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

PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

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 10/24/2013

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID O50F11. Intake NC00091150.	F 000	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 this 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.	11/18/2013
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.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Rhoss NHA
TITLE: Administrator
(X6) DATE: 11/13/2013

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview, the facility failed to notify a resident ' s responsible party regarding new and pertinent medical/dental information for one of three residents sampled (Resident #117). Resident admitted 5/8/2009 with diagnoses of atrial fibrillation, coronary artery disease, hypertension, Diabetes Mellitus, and degenerative joint disease. The quarterly Minimum Data Set (MDS), dated 8/14/13 noted that Resident #117 was severely impaired for cognition and required extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The care plan dated 8/14/13 noted a focus of requiring assistance for hygiene/bathing related to cognitive impairments with a goal that the resident will maintain good oral hygiene and maintain the ability to wash his face till next review. Approaches included: break tasks into segments; encourage the resident to participate in self care as able; praise all efforts made by the resident; mouth care was to be given every day and as necessary. The resident has some natural teeth. In an interview on 10/23/13 at 11:00 AM, Nurse #1 stated that if a resident needs to be seen by the dentist, the nurse will call the resident ' s physician and responsible party and then be placed on a list to be seen by the facility dentist. On 8/21/13, Resident #117 was seen by the	F 157	F157 483.10(b)(11)Notify of Changes (Injury/Decline/Room, ETC) Resident #117, the responsible party has been notified of the results/ recommendations on the Dental Consultation dated 8/21/13 and at this time the responsible party has declined any further dental interventions and this has been documented in the residents medical record. All residents that were seen by the dentist since August 2013 have had their consultations reviewed. Any interventions needed were done including MD/RP notifications. This was completed on 10/23/2013 by Ward Clerk and/or DON. 100% in-servicing was completed with staff on MD/RP notification on 11/13/2013 by DON and/or Staff Facilitator Coordinator.	11/18/2013

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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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F 157	Continued From page 2 facility dentist. A review of the Dental History and Record revealed that Resident #117 needed to go to the hospital for all teeth to be extracted related to rampant decay. Nurse #1 stated that when the nurse has notified the physician and the responsible party (RP) about what the dentist recommended, the nurse would notify the staff that schedules appointments to put the resident on the list to be cleared for the extraction, and would document that it had been done. A review of nurse notes from 8/21/13 to present revealed no documentation of Resident #117 being scheduled to have his teeth extracted, or that the physician or RP were contacted. On 10/24/13 at 9:50 AM, in an interview, the resident's RP stated that she had not been notified of the result of the dentist visit in August. On 10/24/13 at 10:40 AM the Director of Nursing (DON) stated that she did not know if the scheduler would get the dentist recommendation first, then send it to the nurse; or if the nurse would get the recommendation first, notify the RP and the physician, and would then send it to the scheduler.	F 157	Resident's charts are reviewed daily for notifications to MD/RP using a QI tool. Instructions for scheduling on sight specialty appointments will be available to back up appointment scheduling designee. The staff person responsible for scheduling appointments and/or designee will review the consultations for follow up with interventions (such as assuring that MD/RP has been notified, an appointment scheduled) as needed using a QI tool weekly. This tool will be turned into DON for further action. The Executive QI committee will meet monthly X3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	11/18/2013
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	F312 483.25(a)(3)ADL Care Provided For Dependent Residents Oral Hygiene for resident #117 is being done per staff on a daily basis and as needed.	

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F 312	Continued From page 3 by: Based on observation, record review, and staff and family interviews, the facility failed to provide oral hygiene to one of forty residents sampled (Resident #117). Resident #117 was admitted 5/8/2009 with diagnoses of atrial fibrillation, coronary artery disease, hypertension, Diabetes Mellitus, and degenerative joint disease. The quarterly Minimum Data Set (MDS) dated 8/14/13 noted that Resident #117 was severely impaired for cognition and required extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The care plan dated 8/14/13 noted a focus of requiring assistance for hygiene/bathing related to cognitive impairments, with a goal that the resident would maintain good oral hygiene and maintain the ability to wash his face through the next review. Approaches included: break tasks into segments; encourage the resident to participate in self care as able; praise all efforts; mouth care every day and as necessary. The care plan noted that the resident has some natural teeth. On 10/21/13 at 3:00 PM, Resident #117 was observed to have broken, decayed teeth with grayish, brown matter covering all of his teeth. On 10/22/13 at 2:55 PM, in an interview, the resident's family member stated that the resident did not brush his teeth, and that the staff did not brush his teeth. On 10/23/13 at 11:20 AM, in an interview, Nursing	F 312	All dependent residents have been identified per their MDS and oral care is being done daily per staff and as needed. 100% in-servicing for direct care staff on oral care was complet-ed on 11/13/2013 by DON and/or Staff Facilitator Coordi-nator. Resident's oral care will be reviewed at random by Ad-ministrative nurses daily x 1 week and then weekly on-going using QI tool. The QI tool will be turned into DON or designee for review and further action. The Executive QI committee will meet monthly X3 to review trends and/or issues and to de-termine the continued need and frequency of monitoring.	11/18/2013

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F 312	Continued From page 4 Assistant (NA) #1 stated that she would have Resident #117 wash his own face and hands, and she would wash the resident elsewhere. NA #1 stated that she would also shave him. NA #1 stated that the resident has the ability to brush his teeth, but the care tracker has no specific area for oral care. NA#1 stated that she does not cue the resident to brush his teeth. NA#1 also stated that she does not ask the resident if he brushes his teeth. On 10/24/13 at 9:05 AM in an interview, NA #2 stated that she would have the residents do as much as possible for their ADLs. If the residents can feed themselves, the assumes that they can brush their teeth. NA#2 stated that if they won't or can't brush their teeth, she does it, although she does encourage them to do it. On 10/24/13 at 9:15 AM in an interview, the Director of Nursing (DON) stated that her expectation for a NA with a resident who was extensive assist would be that the AM cares would be bathing, dressing, feeding, and oral care.	F 312	F411 483.55(a) Routine/Emergency Dental Services in SNF's	11/18/2013
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making	F 411	Resident #117, the responsible party has been notified of the results/ recommendations on the Dental Consultation dated 8/21/13 and at this time the responsible party has declined any further dental interventions and this has been documented in the residents medical record.	

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F 411	Continued From page 5 appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview, the facility failed to provide dental services to one of four residents sampled (Resident #117). Resident admitted 5/8/2009 with diagnoses of atrial fibrillation, coronary artery disease, hypertension, Diabetes Mellitus, and degenerative joint disease. The quarterly Minimum Data Set (MDS), dated 8/14/13 noted that Resident #117 was severely impaired for cognition and required extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The care plan dated 8/14/13 noted a focus of requiring assistance for hygiene/bathing related to cognitive impairments with a goal that the resident will maintain good oral hygiene and maintain the ability to wash his face till next review. Approaches included: break tasks into segments; encourage the resident to participate in self care as able; praise all efforts made by the resident. Mouth care was to be given every day and as necessary. It was stated in the care plan that the resident has some natural teeth. In an interview on 10/23/13 at 11:00 AM, Nurse #1 stated that if a resident needs to be seen by the dentist, the nurse will call the resident ' s	F 411	All residents that were seen by the dentist since August 2013 have had their consultations reviewed. Any interventions needed were done including MD/RP notifications. This was completed on 10/23/2013 by Ward Clerk and/or DON. 100% in-servicing was completed with staff on MD/RP notification on 11/13/2013 by DON and/or Staff Facilitator Coordinator. Resident's charts are reviewed daily for notifications to MD/RP using a QI tool. Instructions for scheduling on sight specialty appointments will be available to back up appointment scheduling designee. The staff person responsible for scheduling appointments and/or designee will review the consultations for follow up with interventions (such as assuring that MD/RP has been notified, an appointment scheduled) as needed using a QI tool weekly. This tool will be turned into DON for further action.	11/18/2013

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F 411	Continued From page 6 physician and responsible party (RP) and then be placed on a list to be seen by the facility dentist. On 8/21/13, Resident #117 was seen by the facility dentist. A review of the Dental History and Record revealed that Resident #117 needed to go to the hospital for all teeth to be extracted related to rampant decay. Nurse #1 stated that when the nurse has notified the physician and the RP about what the dentist recommended, the nurse would notify the staff that schedules appointments to put the resident on the list to be cleared for the extraction, and would document that it had been done. A review of nurse notes from 8/21/13 to present revealed no documentation of Resident #117 being scheduled to have his teeth extracted, or that the physician or RP were contacted. On 10/24/13 at 9:50 AM, in an interview, the resident's RP stated that she had not been notified of the result of the dentist visit in August. On 10/24/13 at 10:40 AM the Director of Nursing (DON) stated that she did not know if the scheduler would get the dentist recommendation first, then send it to the nurse; or if the nurse would get the recommendation first, notify the RP and the physician, and would then send it to the scheduler; but that she would find out. On 10/24/13 at 10:55 AM in an interview, the facility scheduler stated that usually the dentist would see the residents on the list, meet with the scheduler and indicate, by his Dental History and Record sheets, which residents needed treatments, etc. and the scheduler would take the sheets to the nurses and the nurses would call	F 411	The Executive QI committee will meet monthly X3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	11/18/2013

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F 411	Continued From page 7 the RPs and the physicians to inform them of the treatments that were needed. The scheduler stated that she was not working in the facility for the month of August, so she did not know why the resident was not scheduled for tooth extraction. The scheduler stated that if a resident had any kind of heart problem, they would be scheduled for an appointment with the cardiologist to be cleared for the tooth extraction, and then scheduled for an appointment with the oral surgeon.	F 411		

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	345217	A. BUILDING 01 - MAIN BUILDING 01 B. WING ________	11/25/2013

NAME OF PROVIDER OR SUPPLIER: PREMIER NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 225 WHITE ST, JACKSONVILLE, NC 28546

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=D	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: 42 CFR 483.70(a) By observation on 11/25/13 at approximately noon the hazardous area was non-compliant, specific findings include: the door to the clean side of laundry did not close and latch tightly in it's frame.	K 029	The Maintenance Director adjusted the door to the clean side of laundry on 11/25/2013 to ensure that it would close and latch tightly in its frame. The Maintenance Director and his assistant checked all facility doors on 11/26/2013 to ensure closure and latching. This will be continued on a weekly basis and corrections made 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.	12/01/2013
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. [signature] | TITLE: Administrator | (X6) DATE: 12/11/2013

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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	345217	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/25/2013

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K 038	Continued From page 1 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 11/25/13 at approximately noon the exit access was non-compliant, specific findings include: the exit from the freezer and cooler was not readily visible.	K 038	The Maintenance Director installed an illuminated exit sign in the freezer and in the cooler on 11/29/2013. The Maintenance Director and his assistant checked each facility exit access to ensure that all are readily visible. This monitoring of each facility exit access will continue on a weekly basis and corrections made 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.	12/01/2013

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	345217	A. BUILDING 02 - MAIN BUILDING 02 B. WING ______	11/25/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Dlen
TITLE: Administrator
(X6) DATE: 12/4/2013

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