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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on record review, observation and staff interviews, the facility failed to place a resident's call light within reach to allow for the resident to request staff assistance if needed for 2 of 2 residents (Resident #72 and Resident #12) reviewed for accommodation of needs. Findings included: 1. Resident #72 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was severely cognitively impaired. Resident #72 was observed and interviewed on 12-4-22 at 10:30am. The observation revealed Resident #72 was lying in his bed and his call light was laying on the floor behind the bed. Resident #72 stated he if he needed something from staff he was yelling for help. He explained he used to have a flat button he could push if he needed help but stated he did not know where the flat button was. Another observation occurred with Resident #72 on 12-4-22 at 3:05pm. The observation revealed the resident's call light remained on the floor behind his bed. An interview with Nursing Assistant (NA) #1 occurred on 12-4-22 at 3:30pm. The NA explained she had been working with Resident #72 since 7:00am on 12-4-22. NA #1 said she checked for call light placement each morning when she started her shift and each time, she entered Resident #72's room. The NA stated she had not checked call light placement today (12-4-22) on any of her assigned residents because she forgot. She discussed the capabilities of Resident #72 and stated he was able to use his call light to request assistance from staff. NA #1 verified Resident #72's call light was on the floor behind his bed and the resident would not have been able to reach the call light. The NA was observed to place the call light around Resident #72's side rail. (continued on next page)

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #1 on 12-4-22 at 3:35pm, the nurse explained she sometimes checked for call light placement in resident rooms when she entered their room but stated she had not checked any of her assigned residents today (12-4-22) for call light placement. Nurse #1 discussed it was the NAs' responsibility to ensure each resident had their call light in place. She stated Resident #72 was able to use his call light to obtain assistance from staff and was unaware the resident did not have his call light available. Nurse #1 said she guessed Resident #72 would have had to yell if he had needed assistance. The Director of Nursing (DON) was interviewed on 12-5-22 at 9:00am. The DON discussed call light placement being every staff members' responsibility. She stated Resident #72 was able to use his call light to obtain assistance from staff and had not been aware the resident did not have his call light available on 12-4-22. The DON said she expected every staff member who entered a resident room to ensure the resident had access to their call light. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed daily rounds by the department heads and that they were supposed to be checking for call light placement during their rounds. She said she did not know what had happened and it was not common practice for a resident not to have their call light available. The Administrator stated she expected all residents to always have their call light available. 2. Resident #12 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #12 was severely cognitively impaired. Resident #12 was observed and interviewed on 12-4-22 at 11:35am. The resident was observed sitting up in bed and her call light was on the floor behind her bed and privacy curtain. Resident #12 stated she did not know where her call light was, but she would use it if she had it. The resident said she received help from staff by using my mouth and yelling. Another observation of Resident #12 was made on 12-4-22 at 3:15pm. The resident's call light remained in the same position behind her bed and privacy curtain. An interview with Nursing Assistant (NA) #1 occurred on 12-4-22 at 3:30pm. The NA explained she had been working with Resident #12 since 7:00am on 12-4-22. NA #1 said she checked for call light placement each morning when she started her shift and each time, she entered Resident #12's room. The NA stated she had not checked call light placement today (12-4-22) on any of her assigned residents because she forgot. She discussed the capabilities of Resident #12 and stated she was able to use her call light to request assistance from staff. NA #1 verified Resident #12's call light was on the floor behind her bed and privacy curtain. She also verified the resident would not have been able to reach the call light. The NA was observed to place the call light over the head of the bed down to Resident #12's right hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #1 on 12-4-22 at 3:35pm, the nurse explained she sometimes checked for call light placement in resident rooms when she entered their room but stated she had not checked any of her assigned residents today (12-4-22) for call light placement. Nurse #1 discussed it was the NAs' responsibility to ensure each resident had their call light in place. She stated Resident #12 was able to use her call light to obtain assistance from staff and was unaware the resident did not have her call light available. Nurse #1 said she guessed Resident #12 would have had to yell if she had needed assistance. The Director of Nursing (DON) was interviewed on 12-5-22 at 9:00am. The DON discussed call light placement being every staff members' responsibility. She stated Resident #12 was able to use her call light to obtain assistance from staff and had not been aware the resident did not have her call light available on 12-4-22. The DON said she expected every staff member who entered a resident room to ensure the resident had access to their call light. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed daily rounds by the department heads and that they were supposed to be checking for call light placement during their rounds. She said she did not know what had happened and it was not common practice for a resident not to have their call light available. The Administrator stated she expected all residents to always have their call light available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on observation and staff interviews the facility failed to maintain a clean-living environment for 2 of 2 halls (2nd floor) reviewed for environment. Findings included: Observation of the facility's second floor revealed the following. a. room [ROOM NUMBER] was observed on 12-4-22 at 10:30am. The observation revealed the resident's side rail had a brown and green substance on the rail and the wall heating/air unit vent had black, brown and white substances in the vent. A second observation was made on 12-8-22 at 8:10am with the Maintenance Director and the Environmental Manager. The second observation revealed resident's side rail had a brown and green substance on the rail and the wall heating/air unit vent had black, brown and white substances in the vent. The Maintenance Director was interviewed on 12-8-22 at 8:27am. The Maintenance Director explained he usually had been cleaning the wall heat/air unit vents every 60 days but said he had been occupied with other issues and had not been able to clean the vents in all the rooms. The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails were clean and free of debris. She stated most of her staff were new and she was in the process of continuing their training. b. An initial tour of room [ROOM NUMBER] occurred on 12-4-22 at 10:40am. The initial tour revealed the resident's call light cord, and his side rail had a caked on sticky brown substance and the resident's bathroom ceiling vent contained dust. During a second observation on 12-8-22 at 8:13am with the Maintenance Director and the Environmental Manager, the observation revealed the resident's call light cord, and his side rail had a caked on sticky brown substance and the resident's bathroom ceiling vent contained dust. The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails and call light cords were clean and free of debris. She stated she made daily rounds and was aware of the issues with the cleanliness of the resident rooms. The Environmental Manager stated she had been trying to establish a routine with her staff. c. room [ROOM NUMBER] was observed on 12-4-22 at 10:45am. The observation revealed a brown substance on the resident's call light cord and his side rail. A second observation was completed on 12-8-22 at 8:15am with the Maintenance Director and the Environmental Manager. The second observation revealed a brown substance on the resident's call light cord and his side rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails and call light cords were clean and free of debris. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed having a new Environmental Manager and the improvements/changes the Environmental Manager had made since her arrival. She stated she expected residents to have a clean-living environment.

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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 3 residents reviewed for resident assessments (Resident #63). Findings included: Resident #63 was admitted to the facility on [DATE]. Record review revealed Resident #63's last comprehensive minimum data set assessment was dated 5/20/22 and last quarterly Minimum Data Set (MDS) assessment was dated 7/22/22. 90 days from that date was 10/20/22. During an interview on 12/5/22 at 1:21 PM the MDS Coordinator stated Resident #63's quarterly minimum data set assessments slipped through the cracks and was not completed on or prior to 10/20/22. During an interview on 12/5/22 at 1:39 PM the Administrator stated Minimum Data Set assessments should be completed timely.

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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Resident Review (Residents #5, #44 and #45) oxygen use (Resident #83) and vision (Resident #2) for 6 of 30 resident records reviewed for MDS accuracy. Findings included: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia. Resident #5's Preadmission Screening and Resident Review (PASRR) Level II determination letter dated 10/26/22 revealed he had a Level II determination with no expiration date. The annual Minimum Data Set, dated dated dated [DATE] revealed Resident #5 was coded as no in the Level II PASRR determination section. An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #5 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done. 2. Resident #44 was admitted to the facility on [DATE] with diagnoses that included schizophrenia. Resident 44's Preadmission Screening and Resident Review (PASRR) Level II determination letter dated 6/16/22 revealed he had a Level II determination with an expiration date of 7/16/22. The admission Minimum Data Set, dated dated dated [DATE] was coded as no in the Level II PASRR determination section. An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #44 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done. 3. Resident #45 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #45's Preadmission Screening and Resident Review (PASRR) Level II determination letter was not available for review but based on the applicant lookup information in the North Carolina Medicaid Uniform Screening Program PASRR history detail, starting on 8/23/22 he was given a Level II determination with an expiration date of 11/21/22. The admission Minimum Data Set, dated dated dated [DATE] was coded as no in the Level II PASRR determination section. An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #45 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done. 4. Resident #83 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and acute and chronic respiratory failure. Review of physician's orders revealed an order dated 10/29/22 for oxygen at 2 liters per minute via nasal cannula continuous. The admission Minimum Data Set, dated dated dated [DATE] was not checked as receiving oxygen therapy while a resident section. Review of physician's orders revealed an order dated 10/29/22 for oxygen at 2 liters per minute via nasal cannula continuous. An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the oxygen section of the MDS. She confirmed that Resident #83 should have been coded as using oxygen on the MDS. She stated she had simply missed it. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done. 37468 5. Resident #76 was admitted to the facility on [DATE]. Her active diagnoses included cerebral infarction due to embolism of left middle cerebral artery and diabetes mellitus. Resident #76's minimum data set assessment dated [DATE] revealed she was assessed to have received insulin injections 7 days of the 7 day lookback period. Resident #76's medication administration record for 10/13/22 through 10/20/22 revealed Resident #76 did not receive any insulin injections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/22 at 1:28 the MDS Coordinator stated Resident #76 did not receive insulin during the lookback period of the minimum data set assessment dated [DATE] and it was marked in error. During an interview on 12/5/22 at 1:39 PM the Administrator stated the minimum data set assessments should accurately reflect the resident's use of insulin. 32503 6) Resident #2 was admitted to the facility on [DATE]. Her diagnoses included degenerative myopia bilaterally, macular degeneration and corneal scar and opacity. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was coded as having adequate vision. She was coded as severely cognitively impaired (BIMS score of 04). Resident #2 care plan most recently revised on 11/06/22 by the MDS Coordinator revealed a problem of visual function noting she has side vision problems (decreased peripheral vision) related to degenerative myopia bilateral. On 12/5/22 at 11:43 AM Resident #2 was observed turning pages in a book which was on her over the bed table. The book was noted to be upside down. Resident #2 was not aware the book was upside down. On 12/7/22 at 2:30 PM Nurse #4 said there were times during medication pass when Resident #2 would attempt to reach for the cup of water she was offering but would not reach in the correct direction and would reach toward the nurse's voice instead of toward the cup. During an interview on 12/08/22 at 9:11 AM, the MDS Coordinator said she conducted the vision assessment for Resident #2. She said she asked her questions about items in the room such as the sink, the clock on the wall or the dresser. She said she was unsure if Resident #2 used glasses but had noted she had adequate vision. The MDS Coordinator explained she asked other MDS nurses how they completed the assessments and did not consult the RAI (Resident Assessment Instrument -manual with MDS instructions). The MDS Coordinator explained she may need to do more or different testing and should have asked her about seeing fine details.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 2 of 3 residents with a Level II PASRR (Residents #44 and #45). Findings included: 1. Resident #44 was admitted to the facility on [DATE] with diagnoses that included schizophrenia. Review of a PASRR Level II Determination Notification letter dated [DATE] noted Resident #44 was evaluated and assigned a time-limited Level II PASRR with an expiration date of [DATE]. Further review revealed in part, a placement determination of nursing facility placement is appropriate for limited nursing facility stay lasting no more than 30 calendar days. It continued to read if the resident is expected to extend beyond the end date, further approval and screening must be obtained through N. C. Medicaid Uniform Screening Program. The admitting facility is responsible for initiating further screening through a Level II evaluation process within 5 calendar days of the PASRR expiration date. An interview on [DATE] at 8:37 AM with the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW stated she had not known Resident #44's PASRR expired and had not initiated a follow up. She stated she had not initiated further PASRR screening through the evaluation process. An interview on [DATE] at 10:43 AM with the Administrator confirmed that SW was responsible for keeping track of PASRRs and requesting screening when needed before the expiration date. She did not know why it had not been done. 2. Resident #45 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia. Review of the N. C. Medicaid Uniform Screening Program PASRR detail history revealed Resident #45 had a PASRR Level II Determination with start date of [DATE] and an expiration date of [DATE]. An interview on [DATE] at 8:37 AM with the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW stated she had not known Resident #45's PASRR expired and had not initiated a follow up evaluation until [DATE]. An interview on [DATE] at 10:43 AM with the Administrator confirmed that SW was responsible for keeping track of PASRRs and requesting screening when needed before the expiration date. She did not know why it had not been done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on record review and staff interviews the facility failed to develop and implement an individualized person-centered care plan for 2 of 5 residents (Resident #72 and Resident #34) who were routinely receiving an antidepressant and an antipsychotic medication reviewed for unnecessary medications. Findings included: 1. Resident #72 was admitted to the facility on [DATE] with multiple diagnoses that included dementia and schizoaffective disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was severely cognitively impaired and received antipsychotic medication 7 out of 7 days and an antidepressant 7 out of 7 days. Resident #72's care plan dated 9-12-22 revealed no goals or interventions related to Resident #72's antidepressant or antipsychotic medications. The MDS Coordinator was interviewed on 12-6-22 at 2:19pm. The MDS Coordinator explained she would typically develop a care plan for an antidepressant medication and a separate care plan for the use of an antipsychotic medication. After reviewing Resident #72's care plan and medications the MDS Coordinator stated she had made an oversite on not having a care plan for Resident #72's antidepressant and antipsychotic medication use. The Director of Nursing (DON) was interviewed on 12-6-22 at 2:49pm. The DON stated she thought there had been something wrong with the facility's computer system not saving goals and interventions to Resident #72's care plan as the reason he was not care planned for his antidepressant and antipsychotic medications. She explained she did not know if the facility had contacted their corporate office to have the computer system issues investigated. The DON also said she expected each resident's care plan to reflect the resident's needs and any high-risk medications. 2. Resident #34 was admitted to the facility on [DATE] with multiple diagnoses that included Tourette's disorder. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #34 was severely cognitively impaired and received an antipsychotic medication 7 out of 7 days. Resident #34's care plan dated 12-4-22 revealed no goals or interventions related to his antipsychotic medications. The MDS Coordinator was interviewed on 12-6-22 at 2:19pm. The MDS Coordinator stated when she developed a care plan for antipsychotic medications, she typically would not include interventions other than for the resident to receive the smallest dose possible. After reviewing Resident #34's care plan and medications, the MDS Coordinator stated she had overlooked the resident receiving an antipsychotic medication, so she had not developed any goals or interventions. (continued on next page)

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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 12-6-22 at 2:49pm. The DON stated she thought there had been something wrong with the facility's computer system not saving goals and interventions to Resident #34's care plan as the reason he was not care planned for his antipsychotic medications. The DON also said she expected each resident's care plan to reflect the resident's needs and any high-risk medications. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated she had been aware of the issues with the resident care plans and explained it was the MDS Coordinator's responsibility to assure care plans were up to date and accurate. She explained the facility had hired an assistant for the MDS Coordinator. She also said she expected care plans to be accurate and individualized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37468

Based on record review and staff interviews the facility failed to hold a quarterly care plan meeting and failed to update the care plan for 2 of 2 residents reviewed for care planning (Resident #84 and Resident #37).

Findings included:

1. Resident #84 was admitted to the facility on [DATE].

Resident #84's Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and had no behaviors.

A review of Resident #84's chart revealed Resident #84's last care plan meeting was on 5/31/22.

During an interview on 12/4/22 at 11:01 AM Resident #84 stated she had not attended a care plan meeting since the end of spring or early summer.

During an interview on 12/6/22 at 12:04 PM the MDS Coordinator stated the Social Worker sent out an invitation a week before care plan meeting to invite residents and families. Care plan meetings were to be done every 90 days. She concluded the Social Worker might have more information on if Resident #84 had a care plan meeting since 5/31/22.

During an interview on 12/7/22 at 11:31 AM the Social Worker stated the last care plan meeting for Resident #84 was 5/31/22 and Resident #84's next care plan meeting was set for 12/13/22. She concluded she should have had one prior to 12/13/22 but the Social Worker was behind on care plan meetings.

During an interview on 12/7/22 at 11:37 AM the Administrator stated care plan meetings should be held quarterly.

38920

2. Resident #37 was admitted to the facility on [DATE] with multiple diagnoses that included dementia and unsteadiness on feet.

Resident #37's active care plan dated 10-29-22 revealed a problem of the resident having a history of falling due to muscle weakness. The goal documented was Resident #37 would remain free from injury. The interventions were for Resident #37 to wear non-skid socks during the night while in bed and remind the resident to wear both shoes when ambulating. A second goal was added on 12-5-22 for the resident to meet therapy goals. The interventions for the goal were to monitor Resident #37's progress and response to therapy.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #37's event report dated 11-7-22 revealed Resident #37 had a fall in the facility's dining room while trying to ambulate. The fall was documented as unwitnessed, and Resident #37 complained of mild pain to his left hip. The event report documented staff assisted resident back into his wheelchair. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #37 was severely cognitively impaired. The MDS also documented the resident needed a wheelchair for ambulation and was documented as having falls, one with a major injury. Nurse #2 was interviewed on 12-7-22 at 12:37pm. Nurse #2 stated she was familiar and usually was assigned to Resident #37. She explained she had not seen any updated interventions on Resident #37's care plan since his fall on 11-7-22 but stated typically the interventions for a resident who falls was for their call bell to be in reach, make sure the resident wears non-skid socks, keep their bed in a low position and increase frequency of rounds. Nurse #2 stated since Resident #37's fall he had not been out of bed, but she had made sure his bed was in a low position and his call light was within reach. The Director of Nursing (DON) was interviewed on 12-7-22 at 1:03pm. The DON explained the management team met every morning and discussed any falls that had taken place the previous day. She said the discussion included making any fall intervention revisions or updates to the resident's care plan. The DON reviewed Resident #37's care plan and stated the only update was made on 12-5-22 for therapy. She further stated Resident #37 should have had revisions or an update made for fall prevention. During an interview with the MDS Coordinator on 12-7-22 at 1:08pm, the MDS Coordinator explained the nurses were responsible for updating the care plan after a resident fall. She further explained she tried to review the care plan during morning meetings to ensure the care plan had been updated but she had not reviewed Resident #37's care plan and was not aware the care plan had not been updated from his fall on 11-7-22. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated she had been aware of the care plan issues and that Resident #37's care plan had not been updated to reflect his fall on 11-7-22. She further stated she expected care plans to be completed timely, be accurate and individualized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920 Based on record review, resident and staff interviews the facility failed to obtain a follow up dental care appointment with a dentist for 1 of 3 residents (Resident #13) reviewed for dental. Resident #13 had complaints of teeth and gum pain from as documented in the care plan from 9/20/22 and to have a follow up with a dentist for a complete exam and x-rays after 10/17/22 dental visit. Findings included: Resident #13 was admitted to the facility on [DATE] with multiple diagnoses that included multiple sclerosis and acute kidney failure. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact and was documented for a mechanically altered diet. There was no documentation for gum or teeth issues. Resident #13's care plan dated 9-20-22 revealed the resident had discomfort or difficulty chewing related to poor dental status and required a puree consistency diet. The goal for Resident #13 was she would not exhibit signs of malnutrition or dehydration. The interventions for the goal were to avoid foods that were difficult to chew, inspect mouth for oral abscesses, broken, loose or missing teeth. Review of Resident #13's dental visit dated 10-17-22 at the dental school revealed the resident had a cleaning with instructions for the facility to make an appointment for Resident #13 to have a complete exam, x-rays and follow up with the dentist. Resident #13 was observed and interviewed on 12-5-22 at 8:10am. The resident stated she was not doing well and explained her gums and teeth were hurting. She stated she had gone to the dentist a couple months ago and was supposed to have a follow up but said no one had let her know when she was going back. Resident #13 stated she thought she may have an infection in her gums because they hurt. Upon observing Resident #13's teeth and gums, there were no signs of an infection such as swelling, discoloration or drainage. During an interview with the Appointment Scheduler on 12-5-22 at 4:12pm, the Appointment Scheduler explained when a resident went out for an appointment, a form was sent with them for the Physician to write any orders or follow up appointments. She stated when the resident returned from the appointment, the form was given to the nurse who transcribed any orders then gave her the form to make any follow up appointments. The Appointment Scheduler stated she had never received a form from Resident #13's dental appointment on 10-17-22 so she did not know the resident required a follow up appointment and she did not make Resident #13 a follow up appointment. Nurse #3 was interviewed on 12-5-22 at 4:25pm. The nurse explained when a resident returned from an outside appointment, the nurse would be provided the form the resident took with them with any orders or follow up appointments. She stated the nurse would enter any orders into the computer system and write any follow up appointments needed in the appointment book for the Appointment Scheduler. Nurse #3 stated she was not aware of any needed dental follow up for Resident #13. (continued on next page)

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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Actual harm Residents Affected - Few	Review of the appointment book revealed no documentation of a needed dental follow up for Resident #13. An interview with Nursing Assistant (NA) #4 occurred on 12-6-22 at 8:40am. The NA stated she had not seen any swelling or drainage from Resident #13's gums but said the resident complained of pain and tenderness when brushing her teeth. NA #4 stated she had informed the nurse (Nurse #4) assigned to Resident #13. During an interview with Nurse #4 on 12-6-22 at 8:44am, the nurse stated Resident #13 often complained of pain to her gums. She stated the Physician had ordered Resident #13 a medicated gel to help relieve her pain and said she had provided the medicated gel to Resident #13. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated when a resident goes out for a dental appointment, the dental office would call to schedule a follow up appointment. She stated after Resident #13 returned from her dental appointment on 10-17-22, the dental office did not call for a follow up. The Administrator stated on 12-6-22 Resident #13 had been made a follow up appointment with the Dentist.

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	12/08/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 32503 Based on observations and staff interviews the facility administration failed to provide oversight and leadership to ensure the facility maintained the walk-in freezer in proper working condition to prevent structural damage of the freezer door and the accumulation of ice in the freezer for 8 months. The findings included: This tag is cross referenced to: F 908: Based on observations and interviews with facility staff the facility failed to maintain the walk-in freezer in proper working condition when the exterior door malfunctioned and created the accumulation of ice and ice crystals inside the walk-in freezer for the last eight months for 1 of 1 walk-in freezer. On 12/06/22 at 4:30 PM the Administrator provided a copy of the email verification dated 12/06/22 from the Maintenance Director via the computerized maintenance log system of the approved authorization for repair of the walk-in freezer door separating at the bottom. She was unable to state why it had taken 8 months to receive the authorization to repair the walk-in freezer door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41009 Based on record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 11/3/21 recertification/complaint survey. This was for 3 deficiencies cited on the current recertification/complaint survey of 12/8/22: 3 deficiencies were cited on the 11/3/21 recertification/complaint survey in the areas of F641 Accuracy of Assessments, F644 Pre-Admission Screening Resident Review (PASSR) and F656 Develop/Implement Comprehensive Care plan. The continued failure of the facility during 2 federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Findings included: This tag is cross referenced to: F 641 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Resident Review (Residents #5, #44 and #45) oxygen use (Resident #83) and vision (Resident #2) for 6 of 30 resident records reviewed for MDS accuracy. During the 11/3/21 recertification/complaint survey the facility was cited for failing to accurately code the MDS. F 644 Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 2 of 3 residents with a Level II PASRR (Residents #44 and #45). During the 11/13/21 recertification/complaint survey the facility was cited for failing to provide follow-up psychiatric services in accordance with the recommendations and failing to incorporate the recommendations into the comprehensive plan of care. F 656 Based on record review and staff interviews the facility failed to develop and implement an individualized person-centered care plan for 2 of 5 residents (Resident #72 and Resident #34) who were routinely receiving an antidepressant and an antipsychotic medication reviewed for unnecessary medications. During the 11/13/21 recertification/complain survey the facility was cited for failure to develop comprehensive individualized plans of care. In an interview on 12/8/22 at 11:56 AM the Administrator indicated she felt the continued inaccuracy of assessments was due to the fact the facility had only 1 person completing these. She stated she planned to have an additional person assist now. She went on to say she felt the repeat failures in the areas of PASSR and comprehensive care plans were due to inconsistencies in the way they were being completed. The Administrator stated the facility would review its process and put corrective actions in place to address these issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2022
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Trent		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Hospital Drive New Bern, NC 28560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32503 Based on observations and interviews with facility staff the facility failed to maintain the walk-in freezer in proper working condition when the exterior door malfunctioned and created the accumulation of ice and ice crystals inside the walk-in freezer for the last eight months for 1 of 1 walk-in freezer. The findings included: On 12/04/22 at 10:30 AM the Certified Dietary Manager (CDM) removed a 3-foot-long metal pole which was positioned under the door latch to keep the door to the walk-in freezer closed tightly. Upon entrance to the walk-in freezer an accumulation of ice crystals was observed along the left interior of the freezer. There was also an accumulation of solid ice observed on the left side of the freezer along the outside of the boxes and shelves. There was broken ice on the freezer floor. During the observation on 12/04/22 at 10:30 AM the CDM said she worked on Sundays to remove the ice build up inside the freezer so she could complete the inventory check in preparation for placing the food order on Mondays. She said she used a [NAME] style hammer to break the ice and then she swept it up for disposal. Upon exiting the walk-in freezer on 12/04/22 at 10:35 AM an observation of the freezer door revealed the metal covering of the door was separated away from the interior structure of the door along the interior lower right side (when facing the door from the interior of the freezer) of the door. Facing the door from the exterior of the freezer revealed both the left and right sides of the lower portions of the door were separated revealing the interior structure of the door. On 12/06/22 at 11:34 AM the Administrator reported she was aware of the need to have the walk-in freezer door replaced and the proposal was completed on 11/03/22 but had not followed up on proposal. She said a new thermostat was installed on 11/17/22. The Administrator said she was able to approve facility expenditures but any expenditure over $500.00 required approval from the regional vice president. She said she would request approval for replacement of the walk-in freezer door. On 12/08/22 at 9:30 AM the CDM said she had used a [NAME] to remove the ice for the last 8 months. She said she had requested to have the walk-in freezer and walk-in cooler problems corrected by completing a proposal for replacement a few months back but had not received any information back.