were at the resident's baseline with the exception of her glucose. NP # 2 did not address the low chloride, potassium, or decreased glomerular filtration rate within her progress note. NP # 2 wrote, "Patient seen today on assessment resting in bed, appearing comfortable with NAD (no apparent distress) noted. Patient recently had lab work done where all was at patient's baseline with the exception of her glucose. No leukocytosis noted on CBC (complete blood count) nor S/SX (signs and symptoms) of infection present on exam. Patient is on several antipsychotics which may be contributory due to potential metabolic syndrome with hyperglycemia. Patient also noted to be eating at the time of lab draw as well, which can cause false high readings even in nondiabetic residents. Spoke with upstairs and downstairs unit managers who stated that staff notified triage of the abnormal lab and received an order for 10 U of short acting insulin, that she responded favorably and became euglycemic (normal blood sugars) with her trends. Patient is completely asymptomatic at this time and shows no s/s of infection nor hyperglycemia during assessment. Encouraged staff to monitor for S/S of hyperglycemia and infection, and to take FSBS (Finger Stick Blood Sugar) as well as notify PCP if patient had any status changes. Patient has no other symptoms of hyperglycemia at this time. Additional acute and chronic issues addressed below. MAR (Medication Administration Record), VS (Vital Signs), lab, and full history review performed today. Patient is seen on exam doing well with no acute issues or needs per staff at this time. Will continue to monitor." Within the progress note, NP	F0684		

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F0684 SS = SQC-J	Continued from page 24 # 2 listed Resident # 1's past medical history diagnoses and she also included labs from 7/10/25 as part of "data" within the progress note. There was no mention of the 10/14/25 elevated HgBA1c level of 8.1 within the progress note. Within the 1/15/26 progress note, NP # 2 referenced vital signs from 1/16/26 at 4:17 PM. Under the "assessment and plan" for diabetes, NP # 2 noted in part that staff were encouraged to take the resident's FSBS, notify the provider if the resident's status changed, and that her HgBA1C would be monitored every 12 months. NP # 2 noted the HgBA1C was ordered for the next lab day. The resident's diabetes was currently diet controlled and she would be monitored for hyperglycemia and signs and symptoms of infection. The goal for the HgBA1C was noted to be less than 6.5. At the end of the diabetes "assessment and plan" portion of the progress noted, NP # 2 noted risks for Resident # 1 included but were not limited to diabetic ketoacidosis with coma, hyperosmolar hyperglycemic state, blindness, kidney disease, heart attack as well as further decline and rehospitalization if left untreated and unmonitored. (Hyperosmolar Hyperglycemic State is a critical complication of type 2 diabetes marked by extreme blood sugar, severe dehydration, and high blood viscosity which can cause lethargy and confusion.) Review of the record revealed no orders were written for the HgbA1C or Finger Stick Blood Sugars which were mentioned in NP # 2's 1/15/26 progress note. NP # 2 was interviewed in conjunction with the DON being present on 1/29/26 at 12:05 PM. NP # 2 reported the following information. She saw Resident 1 on 1/15/26 and reviewed the lab report from 1/14/26. She had been told that the resident was eating when the lab was drawn and that the FSBS was done. She had talked to the Unit Manager who reported they had rechecked a FSBS and it had come down in the 80s that day. She did not know that there was no order to check FSBSs and thought that the nurses were doing FSBS checks. She had asked if the staff wanted a sliding scale insulin coverage order and was told this "might be overkill" and the nurses would just watch her. Unit Manager # 1 was interviewed on 1/29/26 at 11:02 AM and reported the following information. Resident # 1's baseline was that she was alert, fed herself and would converse. She knew that Resident # 1 had been placed in the physician's communication book to be seen on 1/15/26 related to an elevated glucose level. That day NP # 2 talked to her about the residents she had seen that day and did not mention anything about Resident # 1. Therefore, she asked NP # 2 if she had seen Resident	F0684		

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F0684 SS = SQC-J	Continued from page 25 # 1 since she was on the list to be seen and NP # 2 responded that she had seen the resident and she “had it” (indicating that she was aware of the resident being on the list and addressing it). After that NP # 2 left the facility. The Unit Manager was interviewed regarding NP # 2 leaving the facility without orders for the resident’s blood sugars. Unit Manager # 1 further reported the following information. At times she (the Unit Manager) thought that the NPs, who were part of a new group of providers to the facility, would leave and review records remotely. They also then put in their own orders. At the end of the day, the NP would then send a list of residents she had seen on that day, and the list would include orders that had been given. Resident # 1 was not on the list of residents as being seen by NP # 2 on 1/15/26. Unit Manager # 1 was interviewed why there was no follow up by the facility staff to NP # 2 when they saw that there were no orders about a plan to deal with the resident’s diabetes and blood sugars and Unit Manager # 1 reported that it never came back up again. Unit Manager # 2 was interviewed on 1/29/26 at 12:50 PM and reported the following information. No one had ever talked to her on 1/15/26 about a resident on another unit having a high blood sugar. She did not oversee Resident # 1’s unit and therefore health issues would not have been addressed with her. On 1/16/26 Nurse # 3 documented a focused observation assessment note in Resident # 1’s electronic record, noting that Resident # 1 was alert, responsive, had regular respirations, clear speech, and no cough. On 1/19/26, Resident # 1’s Medication Administration Record, reflected that the resident received a Minexpike 2025-2026 (COVID vaccine) on the 7:00 AM to 7:00 PM shift by Nurse # 5. On that date (1/19/26) the resident’s temperature registered 97.6 as documented under the vital sign portion of the resident’s electronic record. This was the last vital sign under the vital sign portion of the record. The facility’s consultant pharmacist was interviewed on 1/29/26 at 11:52 AM regarding any information that accompanied the current COVID vaccines for which staff were to monitor residents. The consultant pharmacist reported the following information. Information from the National Institute of Health and other medical literature journals showed in rare instances there could be severe illness or adverse reactions. In rare cases, it could also cause transient hyperglycemia which tended to resolve in a few days or weeks following vaccination.	F0684		

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F0684 SS = SQC-J	Continued from page 26 According to staffing sheets, Nurse # 5 had cared for Resident # 1 from 7:00 AM to 11:00 PM on 1/19/26 (Monday) and again on 1/20/26 (Tuesday) from 7:00 AM to 5:00 PM. Nurse # 5 was interviewed on 1/28/26 at 3:00 PM and reported the following information. She routinely cared for Resident # 1 and the resident was normally alert, verbal, and had minimal confusion. Resident # 1 particularly liked a certain type of soft drink and when she (Nurse # 5) entered the room, Resident # 1 would speak up and ask her if she had that particular type of drink for her. Nurse #5 indicated the resident had received the COVID vaccine and appeared to be at her baseline both days on 1/19/26 and 1/20/26 while she (Nurse # 5) took care of her. According to staffing records, Nurse Aide (NA # 3) had cared for Resident # 1 on the 7:00 AM to 7:00 PM shift on 1/19/26 (Monday) and on the 7:00 AM to 3:00 PM shift on 1/20/26 (Tuesday). NA # 3 was interviewed on 1/29/26 at 11:33 AM and reported the following information. Resident # 1 was usually upbeat, happy, and talkative. She loved a particular type of soft drink, and she would eat and drink independently without any problems. Resident # 1 knew her (NA # 3) by name when she cared for her and she had been fine without any complaints. According to staffing records, NA # 6 had cared for Resident # 1 on 1/20/26 (Tuesday) from 3:00 PM till 7:00 AM on 1/21/26 (Tuesday). NA # 6 was interviewed on 1/28/26 at 4:35 PM and reported the following information. The resident was able to help roll and turn in bed per her normal activity. She normally would talk and was alert enough to remember things that had been in previous conversations. On the evening of 1/20/26 Resident # 1 talked to her (NA # 6) and reported she thought she was getting a cold. She (NA # 6) noticed Resident # 1's voice was deep as if she was getting a cold. She also appeared dark under her eyes and her eyes looked sunken. The resident did not feel warm to the touch as if she might have a fever. She was sleepy but at times she would be in and out. She would routinely drink independently and did not need help that evening drinking fluids. She was able to drink from a straw that evening. Usually, the resident ate well. She (NA #6) thought she had told a nurse about the resident sounding like she was getting a cold, but she could not recall who she had told. There were no nursing progress notes from facility nurses for the date of 1/21/26. On 1/21/26 at 11:07 AM the facility Social Worker noted Resident # 1 had been seen by the psychiatric Nurse	F0684		

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F0684 SS = SQC-J	Continued from page 27 Practitioner that morning for medication management. Review of the Psychiatric Nurse Practitioner's note on 1/21/26 revealed in entirety the following documentation: "ASSESSMENT AND PLAN 1. Schizoaffective disorder, bipolar type: Chronic and stable. No associated behavioral or psychotic disturbances. Currently on Ingrezza 40mg (milligrams) qd (every day), Oxcarbazepine 300 mg twice a day, and Risperidone 1.5mg twice a day. Plan: Continue current medication regimen. Will follow up and continue to monitor patient for changes in cognitive function. (Ingrezza treats movement disorders. Oxcarbazepine is used for mood disorders, and Risperidone is used to treat psychosis.) 2. Extrapyramidal and movement disorder: Chronic and mild. Involuntary movement occasional. Plan: Will continue Ingrezza 40mg qd (every day). Will monitor for any changes in EPS or other side effects. Will follow up to reassess condition and medication efficacy. 3. Depression: Chronic and stable. No associated behavioral or psychotic disturbances. This can indicate current medication of Venlafaxine ER 75 mg daily is managing symptoms. Plan: Continue current medication regimen. Will follow up and continue to monitor patient for changes in cognitive function. GENERAL Note Medications were reviewed for possible GDR (Gradual Dose Reduction) of psychotropics. Any reduction in regimen is likely to risk decompensation and is not recommended. At this time benefits outweigh risks and there is no clinical indication for any GDR of psychiatric medications. ORDERS Orders (as written) for this Visit no new orders." The Psychiatric NP was interviewed on 1/30/26 at 12:12 PM and reported she did not recall what time of morning she saw Resident # 1. She saw a lot of people and the resident was receiving patient care when she was there. She did not recall any specifics of a conversation with her. The Psychiatric NP explained she sometimes jotted down things that were different about residents but she did not see anything in her note that she had jotted down that was not ordinary for Resident # 1. NA # 1 had cared for Resident # 1 from 7:00 AM to 7:00 PM on 1/21/26 (Wednesday). NA # 1 was interviewed on 1/28/26 at 4:05 PM and reported the following	F0684		

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F0684 SS = SQC-J	Continued from page 28 information. Prior to 1/21/26, she recalled last caring for Resident # 1 on the previous Friday. There was a significant change in Resident # 1 from the previous Friday to Wednesday on 1/21/26. All day on 1/21/26 she did not “pep up” and she was sleepy. It was unusual that she would not pep up during the whole shift. She did not eat breakfast, lunch, or her supper meal. It was not unusual for her to not eat breakfast, but she typically ate other meals, and she routinely would feed herself and drink. Usually, Resident # 1 would talk a lot, but that day she did not converse like she usually did. She seemed out of it. If she asked her a question, the resident would answer with a sentence and then not keep talking. Her color also looked darker. She could not get the resident to pull up fluid with a straw which was unusual for her. During the day, the total she was able to get the resident to drink was about one cup of fluid by giving her sips. She recalled she had told Nurse # 2 that the resident did not eat breakfast or lunch, and Nurse # 2 knew Resident #1did not feel well. Nurse # 2 had told her (NA #1) that she was going to get a chest x-ray ordered. Nurse # 5 (who took over care of Resident # 1 at 3:00 PM) also knew that Resident # 1 did not eat her supper. The resident’s urination appeared to be the same, and her mouth did not look dry. During last rounds before she (NA # 1) left at 7:00 PM, the resident’s skin did not feel warm to her. Nurse # 2 cared for Resident # 1 on 1/21/26 from 7:00 AM to 3:00 PM. Nurse # 2 was interviewed on 1/29/26 at 8:52 AM and reported the following information. She did not normally care for Resident #1, and it had been about 2 months since she had been assigned to her. The resident “looked a little funny” to her and she also had a bad cough. Nurses #2 stated she listened to the resident’s lungs, and they were coarse (abnormal breath sounds while listening with a stethoscope which can indicate fluid or mucous). She thought something respiratory was going on with the resident. In the morning when she tried to give her medications she was “half asleep” and she could not get the resident to take medications. She tried at lunch and she was able to get Resident #1 to take the medications at lunch time. The resident said she did not feel good and Nurse #2 asked her what was wrong and she just said she didn’t know. Nurse #2 indicated she was able to get one bite of food in Resident # 1 at lunch, and she drank a “little bit.” She did not see outward signs of dehydration. Given that she had not cared for the resident recently, she talked to Unit Manager # 1 and Nurse Aides to see what was going on with the resident. She looked at Resident # 1’s chart and saw that the resident had a high blood sugar the previous week. She	F0684		

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F0684 SS = SQC-J	Continued from page 29 thought to herself that she had not even known the resident was a diabetic and as she recalled she had mentioned to Unit Manager # 1 that the resident's "blood sugar was crazy days ago." When she was with the resident, the resident did pull up from the straw and NA # 1 had not reported to her at any part of the day that the resident would not pull up fluid through a straw for her (NA #1). She did send a message to a Nurse Practitioner and thought it was NP # 2 that she texted a message to. She let the NP know the resident had a cough and asked if they could get a chest x-ray. The provider responded "yes." Nurse #2 explained the information that the resident had a cough and she was requesting a chest x-ray was the only information provided to the NP. She put the order for the chest x-ray into the computer which would have automatically generated the order going to the mobile x-ray company. She also called to verify that they had received it. The mobile x-ray company did not come on her shift, and she passed along to the next nurse that the resident was due for a chest x-ray. During her shift, she (Nurse # 2) took the resident's temperature and may or may not have written it down but as she recalled it was 98.5. She did not take the rest of the resident's vital signs or check her blood sugar. Nurse #2 stated it had been a "crazy" day with a lot of things going on and she had been very busy all day long. During the interview with Unit Manager # 1 on 1/29/26 at 11:02 AM, Unit Manager # 1 reported the following. She recalled Nurse # 2 telling her that the resident did not seem herself. She knew that the resident was going to have a chest x-ray. She did not recall Nurse # 2 mentioning to her about the resident having a high blood sugar the previous week. She recalled seeing the resident one time that day when she went into the room to do something for the other resident in the room and the resident looked at her. She (the Unit Manager) did not do an assessment and nothing "jumped out" to her as being not normal. According to the assignments, Nurse # 5 cared for Resident # 1 during the first part of the 3:00 PM to 11:00 PM shift on 1/21/26. During the interview with Nurse # 5 on 1/28/26 at 3:00 PM Nurse # 5 reported the following information. On 1/21/26 during the change of shift report at 3:00 PM she was told that Resident # 1 was not feeling well and that a chest x-ray was ordered. Nurse #5 could not recall the reason that was told in report for why the chest x-ray was ordered. She knew the resident had recently had her COVID vaccine. When she checked on Resident # 1 she was alert and she could tell the resident did not feel well. Resident # 1 did not carry on a conversation in the way she usually	F0684		

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F0684 SS = SQC-J	Continued from page 30 did. She (Nurse # 5) asked Resident # 1 if she would like the soft drink that she usually asked for, and the resident said no. She did not want anything. Resident #1 did not eat her supper meal while she (Nurse # 5) was there and Nurse # 5 did not know if Resident # 1 ate anything after she left that night. Nurse #5 recalled she took the resident's temperature and it was okay. She did not take the rest of the resident's vital signs or check her blood sugar. She was aware the resident had been put in the physician's book about blood sugars earlier in the month but there had been no order to check her blood sugars. Nurse #5 indicated she only cared for Resident # 1 for a few hours and left around 6:30 PM. According to assignment sheets, NA # 5 had cared for Resident # 1 on 1/21/26 (Wednesday) from 7:00 PM to 11:00 PM. NA # 5 was interviewed on 2/3/26 at 2:15 PM and reported the following information. Normally the resident was confused but would talk and converse when you cared for her. The resident was normally very active and would help turn when care was provided during rounds. That night she (NA # 5) changed the resident one time while caring for her and the resident just lay in bed and did not help turn. Therefore, she had to get assistance from NA # 2. NA #5 indicated the resident did not talk at all and she briefly opened her eyes partially and then closed them again. She did not recall the resident's skin being warm. NA #5 stated she knew the resident had recently had a shot (vaccine) and she thought that was why she was different and therefore she did not report it to anyone. Nurse # 4 cared for Resident # 1 on the second half of the 3:00 to 11:00 PM shift on 1/21/26 (Wednesday). Nurse # 4 was interviewed on 1/29/26 at 8:23 AM and reported the following information. One of the Nurse Aides had reported that Resident # 1 seemed "a little off." She thought it was NA # 4 who had told her that. She went to check on the resident who appeared to be sleeping. She asked the resident if she was okay and the resident replied "yea" and the resident opened her eyes some. She (Nurse # 4) touched Resident # 1, and she opened her eyes more. She (Nurse # 4) asked Resident #1 if she was sleeping good and the resident responded with a murmur which indicated yes. To her, it appeared the resident seemed to be getting an attitude about being bothered and it seemed to her (Nurse # 4) that the resident was just sleeping well. Therefore, she did not bother her further. She did call and talk to the nurse before her (Nurse # 5) and Nurse # 5 said that the resident had had a COVID vaccine, had some chest congestion, and there was an x-ray ordered. Nurse # 5 had told her (Nurse # 4) that if the x-ray company	F0684		

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F0684 SS = SQC-J	Continued from page 31 did not come by in the morning, then she (Nurse # 5) would follow up with them in the morning. Nurse # 5 also mentioned the resident was not eating as good. Nurse #4 indicated she did not check Resident # 1's vital signs or blood sugar. Nurse # 4 was interviewed about the resident having a critical glucose level the previous week. Nurse # 4 did not recall anything about the resident having high blood sugars or this being reported to her as a problem. Nurse # 4 reported that the resident liked to eat sweets and sugar items and if there had been a onetime blood glucose elevation, this would not have made her think that the resident would necessarily have an ongoing problem. She attributed the resident not feeling well to having the COVID vaccine recently. She took care of Resident # 1 for about four hours and then she reported off to Nurse # 3 that the resident had a chest x-ray ordered and had a COVID vaccine recently. NA # 2 had cared for Resident # 1 on 1/21/26 from 11:00 PM until the time of her discharge on 1/22/26. NA # 2 was interviewed on 1/28/26 at 6:58 PM and reported the following information. Prior to 1/21/26, she had last worked with Resident # 1 on the weekend of 1/17/26 and 1/18/26. When she left work on 1/19/26 (Monday) morning at 7:00 AM, Resident # 1 was okay and was watching television and laughing. She came back to work on 1/21/26 at 7:00 PM and learned that the resident was not doing well. Although she did not have her on her assignment starting at 7:00 PM, she looked in on her and the resident was sleeping and not responding as she usually did. If you called her name, the resident would not say anything. Resident #1 would open her eyes "a little" and then go back to sleep. NA #2 indicated she was assigned to the resident at 11:00 PM and knew she had just recently been changed so she did not change her at that time. At 2:00 PM rounds, she did not need changing. During the next rounds at around 4:00 to 4:30 AM the resident felt warm to the touch and she got the nurse. She took the resident's vital signs, and the nurse (Nurse # 3) wrote them down. She recalled the resident had a high fever and the nurse called EMS (Emergency Medical Services) right away. Nurse # 3 had cared for Resident # 1 on the shift which began at 11:00 PM on 1/21/26 until the resident's discharge to the hospital. Nurse # 3 was interviewed on 1/28/26 at 8:27 PM and again on 2/4/26 at 4:44 PM and reported the following information. Nurse #3 recalled Nurse # 4 had given her report at change of shift at 11:00 PM and there was nothing critical shared with her about Resident # 1. It was passed along in report that Resident # 1 was not eating, and she was due for a chest x-ray. The X-ray company did not come that night	F0684		

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F0684 SS = SQC-J	Continued from page 32 and she did not follow up with them. She went in and looked at the resident at the beginning of her shift, and she appeared to be sleeping and breathing okay. She did not awaken the resident to do vital signs or check her blood sugar. Nurse #3 stated she was not aware that anyone had noticed Resident #1 had a change in responsiveness as this had not been reported to her. Later, as she was passing medications around 5:00 AM the assigned Nurse Aide (NA # 2) came to get her and said something was wrong. She went to check on the resident, and her skin was “fire hot.” Nurse #3 stated she had never felt someone’s skin to have ever been as hot as the resident’s skin was that night. Her breathing was labored and slow as if she was about to pass away. She told the Nurse Aide to get the resident’s vital signs, and she called EMS right away. Nurse #3 indicated if she had known the resident had had critical blood sugars recently or that she had not been responding per her baseline earlier in the day, she would have checked her further at 11:00 PM and done her vital signs. On 1/22/26 at 5:53 AM Nurse # 3 documented a focused observation note under assessments in the resident’s electronic record. Nurse # 3 documented the resident was observed to have labored breathing with a temperature reading of 104.6. The resident was warm, clammy, flushed, with skin turgor slow to return to normal position. The resident was unable to answer related to any pain she might have. On 1/22/26 at 6:00 AM Nurse # 3 completed a Nursing Home to Hospital transfer form and noted the resident was observed with short, labored breathing, diaphoretic (heavy perspiration) skin, and temperature of 104.6. On 1/23/26 at 10:11 AM Nurse # 3 entered a late entry which noted the following information. “CNA (certified nurse aide) assigned alerted nurse to resident’s change in condition. Upon entry into resident’s room, writer observed her respiratory status as labored and slow. Writer attempted to assess heart rate, but upon touching resident, she was extremely hot. Writer instructed the CNA to get resident’s vitals while she contacted EMS for transport to the ER for evaluation. VS: BP 57/32, P-131, R-12, T-104.6, O2 (Oxygen saturation) = 89 RA (room air) (Readings below 90% to 92 % are considered low.) EMS arrived shortly after contact, and resident was transported to the [name of hospital] ER.” Nurse # 3 also noted she contacted the resident’s Responsible party and the DON. Review of EMS notes revealed they were dispatched on 1/22/26 at 5:44 AM and were on the scene at 5:47 AM.	F0684		

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F0684 SS = SQC-J	Continued from page 33 The paramedic noted they arrived to find the resident altered with two staff members at the bedside who were unsure how long the resident had been that way and were not able to provide an accurate last known well time. The paramedic did not note in the narrative note portion of the EMS report a further description of “altered.” In another portion of the EMS report, the paramedic noted the resident was alert. The paramedic further documented the following information in the narrative. The staff reported the resident had a temperature of 104 prior to calling. EMS noted the resident’s blood sugar was taken by them (the EMS crew) and that the reading was “H” (high). The resident’s temperature was 103 axillary. (An axillary temperature is taken in the armpit, and the reading is generally one degree less than an oral temperature reading). The resident’s first blood pressure registered 154/98, first pulse 120, first oxygen saturation 89 %, and first respirations 18. Oxygen was started and the resident was transported to the hospital and transferred to hospital care at 6:10 AM. Review of hospital 1/22/26 ED records revealed the following information. The physician noted the resident was obtunded upon exam. Her temperature was 41.7 Celsius and blood pressure was 64/31 with tachycardia. She had agonal respirations and was extremely warm to touch. The staff were unable to perform ultrasound guided peripheral access (a technique used to place an intravenous catheter in an arm) due to the severity of her volume status depletion and a central line was placed. Large volumes of fluids were infused. Labs drawn at 6:21 AM revealed a blood glucose level of 882, a BUN of 38, a Creatinine of 4.58, a sodium level of 156 (normal 136-145) along with other abnormal lab values. The resident’s white blood count was 4.3 (normal 4.8-10.8). Soon after the central line (a catheter inserted into a large vein extending to near the heart) was placed the physician was notified that the resident was becoming bradycardic (low heart rate) and she went into cardiac arrest. CPR (cardiopulmonary resuscitation) was initiated at 6:53 AM but efforts to resuscitate the resident were unsuccessful, and the resident expired. Blood culture results which were drawn prior to the resident’s death and returned after she expired, revealed the blood cultures grew no growth (indicating there had been no bacteria or fungus within the resident’s bloodstream.) Review of Resident # 1’s death certificate reflected the first cause of death was listed as advanced adult failure to thrive which the resident had for “weeks” and Type 2 diabetes which the resident had for “years.”	F0684		

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F0684 SS = SQC-J	Continued from page 34 The ED physician was interviewed on 1/28/26 at 5:31 PM and reported the following information. The resident arrested very quickly in the ED, and they did not have much time to render treatment before this occurred. Resident # 1 had been very dehydrated when she arrived. He recognized that blood sugars can rise quickly but felt it had taken Resident # 1 a couple of days to become as dehydrated as she was. He reported that she was approximately 6 liters of fluid in deficit. The ED physician also reported he felt the resident would not have expired if she had received medical attention sooner. The Director of Nursing was interviewed on 1/29/26 at 9:35 AM. The DON reported the following information. She had not been aware that no orders or plan had been made to address the resident's diabetes on 1/15/26 when the Nurse Practitioner saw the resident and she had not realized the resident's blood sugars were not being monitored. There had been a recent time when there had been a widespread phone outage through her phone service provider and she was unsure if that might have contributed to her not being aware. Nurse # 3 had called her on 1/22/26 when Resident # 1 was sent to the hospital, but she did not recall staff mentioning anything to her that Resident # 1 was experiencing any acute problems on 1/21/26. During the interview with the DON details from interviews from facility staff who had cared for Resident # 1 on 1/21/26, were shared with the DON and the DON was interviewed regarding whether the resident's complete vital signs and blood sugar should have been checked. The DON reported if the resident was not responding per her baseline, she would have done so and her staff were usually very good to also check and do so. The facility Administrator was interviewed on 1/29/26 at 10:30 AM and reported the following information. She usually checked on the residents often, and the facility staff were very good at checking on residents as well. There had been new providers in the facility starting in January 2026 and according to the Administrator she felt this had contributed to some of the problems in a plan being developed for the resident's monitoring and care. Resident # 1's Physician, who served as the facility's Medical Director, was interviewed on 1/29/26 at 1:40 PM and again on 2/2/26 at 3:25 PM and reported the following information. He had not personally seen Resident # 1 since the new providers had assumed care of the resident in January 2026. When NP # 2 saw Resident # 1 on 1/5/26 as a new provider, she was supposed to do a broad overview. If he had been	F0684		

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F0684 SS = SQC-J	Continued from page 35 evaluating the resident as a new patient, he would have looked at the elevated 10/14/25 HGB1AC result of 8.1. The resident should have been receiving blood sugar checks. As Medical Director he had not been made aware of any problems with assessment and monitoring of Resident # 1 while she resided at the facility. The Physician stated a resident's blood sugar can rise even though they are not eating when there is a stress response in their body, and this in turn can also lead to dehydration when the individual goes into a hyperosmolar state. Given that facility staff were reporting that the resident had cold symptoms on 1/20/26 and respiratory symptoms on 1/21/26, it appeared the resident had developed an acute rapid onset of respiratory sepsis syndrome (an overwhelming or impaired immune whole-body response to an infection or some other factor that provokes the immune response) which also resulted in the resident having a hyperosmolar syndrome. Therefore, after his (the physician's) hearing and reviewing details on 2/2/26 regarding staff reports of the resident having respiratory symptoms prior to the resident's hospital transfer, her death may have not been avoidable. It appeared she had rapidly declined in a 24-hour period's time. In reviewing the resident's hospital BUN and creatinine level results, her elevated levels may have been because there was an insult to her kidneys from an infection. The Physician indicated for the severity of fluid deficit noted by the ED physician, he would have anticipated her BUN be higher. On 1/29/26 at 5:05 PM the Administrator was informed of Immediate Jeopardy. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of noncompliance: Resident #1 was a long-term care resident of the facility who was admitted on 06/19/2020 and discharged on 1/22/2026. She had medical diagnoses to include but not limited to Schizophrenia, Epilepsy, and Type 2 Diabetes. Resident #1's diabetes had been managed with diet and monitoring of Hemoglobin (Hgb) A1C laboratory (lab) testing. Resident #1's Hgb A1C on 10/15/2025 was 8.1%. Although this lab result is an abnormal result, there were no provider orders related to this result, which was signed off by the provider on 11/5/2025. There was no additional glucose monitoring between 10/14/2025 and 1/13/2026. On 1/13/2026 Resident #1 had a Comprehensive Metabolic Panel (CMP) drawn that resulted on 1/14/2026. This laboratory test resulted in a critical glucose level of	F0684		

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F0684 SS = SQC-J	Continued from page 36 466mg/dl. This result was reported to Nurse #1 on 1/14/2026 at approximately 6:00pm by the lab technician. Nurse #1 did a recheck at approximately 6:10 pm of the blood glucose level via finger stick which read 496. Nurse #1 immediately called the facility's provider on call via the triage communication application. Nurse #1 received an order for 10-units of insulin and repeat finger stick, and to call Triage back if repeat finger stick glucose check was greater than 450. The repeat finger stick glucose check was 386. This was communicated to the facility provider via facility communication book as directed by the triage provider. There was no additional glucose monitoring after 1/14/2026. The critical blood glucose fingerstick result was communicated verbally by Nurse #1 to Nurse #4 at 8pm on 1/14/2026 and Nurse #4 documented this result on the nurse shift-to-shift report to the incoming Nurse #3 at 12 midnight on 1/15/2026. The surveyor interviewed Nurse #3 on 2/4 and she indicated she could not recall if the result was told to her or that she actually saw it on the report. Provider #1 saw Resident #1 in-house on 1/15/2026. On 1/16/2026 a focused observation was completed by Nurse #3 on Resident #1 that included the following body systems: mental, neuro, respiratory, cardiovascular, gastrointestinal, genitourinary, musculoskeletal, pain, eyes, ears, nose and throat with no abnormal findings per Resident #1's baseline. On 1/21/2026 the Nurse Aide (NA) #1, per surveyor interview reported that Resident #1 appeared sleepy, did not respond to conversation per baseline, and did not eat her breakfast, lunch, or dinner. Per Nurse #2's interview on 1/29/2026 by the facility Director of Nursing (DON), NA #1 did not communicate this to her (Nurse #2). NA #1 did not verbalize these concerns to the nurse managers, DON, or Administrator either. The facility became aware of NA #1's statement when the surveyor relayed this information to the facility on 1/28/2026. The facility was unable to validate this information due to NA #1 refusing to discuss her interview with the surveyor with the DON on 1/28/2026. This information was not in Resident #1's medical record. No further actions were taken. On 1/21/2026 at approximately 11:00am Nurse #2 assessed the resident for congestion. Nurse #2 was in the room and asked Resident #1 how she was feeling. Nurse #2 identified the congestion independently. Per interview with Nurse #2 by facility the DON on 1/29/2026, this assessment revealed a moist non-productive cough with	F0684		

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F0684 SS = SQC-J	Continued from page 37 coarse breath sounds. Nurse #2 notified the provider of changes and received an order for a chest x-ray. Nurse #2 did not find any signs and symptoms of any other changes in Resident #1's condition. Nurse #2 was not aware on 1/14/26 of the elevated blood glucose result of 1/14/2026 because she was not the nurse responsible for Resident #1 on 1/14/2026. The surveyor interviewed Nurse #2 and she reported she had not taken care of the resident for about 2 months prior to the date of 1/21/26 and on the date of 1/21/26 she reviewed the chart and saw the 1/14/26 blood sugar in the chart at some point. She also reported the Resident #1 did not take her medication at breakfast, but she did take them at lunch. Per Nurse #2's interview, Resident #1's temperature at the time was 98.5 degrees and no blood glucose was obtained. The x-ray was scheduled for 1/21/2026; however, it was not completed on this day. The x-ray technician arrived at the facility on 1/22/2026 and Resident #1 had already been discharged to the hospital. On 1/22/2026 at approximately 4:00am, NA #2 alerted Nurse #3 that Resident #1 felt extremely hot. Nurse #3 immediately assessed Resident #1 and observed Resident #1 to be in respiratory distress. Abnormal vital signs were obtained and EMS was called. EMS arrived shortly after calling and transferred Resident #1 to the hospital. The facility called the hospital for an update on Resident #1's status and was told Resident #1 had coded and expired. On 1/29/2026 after conversation with the surveyor, the surveyor indicated a breakdown in resident assessment, monitoring, nurse to nurse communication, and nurse to provider notification process related to a resident change in condition. Resident #1 experienced an acute change in conditions. Although an initial provider notification occurred and a one-time order was obtained, no ongoing glucose monitoring occurred. On 1/29/2026 an ad hoc Quality Assurance Performance Improvement meeting to include the Medical Director, Administrator, DON, Social Worker, Unit Managers, Treatment Nurse, Assistant Dietary Manager, Maintenance, Nurse Navigator and Housekeeping Supervisor was held to discuss the systemic breakdown between the nurse to provider notification, nurse to nurse communication, the escalation process and change in condition based on the surveyor's report. The facility identified opportunities to strengthen these processes through a root cause analysis (RCA). On 1/29/2026 the RCA revealed that although there was only a one-time order for insulin and repeat fingerstick to address the elevated blood glucose level, the facility	F0684		

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F0684 SS = SQC-J	Continued from page 38 identified the need to strengthen processes to ensure ongoing assessment, monitoring, and escalation of resident changes in condition to include abnormal findings. Although Resident #1 no longer resides in the facility, effective immediately on 1/30/2026 the facility implemented actions to remove the immediate jeopardy related to resident assessment, monitoring, nurse to nurse communication, and nurse-to-provider notification process related to resident change in condition. On 1/28/2026 the DON, Unit Managers, and Skin Integrity Coordinator did an audit to identify all residents with a diagnosis of diabetes. Charts were audited to identify orders needed for hemoglobin A1C, blood glucose monitoring, and monitoring for signs and symptoms of hyperglycemia and hypoglycemia. On 1/29/2026 the DON received orders from Medical Director for all residents with a diagnosis of diabetes. Residents that did not have an order for Hemoglobin A1C every 6 months, in collaboration with the provider, an order was obtained for this lab to be completed every six months. Orders to monitor hyperglycemia and hypoglycemia were also placed on each diabetic resident's medication administration record to be monitored every shift. Orders were also obtained to monitor finger stick blood glucose twice a week, unless previously ordered otherwise. Initial blood glucose was obtained on each diabetic resident by the assigned charge nurse. On 1/29/2026 the DON, Unit Managers, Wound Nurse, and Charge Nurses initiated an assessment on all residents in the facility for any change in condition to include altered mental status, abnormal vital signs that are outside of resident baseline, blood glucose levels, and any concerns identified by staff, resident, or family member as a change in condition. Any change in condition was communicated to provider for follow up. Six residents were identified through the review process with a new change in condition and were reported to the provider immediately. In addition, a 100% seven-day chart review of current residents was completed by the DON, to identify any resident changes in condition and ensure notification to the Provider was made. There were seven residents' condition that warranted provider notification, but did not represent a significant change in condition on 1/30/2026. These changes were reported to the Medical Director for further guidance. This was completed on 1/31/2026.	F0684		

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F0684 SS = SQC-J	Continued from page 39 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring Specify or recurring, and when the action will be complete: Effective 1/29/2026, all new admissions who have a diagnosis of diabetes with no diabetic regimen will have a Hemoglobin A1C drawn within 30 days of admission (if there is no prior Hemoglobin A1C within 6 months of admission), and then every 6 months thereafter. An order will be obtained for finger stick blood sugars twice weekly and as a needed, and to monitor for signs and symptoms of hypoglycemia and hyperglycemia every shift. The Unit Managers are responsible for this. They were educated by the DON on 1/29/2026. The DON will be responsible for tracking this education. Education will be given to all new hires in a Unit Manger position. On 1/29/2026 education was initiated by the Clinical Competency Coordinator to all licensed nurses on tag F684 requirements, including ongoing assessment, provider notification for residents with changes in condition and timely interventions. 100% of nurses have been educated as of 1/30/2026 at 5:00pm. This education will be included in the new hire orientation for all licensed nurses. The Clinical Competency Coordinator will ensure and track that all education is completed. The Administrator will ensure the compliance of the education to all nurses hired after 1/29/2026. On 1/29/2026 the DON/Clinical Competency Coordinator educated all licensed nurses and implemented an escalation protocol requiring nurses to communicate any change in condition to the medical provider, nurse to nurse and the DON. If the interventions ordered by the provider are not satisfactory, the next step in the escalation process will be to notify the DON or the Administrator who will discuss further with the provider or the Medical Director for guidance. Nurses will be in-serviced prior to the next scheduled shift. The DON will track the education. This will be added to the orientation for all new nurses hired after 1/29/2026. Additionally, 100% of NAs were re-educated on communicating resident changes in condition to the nurse utilizing the Stop and Watch tool, which is used to identify and communicate a change in condition. On 1/30/2026, the DON/Clinical Competency Coordinator completed a re-education of 100% of all licensed nurses on providing accurate shift-to-shift verbal and written handoff communication regarding residents' clinical condition, significant changes in condition and need	F0684		

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F0684 SS = SQC-J	Continued from page 40 for required follow up and monitoring until the condition is resolved. The DON will track the education. This will be added to the orientation for all new nurses hired after 1/30/2026. Alleged date of the immediate jeopardy removal: 2/01/2026 Onsite validation of the immediate jeopardy removal plan was completed on 2/4/25. The ad hoc Quality Assurance Performance Improvement meeting conducted on 1/29/26 as well as the initial audits and assessments of all residents completed between 1/28/26 through 1/31/26 were verified. The physician was notified for residents identified with a change of condition through the audit and/or assessment. It was verified that all residents with a diagnosis of diabetes had physician orders for: Hemoglobin A1C every 6 months; monitoring every shift for signs or symptoms of hyperglycemia and hypoglycemia; and monitoring finger stick blood glucose twice a week, unless previously ordered otherwise. Interviews with Unit Managers confirmed they were educated on the new process implemented for all new admissions who have a diagnoses if diabetes that included the following orders: Hemoglobin A1C if there was no prior Hemoglobin A1C in the six months prior to admission with this laboratory test completed every 6 months thereafter; finger stick blood glucose twice weekly and as needed; and monitor for the signs of hypoglycemia and hyperglycemia every shift. Staff interviews confirmed that all licensed nurses were educated on the following: requirements of F684, ongoing assessments of residents, provider notification of residents with changes in condition, implementation of interventions, the escalation protocol for changes in condition, accurate shift-to-shift verbal and written communication regarding residents' clinical condition, significant changes in condition and need for follow up and monitoring until the condition was resolved. Interviews with NAs revealed they were educated on communicating resident changes in condition to the nurse utilizing the Stop and Watch tool in addition to education on verbally notifying nurses of any emergent conditions such as falls, breathing difficulties and injuries. All education was added to new hire orientation. The immediate jeopardy removal date of 2/1/26 was validated.	F0684		
F0711 SS = D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F0711		

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F0711 SS = D	Continued from page 41 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview with staff and Nurse Practitioner, the facility failed to ensure that the medical provider documented a plan to address Resident # 1's diabetes during a required regulatory visit. This was for 1 of 3 residents whose medical records were reviewed related to medical needs (Resident #1). The findings included: Record review revealed Resident # 1 was admitted to the facility on 6/19/20 with a diagnosis of diabetes. Record review revealed Nurse Practitioner (NP) # 1 documented she was seeing the resident for a regulatory visit on 9/26/25, and Resident # 1's diabetes was diet controlled. Review of labs revealed Resident # 1 had a HgbA1C (Hemoglobin A1C), which was ordered on 10/14/25, by Nurse Practitioner # 1. The lab report included that the lab was drawn on 10/14/25 at 7:18 AM and the results on 10/15/25 showed a result of 8.1 % with a normal range noted on the lab report to be less than or equal to 5.7. (A Hemoglobin A1C measures average blood sugar levels over the past 2–3 months by checking the percentage of hemoglobin coated with sugar and does not require an individual to be fasting when drawn.) The electronic copy of the lab showed the results were signed by Nurse Practitioner # 1 on 11/5/25. Review of the medical record revealed there was no corresponding provider progress note dated 11/5/25.	F0711		

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F0711 SS = D	Continued from page 42 Following 9/26/25, the next documented regulatory visit by a provider was on 12/18/25. On 12/18/25, NP # 1 noted she was seeing Resident # 1 for a regulatory visit and follow-up to chronic medical conditions. NP # 1 documented Resident # 1 reported she felt “okay” and did not offer any complaints. Under “plan” for “Type 2 Diabetes Mellitus with diabetic chronic kidney disease,” NP # 1 did not reference and address the 10/14/25 elevated HgbA1C of 8.1. Instead, NP # 1 documented that the resident’s HgbA1C was 6.5 on 9/1/24 and was diet controlled. The plan was to continue a healthy diet. The resident’s chronic kidney disease was documented to be mild and as Stage 2 with a glomerular filtration rate of 64 on 7/6/25. (Glomerular filtration rate is a measure of kidney function, which measures how many milliliters of blood the kidneys filter per minute with a normal rate equal to or greater than 90 ml (milliliters per minute). NP # 1 also included within her progress note labs from 7/10/25 which noted that the resident’s BUN (Blood Urea Nitrogen) and Creatinine were normal. The resident’s BUN was 10 (normal 9-23) and the resident’s creatinine was .94 (normal .55-1.02). (Elevated BUN and Creatinine levels can at times signify kidney problems or dehydration.) NP # 1 was interviewed on 1/30/26 at 11:46 AM and reported the following information. She spoke to Resident # 1 about doing checks of her blood sugar more often and treating her diabetes after the result of the 8.1% HgBA1C returned. The result of 8.1 would have correlated to a daily blood sugar of around 200. The resident was not interested in doing that and wanted only to control it with diet. Given the result of 8.1, she thought attempts to control Resident # 1’s diabetes with diet would be reasonable and then have another evaluation after three months. NP #1 indicated she should have documented in her December 2025 regulatory visit note that she had talked to the resident about possibly starting treatment for the elevated HGBA1C by doing blood sugar checks and treating any elevated blood sugar results when the checks were done. NP # 1 also indicated within the December 2025 regulatory progress note, she should have documented the resident wanted to try to control her diabetes with diet and that the plan would be evaluated again in three months. After December 2025 she did not see the resident again. NP # 1 confirmed she had not documented the discussion with Resident # 1 and the diabetic plan in her regulatory note and should have done so. Interview with the Administrator on 1/28/26 at 3:35 PM revealed NP # 1 was part of a provider group who had seen residents at the facility through the end of	F0711		

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F0711 SS = D	Continued from page 43 December 2025, and NP # 1 was very good to address problems that the residents might have.	F0711		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure food was sealed when stored, the floor was clean, and food storage shelves were free of grainy food particles for 1 of 1 main facility kitchen. The findings included: During kitchen observations made on 1/30/26 beginning at 7:50 AM the following were observed. In the dry storage room there was a container of multiple large bags of cereal. The top bag was open. The lid to the container was found on the floor underneath another shelving unit in the dry storage room. Grits were on a shelf and not sealed up and closed, rather the top of the grits bag was rolled up. The metal shelf, where the grits were located, had a liner. The liner on this shelf and another kitchen shelf in the dry storage room had very fine grainy particles visible on the liner.	F0812		

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F0812 SS = D	Continued from page 44 Underneath the shelving units in the dry storage room were multiple items and food crumbs which included but were not limited to loose, dry cereal, a dried up orange peeling, two closed packets of cookies, two water bottles, two condiment packets, a carbonated drink, a closed bag of Cheetos, a closed pudding cup, a loose cigarette, and a pair of shoes (sandal slides). Underneath the kitchen oven there was a span of about 12 inches of black, dried-up grease. Dietary Aide # 1 was interviewed at the time of the observation and reported they had to be careful when they cleaned under the oven because part of the bottom of the oven would come off. During the kitchen observations on 1/30/26, which began at 7:50 AM, the Administrator also viewed the dry storage floor and the food items that were not in a sealed bag or container. At 8:50 AM on 1/30/26, the Administrator reported that the former Dietary Manager had walked out in October 2025 without a notice and that the current Dietary Manager worked one to two days per week until a full time Dietary Manager could be hired. The Dietary Supervisor was interviewed on 1/30/26 at 10:40 AM and reported the following information. She would normally seal any opened food items if the kitchen staff forgot and did not seal the food items up. The staff were supposed to sweep and clean nightly before leaving and given the amount of items found on the floor in dry storage during kitchen observations which began on 1/30/26 at 7:50 AM by the surveyor, it would not appear they had not done so. The Dietary Supervisor also reported that there was a cleaning schedule that the kitchen utilized and provided a copy of the cleaning schedule to the surveyor. Review of the cleaning schedule revealed it did not mention the dry storage cleaning. The Dietary Manager was interviewed on 2/2/26 at 2:40 PM and reported the following information. She worked part time at the facility and was usually there one day per week. She tried to be there on weekends and afternoons. The Dietary Manager stated the staff should be cleaning and mopping every night before they leave and instructions had been given to them to do this. All food should be sealed, covered, and dated. The Dietary Manager indicated she had made a new cleaning schedule when she started to work, and it did incorporate the dry storage area, but she had been told that the facility needed to use a corporate cleaning schedule which was not the same as hers and did not include the dry storage room.	F0812		
F0925 SS = D	Maintains Effective Pest Control Program	F0925		

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F0925 SS = D	Continued from page 45 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and interviews with staff, contracted pest control technicians, and a local health department employee, the facility failed to ensure 1) cleaning practices and food storage practices were carried out in the main kitchen to deter attraction of pests and 2) communicate effectively with pest control technicians to ensure contributing factors to pests could be identified and efforts made to resolve any issues for 1 of 1 main kitchen area in the facility. The findings included: Review of pest control records provided by the facility's corporate office and Health Department records revealed the following information: On 5/19/25 Contracted Pest Control Technician # 1 noted the following in an invoice. A few roaches were found in the kitchen area. The area was inspected and serviced. There were sanitation issues identified in the kitchen which could lead to pest problems. The floor under the cook/steam line was in need of cleaning and there was food or grease build-up observed in the kitchen. The inspection report invoice noted, "Please clean regularly." On 7/30/25 Pest Control Technician # 1 noted the following in an invoice report. No pest activity was found. On 8/13/25 the local health department completed a main kitchen review and noted a large amount of roaches were found in an electrical box above the three-compartment sink. The inspector also noted that there were kitchen cleaning issues. Specifically, the inspector noted 1) general floor cleaning was needed and cleaning was needed under food equipment 2) cleaning was needed under shelving in the walk in closet, walk in freezer, and dry storage 3) floor behind the equipment and under three compartment sink was in need of cleaning. Additionally, the inspector noted there was wall damage throughout the kitchen. On 8/26/25 Pest Control Technician # 1 noted the following in an invoice report. They had performed	F0925		

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F0925 SS = D	Continued from page 46 interior rodent service, checked and reset traps. No pest activity was found. On 9/18/25 Pest Control Technician # 1 noted the following in an invoice report. Pest activity was found in the kitchen area. Cockroaches were noted during service coming out of the trash disposal door and other places in the kitchen. The technician noted he would return to do a follow-up service in 7 to 10 days and was looking to do a night service the next Saturday. There were sanitation issues found that could cause pest problems which included that the floor drains needed to be cleaned. There were dirty strainers. The floor was normally wet all the time. The technician wrote for the facility to keep as dry as possible in the kitchen and to clean in and around drains frequently to help prevent pest breeding sites. The facility was not able to provide during the survey a specific date or invoice when the Pest Control Technician returned in September 2025 to do the nightly service they noted they wished to do. Following 9/18/25, the next pest service record provided by the facility was on 10/26/25 which noted no pest activity during service. The next service record following 10/26/25 provided by the facility was on 12/5/25. Pest Control Technician # 1 noted there were no pests but there was sanitation issues found in the kitchen that could cause pest problems in the kitchen. The technician noted there was food debris found during most pest control services and standing water every service. The technician wrote, “Please clean regularly.” On 1/15/26 the contracted pest control company’s Technician # 2 noted the following on an invoice for a service. Roaches were noted during service along wall piping in the kitchen. The area was inspected and serviced. There were structural concerns that could cause pest problems. This included holes and gaps throughout the kitchen and “prof” peeling (a plastic covering) off the walls. There were sanitation issues. The report noted that food debris was found throughout the kitchen. There was a note, “Please clean regularly.” During kitchen observations made on 1/30/26 beginning at 7:50 AM the following was observed. There was a dead roach behind the ice machine and another roach in one corner of the kitchen that moved slowly. In the dry storage room there was a container of multiple large bags of cereal. The top bag was open. The lid to the	F0925		

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F0925 SS = D	Continued from page 47 container was found on the floor underneath another shelving unit in the dry storage room. Grits were on a shelf and not sealed up and closed, rather the top of the grits bag was rolled up. The metal shelf, where the grits were located, had a liner. The liner on this shelf and another kitchen shelf in the dry storage room had a very fine grainy substance visible on the liner. Underneath the shelving units in the dry storage room were multiple items and food crumbs which included but were not limited to loose, dry cereal, a dried up orange peeling, two closed packets of cookies, two water bottles, two condiment packets, a carbonated drink, a closed bag of Cheetos, a closed pudding cup, a loose cigarette, and a pair of shoes (sandal slides). Underneath the kitchen oven there was a span of about 12 inches of black, dried-up grease. Dietary Aide # 1 reported they had to be careful when they cleaned under the oven because part of the bottom of the oven would come off. There was a portion of the wall that was peeling off near the sink in more than a foot of area. At the time of the kitchen observations, staff were not observed actively preparing grits and cereal. During the kitchen observations on 1/30/26, which began at 7:50 AM the Administrator also viewed the dry storage floor and the food items that were not closed. At 8:50 AM on 1/30/26, the Administrator reported that the former Dietary Manager had left employment in October 2025 and that the current Dietary Manager worked one to two days per week until a full time Dietary Manager could be hired. In the interim, the Dietary Supervisor also covered. The Administrator stated the pest control company had been in to treat for roaches multiple times at night in January 2026. According to the Administrator, the pest control company had just finished a treatment on the night of 1/29/26. The Dietary Supervisor was interviewed on 1/30/26 at 10:40 AM and reported the following information. She would normally close any opened food items if the kitchen staff forgot. The dietary staff were supposed to sweep and clean nightly before they left and should have swept up the items on the floor in the dry storage room/area. The Dietary Supervisor also reported that there was a cleaning schedule that the kitchen utilized. Review of the cleaning schedule revealed it did not mention the dry storage cleaning. The Dietary Supervisor reported that because of a current physical limitation, she could not see under the stove well enough to view the grease build up, but there were plans to power wash under it. The Dietary Supervisor reported that she had been coming in at night and that the facility's pest control company had been "bombing	F0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2026

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

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F0925 SS = D	Continued from page 48 the kitchen" recently to alleviate the roaches. The interview further revealed the nightly treatments started after all food preparation activities were completed for the day. The Dietary Manager was interviewed on 2/2/26 at 2:40 PM and reported the following information. She worked part time at the facility and was usually there one day per week. She had done a complete inspection of the kitchen on 1/4/26 and did not see roaches at that time. She tried to be there on weekends and afternoons. The dietary staff should be cleaning and mopping every night before they left, and instructions had been given to them to do this. All food should be sealed, covered, and dated. The Dietary Manager had made a new cleaning schedule when she started to work, and it did incorporate the dry storage area, but she had been told that the facility needed to use a corporate cleaning schedule which was not the same as hers and which did not include the dry storage room. The Dietary Manager stated the grease under the oven should be cleaned but they had to be careful about power washing under the oven because in past times, power washing had caused an electric outlet to not function. She was aware that roaches had been found in the kitchen, the pest control company was performing treatments, and she had instructed the staff to unpack boxes of supplies as soon as possible. She thought some of the bugs that were seen were possibly "water bugs" and not roaches. The interview further revealed the Administrator was in the kitchen "all the time" checking on things. Pest Technician # 1 was interviewed on 1/30/26 at 11:30 AM and reported the following information. Staff had reported to him that they saw roaches in the residential part of the facility at times during his visits. While servicing the building he did not see them in the residential part. He did find live roaches in the kitchen, and he thought any sightings in the facility originated from the kitchen. In December 2025 he saw about 15 to 20 live roaches coming from an electrical box in the kitchen. There were a "bunch" of dead ones also on the glue board he had set out. When he routinely serviced the facility there were sanitation issues in the kitchen and "always stuff on the floor" such as trash and food particles. He talked to the kitchen staff about it. Also, the floor tended to be wet around the ice machine which could attract the roaches and the bait the pest control company used also needed to be kept dry. In December 2025, he also talked to an employee in the front of the building about servicing the kitchen at night. Pest Technician # 2 was interviewed on 1/30/26 at 11:05	F0925		

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F0925 SS = D	Continued from page 49 AM and reported the following information. He had treated the kitchen three times in January 2026 at night after all food preparation was finished for the day. On his first visit, which took place on 1/15/26, he had seen about 6 or 7 active roaches. They hid behind some white piping in the kitchen area and in the dishwasher area. When he was there at night there was food still in the food trap from the dishwasher machine and the prep sink had not been rinsed out. Pest Technician #2 explained that food can attract roaches. The “prof” covering to the wall was coming loose and roaches could hide under the wall covering where it was loose and not adhered to the wall. He felt the treatment he had initially done on 1/15/26 had eradicated probably 85% of any roach population in the kitchen. He had been out three times in January for treatment on 1/15/26, 1/23/26, and 1/28/26. He saw one active roach during his last visit, which he reported to be on the night of 1/28/26. A local Health Department Employee, who had completed the kitchen inspection in August 2025, was interviewed on 2/5/26 at 1:49 PM and again on 2/5/26 at 3:40 PM and reported the following information. He completed the facility’s main kitchen’s inspection in August 2025 and observed sanitation issues while in the kitchen. He had also seen 10-20 roaches in the kitchen that came from an electrical box in the kitchen. He had spoken to the Administrator during his August 2025 inspection about the issue and the Administrator had said that there were no roaches. Therefore, he took a video of the roaches and showed it to the Administrator. The facility was asked to send evidence they had pest control services to the health department. The Health Department Employee had not returned to the main kitchen since August 2025. He had returned to do an inspection of residential areas which included nourishment rooms in December 2025 and had also been in the facility in residential areas in October 2025 and January 2026 due to complaints of roaches in residential areas. The interview further revealed while in the residential areas, he had not seen roaches. The Business Office Manager and Maintenance Employee # 1 were interviewed on 2/4/26 at 10:33 AM. The Business Office Manager reported the following information. The pest control invoices with notations about pests and structural issues were not given directly to the facility. They (the facility) had to call and obtain reports which were provided to the surveyor, and this was done following the surveyor’s request for pest control records during the survey. The facility only had one invoice/report from 12/5/25 and no other report. Maintenance Employee # 1 reported the following	F0925		

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F0925 SS = D	Continued from page 50 information. He thought there was a date the Pest Control Technician returned in December 2025 and saw roaches in the kitchen. At that time a plan was made for another technician to come and do treatment. The technicians had not reported to him any structural issues or sanitation issues that could be causing a problem in managing roaches. He had not been aware of the problem with the kitchen wall facing coming off and did not know what other holes the technicians were referencing in their reports. Normally when the technicians came into the facility, they did not routinely go around and point out problems to the maintenance employees about issues they saw and they sometimes left without giving a report. Maintenance Employee #1 stated the facility also did not receive the invoice reports noting problems that could be contributing to the issues. During a follow up interview with Maintenance Employee # 1 on 2/6/26 at 12:00 PM regarding whether the Pest Control Company had ever done a nightly visit following the September 2025 roach sightings as they had documented in their report. Maintenance Employee #1 reported he was not fully involved until January 2026 with the pest control issues, but it was his understanding that they had returned in September after 9/18/25 and sprayed at night. The Administrator was interviewed on 2/4/26 at 2:56 PM regarding the notations of structural issues and sanitation issues in the pest control invoices and reported the following information. Their pest control company was supposed to come in monthly. She could not find records for November 2025 to validate if they came to the facility. She thought a pest technician had been back in at some point in December 2025 and determined a problem in the kitchen which needed nightly treatments. Since the holidays were near, the timeframe for treatment was set up for January 2026. The Administrator was not clear on what all was found in December 2025 by the technician which prompted the three nightly treatments in January 2026. The Administrator reported the technicians did not always talk to her about sanitation or structural issues that needed to be resolved and did not give her written reports that needed follow up. She recalled the local health department had been in recently and the employee told her he did not find roaches.	F0925		