DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING ____ B. WING ____	C 05/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE ST JACKSONVILLE, NC 28546

JUN 01 2011

(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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a two person assistance with turning and repositioning while performing personal hygiene care for one (1) of four (4) sampled residents who sustained falls and/or injury of unknown origin. As a result, Resident #1 fell from the bed and sustained facial injuries. Findings included: Resident #1 was recently readmitted to the facility 03/30/2011 following hospitalization 03/27/2011-03/30/2011. Cumulative diagnoses included: Cerebrovascular accident (CVA) with hemiparesis and aphasia. A Quarterly Minimum Data Set (MDS) dated 02/19/2011 stated Resident #1 had long and short term memory impairment and was moderately impaired in decision-making. She required total assistance of two staff personnel with bed mobility, transfers, toileting, bathing and personal hygiene. Balance was impaired in surface to surface transfer. Range of motion was impaired on one side of her upper extremities and both sides on her lower extremities.	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Pless — TITLE: Administrator — (X6) DATE: 5/21/2011

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 323	Continued From page 1 A Care plan dated 02/19/2011 stated Resident #1 required total assistance with bathing, transfers and mobility. Resident #1 was at risk for falls due to CVA with right hemiplegia and poor safety awareness. Approaches included two person physical assist with all areas of ADL (activities of daily living) care and transfers. Medical record was reviewed. Nursing note dated 03/27/2011 at 10:30 PM. stated Nurse #3 was called to Resident #1's room. Resident #1 was noted on the floor face down. There was swelling on the left side of the lower lip with moderate bleeding noted from the area. A raised area was noted on the left side of the head. Small bruises were noted to the left thigh. Bruising was noted to the left and right shoulders. The Investigation report for Resident #1's fall on 03/27/2011 was reviewed and revealed a witness statement dated 03/27/2011. NA #3 stated she changed Resident #1's incontinent brief by herself. The right side of the bedrail was down so Resident #1 could be turned to the left side. When Resident #1 was turned, the left rail widened and Resident #1 fell completely out of the bed to the floor. NA #3 no longer worked at the facility and was unable to be interviewed. Emergency Room Hospital record dated 03/28/2011 stated Resident #1 fell off the bed at the nursing facility and hit her face on the floor. A laceration of the lip was noted and sutures were applied.	F 323		

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F 323	Continued From page 2 Hospital Transfer summary dated 03/30/2011 stated Resident #1 was seen in the emergency room at 11:25 PM. on 03/27/2011. Resident #1 was found to have a UTI (urinary tract infection) and was admitted for observation for intravenous administration of antibiotics. The physician stated on the transfer summary that she was admitted for observation only. Hospital admission was not indicated and Resident #1 was transferred back to the facility on 03/30/2011. Quality Improvement fall review dated 03/31/2011 stated Resident #1 had an observed fall from the bed on 03/27/2011. Resident #1 was sent to (name) hospital for evaluation and treatment. Resident #1 was readmitted to the facility 03/30/2011. Facility would continue with two person assist for all ADL care. On 05/09/2011 at 3:25 PM., Nurse #1 stated she assisted nursing staff when Resident #1 fell out of bed on 03/27/2011. When she entered the room, the left side rail was down with the bottom end of the rail still connected to the bed. Resident #1 was on the floor lying on her back with blood on her lip. There was one aide in the room at the time of the fall. She talked to the nursing assistant (NA) who told her she was on the right side of the bed and turned Resident #1. The side rail swung out and Resident #1 fell from the bed. Nurse #1 stated Resident #1 could not have stopped herself from falling. On 05/09/2011 at 3:50 PM., Nurse #2 stated she was the on-call administrative nurse on 03/27/2011. She arrived at the facility after Resident #1 went to the hospital and immediately began an investigation. Nurse #2 stated the NA	F 323		

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F 323	Continued From page 3 who cared for Resident #1 at the time of the fall did not follow the Resident Care Guide and performed ADL care by herself. She said the full side rail was bent where the two sections of bed rail come together. No maintenance requisitions had been submitted to indicate there was anything wrong with the bedrail. Nurse #2 stated the bed rail came off from the weight of Resident #1 when NA turned Resident #1. Nurse #2 stated all of the beds in the facility were checked by Nurse #2 and the Maintenance personnel immediately following the incident with the bed check completed on 03/28/2011. On 05/09/2011 at 4:00 PM., Nurse #3 stated she went to the resident's room when Resident #1 fell on 03/27/2011. Resident #1 was on the floor face down. Resident #1 had bleeding from her mouth and on her head. Nurse #3 stated Na #3 was the only NA in the room. She could not remember anything about the side rails. On 05/09/2011 at 4:20 PM., Nurse #2 stated the Resident Care Guide was located inside each resident ' s closet door. It provided all information staff needed to properly care for each resident and staff was expected to follow the Guide. Nurse #2 went to Resident #1's room and opened the closet door. The Resident Care guide dated 03/30/2011 and updated 04/18/2011 stated Resident #1 required the aid of two people for all ADL (activities of daily living) care. On 05/09/2011 at 4:25 PM., Nurse #5 stated she went to Resident #1's room on 03/27/2011. Resident #1 was face down on the floor. The left side rail at the top of the bed was partially on top of Resident #1 with the bottom of the bed rail still	F 323		

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F 323	Continued From page 4 attached to the bed. Nurse #3 stated she lifted the bed rail and blood was noted under Resident #1's head and on her lower lip. Bruising was noted on both shoulders. On 05/09/2011 at 4:30 PM., Nurse #4 was asked regarding Resident #1's fall on 03/27/2011. Nurse #4 stated there should have been two people in the room during ADL care and there was only one person in the room at the time of the fall. On 05/09/2011 at 4:40 PM., NA #1 stated she went to Resident #1's room on 03/27/2011. NA #1 saw Resident #1 on the floor face down with blood on Resident #1's face and a swollen lip. She could not recall anything about the side rails. On 05/10/2011 at 8:00 AM., the Administrator stated there was a full investigation initiated on 03/27/2011 when Resident #1 fell out of bed. No malfunctions or problems were noted with the bed itself. The Administrator stated Resident #1 was a two person assist and NA#3 was alone during ADL care. She expected nursing staff to follow the Resident Care Guide especially with safe handling of residents. The Safe Resident Handling and Movement Policy stated "Failure to adhere to the Resident Care Guide/ Lift Signage will result in: First offense with no injury to resident-final warning with two day suspension without pay and retraining before being allowed to work on the hall; Second offense with no injury to resident-termination of employment; First offense, with injury to resident-termination of employment." NA #3 did not follow the Resident Care Guide and, therefore, no longer worked at the facility.	F 323		

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F 323	Continued From page 5 On 5/10/2011 at 8:00 AM., the Administrator stated Safe Resident Handling and Movement Policy and Resident Care Guide in-servicing began immediately. Maintenance personnel checked every bed in the building for problems/ repairs needed and removed any beds that required repair. The Maintenance bed check report was completed on 03/28/2011. On 05/09/2011 at 2:30 PM., Nursing assistant (NA) #2 stated Resident #1 always required two people to assist when all ADL care was performed. NA #2 stated Resident #1 could draw her arms up toward her body and did not move her legs except to tense up when care was being given. When asked how nursing staff knew what type of care residents should receive, NA #2 stated the information needed to care for the resident was located on a Resident Care Guide located in the closet. On 05/09/2011 at 3:00 PM., NA #2 was observed performing incontinent care for Resident #1. Incontinent care was performed using two person assist as noted on the Resident Care Guide. On 5/10/2011 at 8:20 AM., Resident #2 was observed lying in bed with her bed in the low position. Bed alarm was in position and bed mat was on the floor between the bed and the wall. Nurse #6 stated staff knew how to care for the resident by looking at the Resident Care Guide. On 05/10/2011 at 8:25 AM., Resident #3 was observed and received assistance as noted on the Resident Care Guide. When asked how she knew how to care for resident #3, Nurse # 6	F 323		

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F 323	Continued From page 6 stated she knew how to care for resident by looking at the Resident Care Guide in the closet. On 5/10/2011 at 9:30 AM., Resident #4 was observed sitting in her wheelchair. As noted on the Resident Care Guide, there were no footrests on the wheelchair. Anti-tippers were in place on the back of the wheelchair. Resident #3 had a personal alarm in place and a wheelchair alarm was also on her wheelchair. On 05/10/2011 at 8:35 AM., the Director of Nursing (DON) and nursing facility consultant stated the Resident Care Guides are located in each Resident's closet and are used by all staff to inform them of care needs, safe resident handling, etc. The DON said Resident Care Guides are initiated during the admission process and updated as needed. Before NA's provide specific care, they should read the Resident Care Guide and she expected the Resident Care Guide to be followed as written. The Resident Care Guide for Resident #1 that was posted in the closet on 03/27/2011 stated two person assist for ADL's (activity of daily living) at all times. A reposition sheet should be used for turning and repositioning. Two person support was indicated for turning and incontinent care. On 05/10/2011 at 9:57 AM., the Director of Nursing stated the Safe Handling In-services for licensed staff, nursing assistants and administrative staff were one hundred per cent (100%) completed on 03/29/2011. In-service training attendance records were reviewed with completion date noted as 03/29/2011. Resident Care Guides were reviewed for all residents by the Director of Nursing, Nursing Administrative	F 323		

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F 323	Continued From page 7 staff and the Regional nurse consultant and updated as appropriate. This was completed on 03/28/2011. Care Audits were initiated on 03/28/2011 with daily audits until 04/25/2011, then every other day until 05/09/2011. Weekly Care Audits are now being done. Random audits included staff observation of direct care being given (the care was performed correctly using the correct procedure, Resident Care Guide followed correctly by staff, dignity and privacy provided during care) and retraining if the care was performed incorrectly. Care Audit results were taken to the Quality Improvement Action Team for review on 04/25/2011 and 05/09/2011.	F 323		