STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	01/19/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		2/15/17

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

Electronically Signed | 02/10/2017

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F 225	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately report an allegation of abuse to the administrator. The facility subsequently failed to investigate the allegation of abuse, filed a 24 Hour Initial Report or a 5 Working Day Report to the Health Care Personnel Investigations, and to prevent further potential abuse during an abuse investigation for one (1) of two (2) residents reviewed for abuse. (Resident # 21) The findings include: Resident # 21 was admitted to the facility on	F 225	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The 24-hour report was submitted immediately after discovery of the issue with resident #21 to the NCNAR. The C.N.A was suspended pending investigation of the event in question until the investigation was concluded. How will you identify other residents having the potential to be affected by the	

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F 225	Continued From page 2 6/16/2016 with diagnoses of hemiplegia, abnormal posture, Parkinson's disease and chronic obstructive pulmonary disease. The resident ' s Minimum Data Set (MDS) dated 11/24/2016 indicated the resident ' s cognition was severely impaired. The facility's records for allegations of abuse were requested on 1/18/2017 at 9:00 AM. The review revealed facility's investigations of alleged abuse for the months of December 2016 and January 2017 did not include Resident # 21's allegation of abuse. Review of the "24- hour initial report Form," dated 1/18/2017 revealed " Speech Therapist reported to Administrator that Resident # 21 felt as if she was touched inappropriately by a male a few weeks ago. " Review of the facility's abuse investigation report dated 1/18/2017 revealed the staff member who was named in the allegation had been suspended on 1/18/2017 and the staff members who were assigned to the resident had been interviewed by the Administrator. During an interview on 1/18/2017 at 10:00 AM, the Speech Therapist (ST) stated Resident # 21 reported to her a few weeks ago she felt as if she was touched inappropriately by a male staff member. The resident stated to her that " a male staff member touched her bottom. " The ST stated the resident was not upset. She added that Resident # 21 made the statement during her visit with Resident # 21's roommate. The ST further indicated she reported the allegation of abuse to a supervisor who was working on the first shift but she could not recall the supervisor ' s name.	F 225	same deficient practice and what corrective action will be taken? All residents were interviewed by the Administrator, Director of Health Services, and the Clinical Competency Coordinator if they had ever been abused or witnessed abuse by anyone in the facility during their stay here. After completing the interviews, no residents stated that they had been abused or had witnessed any abuse while staying here at the facility. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education by the Clinical Competency Coordinator began on 1/18/2017 to all employees on reporting suspected abuse directly to the administrator via the abuse notification form or either by mobile phone after normal business hours. Education on Abuse will remain an essential part of the new hire process. The Clinical Competency Coordinator will interview 5 employees per week for 6 weeks on how, when, and who to report abuse to. The employees responses will be recorded on an interview questionnaire. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued	

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F 225	Continued From page 3 During an interview with Director of Nursing (DON) on 1/19/2017 at 10:30 AM, she stated she was not made aware of the allegation of inappropriate touching of Resident # 21 by a male staff member. DON added the first time she was made aware of the report was on 1/18/2017 by the Speech Therapist. During an interview with the Administrator, on 1/19/17, at 3:50 PM, he stated he did not know about an allegation of abuse by Resident # 21 until on 1/18/2017 at 9:30 AM when ST reported to him about the allegation of abuse. He added when he was made aware by the Speech Therapist about the allegation of abuse, he started an investigation. He further indicated his expectation was for the staff to report on the same day to him any allegation of abuse. He also stated the investigation was not completed timely because the Speech Therapist delayed reporting the allegation of abuse. The Administrator indicated the facility was unable to prevent potential further abuse to the resident during the weeks after allegation since it was not reported. He also reported any allegation from the residents at the facility including cognitively impaired residents were to be reported and investigated within 24 hours. In 5 days the investigation was to be reported to Health Care Personnel Investigation (HCPI) agency.	F 225	compliance. The results from the monitoring/interviewing will be reviewed and brought to the monthly QA meeting by the CCC, and the findings will be discussed and continue monitoring and education as needed to continue compliance.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		2/15/17

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F 226	Continued From page 4 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and review of the facility's established abuse prohibition policy and procedures, the facility failed to follow its "Reporting Abuse to Facility Management" for one (1) of two (2) sampled residents who reported allegations of abuse and/or mistreatment. (Resident #21) The findings include:	F 226	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The 24-hour report was submitted immediately after discovery of the issue with resident #21 to the NCNAR. The C.N.A was suspended pending	

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F 226	Continued From page 5 Review of the facility policy entitled " Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property " dated 11/21/2016 revealed, " The Administrator of the provider is responsible for assuring that an accurate and timely investigation is completed. If there is an occurrence of or allegation involving patient abuse (including injuries of unknown source), neglect, exploitation, mistreatment or misappropriation of patient property, the following investigation and reporting procedures will be followed: 1-If an actual injury has occurred, including an injury of unknown origin, or abuse, neglect, exploitation, mistreatment, misappropriation of property is observed, an occurrence report with supervisory investigation should be completed. 2-If a patient, staff member, or family member makes an allegation of the same, a complaint form should be completed. " The report further indicated, " A written report of the investigation and follow-up should be submitted to the appropriate agency within five working days of the occurrence, unless otherwise if indicated. " Resident # 21 was admitted to the facility on 6/16/2016 with diagnoses of hemiplegia, abnormal posture, Parkinson disease and chronic obstructive pulmonary disease. The resident ' s Minimum Data Set (MDS) dated 11/24/2016 indicated the resident ' s cognition was severely impaired. During an interview, on 1/18/2017 at 10:00 AM, the Speech Therapist (ST) stated Resident # 21 reported to her a few weeks ago she felt as if she was touched inappropriately by a male staff	F 226	investigation of the event in question until the investigation was concluded. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents were interviewed by the Administrator, Director of Health Services, and the Clinical Competency Coordinator if they had ever been abused or witnessed abuse by anyone in the facility during their stay here. After completing the interviews, no residents stated that they had been abused or had witnessed any abuse while staying here at the facility. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education by the Clinical Competency Coordinator began on 1/18/2017 to all employees on reporting suspected abuse directly to the administrator via the abuse notification form or either by mobile phone after normal business hours. Education on Abuse will remain an essential part of the new hire process. The Clinical Competency Coordinator will interview 5 employees per week for 6 weeks on how, when, and who to report abuse to. The employees responses will be recorded on an interview questionnaire.	

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F 226	Continued From page 6 member. The resident stated to her that " a male staff member touched her bottom. " The ST stated the resident was not upset. She added that Resident # 21 made the statement during her visit with Resident # 21 ' s roommate. The Speech Therapist further indicated she did not recall the name of the staff member to whom she reported this allegation. During an interview with the Administrator, on 1/19/17, at 3:50 PM, he stated he was not made aware of the allegation of inappropriate touching of Resident # 21 by a male staff member before 1/18/2017. He added he was made aware of the allegation of abuse on 1/18/2017 by the Speech Therapist and he started the investigation of the alleged abuse. He further indicated his expectation was for the staff to report on the same day to him any allegation of abuse. He also stated the investigation was not completed timely due to the Speech Therapist delaying to report to him the allegation of abuse. He also reported any allegation from all the residents at the facility including cognitively impaired residents were to be reported and investigated within 24 hours. In 5 days the investigation was to be reported to Health Care Personnel Investigation (HCPI) agency.	F 226	How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring/interviewing will be reviewed and brought to the monthly QA meeting by the CCC, and the findings will be discussed and continue monitoring and education as needed to continue compliance.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441		2/15/17

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F 441	Continued From page 7	F 441		

investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

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F 441	Continued From page 8 contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility staff failed to do hand hygiene after providing incontinence care and before touching Resident #5 ' s environment. The facility staff failed to do hand hygiene in between providing incontinence care for Resident #5 and Resident #48. This is evident in 2 of 2 residents observed to receive care (Resident #5 and Resident #48). Findings Included: A review of the facility policy titled Hand Hygiene, revised 04/15/16, indicated key moments in patient care which health care workers should perform hand hygiene. The key moments included before putting on gloves, after removing gloves, before touching a patient, after body fluid exposure risk, after touching a patient and after touching patient surroundings. A review of the facility policy titled Perineal Care of the female patient, revised 10/02/15, indicated	F 441	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The linen cart was immediately removed from the hall and disinfected after contamination from failure to complete hand hygiene. The sink in the resident□s room and the basin were immediately disinfected using a 10% bleach solution. The nurse aide was immediately in-serviced on proper handwashing protocol. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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F 441	Continued From page 9 the health care worker should perform hand hygiene before beginning care and after completing care. During a continuous observation on 01/19/17 starting at 6:11 a.m., Nursing Assistant # 1 (NA #1) was observed to provide perineal care for Resident #5 and then Resident #48, both of whom resided in the same room. The NA provided Resident #5 with incontinence care of stool. The resident was heavily soiled with runny stool and the NA had to wipe the stool multiple times to clean the resident. Once perineal care to Resident #5 was completed, NA #1 did not remove his gloves, lowered Resident #5 ' s bed and placed her call bell within her reach. NA #1 removed his gloves and did not wash his hands. NA #1 then opened Resident #5 ' s privacy curtain and adjusted her over-bed table. NA #1 was observed to take the trash and soiled laundry to the bins in the hallway outside of the residents ' room. At 6:43 a.m., NA #1 was observed to return to the residents ' room, wash his hands, put on gloves and pour out the dirty water (the NA used this water to rinse the washcloth soiled with urine and stool) from Resident #5 ' s basin into the sink of this semi-private room. NA #1 was then observed to put Resident #5 ' s soiled basin in a trash bag, remove his gloves and place the gloves in the trash bag. NA #1 took the trash bag to the trash bin in the hallway and immediately went to the clean linen cart on the hallway and gathered clean linen. At 6:50 a.m., NA #1 returned to the residents ' room, did not wash his hands, put on a pair of gloves, pulled the privacy curtain around Resident #48 and began to provide perineal care to her. During an interview with NA #1 on 01/19/17 at 7:00 a.m., NA #1 stated he knew he should wash his hands before putting on gloves, after taking	F 441	Education began on 1/18/17 by the Clinical Competency Coordinator for all nursing staff on proper handwashing protocol and infection control principles. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The DHS or CCC will observe and document on 4 nurse aides each week for 4 weeks, then 2 nurse aides each week for 3 weeks to ensure that the proper procedure for handwashing and infection control is adhered to. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and changes implemented to maintain compliance.	

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F 441	Continued From page 10 off gloves and in between resident contact. A review of the observation was discussed with NA #1. When asked about his lack of hand washing, NA #1 stated he thought he washed his hands before beginning care on Resident #48. When asked why he poured dirty water from Resident #5 ' s basin into the resident ' s sink in the room, he did not offer an answer. During an interview with the Director of Nursing (DON) on 01/20/17 at 2:13 p.m., the DON stated it was her expectation nursing staff follow the facility ' s hand washing policy.	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are	F 520		2/15/17

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F 520	Continued From page 11 necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions the committee put into place in April 2016. This was for 1 deficiency which was originally cited in April 2016 on a recertification and complaint investigation survey and was cited again on the current recertification and complaint investigation survey. The deficiency was in the area of infection control. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to F 441 Based on observation, record review and staff interviews, the facility staff failed to do hand hygiene after providing incontinence care and before touching Resident #5 ' s environment. The facility staff	F 520	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The QA team will continue to meet monthly as always and address any identified concerns from any areas, including infection control. This was a per instance infection control issue that was not related to the glucometer cleaning from last year. The Nurse Aide that did not perform appropriate handwashing protocol had been in-serviced on handwashing protocol within 3 months prior to the date of this survey, along with the rest of the direct care staff. The QA team will continue to meet monthly as always and address any identified concerns from any areas, including infection control.	

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PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 12 failed to do hand hygiene in between providing incontinence care for Resident #5 and Resident #48. This is evident in 2 of 2 residents observed to receive care (Resident #5 and Resident #48). During an interview with the Administrator on 01/20/17 at 3:00 p.m., the Administrator stated after the Recertification Survey of April 2016, sufficient training was completed. The Administrator stated the current issue was a " per instance one-time event " . The Administrator stated Nursing Assistant (NA) #1 had received sufficient training during orientation and had been aware of the proper protocols of the facility.	F 520	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 1/18/17 we began education by the Clinical Competency Coordinator for all nursing staff on proper handwashing protocol and infection control principles. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Education for other areas of concern will continue to be scheduled and monitored by the QA team each month, and any areas that need to be added or removed will be done so at the monthly meeting. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The QA team will continue to meet monthly and address any instances of noncompliance. Education will continue to be scheduled for any areas that are required. Focus areas will be reviewed monthly and removed from the focus two months after substantial compliance is achieved. For infection control (441) the DHS or CCC will observe and document on 4 nurse aides each week for 4 weeks, then 2 nurse aides each week for 3 weeks to ensure that the proper procedure for handwashing and infection control is adhered to, if the correct procedure is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	01/19/2017

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PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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F 520	Continued From page 13	F 520	utilized then remedial training will be offered and documented as such. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting and will be reviewed by the interdisciplinary team, where we will discuss any changes that require further implementation in order to maintain compliance, not only with infection control but each area.	