STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH-NEUSE	1303 HEALTH 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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff, guardian and resident interviews, and record review the facility allowed a resident with an appointed permanent guardian to sign herself out of the facility against medical advice, without involving or notifying the resident's guardian of this decision for 1 of 1 resident reviewed for guardianship (Resident #1). The findings included: The facility's Refusal of Care: Against Medical Advice form effective date 7/2/2015 specified in the instructions the form was not to be used for residents who had a guardian. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A hospital physician progress notes [REDACTED].#1 was being treated for [REDACTED]. It also stated the doctor believed she was medically incapacitated to make healthcare decisions for herself and was being evaluated by Craven County Department of Social Services (DSS) for guardianship. An Order on a Motion for Appointment of Interim Guardian revealed Craven County DSS was appointed her interim guardian on 5/20/20. A physician's orders [REDACTED]. Resident #1's admission Minimum (MDS) data set [DATE] revealed she was assessed as cognitively intact with no behaviors. She required limited assistance with bed mobility, transfers, and walking. She required oxygen therapy while a resident of the facility. A Letter of Appointment General Guardian revealed Craven County Department of Social Services was appointed her permanent guardian on 7/2/20. A nurse's progress note written by Nurse #1 dated 7/6/20 revealed Resident #1 stated she was leaving the facility. All her belongings were packed and placed in her wheelchair. She reported she had contacted a cab. The nurse informed the resident if she left she would not be able to take any of her medications and it would be against medical advice. The resident signed a Refusal of Care: Against Medical Advice form at 2:15 PM. The nurse contacted the facility social worker to let her know. An interview with Nurse #1 was conducted on 7/28/20 at 12:30 PM. Nurse #1 reported she tried to convince Resident #1 to stay in the facility on 7/6/20 but Resident #1 had contacted a cab which was waiting for her. Nurse #1 stated she told the cab driver that Resident #1 was a ward of the state in hopes he would not transport her. Nurse #1 indicated she was aware that Resident #1 had a guardian but since the resident was alert and oriented she didn't think it was applicable. The nurse stated that since Resident #1 was alert and oriented she had her sign a Refusal of Care: Against Medical Advice form. An interview was conducted with Resident #1 on 7/28/20 at 1:55 PM. She reported she did not feel she needed to be in the facility any longer. Resident #1 stated she was not aware she couldn't sign herself out of the facility. She indicated that had she known that she could not sign out she would have waited for her guardian. A social work progress note dated 7/6/20 revealed the social worker contacted Resident #1's guardian who stated she was on the way. The guardian arrived at the facility just after the resident left. An interview was conducted with the social worker on 7/28/20 at 1:27 PM who stated she was told by the nurse on 7/6/20 Resident #1 was leaving. She stated the nurse informed her that Resident #1 had signed a Refusal of Care: Against Medical Advice form. The social worker indicated the resident was alert and oriented so the resident signing the form was appropriate. The social worker stated the guardian and law enforcement located Resident #1 and brought her back to the facility. During an interview with Resident #1's guardian on 7/28/20 at 10:01 AM she stated law enforcement located Resident #1 on 7/7/20 at a neighbor's home. She stated Resident #1 was transported back to the facility by law enforcement. An interview was conducted with the Admissions Coordinator on 7/28/20 at 3:32 PM who stated she was aware that Resident #1 had a guardian. She stated guardianship status prevented Resident #1 from signing the admission paperwork. She reported it was her understanding that residents who had guardians could sign out of the facility Against Medical Advice form if they were alert and oriented. An interview was conducted with the Director of Nursing (DON) on 7/28/20 at 1:04 PM. She reported she was not in the building when Resident #1 left. She stated the resident should not have been able to sign herself out of the facility due to having a guardian. The DON stated this was a facility policy. She indicated the guardian should have been notified immediately.
F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, family and resident interviews, the facility failed to permit a resident to return to the facility from the hospital for 1 of 2 residents reviewed for discharge (Resident #2). The findings included: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was severely cognitively impaired. The discharge assessment was coded as discharge to acute hospital with return anticipated. A nurse's note dated 1/31/20 written by Nurse #2 revealed Resident #2 was discharged to a local hospital on [DATE] due to exhibiting behaviors which included swinging his cane, dancing in the hallway and yelling at people in the hallway. Review of the medical record revealed no documentation of the efforts the facility made to enable or allow the resident to return. An interview was conducted with Nurse #2 on 7/30/20 at 4:51 PM who stated Resident #2 attempted to strike her with his cane while she was doing an assessment. She reported she notified the Director of Nursing and Administrator. Nurse #2 further stated she was instructed by the Administrator to get him transferred to the hospital. She also stated the Administrator told her at that time she did not want him to come back to the facility. A nurse's note dated 2/3/20 written by Nurse #3 revealed she had received a call from the Ombudsman regarding Resident #2 returning to the facility. The note stated she discussed Resident #2 and the Administrator stated she would follow-up. An interview was conducted with Nurse #3 on 7/29/20 at 11:29 AM who stated she could not recall Resident #2. A social work note dated 2/4/20 revealed the Social Worker faxed information regarding Resident #2 to a local hospital. An interview was conducted with the social worker on 7/28/20 at 1:27 PM who reported she did not recall Resident #2. An interview was conducted with the Physician on 7/29/20 at 9:15 AM who indicated he was not familiar with the resident. An interview was conducted with the regional ombudsman on 7/29/20 at 10:32 AM who stated the facility would not take Resident #2 back into the facility. An interview was conducted with the Administrator on 7/29/20 at 11:30 AM. He stated he was not employed at the facility when the discharge occurred and was unfamiliar with the circumstances. An interview was conducted with the former administrator on 7/30/20 at 5:55 PM who stated she felt Resident #2 never should have been admitted to the facility. She reported that she did not feel that it was safe for him to come back to the facility. During an interview with Resident #2's responsible party on 7/30/20 at 3:29 PM she stated Resident #2 remained in the Emergency Department of the hospital for seven days without placement then returned to his residence. She stated the family provided necessary care upon his return home. The family member reported that she had spoken with the Administrator and the Administrator refused to allow him to return to the facility. The Responsible Party indicated Resident #2 was not interviewable.
F 0742 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed**

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

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.

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F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, guardian and resident interviews, the facility failed to provide requested treatment for [REDACTED].#1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Her admission Minimum Data Set ((MDS) dated [DATE] revealed her to be assessed as cognitively intact with no behaviors. She required limited assistance with bed mobility, transfers, and walking. She required oxygen therapy while a resident of the facility. She did not have any behaviors or moods coded on the assessment. There was no mention of a need for psychiatric referral on the Resident #1's care plan. Her care plan dated 6/12/20 stated she received an anxiolytic medication for anxiety. An Order on a Motion for Appointment of Interim Guardian revealed Craven County Department of Social Services (DSS) was appointed her interim guardian on 5/20/20. A Letter of Appointment General Guardian revealed Craven County DSS was appointed her permanent guardian on 7/2/20. During an interview with Resident #1's guardian on 7/28/20 at 10:01 AM she stated she had requested psychological services for the resident due to the transition to a long-term facility with DSS guardianship and previous trauma. She reported she requested these services during the initial treatment team meeting in June. The guardian stated she was unsure if any referrals had been made. An interview was conducted with the MDS Nurse on 7/28/20 at 10:44 AM who stated a referral to a psychiatrist had been discussed to evaluate Resident #1 for competency. She stated that once she had spoken to the guardian and they disagreed about competency, a referral had not been made. The MDS Nurse checked the medical record and no order for psychological services had been placed. She reported no knowledge of Resident #1 having behaviors. During an interview with the social worker on 7/28/20 at 1:27 PM she indicated she had no knowledge of any discussion of psychological services for Resident #1. She stated that she was unaware of any behaviors. An interview was conducted with Resident #1 on 7/28/20 at 1:55 PM who stated she had requested psychological services since her admission to the facility. She indicated she has serious health problems and her guardianship status has made her feel a loss of autonomy. Resident #1 indicated she made these requests to the Medical Director and nursing staff. Resident #1 stated it is her impression that if she sees a psychiatrist her guardianship could possibly be overturned. During an interview with the Medical Director on 7/29/20 at 9:15 AM he stated he felt Resident #1 was not incompetent and the facility was attempting to refer her for a psychiatry consult. The Medical Director stated he was not aware of any trauma or psychiatric diagnoses. He stated he was unsure of the process. An interview was conducted with the Nurse Navigator on 7/29/20 at 11:55 AM who stated she faxed a referral to a psychiatrist on 7/10/20 and has not heard back. The Nurse Navigator stated the referral was made for a competency evaluation as the facility felt that she is competent. The Nurse Navigator provided a referral for the resident's competency evaluation that was dated 7/09/20. She stated the Social Worker would be notified.