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 01/07/2022

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

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E 000	Initial Comments An unannounced recertificatin survey was conducted on 01/03/22 through 01/07/22. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SO9811	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/03/22 through 01/06/22 and finished remotely on 01/07/22. Event ID#SO9811. Two of the 28 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to accurately code for wander/elopement on one Minimum Data Set (MDS) assessment for 1 of 31 residents (Resident #90) observed and failed to accurately code a MDS assessment for urinary bladder and bowel for 1 of 2 residents (Resident #228) observed for urinary catheters. Findings included: 1. Resident #90 was admitted to the facility on 10/02/21 with diagnosis of benign neoplasm of ascending colon, diabetes (DM), acute pancreatitis, rhabdomyolysis, myocardial infarction (MI), vascular tachycardia, and	F 641	F641 – Accuracy of Assessments Affected Residents Resident #90- most recent and completed MDS was corrected by coding the Wanderguard bracelet under Section P and was resubmitted on 1/6/22 by the MDS Nurse . Resident #228 – most recent and completed MDS was corrected and coded for an indwelling catheter under Section H and was resubmitted on 1/6/22 by the MDS Nurse. Other Residents	2/3/22

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

Electronically Signed | 01/28/2022

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F 641	Continued From page 1 hypertension (HTN). The quarterly Minimum Data Set (MDS) assessment dated 11/05/21 specified Resident #90 did not have a wander/elopement alarm. Further review of this MDS revealed this section was completed by the MDS Nurse. An observation on 01/05/22 at 1:15 PM revealed Resident #90 sitting in the facility's locked memory unit with an ankle wander guard on. In an interview on 01/06/22 at 2:00 PM the MDS Nurse #1 stated that when she filled out the restraint section on the MDS (dated 11/05/22) she reviewed the residents Behavior Section- E to see what wandering behavior was present during the 7-day look back period, which was checked no. When asked about the wander guard, the MDS Nurse reviewed Resident #90's Medical Record (MR) and indicated Resident #90 was at risk for elopement, as evidenced by an Elopement Assessment dated 10/11/21 score of 11 and was placed in their locked memory unit with an ankle wander guard on 10/13/21. The MDS Nurse stated Resident #90 had a history of wandering prior to being placed on the locked memory unit and had two elopement attempts since being on the unit. The MDS Nurse indicted that she had mistakenly documented Resident #90's wander/elopement guard as not used. The MDS Nurse expressed that the restraint section of the MDS needed to be corrected because it monitored elopement risk residents and served as a snapshot of any restraints the resident was utilizing during the look back period. In an interview on 01/06/22 at 2:38 PM the Director of Nursing (DON) and Administrator	F 641	100% audit of Section P on the most recent completed MDS was completed by the MDS Nurse and MDS Consultant on 1/6/22. This was to ensure accuracy of coding of residents wearing Wanderguard bracelets . Any identified issues were corrected. 100% audit was completed of all residents with catheters on 1/6/22 by the MDS Consultant and MDS Nurse to ensure coding accuracy of catheters in Section H. Any identified issues were corrected. Systemic Changes Reeducation and additional one-on-one training was provided to the MDS Nurses by the MDS Consultant on 1/19/22 with specific focus on Sections H and P of the Minimum Data Set. All residents with Wanderguard bracelets and new orders for catheters will be discussed in the daily Cardinal IDT meeting. The MDS Nurse will ensure that all catheters and Wanderguard bracelets discussed in the meeting are coded accurately on each MDS Assessment. QA Monitoring The Unit Manager will audit 10% of the most recent completed MDS Assessments, weekly for 4 weeks then monthly x 1 month utilizing the MDS	

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F 641	Continued From page 2 indicated that the MDS should be coded accurately to reflect the resident's wander guard status. 2. Resident #228 was admitted to the facility on 12/21/21. Diagnoses included, in part, urinary retention and incomplete bladder emptying. A progress note written by Nurse #7 on 12/21/21 revealed Resident #228 was admitted to the facility with a 16fr. (French scale size of catheter tubing) urinary catheter with 10 cubic centimeters (cc) balloon intact draining dark yellow urine. A Nurse Practioner (NP) note written on 12/22/21 revealed her plan was to maintain the indwelling urinary catheter until the resident was seen by a Urologist (a physician who specializes in disorders of the urinary system). The MDS admission assessment dated 12/27/21 revealed Resident #28 was moderately cognitively impaired and was coded as having an external catheter with intermittent catheterization. A Physician note written on 12/28/21 revealed, in part, resident had an indwelling urinary catheter. The note indicated the plan was to keep the catheter in place pending Urologist follow up. An observation of Resident #228 on 01/03/22 at 12:30 PM revealed the resident had a continuous indwelling urinary catheter, draining clear yellow urine, urinary drainage bag was positioned below his bladder and the drainage bag was covered with a privacy cover.	F 641	Section H and P Audit Tool. to ensure accurate coding of Wanderguard bracelets and urinary catheters. The Director of Nursing will review and initial the Section H and P Audit Tool to ensure completion and all areas of issues and/or concerns have been addressed. The Director of Nursing will forward the Section H and P Audit Tools to the Executive QA Committee monthly x 2 months. The Executive QA Committee will review monthly x 2 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or increased frequency of monitoring.	

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F 641	Continued From page 3 An interview with Resident #228 on 01/03/22 at 12:30 PM revealed he had a urinary catheter that was put in while he was at the hospital. An interview was conducted with the MDS Nurse on 01/06/21 at 3:00 PM. The MDS nurse confirmed that the MDS assessment was inaccurately coded and the assessment should have indicated Resident #228 had an indwelling urinary catheter instead of intermittent catheterization. An interview was conducted on 01/06/22 at 4:10 PM with the Director of Nursing (DON) and the Administrator who indicated that the MDS assessments should be coded accurately to reflect the resident ' s current care.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		2/3/22

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F 655	Continued From page 4 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to include a plan of care for an indwelling urinary catheter in the baseline care plan within 48 hours of admission for 1 of 2 residents (Resident #228) observed for catheter care. Findings included: Resident #228 was admitted to the facility on 12/21/21. Diagnoses included, in part, urinary retention and incomplete bladder emptying.	F 655	F655 – Baseline Care Plan Affected Residents Resident #228 - baseline care plan was updated to include catheter care. Resident #228 was provided with a written copy of baseline care plan. Other Residents On 1/28/21, a 100% audit of all admissions and/or readmissions for the	

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F 655	Continued From page 5 Discharge physician orders from the hospital dated 12/21/21 revealed Resident #228 had an existing indwelling urinary catheter 16fr. (French scale size of catheter tubing) with 10 cubic centimeters (cc) balloon. A progress note written by Nurse #7 on 12/21/21 revealed Resident #228 was admitted to the facility with a 16fr. urinary catheter with 10cc balloon which was intact and draining dark yellow urine. A review of the baseline care plan for Resident #228 initiated on 12/21/21 did not include care of an indwelling urinary catheter. The Minimum Data Set (MDS) admission assessment dated 12/27/21 revealed Resident #228 was moderately cognitively intact and was coded as having an external catheter with intermittent catheterization. The care area assessment on this MDS indicated the care area for urinary incontinence and indwelling catheter triggered and should be addressed in the care plan. An observation of Resident #228 on 01/03/22 at 12:30 PM revealed the resident had a continuous indwelling urinary catheter, draining clear yellow urine, urinary drainage bag was positioned below his bladder and the drainage bag was covered with a privacy cover. An interview was conducted with the MDS Nurse on 01/06/21 at 3:00 PM. The MDS nurse stated a baseline care plan should have been completed within 48 hours and should have included the urinary catheter since Resident #228 was admitted with it.	F 655	past 30 days was initiated by the Social Services Director and MDS Nurse . This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative were provided a copy of the care plan. All areas of concerns were immediately addressed by the Director of Nursing. Systemic Changes On 1/28/22, 100% in-service was initiated by the QI Nurse with all nurses in regard to Baseline Care Plans. Emphasis includes guidelines to develop and implement a baseline care plan for each new admission and/or readmission within 48hrs that includes instructions needed to provide effective and person-centered care of the resident, minimum healthcare information necessary to properly care for a resident, and that the facility must provide the resident and their resident representative with a summary of the baseline care plan. All newly hired nurses will be in-serviced in regard to Baseline Care Plans during orientation. 100% in-service will be completed by 2/3/22 QA Monitoring	

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F 655	Continued From page 6 An interview was conducted on 01/06/22 at 4:10 PM with the Director of Nursing (DON). The DON reported there was no actual baseline care plan at this point because it was rolled into the comprehensive care plan which the facility was still in the process of completing. The DON stated although the baseline care plan rolled into the comprehensive care plan, the urinary catheter should have been on the baseline care plan to facilitate care of the catheter upon admission.	F 655	10% audit of all admissions and/or readmissions will be completed by the Social Worker and MDS Nurse utilizing the Admission/Readmission census list. This will be done weekly x 4 weeks then monthly x 1 month. This audit is to ensure all admissions or readmissions had a baseline care plan developed and implemented within 48 hours of admission to the facility that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and that the resident and/or resident representative was provided a copy of the care plan. All areas of concerns will be immediately addressed by the Social Worker to include retraining of staff as indicated. The Director of Nursing will review and initial the weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns have been addressed. The Director of Nursing will forward the results of Baseline Care Plan Audits to the Executive Quality Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		2/3/22

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F 656	Continued From page 7 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 §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.	F 656		

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F 656	Continued From page 8 (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 observations, record reviews, and staff interviews the facility failed to develop a comprehensive care plan for a resident with a known history of wandering for 1 of 31 residents reviewed for a comprehensive care plan (Resident #90). Findings included: Resident #90 was admitted to the facility on 10/02/21 with a diagnoses that included myocardial infarction (MI). A nursing note dated 10/11/21 at 2:56 PM for Resident #90 revealed resident wandered onto the beginning of 800-hall. A wander risk evaluation dated 10/11/21 at 3:16 PM for Resident #90 revealed a score of 11.0 with resident at risk to wander. A nursing note dated 10/11/21 at 10:02 PM for Resident #90 revealed resident was placed on every 15-minute supervision checks related to wandering. A social service note dated 10/12/21 at 2:16 PM for Resident #90 revealed Social Worker (SW) made aware of resident's wandering throughout the hall. Resident was alert with confusion which required frequent redirection. A wander guard bracelet (used to help ensure residents safety, and alarms when a resident attempts to leave a	F 656	F656-Develop Comprehensive Care Plan Affected Resident Resident #90 – care plan was updated by the MDS Nurse on 1/6/22 to include wandering behaviors with intervention of Wanderguard Bracelet. Other Residents All other residents exhibiting wandering behaviors were reviewed by the QI Nurse on 1/6/22 to ensure a wandering care plan was in place. Any identified issues were addressed. Systemic Changes The MDS Nurse was in-serviced by the MDS Nurse Consultant on 1/19/21 regarding the importance of ensuring there is a care plan in place for residents exhibiting wandering behaviors and/or wearing a Wanderguard bracelet. Social Services will review orders daily to see if there are any new orders for Wanderguard bracelets and ensure there is a corresponding care plan in place All residents exhibiting wandering behaviors and/or wearing a Wanderguard	

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F 656	Continued From page 9 safe area) was in place on resident's ankle and was on every 15-minute nursing checks. A social service note dated 10/13/21 at 12:18 PM for Resident #90 revealed SW was notified of resident's room change to the facility's locked memory unit due to wandering and exit seeking behavior. Resident was alert and disoriented. A nursing note dated 10/18/21 at 8:57 AM for Resident #90 revealed night-shift reported to the day-shift nurse resident had attempted to escape the locked memory unit 2-times by trying to open the back-emergency door and by breaking the emergency exit's red box glass. Resident was being monitored for safety; psychiatric nurse was notified. Resident #90's quarterly Minimum Data Set (MDS) dated 11/05/21 revealed resident had severe cognitive impairments. The resident was not coded for wandering or for a wander guard. The active comprehensive care plan revealed no care plan for risk for wandering. In an interview on 01/06/22 at 2:00 PM the MDS Nurse #1 reviewed Resident #90's Medical Record (MR) and indicated that Resident #90 was at risk for elopement as evidenced by an Elopement Assessment dated 10/11/21 score of 11 and was placed in their locked memory unit with an ankle wander guard on 10/13/21. The MDS Nurse explained the 11/5/21 MDS was inaccurately coded for no wanderguard and she indicated this was why the care plan had not included wandering. In an interview on 01/06/22 at 2:38 PM the	F 656	bracelet will be discussed daily in the Cardinal IDT meeting and the MDS Nurse will ensure that there is a wandering care plan in place for each of these residents. QA Monitoring The Social Service Director will monitor the care plan of all residents exhibiting wandering behaviors weekly x 4 weeks and monthly x 1 month to ensure that all residents exhibiting wandering behavior and/or wearing a Wanderguard bracelet have a wandering care plan in place. The Director of Nursing will forward the results of the audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The Executive QAPI Committee will meet monthly for two (2) months and review the audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further interventions and/or frequency of monitoring.	

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F 656	Continued From page 10 Director of Nursing (DON) revealed Resident #90 was not care planned for wandering with exit seeking behavior and should have been due to his wandering, wander guard placement, and previous 2 elopement attempts.	F 656		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 661		2/3/22

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F 661	Continued From page 11 Based on record review and staff interviews the facility failed to complete a recapitulation of the facility stay for 1 of 1 residents reviewed for a planned discharge from the facility to the community (Resident #177). Findings included: Review of the medical record revealed Resident #177 was admitted to the facility on 09/29/21 with diagnosis of renal failure, hydrocephalus, depression, and anxiety. Review of the 5-day Minimum Data Set dated 10/09/21 revealed Resident #177 was cognitively intact and needed the extensive assistance of one person for bed mobility, transfers, toilet use, dressing and hygiene. There was an active return to the community discharge plan in place for Resident #177. Review of the medical record revealed Resident #177 was discharged home on 10/17/21. Further review revealed the facility did not complete a recapitulation of Resident #177's stay in the facility. A review of the Discharge Summary dated 10/17/21 at 11:06 AM by Nurse #2 for Resident #177 revealed a discharge summary stating, "resident discharged to home, left with his belongings with his family. Alert and oriented. All medications sent with him." In an interview on 01/06/22 at 2:38 PM the Director of Nursing (DON) and Administrator indicated that no recapitulation of Resident #177's stay had been completed. The DON stated the facility had not completed a recapitulation for the	F 661	F661-Discharge Summary An audit of the Discharge Summaries of all discharged residents from the facility within the last 30 days was initiated by the DON on 1/25/22. This is to ensure that all Discharge Summaries included a comprehensive recapitulation of the facility stay. Any issues were addressed. Audit completion date: 2/3/22. Systemic Changes 100% in-service of licensed nurses was initiated by the SDC on 2/28/22 in regard to the requirements of a Discharge Summary, to include a comprehensive recapitulation of the resident's stay when the facility anticipates a resident's discharge. In-service to be completed by 2/3/22. All residents being discharged from the facility will be discussed in the daily Cardinal IDT meeting and Discharge Summaries will be reviewed as an Interdisciplinary Team to ensure all summaries include a recapitulation of the facility stay. QA Monitoring The Unit Managers will audit 10% of Discharge Summaries weekly x 4 months and monthly x 1 month. This will be done utilizing the Discharge Summary Audit	

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F 661	Continued From page 12 resident at discharge. The DON stated the facility was not completing a recapitulation of any residents stay because she was unaware that the recapitulation of the facility for residents needed to be completed. An interview was completed with the Administrator on 01/06/22 at 2:40 PM. She stated it was her expectation that the facility should have completed a "Recapitulation of Stay" which was a concise summary of Resident #177's stay and course of treatment in the facility per regulation at the time of discharge from the facility and did not.	F 661	Tool. This is to ensure that all Discharge Summaries for residents who are being discharged from the facility are completed per requirements and include a comprehensive recapitulation of the facility stay. The Director of Nursing will forward the Discharge Summary Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The Executive QAPI Committee will meet monthly for two (2) months and review the Discharge Summary Audit Tool to determine trends and/or issue that may need further interventions put into place and to determine the need for further monitoring.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		2/3/22

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F 690	Continued From page 13 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews and Nurse Practioner interviews, the facility failed to obtain a physician ' s order for a continuous indwelling urinary catheter to include the size of the catheter and orders to maintain and care for the catheter for 1 of 2 residents (Resident 228) and failed to position the indwelling urinary catheter below the level of the bladder to prevent back flow of urine for 1 of 2 residents observed for catheters (Resident #61). Findings included: 1. Resident #228 was admitted to the facility on 12/21/21. Diagnoses included, in part, urinary retention and incomplete bladder emptying. Discharge physician orders from the hospital dated 12/21/21 revealed Resident #228 had an	F 690	F690-Bowel/Bladder Incontinence, Catheter, UTI Resident #228 order for Foley Catheter was discontinued on 1/17/22 Resident #61 is no longer a resident in the facility. 100% audit of resident with catheters was completed by the QI Nurse on 1/16/22 to ensure all had M.D. orders that included size of catheter and instructions to maintain and care for the catheter. Any identified issues were addressed. Charge Nurses are routinely checking to ensure that catheters are positioned appropriately on all residents with catheters to ensure the catheter is positioned below the level of the bladder	

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F 690	Continued From page 14 existing indwelling urinary catheter 16 Fr. (French scale size of catheter tubing) with 10 cubic centimeters (cc) balloon and an order to follow up with the Urologist. A nursing progress note written by Nurse #7 on 12/21/21 revealed Resident #228 was admitted to the facility with a 16 Fr. urinary catheter with 10 cc balloon intact draining dark yellow urine. A Nurse Practioner (NP) note written on 12/22/21 revealed her plan was to maintain the indwelling urinary catheter until the resident was seen by a Urologist (a physician who specializes in disorders of the urinary system). The Minimum Data Set (MDS) admission assessment dated 12/27/21 revealed resident was moderately cognitively impaired and was coded as having an external catheter with intermittent catheterization. A review of the care plan dated 12/27/21 revealed there was no plan of care in place for an indwelling urinary catheter. A review of the current physician orders revealed there were no orders for an indwelling urinary catheter or care for the catheter for Resident #228. A Physician note written on 12/28/21 revealed, in part, resident had an indwelling urinary catheter. The note indicated the plan was to keep the catheter in place pending Urologist follow up. An observation of Resident #228 on 01/03/22 at 12:30 PM revealed the resident had an indwelling urinary catheter, draining clear yellow urine,	F 690	to prevent back flow of urine and reporting any issues to the Director of Nursing. Systemic Changes An 100% in-service for licensed nurses was initiated by the SDC on 1/28/22 regarding ensuring that there is an order for all indwelling urinary catheters and that the order includes the size of the catheter and instructions to maintain and care for the catheter. In-service to be completed by 2/3/22. A 100% in-service for all licensed nurses and nursing assistants was initiated by the SDC on 1/28/22 in regard to ensuring that all continuous indwelling urinary catheters are positioned below the level of the bladder to prevent back flow of urine. In-service to be completed by 2/3/22. All new orders for catheters will be discussed in the daily Cardinal IDT meeting. During the meeting the QI Nurse will ensure there is an order in place for all new catheters that includes the size of the catheter and instructions to maintain and care for the catheter. Any issues will be addressed during the meeting. QA Monitoring The QI nurse will audit 10% of catheters weekly x 4 weeks and monthly x 1 month utilizing the Catheter Audit Tool. This is to ensure that all residents with indwelling urinary catheters have an order that	

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F 690	Continued From page 15 urinary drainage bag was positioned below his bladder and the drainage bag was covered with a privacy cover. An interview with Resident #228 on 01/03/22 at 12:30 PM revealed an alert and oriented resident who reported he had a urinary catheter that was put in while he was at the hospital. An observation of urinary catheter care on Resident #228 was conducted on 01/06/22 with Nurse Aide (NA) #4 at 9:40 AM. The continuous indwelling urinary catheter site was noted to be clean with no signs or symptoms of infection and draining clear yellow urine. The catheter tubing was secured to Resident #228 ' s leg to prevent kinking and the size of the catheter was labeled 16 Fr. with 10 cc balloon size. An interview with Nurse #1 on 01/06/21 at 10:45 AM revealed she was aware Resident #228 had an indwelling urinary catheter. Nurse #1 reviewed the current physician orders for Resident #228 and confirmed there were no orders in place for an indwelling urinary catheter. Nurse #1 stated there should have been an order for the catheter which would indicate the size of the catheter, the amount of saline that should be in the balloon to secure the catheter in place, and orders to maintain and care for the catheter. Nurse #1 stated if the orders had been put into the computer system, they would have transferred to the treatment administration record so that nursing staff could document that the catheter was assessed each shift to make sure the catheter was patent (draining) and to make sure the tubing was secured to the resident ' s leg to prevent kinking. Nurse #1 did not know why the order was not put in the computer system for	F 690	includes the size of the catheter and orders to maintain and care for the catheter. The Unit Managers will conduct a 100% observation of catheters weekly x 4 weeks and monthly x one month to ensure and educate staff that all catheters must be positioned below the level of the bladder to prevent back flow of urine. The Director of Nursing will forward the Catheter Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The Executive QAPI Committee will meet monthly for two (2) months and review the Catheter Audit Tool to determine trends and/or issue that may need further interventions put into place and to determine the need for further monitoring.	

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the indwelling urinary catheter. Nurse #1 stated the follow up appointment for the Urology appointment was made and was scheduled for 01/27/22.

An interview was conducted with NP #1 via phone on 01/07/22 at 12:50 PM. NP #1 stated when a resident was admitted to the facility with an indwelling urinary catheter the nursing staff would obtain the orders for the catheter as well as care of the catheter.

An interview was conducted with the Director of Nursing (DON) on 01/06/21 at 4:00 PM. The DON stated the nurses should have put the orders in place for the indwelling urinary catheter to indicate the size of the catheter, the balloon size, the diagnosis for having the catheter, and orders to care and maintain the catheter when the resident was admitted.

2. Resident #61 was admitted to the facility on 11/2/21 with diagnosis to include urinary retention.

Review of the quarterly MDS Assessment dated 12/15/21 noted Resident #61 was moderately cognitively impaired and required extensive assistance with activities of daily living (ADL ' s). The MDS noted Resident #61 had an indwelling urinary catheter.

Review of the care plan for Resident #61 dated 11/2/21 noted she required an indwelling urinary catheter due to inability to empty bladder. The interventions included to check for patency and urinary output per acceptable standards of practice or as ordered by a physician.

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Review of the Physician ' s orders for Resident #61 revealed orders, in part, for a 16Fr with a 30cc balloon foley catheter and to check placement of catheter and primary bag every shift.

On 1/6/22 at 11:40 AM Resident #61 was observed to be up in a chair in the reclining position with a lift pad underneath her and covered with a blanket. Resident #61 ' s urinary drainage bag was laying on her abdomen and urine was not draining in the tubing. Resident #61 stated the nurse aides (NA) had forgotten to hook the catheter bag to the chair.

An observation and interview with Nurse #6 was conducted on 1/6/22 at 11:45 AM. Nurse #6 was shown where the urinary drainage bag was placed. She attached the urinary drainage bag on the chair frame below the level of the resident ' s bladder. She stated the NAs ' must have forgotten to move the drainage bag after they transferred her to the chair. She stated NA #6 was assigned to care for Resident #61.

An interview was conducted on 1/6/22 at 11:48 AM with NA #6. She stated she forgot to move the urinary drainage bag after they transferred Resident #61 to the chair. She further stated the urinary drainage bag should be below the resident ' s bladder or it would not drain properly.

An interview was conducted on 1/6/22 at 11:51 AM with the Administrator and the Director of Nursing (DON). They stated they expected the urinary drainage bag to be placed below the level of the bladder. They further stated it should not have been in the chair with the resident.

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F 690	Continued From page 18	F 690		
F 849 SS=D	. Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 849		2/3/22

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(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms

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associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is

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responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

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F 849	Continued From page 22 §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain the hospice provider's plan of care for 1 of 1 sampled resident reviewed for hospice care. (Resident #84) The findings included: Resident #84 was admitted to the facility on 01/09/2021 and most recently readmitted on 07/29/2021 with diagnoses that included anemia, heart failure, hypertension, neurogenic bladder, diabetes, hyperlipidemia, and Alzheimer ' s disease. A physician's order dated 08/04/2021 indicated Resident #84 was admitted to hospice services. The quarterly Minimum Data Set (MDS) assessment dated 11/10/2021 indicated Resident #84 ' s cognition was intact, and he was receiving hospice services. The electronic medical record on 01/06/2022 revealed there was no plan of care from the hospice provider in Resident #84's medical record. An interview was conducted with the Minimum data Set (MDS) nurse on 01/06/2022 at 11:35	F 849	F849-Hospice Services Resident’s #84’s hospice care plan was obtained on 1/6/22 and placed in resident’s chart. The Social Service Director reviewed the care plans of all other residents receiving hospice service on 1/28/22 to ensure the hospice care plan was obtained and present in each resident’s medical record. Any issues were corrected. Systemic Changes Social Service staff was in-serviced by the Regional Nurse Consultant on 1/28/22 regarding ensuring hospice care plans are obtained from the hospice service, when complete, and placed in each resident’s medical record. The Social Service Director notified the hospice companies on 1/28/22 regarding the expectation that all residents’ hospice care plans be provided as soon as soon as completed and placed in each resident’s medical record.	

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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 849	Continued From page 23 AM, and she indicated the provider ' s care plan was not in the resident ' s record and she was going to follow up with the hospice provider to fax the hospice care plan to the facility. The MDS nurse also indicated the hospice provider did not attend the last resident ' s care conference meeting. An interview was conducted with the Director of Nursing (DON) on 01/06/2022 at 12:10 PM. She reported that the facility Social Worker (SW) #1 was the designated staff who coordinated care with the hospice providers. The DON confirmed the hospice provider's plan of care was not in the record. She stated she was going to have Medical Records staff obtain this document. SW #1 was interviewed on 01/06/2022 at 3:00 PM, She indicated her responsibility was only to invite the hospice provider to attend the care plan conference. SW indicated she did not review the records of residents on hospice services to ensure the hospice care plan was in place. On 01/06/2022 at 3:34 PM the hospice provider's plan of care for Resident #84 was received by fax at the facility. This plan of care was for the certification period of 11/01/21 through 11/29/2022. During a follow up interview with the DON on 01/06/2022 at 4:25 PM, she stated SW should coordinate care plan conference with the hospice provider and the MDS should be making sure the hospice provider ' s plan of care was placed in the record.	F 849	The Social Service Director will audit 10% of residents receiving hospice weekly x 4 weeks and monthly x one month to ensure the hospice care plan has been obtained and is part of the Comprehensive Care Plan The Director of Nursing will forward the results of the audit to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The Executive QAPI Committee will meet monthly for two (2) months and review the to determine trends and/or issue that may need further interventions put into place and to determine the need for further monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/3/22

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F 880	Continued From page 24 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 25 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to follow facility policy and the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment (PPE) for staff entering rooms with residents on Enhanced Droplet Contact Precautions (EDCP). These observations were made for 3 of 3 staff members (Nurse Aide #3, Nurse Aide #4, and the Dietary Aide) observed for infection control on the COVID-19 quarantine unit. This occurred during	F 880	F880-Infection Prevention and Control 100% quizzes of all staff, including agency staff, were initiated by the QI Nurse on 1/27/21 to ensure that staff can successfully validate knowledge and understanding of proper Donning and Doffing full PPE. Quizzes will be completed by 2/3/22 On 1/16/22, a 100% audit was completed	

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F 880	Continued From page 26	F 880		

the COVID-19 pandemic.

Findings included:

The facility ' s infection control policy for "Personal Protective Equipment for Droplet and Contact Precautions" revised 7/15/21 revealed staff were required to perform hand hygiene and wear N95 mask, eye protection (goggles or face shield), gown, and gloves before entering resident rooms on the COVID-19 quarantine unit (rooms 816, 818, and 820).

Observation of the COVID-19 quarantine rooms on 1/3/22 at 3:13 PM revealed there were signs on the wall beside the room doors from the CDC for Enhanced Droplet Contact Precautions with instructions, in part, to perform hand hygiene, apply N95 mask if available, eye protection, and gown and gloves prior to entering room. There were no masks (N95 or surgical) or eye protection (face shields or protective eyewear) in the door caddy which contained gowns and gloves.

On 1/5/22 at 4:20 PM the Dietary Aide was observed passing snacks in room 816 wearing only a surgical mask and protective eyewear. He was not wearing a gown, gloves or N95 mask. Face shields and N95 masks were available in the caddy on the door with the gowns and gloves.

On 1/6/22 at 9:15 AM Nurse Aide (NA) #3 was observed in room 818 picking up a meal tray. She was wearing a surgical mask and protective eyewear. She was not wearing a N95 mask, gloves, or gown. NA #4 was observed picking up a meal tray in room 816 wearing a N95 mask and protective eyewear. She was not wearing a gown

by the QI Nurse of all staff to ensure proper use of PPE. There were no additional identified areas of concern during the audit.

An Inservice was initiated on 1/16/22 with all staff by the Staff Development Coordinator regarding proper Donning and Doffing of full PPE to include gown, gloves, mask, and eye protection. This Inservice will include agency staff and CNA waiver students.

The Administrator, Staff Development Coordinator, or Director of Nursing will ensure that all staff have completed the Inservice to include agency employees or CNA waiver students by validation of signatures. The Inservice will be completed by 2/3/22.

An In-service was initiated on 1/27/22 with all staff on the CDC video regarding Keep Covid Out. In-service will be completed by 2/3/22.

The Administrator, Staff Facilitator, or Director of Nursing will ensure that all staff completed the Inservice by validation of signatures.

The Staff Development Coordinator will observe 10 staff/resident care interactions weekly x 4 weeks then monthly x 1 month to include agency staff and CNA waiver students utilizing the PPE Audit Tool. This audit is to ensure staff are utilizing appropriate PPE to include gown, N95 mask, eye shield and gloves per facility

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F 880	Continued From page 27 or gloves. The Infection Preventionist (IP) also observed the staff not wearing required PPE. He asked NA #3 and NA #4 why they were not wearing PPE and they both stated they did not know it was the COVID-19 quarantine unit. An interview was conducted on 1/5/22 at 4:20 PM with the Dietary Aide. He stated he had not looked at the signs on the wall prior to entering room 816. He stated he had not been educated on EDCP for the COVID-19 quarantine unit. An interview was conducted on 1/6/22 at 9:30 AM with the Staff Development Coordinator (SDC). She stated the last inservice for use of PPE for all staff was the company ' s computer-based training on 12/7/21. She further stated the staff had to print the certificate when they completed the training and bring it to her within 30 days. Staff that do not complete the training within 30 days were removed from the schedule and not allowed to work until it was completed. She indicated the Dietary Aide had been reeducated on use of PPE. An interview was conducted with the Administrator and the Director of Nursing (DON) on 1/6/22 at 8:50 AM. They both stated they expected all staff to follow the PPE guidance posted on the signs at the residents ' doors.	F 880	protocol. The Staff will address all areas of concern during the audit to include providing use of appropriate PPE and/or re-education of staff/residents. The DON will review and initial the PPE Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the PPE Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the PPE Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	