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 _____	10/20/2011

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

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Premier's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	11/11/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy K. Rless	Administrator	11/10/2011

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T.E.P. M.P. S.W

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to assess the need for vision services for one of two residents (resident #44) with visual impairment. Findings included: Resident #44 was admitted to the facility on 05/09/2011 with cumulative diagnoses that included Lack of Coordination, Unspecified Falls, Insomnia and Difficulty In Walking. Review of the resident's admission Minimum Data Set (MDS) dated 05/92/11 indicated the resident had vision impairment "sees large print but not regular print in newspapers and books "and did not use corrective lenses. The MDS further indicated it was somewhat important for the resident to have books, newspapers and magazines to read. Vision triggered as a care area on the MDS. Review of the resident's initial care plan dated 05/19/2011 indicated "Visual alteration with decreased/impaired ability to read regular print. No glasses" as a focus problem. Interventions included obtain eye exam as needed. Review of the resident's clinical record indicated no vision follow ups or vision services were done since admission. The resident was observed in her room on	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS Appointment was made for visual examination on 11/10/2011 for resident #44. A 100% review of each resident's MDS and triggered care areas to include vision was done by the MDS coordinator and completed on 10/28/2011 to ensure that any resident who triggered vision as a care area had appropriate interventions and appointments scheduled as necessary. Director of Nursing in-serviced MDS staff on the importance of follow-up on care areas triggered on the resident MDS on 10/28/2011. Residents who have been seen by On-sight visual services provided at the facility will continue to be seen and those residents who need an appointment will be scheduled for the next facility visit by visual services.	11/11/2011

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	345217	A. BUILDING _____ B. WING _____	10/20/2011

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PREMIER NURSING AND REHABILITATION CENTER	225 WHITE ST JACKSONVILLE, NC 28546

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F 272	Continued From page 2 10/20/11 at 10:00 AM resident sitting on her bed. The resident reported she used to wear glasses but broke them a long time ago. She further reported glasses helped her see better. The facility Director of Nursing (DON) was interviewed on 10/20/2011 at 10:45 AM and indicated it was the responsibility of the MDS Coordinator to assess residents on admission for vision problems. The facility MDS coordinator was interviewed on 10/20/2011 at 11:05 AM and reported either she or another nurse performed the initial assessment for resident #44. She explained when residents were assessed in the area of vision, the question on the laminated card used by the facility was " Were glasses present during the interview? " She further explained the answer was no for this resident, and that was the reason "No Glasses" was documented on the care plan. The MDS Coordinator reported she was uncertain if any staff asked the resident if she wore or had ever worn glasses during the initial interview or at any other time since admission. She further indicated, to her knowledge, no follow ups for vision services had been done for the resident since admission.	F 272	The MDS coordinator will do audits, to include resident #44, weekly for four weeks and then monthly for two months to ensure compliance. Audit reports will be given to the Director of Nursing weekly for four weeks and then monthly for two months for review and follow-up. The executive QI committee will review the results of the audits weekly for four weeks then monthly for two months for any identified areas of concern or trends and will follow-up as indicated to determine the need for and/or frequency for continued monitoring.	11/11/2011

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 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation for 10/17/11-10/20/11. Event #SL8D11	F 000		

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

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	345217	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/17/2011

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) The non occupied resident rooms in the L wing were found to be used for temporary storage and the doors were not equipped self-closing devices. 2) The Clean Linen room corridor door on 300 hall did not close, latch and seal. 42 CFR 483.70(a)	K 029	1) The non-occupied resident rooms on the L- wing will be equipped with self-closing devices by Support Services and completed by 12/31/2011. 2) The corridor door to the clean linen room on 300 Hall was adjusted by the maintenance supervisor on 12/01/2011 to ensure that it will close, latch, and seal. All corridor doors (to hazardous areas) will be checked by maintenance supervisor or maintenance assistant to ensure that they close, latch, and seal. Adjustments or replacements will be done as necessary. All corridor doors (to hazardous areas) will be checked weekly by maintenance supervisor or maintenance assistant to ensure closure, latch, and seal, and adjustments or replacements done as necessary. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed	12/31/11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045	Charles Taylor Electric installed lighting to illuminate the exit path to the public way from the exit door for the 700 Hall SPARK Unit exit door on 12/14/2011. Maintenance supervisor or maintenance assistant will monitor egress lighting, including Exit discharge on a weekly basis and make repairs as necessary.	12/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy K. Allen MHA	Administrator	12/14/2011

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	345217	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/17/2011

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

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K 045	Continued From page 1 Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) The exit path to the public way was not illuminated from the exit door for the 700 Hall Sparks Unit exit door. 42 CFR 483.70(a)	K 045	(cont.) A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and follow-up as needed.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) Upon testing the fire alarm on battery backup the Fire Alarm Control Panel (FACP) went down due to loss of power and failed to continue to operated. (Fire did operate on AC power) 42 CFR 483.70(a)	K 052	Charles Taylor Electric replaced the back-up battery for the fire alarm control panel on 11/18/2011. The maintenance supervisor or maintenance assistant will test fire alarm on battery backup weekly to ensure that it is operable. Should the battery fail, it will be replaced. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	11/18/11
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	1)The deep fat fryer was positioned under the hood on 11/18/2011 by the maintenance supervisor. The dietary staff was instructed to keep the deep fat fryer positioned under the hood at all times by the maintenance supervisor on 11/18/2011.	11/18/11

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	345217	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/17/2011

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K 069	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) A deep fat fryer was not properly protected under the hood. 2) The kitchen air exhaust and supply systems was not properly balanced. The Kitchen was experiencing a high negating pressure with the exhaust hoods operating. 42 CFR 483.70(a)	K 069	The maintenance supervisor or maintenance assistant will monitor the positioning of the deep fat fryer 3 x weekly to ensure compliance. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed. 2) See Request for 21 day waiver – Attached.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) The generator annunciator panel for generator #1 did not show generator supplying emergency power under load. 42 CFR 483.70(a)	K 144	The generator annunciator panel for generator #1 was repaired by Charles Taylor Electric on 12/14/2011. The maintenance supervisor or maintenance assistant will test the annunciator panel weekly and make any repairs if necessary. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	12/14/11

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	345217	A. BUILDING 02 - MAIN BUILDING 02 B. WING	11/17/2011

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PREMIER NURSING AND REHABILITATION CENTER	225 WHITE ST JACKSONVILLE, NC 28546

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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 11/17/2011 at approximately 11:15 AM onward the following was noted: 1) There are holes and/or penetrations in the smoke wall that were not sealed in order to maintain the required fire resistance rating of the wall in the following locations. a) Therapy room smoke wall 800 rehab b) Therapy room smoke wall 800 A smoke wall. 42 CFR 483.70(a)	K 025	Penetrations in the smoke walls were sealed in the therapy room 800 Rehab and in the therapy room 800A by maintenance supervisor on 12/08/2011. All smoke walls throughout the facility will be inspected by maintenance supervisor or maintenance assistant and penetrations sealed as necessary. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	12/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Rose MHA | TITLE: Administrator | (X6) DATE: 12/14/2011

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