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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	**225 WHITE STREET 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 A complaint investigation survey was conducted from 12/21/2020 through 12/23/2020. Event ID# QBC611. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		1/14/21

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

Electronically Signed | 01/14/2021

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET 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 609	Continued From page 1 by: Based on record review and staff interview the facility failed to submit an initial resident abuse allegation to the state agency within the required 2-hour timeframe for 1 of 1 resident (Resident #1) reviewed for abuse. The findings included: Resident #1 was admitted to the facility on 2/14/2019. Her diagnoses included cardiovascular accident (CVA), dementia with behavioral disturbances and contracture of the right and left knees. The annual Minimum Data Set dated 11/6/2020 revealed Resident #1 was moderately cognitively impaired. She made herself understood and she understood others. She had behaviors not directed towards others and no rejection of care. She required total assistance for transfers. Resident #1 also had limited range of motion on both lower extremities. A review of the facility's Abuse, Neglect or Misappropriation of Resident Property policy revised on 3/10/2017 revealed; "The Administrator will ensure all allegations that involves abuse or results in serious bodily injury, the Division of Health Services Regulation, Health Care Personnel Section, and Adult Protective Services are notified immediately but no later than 2 hours after the allegation is received and determination of abuse is made." A review of the facility investigation revealed a statement written on 12/16/20 which stated at approximately 8:00 PM Nurse #1 was taken by Nursing Assistant (NA) #2 to a resident's room	F 609	On 12/16/20 at approximately 8:30 pm the facility became aware of an abuse allegation. The facility submitted the initial allegation report on 12/17/20 at approximately 2:30 pm. On 12/21/20, 100% audit of all Initial Allegation Reports related to Abuse from 6/22/20- 12/21/20 was completed by the facility consultant to ensure all initial allegation reports related to abuse was reported per CMS regulations. There were no identified areas of concern during the audit. On 12/21/20, I00% in-service was completed with the Administrator and Director of Nursing in regard to reporting initial allegations of abuse within 2 hours per the CMS regulations and facility policy. 100% of Initial Allegations related to Abuse will be reviewed by the Facility Consultant weekly x 4 weeks to ensure that any abuse allegation is reported per CMS regulations and facility policy. The Facility Consultant will address all areas of concern identified during the audit.	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET 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 609	Continued From page 2 because NA #2 heard a staff member hitting one of the residents. A review of the skin assessment completed by Nurse #1 on 12/16/20 at 10:04 PM revealed no redness or fresh bruising noted. On 12/21/20 at 1:05 PM Nurse #1 said she was the nurse for Resident #1 on 12/16/20. She stated at about 8:00 or 8:30 PM NA #2 pulled her down to Resident #1's room and stated she heard another NA hitting Resident #1 because the resident was yelling stop. She added she and Nurse #2 completed a skin assessment on Resident #1. On 12/21/20 at 2:00 PM the Director of nursing stated she was notified of the allegation of abuse around 8:30 -9:00 PM on 12/16/20. A review of the 24-hour report revealed it was sent to the state agency on 12/17/20 at 2:49 PM. On 12/21/20 at 4:40 PM the Administrator stated she did not submit a report within 2 hours because there was no evidence of injury or bodily harm on Resident #1. She said the alleged abuse which occurred at approximately 8:30 PM on 12/16/20 was reported within 24 hours but not within 2 hours.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		1/14/21

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET 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 656	Continued From page 3 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement a resident's care plan	F 656	Facility failed to implement a residents care plan when staff transferred a resident	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET 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 656	Continued From page 4 when staff transferred a resident from her wheelchair to her bed without using a mechanical lift for 1 of 1 resident (Resident #1) reviewed for transfers. The findings included: Resident #1 was admitted to the facility on 2/14/2019. Her diagnoses included cardiovascular accident (CVA), non-Alzheimer's dementia, dementia with behavioral disturbances and contracture of the right and left knees. The annual Minimum Data Set dated 11/6/2020 revealed Resident #1 was moderately cognitively impaired. She made herself understood and she understood others. She had behaviors not directed towards others and no rejection of care. She required total assistance for transfers. Resident #1 also had limited range of motion on both lower extremities. Resident #1's care plan last reviewed on 11/25/20 included a focus area which revealed she required assistance for transferring related to severe cognitive impairment, knee flexion contractures, decreased strength/coordination, decreased dynamic/static balance and functional activity tolerance. The interventions included "transfers: Viking lift." The resident care guide also listed "transfers: Viking lift." On 12/22/20 at 12:00 PM Nursing Assistant (NA) #2 stated she observed NA #1 transfer Resident #1 from her wheelchair into the bed on 12/16/20. She said NA #1 was not using a mechanical lift and had placed Resident #1 into the bed with no additional assistance.	F 656	from her wheelchair to her bed without using a mechanical lift for 1 of 1 sampled resident (Resident #1) 100% audit was initiated on 1/12/2021 of all nursing staff, to include NA #1, on observation for method of transfers, to include mechanical lifts, with return demonstration, will be reviewed to ensure the care plan is followed to transfer the resident, by the Staff Facilitator. Retraining will be conducted during the audit by the Staff Facilitator with assigned nursing assistant and licensed nurse for any identified areas of concern and will be completed on 1/14/2021. Any nursing staff that have not completed the observation/return demonstration by 1/14/2021 will not be allowed to work until completion of the observation/return demonstration. An in-service for 100% of all license nurses and nursing assistants (NA) was initiated on 12/23/2020 by the Staff Facilitator regarding following the care plan/care guide to include using the correct mechanical lift per the resident care guide, needed to transfer the resident. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator regarding following the care plan/care guide to include using the correct mechanical lift per the resident care guide, needed to transfer the resident,completed by 1/13/2021. 10% of nursing staff, to include NA #1, on	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET 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 656	Continued From page 5 On 12/22/20 at 3:20 PM NA #1 said on 12/16/20 she assisted Resident #1 from her wheelchair into the bed. NA #1 said Resident #1 did not have a lift pad under her. NA #1 described how she assisted Resident #1 back into bed and reported she did not use a mechanical lift to put Resident #1 back to bed. On 12/23/20 the Director of Nursing stated NA #1 assisted Resident #1 without using the mechanical lift so she had completed a disciplinary action to NA #1.	F 656	observation for method of transfers, to include mechanical lifts, will be reviewed to ensure the care plan/care guide is followed to include using the correct mechanical lift per the resident care guide, needed to transfer the resident utilizing a Care plan/Care guide Transfer audit tool by the RN Supervisor, the Staff Facilitator, Unit Manager and/or QI nurses weekly times 8 weeks then monthly times 1 month. The nursing assistant and licensed nurse will be reeducated by the RN Supervisor, the Staff Facilitator, Unit Manager and/or QI nurses for any identified areas of concern during the audit. The DON will review and initial the Care plan/Care Guide audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Care plan/Care Guide Transfer audit tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring for 3 months.	