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 _____	06/18/2020

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for behaviors for 1 of 3 resident records reviewed for MDS accuracy (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] and discharged to the hospital on [DATE] with [DIAGNOSES REDACTED]. A review of the discharge MDS assessment dated [DATE] indicated that Resident #1 was coded as did not exhibit behaviors related to rejection of care and no physical, verbal or other behavior symptoms. A review of Resident #1's care plan last revised 3/13/20 revealed he had a problem category for resisting care which included an approach to administer and monitor the effectiveness of medications as ordered. A review of the Treatment Administration Record (TAR) revealed Resident #1 had documentation of refusal of care 4 out of 9 times for a wound dressing change. A review of the Nurses Progress Notes revealed 9 of the 21 progress notes had documentation related to resident behavior. During an interview with the Social Worker on 6/18/20 at 1:20 PM she stated she inaccurately coded Section E (Behavioral Symptom Presence and Frequency) on Resident #1's 3/24/20 MDS. She further stated she was not sure why she coded it incorrectly and stated it was an error on her part. During an interview with the Acting Administrator on 6/18/20 at 2:50 PM he stated he was unaware of the MDS coding error made by the Social Worker and did not know why it had been coded incorrectly.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, nurse practitioner interviews, and physician interview, the facility failed to assess a resident's pressure ulcer on admission, provide a redistribution/pressure relief mattress as indicated on the resident's care plan and communicate to the physician the pressure ulcer was getting worse for 1 of 3 sampled residents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] and discharged to the hospital on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's hospital discharge orders dated 3/12/20 revealed an order for [REDACTED].#1's Admission nursing assessment dated [DATE], completed by Nurse #3, revealed the skin assessment section was not completed and there was no indication the resident had a pressure ulcer. An interview with Nurse #3 on 6/18/20 at 12:22 PM revealed she did not remember if Resident #1 had a pressure ulcer. She confirmed a skin assessment should have been done on admission, but she did not know why it had not been completed. Resident #1's Care Plan dated 3/13/20 indicated he had a coccyx wound. The resident's Care Plan approaches included: to provide Resident #1 with a redistribution (pressure relief) mattress to bed and for nursing to perform a weekly body audit. Resident #1's Treatment Administration Record (TAR) revealed an order dated 3/12/20 to clean coccyx with normal saline and apply [MEDICATION NAME] dressing every 3 days and as needed. Further review of the TAR revealed 5 comments associated with this order. These comments included; 4 refusals of care by the resident dated 3/13/20 at 4:37 PM, 3/16/20 at 5:26 PM, 3/19/20 at 2:17 PM, and 3/21/20 at 12:52 PM. One comment dated 3/12/20 at 3:29 PM stated not appropriate at this time. Resident #1's Skin Assessments dated 3/12/20 through 3/15/20 which contained 7 skin assessments revealed documentation which stated there were no alterations in skin. Resident #1's Skin assessment dated [DATE] revealed a scratch on the inner leg. Resident #1's Skin assessment dated [DATE] which contained 2 skin assessments revealed no alterations in skin. Resident #1's Skin assessment dated [DATE], written by Nurse #1, revealed documentation in comment section which stated stage 2 pressure ulcer to coccyx. An interview with Nurse #1 on 6/17/20 at 11:15 AM revealed she thought the Treatment Nurse was aware of Resident #1's sacral pressure ulcer and she did not communicate any concerns to the Nurse Practitioner, Physician, or Treatment Nurse. Nurse #1 also stated she did not remember if Resident #1 had a specialty mattress to prevent further skin impairment. Resident #1's Physician Physical Exam note dated 3/18/20 revealed no wound documentation. Resident #1's Skin assessment dated [DATE], written by Nurse #2, revealed documentation of a sacral wound measurements of 5 centimeters (cm) length and 8 cm width. The wound type was unstageable pressure ulcer with partial thickness (loss of epidermis and into but not through the dermis). The wound bed was 75% slough (yellow, green, gray, necrotic tissue). The date identified was 3/12/20. The documentation included a comment which stated, resident noncompliant with repositioning, altered mental status (AMS) impairs understanding of instruction and staff ability to treat and prevent decline. An interview with Nurse #2 on 6/16/20 at 11:03AM revealed she was aware the resident's sacral pressure ulcer had increased in size and did not remember if she communicated that to the Nurse Practitioner, Physician, or Treatment Nurse. A skin assessment dated [DATE] at 8:06 AM, written by Nurse #5, included a sacral wound notation which included measurements of 1cm x 1 cm and comment of covered with occlusive dressing. An interview with Nurse #5 on 6/17/20 at 1:08 PM revealed she had seen Resident #1's dressing but had not removed the dressing to visual the sacral wound. Nurse #5 also revealed Resident #1 did not have a specialty pressure relief mattress to prevent further skin impairment. A skin assessment dated [DATE], written by Nurse #6, revealed Resident #1 had a sacral wound which included measurements of 6 cm length and 8 cm width. The wound type was unstageable pressure ulcer with partial thickness (loss of epidermis and into but not through the dermis). The wound bed was 25% slough (yellow, green, gray, necrotic tissue). The date identified was 3/12/20. The documentation included a comment which stated, covered with sacral [MEDICATION NAME]. An interview with Nurse #6 on 6/16/20 at 1:49 PM revealed she did not remember if Resident #1 had a sacral pressure ulcer and did not remember if she had communicated any wound concerns to NP or MD. A skin assessment, written by Nurse #6, dated 3/23/20 at 4:13 PM revealed sacral wound measurements of 1 cm length by 1 cm width and a comment resident not cooperative with attempts to assess and treat wound. A skin assessment, written by Nurse #6, dated 3/24/20 at 3:47 AM revealed documentation in the comment section sacral wound dressing intact. An interview with Nurse #6 on 6/16/20 at 1:49 PM revealed she did not remember if Resident #1 had a sacral pressure ulcer. A nursing transfer note, written by Nurse #2, dated 3/24/20 at 7:26 PM revealed Resident #1 was transported to the hospital due to an unwitnessed fall. A hospital history and physical report dated 3/25/20 revealed Resident #1 had a significant decubitus ulcer in the sacral area with some surround [DIAGNOSES REDACTED] and a very foul smell with a necrotic base. An interview with the Treatment Nurse on 6/17/20 at 12:22 PM revealed she was responsible for wound care during March 2020. She stated she was doing wound care once a week instead of the usual 5 days per week. She stated she was not a full-time wound nurse due to staffing issues and had to work on the halls to provide floor nurse coverage. She also stated a skin assessment should have been completed for Resident #1 on admission and at least weekly. She stated the floor nurses were responsible for wound care if there was no treatment nurse available. She stated she was not aware Resident #1's pressure ulcer was not healing, and she did not remember any communication with the Nurse Practitioner or Physician regarding his wound. Nurse to Physician communication forms, from 3/13/20 to 3/24/20 for Resident #1 included 7 forms. A form dated 3/13/20 regarded fall and possible hallucinations. A form dated 3/19/20 related the resident's fall with no injury. A form dated 3/19/10 related the resident had a fall. A form dated 3/19/20 requested lab work. A form dated 3/22/20 related concern about Resident #1's pain and not swallowing food. A form dated 3/23/20 related Resident #1's family requested to speak with MD and nurse requested speech evaluation due to 'not swallowing his food'. A form dated 3/24/20 related to blood pressure elevation. All of these forms had documentation of review by the nurse practitioner or physician with comments and signatures. An interview with

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the Wound Consultant Nurse Practitioner on 6/16/20 at 9:45 AM revealed there was no resident in their system with Resident #1's name and they had not provided care to him. An interview with the Nurse Practitioner (NP) on 6/16/20 at 2:36 PM revealed she was aware of the resident's sacral wound and had never observed the wound. She stated Resident #1 was uncooperative and confused. She stated she felt the facility had done what they could to prevent his wounds and due to his medical history and poor nutritional status his wounds were unavoidable. The NP stated the facility did not notify her of concerns related to Resident #1's sacral pressure getting worse. An interview with the Medical Doctor (MD) on 6/17/20 at 10:45 AM revealed he was aware of Resident #1's sacral wound and that he had refused wound care at times. He stated the facility had to honor the resident's refusal of care and he felt the facility had done everything they could to provide appropriate resident care. The MD stated he was unaware Resident #1's wound had gotten to a stage IV. An interview with the Acting Director of Nursing (DON) on 6/17/20 at 2:57 PM revealed she felt there was a lack of communication related to his wound treatment and his wound should have been reported to the DON, NP, or MD. She also revealed she did not know why his worsening sacral pressure ulcer had not been reported to the NP or MD. The Acting DON also stated she was unable to locate any documentation regarding provision of a specialty redistribution mattress for Resident #1 as specified on the resident's plan of care. An interview with the Acting Administrator on 6/18/20 at 2:58 PM revealed he was unaware if Resident #1 had been seen by wound care. He stated he did not know why the resident's wound had not been assessed on admission or communicated to the treatment nurse, NP or MD. He further stated the floor nurses were supposed to provide wound care if there was no treatment nurse available.