STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL 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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		8/17/18

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

Electronically Signed | 08/17/2018

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F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of discharge to the resident's representative for 1 of 2 residents reviewed for hospitalization (Resident #49). The findings included: Resident # 49 was admitted to the facility on 12/18/17. Her diagnoses included: diabetes mellitus, chronic kidney disease and a history of deep vein thrombosis. A review of a nurse's note dated 5/12/18 revealed Resident # 49 was sent to the hospital for evaluation for abdominal discomfort and confusion. A review of a second nurse's note dated 7/6/18 revealed Resident # 49 was transferred to the hospital due to leg pain. A review of the medical record revealed no	F 623	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Administrator mailed Discharge	

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F 623	Continued From page 3 written notice of transfer was provided to the resident representative for the resident's transfers to the hospital on 5/12/18 and 7/6/18. An interview with the Administrator and the facility's Nurse Consultant was conducted on 7/26/18 at 2:50 PM. The Administrator stated that the resident representative was notified via phone the day of each hospital transfer but no written notice was given to the resident's representative for the hospital transfers on 5/12/18 and 7/06/18. The Administrator stated that she was unaware written notices were a requirement so the task was not assigned to any staff.	F 623	Letter to resident□s responsible party for 5/12/18 and for 7/6/18. The cause of the deficiency was due to the facility not being aware that responsible party was to be notified via mail of hospital discharge. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Administrator educated DHS, Social Worker, and Admissions Director of notification to hospital via mail. A discharge letter will be mailed to the responsible party of all discharges to the hospital. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Administrator, DHS, Social Worker or Admissions Director will monitor that a letter is mailed to responsible party for each discharge to the hospital. Administrator and/or DHS will monitor weekly x4 and then monthly x3 and then quarterly thereafter until QA assess that compliance has been maintained. " The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction.	

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F 623	Continued From page 4	F 623	8/17/18	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code stage II pressure ulcers as not present upon admission or reentry on a Minimum Data Set (MDS) assessment for 2 of 2 residents reviewed for pressure ulcer care. (Resident #86, Resident #74) Findings included: 1. Resident #86 was admitted to the facility on 12/3/10. Her active diagnoses included hypertension, and diabetes mellitus. Review of Resident #86's wound observation assessment form revealed Resident #86 had a stage II pressure ulcer identified on 6/15/18. The stage II pressure ulcer was documented as not being present on admission to the facility. Review of Resident #86's MDS assessment dated 7/1/18 revealed under section M question 0300 she was coded as having one stage II pressure ulcer that was present upon admission or reentry to the facility. During an interview on 7/25/18 at 9:50 AM the Wound Care Nurse stated that Resident #86's Stage II pressure ulcer on her left buttock was an	F 641	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #74 MDS was opened and corrected to reflect facility acquired pressure ulcer. The MDS will be transmitted. Resident #86 was opened and corrected to reflect facility acquired pressure ulcer. The MDS will be transmitted. The cause of the deficiency was due to the miscommunication between the Interdisciplinary Team. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The MDS Director, Coordinator and both skin integrity nurses will successfully complete training under A.I.S. for Section M skin conditions. Any additional new hires in MDS and/or skin integrity will also need to successfully complete Section M skin conditions training under A.I.S. The Interdisciplinary Team will meet weekly to review the MDS prior to submission with a concentration on Section M. " The monitoring procedure to ensure	8/17/18

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F 641	Continued From page 5 inhouse acquired pressure ulcer. She further stated it was identified 6/15/18 and Resident #86 had not been out of off the facility this years. She further stated it was the only pressure ulcer present on Resident #86 at that time. During an interview on 7/25/18 at 3:37 PM the MDS Coordinator stated Resident #86 ' s pressure ulcer was not present upon admission or reentry and the MDS dated 7/1/18 was incorrect. During an interview on 7/25/18 at 3:42 PM the Administrator stated if pressure ulcers were not present upon admission or reentry to the facility then it was her expectation it be correctly captured on the MDS assessments. She further stated if the Wound Care Nurse agreed the pressure ulcer was in house acquired then the MDS assessment dated 7/1/18 for Resident #86 was incorrect. 2. Resident #74 was admitted to the facility on 5/2/18. Her active diagnoses included diabetes mellitus, depression, and coronary arterial disease. Review of Resident #74 ' s wound observation assessment form revealed Resident #74 had a stage II pressure ulcer identified on 5/24/18 and another stage II pressure ulcer identified on 5/29/18. Both stage II pressure ulcers were documented as not being present on admission to the facility. Review of Resident #74 ' s minimum data set assessment dated 6/2/18 revealed under section M question 0300 she was coded as having two stage II pressure ulcers that were present upon	F 641	that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Health Services will audit MDS Section M skin conditions for accuracy weekly x4 and then monthly x 3 and then quarterly thereafter until QA assesses that compliance has been maintained. " The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction. 8/17/18	

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F 641	Continued From page 6 admission or reentry to the facility. During an interview on 7/25/18 at 11:54 AM the Wound Care Nurse stated Resident #74 had two stage II pressure ulcers. She further stated the two stage II pressure ulcers were the only pressure ulcers Resident #74 had since arriving at the facility. She further stated both stage II pressure ulcers were developed in the facility and Resident #74 had never had to go out of the facility during her stay. During an interview on 7/25/18 at 3:37 PM the MDS Coordinator stated Resident #74 ' s pressure ulcers were not present upon admission or reentry and the MDS dated 6/2/18 was incorrect. During an interview on 7/25/18 at 3:42 PM the Administrator stated if pressure ulcers were not present upon admission or reentry to the facility then it was her expectation it be correctly captured on the minimum data set assessment. She further stated if the Wound Care Nurse agreed the pressure ulcers were in house acquired then the minimum data set dated 6/2/18 for Resident #74 was incorrect.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		8/17/18

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F 761	Continued From page 7 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep an unattended medication cart locked for 1 of 4 medication carts observed. (100 Hall Medication Cart) Findings included: During observation on 7/23/18 at 4:31 PM the 100 Hall Medication cart was observed to be unlocked and unattended approximately forty feet down the 100 Hall from the nurse ' s station. Two residents were observed at the 100 Hall nurse's station near the unlocked medication cart with no staff members present. At 4:32 PM a social worker was observed to walk past the unlocked medication cart. At 4:32 PM Nurse #1 returned to the 100 Hall Medication Cart. During an interview on 7/23/18 at 4:32 PM Nurse #1 stated it was the facility's policy to lock	F 761	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; 100 Hall Medication Cart Nurse for 7/23/18 was Cathy Hopkins, RN. Hopkins was in-serviced immediately after the incident was brought to the DHS□s attention. The nurse was educated that all medications will be maintained in a locked area. The medication cart will be locked each time the nurse walks away or the cart is not visible to the nurse. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The CCC educated all licensed nurses that all medications will be maintained in a	

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F 761	Continued From page 8 medication carts when they are left unattended by the nurse. She further stated the 100 Hall Medication Cart was her cart and it was unlocked and it should have been locked while she was in a resident room. During an interview on 7/26/18 at 10:22 AM the Director of Nursing stated it was her expectation medication carts be locked when unattended and Nurse #1 should have locked her medication cart prior to going into a resident's room.	F 761	locked area. The medication carts will be locked each time the nurse walks away or the cart is not visible to the nurse. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Health Services and/or the Unit Managers will audit medication carts for being locked weekly x4 and then monthly x 3 and then quarterly thereafter until QA assesses that compliance has been maintained. " The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction.	
F 812 SS=E	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	F 812		8/17/18

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F 812	Continued From page 9 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 observation and interviews the facility failed to maintain the temperature of the pudding at 41 degrees or below during 1 of 1 tray line observations. The findings included: On 7/25/18 at 11:38 AM the temperatures of the food items being held for service on the tray line were obtained using a calibrated thermometer. Numerous 4 ounce insulated bowels of pudding were observed stored in a pan of ice along with other items. The Dietary Manager used the calibrated thermometer to obtain the temperature of the pudding. The pudding registered a temperature of 43.9 degrees. During an interview with the Dietary Manager on 7/26/18 at 11:00 AM she stated the pudding was stored in the walk in cooler overnight then placed into the insulated serving bowels that morning. She said the pudding should be kept at 41 degrees or less.	F 812	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Dietary Manager immediately added ice to container holding pudding. The cause of the deficiency was due to the pudding being placed next to the steam table causing the temperature to increase unexpectedly. Staff member removed roll from wrapper without utilizing glove. Staff member was immediately educated. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Dietary Manager will educate the dietary department on appropriate temperatures for cold foods. Dietary Manager will highlight all cold foods on menu and cold items will be placed away from the steam table. All staff will be educated on safe food handling during tray passing and meal times. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains	

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F 812	Continued From page 10	F 812	corrected and/or in compliance with the regulatory requirements; Department Managers will monitor dining rooms and in room trays for safe food handling practices weekly x4 and then monthly x 3 and then quarterly thereafter until QA assesses that compliance has been maintained. Dietary Manager/Assistant Manager will monitor food temperatures weekly x4 and then monthly x3 and then quarterly thereafter until QA assess that compliance has been maintained. " The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction.	
F 925 SS=E	Maintains Effective Pest Control Program 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, resident and staff interviews and record review the facility failed to prevent the presence of flies in the dining room where flies were observed on residents' food and beverage containers and to prevent the presence of flies in residents' rooms on 1 of 2 resident care areas. The findings included:	F 925	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Administrator swatted flies that were in the dining room. Maintenance Director purchased sticky strips and fly spray for outside of building and behind nursing stations. Maintenance Director placed fly bait around perimeter of building. Trashcans were removed from front porch	8/17/18

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F 925	Continued From page 11 1a. Resident #30's significant change minimum data set dated 5/10/18 indicated he was cognitively intact. During an interview with Resident #30 on 7/23/18 at 11:46 AM, in his room, he stated there were flies in the dining room and also in his room. He pointed towards the window to demonstrate a fly present in his room. He also stated he had 2 flies in his tea the previous day while he was eating in the dining room. During an interview with Nursing Assistant #2 on 7/25/18 at 5:20 PM she stated Resident #30 had complained to her about the flies. 1b. Resident #18's quarterly minimum data set dated 4/27/18 revealed Resident #18 was severely cognitively impaired and required supervision for eating. On 7/23/18 from 12:17 pm until 1:17 PM Resident #18 was observed eating her lunch meal in the dining room. Flies were observed on her plate and she was observed shooing them away with her hand. During the continuous observation she was also observed shooing flies from the rim of her beverage cup. During an additional dining observation on 7/25/18 at 9:10 AM Resident #18 was observed eating breakfast in the dining room. She was eating a banana in her left hand and a blueberry muffin in her right hand. There were 2 flies pitched on the rim of her coffee mug. Nursing Assistant (NA) #1 was observed shooing the flies away. During an interview on 7/25/18 at 9:10 AM in the dining room where she was monitoring Resident	F 925	and placed at ends of building on outside. The cause of the deficiency was due to 7.5 inches of rain within 5 days and heat/humidity of 95+ degrees. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Ecolab was contacted and a new fly light was ordered for the dining room. A fly fan was ordered and installed on front door by Maintenance Director. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Department Managers will monitor rooms and common areas for flies and report to Maintenance Director if excess flies are noted. The monitoring will be weekly x4 and then monthly x 3 and then quarterly thereafter until QA assesses that compliance has been maintained. " The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the plan of correction.	

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F 925	Continued From page 12	F 925		

#18, NA #1 stated she hated flies. Resident #18 was then observed shooing flies away from her plate.

During an interview on 7/25/18 at 4:10 PM NA #1 stated Resident #18 eats meals in the dining room and preferred to eat independently. She stated she observed flies in the dining room at lunch and at breakfast. She stated she had seen 5-6 flies that day and if she saw flies she would inform the maintenance person.

1c. Resident #44's quarterly minimum data set dated 5/20/18 revealed Resident #44 was cognitively intact and independent with eating.

During an interview on 7/23/18 at 12:41 PM Resident #44 was in her room eating her lunch meal. Two flies were observed in her room while she was eating. She stated she did not like having flies in her room and they bothered her while she was trying to eat. She said she could not use her left arm so she had a difficult time trying to eat when flies were near her food. She stated she eats all her meals in her room.

On 724/18 at 8:40 AM the facility Administrator was observed in the dining room. She walked to a table in the back of the room where 3 residents were eating breakfast. She was observed shooing at a fly.

During an interview with Nurse #2 on 7/26/18 at 9:38 AM she stated she was aware that the facility had a problem with flies inside the facility and she said the Maintenance person was aware.

On 7/26/18 at 9:46 AM the Maintenance Director stated the Dietary Manager kept the logs for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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contracted pest control company visits. The Maintenance Director said he would treat the outside of the building but did not use any chemicals on the inside of the building. He stated the flies were a nuisance and over the past week there was a significant amount of flies inside the facility. He reported that last week the contracted pest control company identified the bug light in the dining room was not working so the contracted pest control company had ordered another bug light for the dining room. He said the felt the west winds were causing more flies as well as the open stairwells.

The Dietary Manager was interviewed on 7/26/18 at 11:32 AM. She reported the flies had been a problem for the last 2 weeks. She said the contracted pest control company only identified one concern and it was that one of the bug lights was not working so the company had ordered another bug light. She stated she did see the Administrator killing flies in the dining room yesterday before the lunch meal service.

The Dietary Manager provided the documentation from the pest control company which revealed a visit on 7/11/18. The receipt revealed the exterior and garbage area were treated for large flies, 10 glue boards for flies were applied in the dining interior area and kitchen interior area and 5 fly lights were checked in the dining interior and kitchen area interior. Additional receipts revealed the pest control company previously visited and treated on 6/25/18 and on 5/30/18.

During an interview with the Administrator on 7/26/18 at 12:55 PM she stated for the past one and a half weeks the facility had an increase in the number of flies in the building and that the

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F 925	Continued From page 14 contracted pest control company was there on 6/26/18 based on a receipt she had. She stated she expected the residents to be able to eat without flies landing on their food and drinking cups.	F 925		