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 05/10/2012

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to inform the guardian of a discharge	F 157	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 through informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	06/05/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy K. Allen	Administrator	5/31/2012

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.

A-G M.P

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F 157	Continued From page 1 to the hospital for 1 of 2 residents (#3). The findings include: 1. Resident #3 was admitted to the facility on 01/18/11 with cumulative diagnosis that included Dysphagia, Dementia, Muscle Weakness, Atrial Fibrillation, Asthma and Pneumonia. The resident was coded on the most recent MDS (minimum data set) dated 01/13/12 as being severely impaired in the decision making process and requiring extensive assistance with all ADL's (Activities of Daily Living). A review of the medical record revealed a nurse note dated 01/30/12 timed 00:05 (12:05AM) that read "called to residents room at 10:00PM. Cool to touch, hard to respond to verbal/tactile (stimulus). 120/68 (blood pressure), 92(pulse), 30(respirations) 90% (oxygen level)." The note then listed repeat vital signs "(blood pressure, pulse, respirations and temperature) 126/54, 72, 28, 97.6(temperature) 79 -80% (oxygen level). MD (doctor) called at 10:10PM gave order to send to ED (emergency department) continue to use accessory muscles. Little response to tactile stimuli 911 called EMS arrived and transported the resident." A review of the facility "Resident Concern Log" revealed a concern for resident #3 dated 02/01/12. The concern read "(name of Guardian) approached me at 2:20PM today and states she was not notified that resident was sent to hospital on 01/29/12. (Name of Guardian) was also never notified that resident expired until today. RP (responsible party) very concerned because residents family have not been notified."	F 157	F157 1) Resident #3 no longer resides in the facility. 2) The Director of Nursing reviewed discharges for the past 45 days to ensure MD/RP notification was made as warranted to include discharges to the hospital. The review and any needed follow up was completed on 05/25/2012. Administrative nurses reviewed progress notes dating back to 5/1/12 to identify issues that required MD/RP notification. The review and any notifications warranted will be completed by 06/01/2012. 3) A 100% in-service covering nurses' responsibility in timely notification of MD/RP when change of condition occurs will be completed by Staff Facilitator by 06/01/2012. An Administrative Nurse will review progress notes of facility residents daily to ensure MD/RP notifications have occurred if warranted. Findings and follow up as needed will be recorded on a QI tool.	06/05/2012

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F 157	Continued From page 2 During an interview on 05/10/12 at 10:00AM, with nurse#1 (the nurse that wrote the note), it was revealed "I was on call, when I came in around 7:00PM she (resident #3) had had nausea, vomiting and some diarrhea. She was in no acute distress at that time. Around 10:00PM the nurse aide called me to the room. She was cool to the touch and hard to respond. I took her vital signs and I called the doctor. I got an order to send her out and we did that. The hospital called back and asked me for more information. I told them that she was a ward of the state. I tried the office number of the Guardian but did not get anyone. I passed this information on to the next shift. The next day I did not tell anyone that I had not been able to reach the Guardian. I would have thought that it was discussed in the Department Head meeting on Monday morning. I guess I dropped the ball." During an interview with the Director of Nursing (DON) on 05/10/12 at 10:48 AM it was revealed "if a nurse cannot reach the RP they need to pass it on to the next shift. I would expect each shift to continue to try until the party was reached. If they continued not to be able to reach the person, I would expect them to let me know about that. I looked back on my notes from the Department Head meeting and do not see anything about not being able to notify (name of guardian)."	F 157	4) The findings will be reviewed by the Quality Improvement Nurse on a weekly basis, compiled and forwarded to the monthly QI committee for review and follow-up for any identified areas of concerns or trends and will follow-up as indicated to determine the need for and/or frequency for continued monitoring.	06/05/2012
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242	F242 1) Resident # 4 is receiving thin liquids as requested.	

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F 242	Continued From page 3 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and family interview, the facility failed to honor a preference for regular liquids for one of one residents (resident #4) sampled. Findings include: Resident #4 admitted to the facility on 11/01/1999 with diagnoses of Chronic Obstructive Pulmonary Disease, Type II diabetes, and cognitive impairment. The most recent Minimum Data Set (MDS) dated 4/14/12, identified the resident as being cognitively impaired with long and short term memory loss, and as being independent for feeding. The resident needed the assistance of a lift to get into a motorized wheelchair, but could propel himself around the facility. The care area assessments (CAAs) indicated that resident #4 had difficulty swallowing due to dysphagia. The resident was placed on a pureed diet with honey thickened liquids on 3/28/2012. A review of the nurses notes revealed instances of the resident stating that he did not want the thickened liquids, but wanted thin liquids. On 4/09/12 resident #4 stated to the nurse that drinking the thick liquids was like snot, and he did not care if he got sick, he wanted the thin liquids. On 4/12/12 the resident stated to a nurse, " I hate that thicken liquids I want to drink regular water. " A note written by the facility physician on 4/12/12 stated that resident #4 told the physician that the resident hated the thickened liquids.	F 242	2) A 100% audit was completed by Administrative Staff to include Resident # 4 and all Interviewable Residents, utilizing a QI InterviewTool to determine if resident's rights, choices, and dignity are being honored to include honoring preferences. The interviews were completed on 05/21/2012. 3) A 100% in-service covering Federal Bill of Rights and the right to choice will be completed by Staff Facilitator on 05/31/2012 for all staff. An audit was completed by Administrative nurses on 05/25/2012 to ensure current physician orders are congruent with resident choices as follow-up to the 100% audit of Interviewable residents. Audits will be completed weekly x 4 weeks the every two weeks x 2 and monthly x 2 on Interviewable Residents to determine if resident's rights, choices, and dignity are being honored with follow-up as warranted.	06/05/2012

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F 242	Continued From page 4 On 5/10/12 at 1:20 PM, resident #4 ' s family member was interviewed and stated that on 4/28/12 the family member called the facility and asked Nurse #4 to please give resident #4 thin liquids, because the resident had signed a waiver. Nurse #4 stated to the resident ' s family member that the staff could not do that because it was against the physicians orders. The family member asked for the physician phone number and Nurse #4 stated that the phone number could not be given to the family member. The family member stated that they did speak to the administrator that same day and that the administrator told the family member that since the family member was the responsible party, the family member would have to come to the facility and sign a waiver. The family member stated that they were unable to go to the facility until the next day (4/29/12), and that they did go to the facility and sign the waiver. The waiver was reviewed. It had been signed on 4/29/2012 by resident #4, the responsible party and a registered nurse who worked in the facility. An order for a regular diet with thin liquids was given by the facility physician on 5/3/2012. An interview on 5/10/12 at 1:30 PM, NA #2 stated that resident #4 had asked for thin liquids several times, but she told him that she could not give the thin liquids to him because of the physician orders. On 5/10/2012 at 2:20 PM, resident #4 was interviewed. The resident stated that after he had signed the waiver and was told that he could only get the thin liquids if he got them himself, " it made me feel like nothing, like I wasn ' t even	F 242	4) The findings will be reviewed by the Quality Improvement Nurse on a weekly basis, compiled and forwarded to the monthly QI committee for review and follow-up for any identified areas of concerns or trends and will follow-up as indicated to determine the need for and/or frequency for continued monitoring.	06/05/2012

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F 242	Continued From page 5 here. " On 5/10/12 at 2:30 PM an interview with NA #3 revealed that the NA had gone into resident #4 ' s room and was going to give the resident a soda to drink, because the NA was aware that resident had signed a waiver against medical advice to have thin liquids. Before giving resident #4 the soda, NA #3 was called out of the resident ' s room by Nurse #5 and told that there was not a physician order for thin liquids, and that NA #3 could lose his job if he gave resident #4 the soda. NA #3 stated that he thought it would be allowed because resident #4 had signed the waiver. Nurse #5 said that, even though the resident had signed the waiver, staff was not allowed to give resident #4 thin liquids. NA #3 stated that he went back into resident #4 ' s room and told the resident that he could not give him the soda. On 5/10/12 at 3:30 PM, in an interview, the administrator stated that the family member, who was the responsible party, did speak with the administrator in regard to signing a waiver so that resident #4 could have thin liquids. The administrator stated that it was the administrator ' s job to try and please everyone. The administrator stated that after the family member came to the facility and signed the waiver, it was explained to the family member that the staff would not give resident #4 thin liquids, but that the resident or the family member could get them for the resident. The administrator also stated that, in the future, the facility should try and get the order as soon as possible for the resident.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 1) Resident # 5 no longer resides in the facility.	06/05/2012

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F 280	Continued From page 6 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff and family interview and record review, the facility failed to invite the responsible party for 1 of 2 residents (#5) to the resident ' s care plan meeting. The findings include: Resident #5 was admitted to the facility on 11/01/11 with cumulative diagnosis that included Abnormality of gait, Fracture of the metacarpal, Dehydration, History of Urinary Tract Infection, Dementia, Muscle Weakness and Hypertension. The resident was coded on the most recent MDS (minimum data set) dated 01/28/12 as being severely impaired in the decision making process. In addition, the resident was coded as requiring	F 280	2) MDS team reviewed all residents currently due for care planning according to the care plan schedule to ensure that invitations have been completed and sent to resident and family. A copy of the invitation is being kept on file in the MDS office as assurance that invitations were sent inviting responsible parties to care plan meetings. The review was completed on 05/11/2012, for care planning due through 05/18/2012. 3) The Director of Nursing will complete an in-service for the MDS team to include the Dietary Manager, Activity Director, Social workers and Nurses regarding the care plan teams' responsibility that resident and family are provided the opportunity to participate in the development of the care plan on 06/01/2012. A weekly audit will be done by the Director of Nursing or designee to ensure compliance that residents and family members are invited to participate in care planning. The results of the audit will be recorded on a QI Tool.	06/05/2012

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F 280	Continued From page 7 extensive assistance with her ADL's (activities of daily living). During an interview with a family member on 05/0/12 at 8:59 AM it was revealed "I know that my (relation to family member) was only here a few months, but I was never invited to a care plan meeting." During an interview with Nurse#1 on 05/10/12 at 10:15 AM it was revealed "the Social Worker lets the families know when the meeting is scheduled. They send out a post card that advises them to call us about the meeting. I'm not sure but I think the Social Worker would document if the family responded. If the family is here for the care plan meeting they sign the Interdisciplinary form during the meeting. We do not handle the family notification at all." During the interview, Nurse #1 showed me the form for resident #5. There were no signatures on the form. During an interview with Nurse #2 on 05/10/12 at 10:30 AM it was revealed "the Social Worker handles all the family invitations. (Names of the two social workers) are no longer here. I don't recall the meeting for (name of resident#5). If a family member had been at the meeting, we would have them sign a form. If the form is not signed, I would assume that the family did not attend the meeting." During an interview with the Director of Nursing (DON) on 05/11/12 at 3:00 PM, it was revealed "neither of the Social Workers work here anymore. I know that copies of the postcard were kept. I will look in their offices to see if I can find one for (name of resident)."	F 280	4) The findings will be reviewed by the Quality Improvement Nurse on a weekly basis, compiled and forwarded to the monthly QI committee for review and follow-up for any identified areas of concerns or trends and will follow-up as indicated to determine the need for and/or frequency for continued monitoring.	06/05/2012

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F 280	Continued From page 8 During an interview with the DON on 05/11/12 at 4:00PM. It was revealed "I have not been able to find any invitation for (name of resident) in the offices."	F 280		