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 11/07/2014

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 started on 10/28/14 through 10/30/14 resulting in a deficiency at tag F312. The survey team went back to the facility on 11/3/14 to conduct a recertification survey with additional complaints. The survey team exited the facility on 11/07/14. The complaint investigation survey and the recertification/complaint investigation were combined into one Event ID# CRC311.	F 000		
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 by: Based on observation, record review and staff interviews, the facility failed to ensure that staff thoroughly cleansed the skin of 1 of 1 sampled residents (Resident #6) when being observed receiving personal care. Findings included: The objective of the facility's procedure for providing PERINEAL CARE, dated April 2013, was to cleanse the perineum and to prevent infection and odors. A nurse assistant orientation skills checklist, with a date of hire of 08/05/14 for Nurse Aide #1 (NA #1), noted that she had been checked off for providing care to the incontinent resident.	F 312	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 Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any	11/10/14

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

Electronically Signed | 11/21/2014

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F 312	Continued From page 1 Resident #6 was admitted to the facility on 08/08/14. Cumulative diagnoses included diabetes mellitus, hypertension and dementia. The Admission Minimum Data Set (MDS) assessment of 08/15/14 noted the resident required extensive to total assistance from staff for hygiene and bathing. Resident #6 was continent of both bowel and bladder. According to the Care Area Assessment (CAA) detail she triggered in urinary incontinence and activities of daily living which were to be addressed in the care plan. Resident #6's care plan of 10/10/14 identified problems with requiring assistance for the physical process of toileting related to decreased strength. It was noted that Resident #6 had generalized weakness 2 weeks prior to admission and had fecal incontinence. Staff were to assist her on and off of the bedpan. A problem was also identified with being at risk for skin breakdown related to needing assistance with turning and repositioning. Staff were to inspect her skin during care and report any abnormalities. On 10/30/14 beginning at 9:45 AM, NA #1 went into Resident #6's room to provide personal care. She told the resident what she was about to do and proceeded to prepare a basin of warm water. She washed her hands and gloved. She obtained a no rinse soap from the night stand and placed it on the overbed table alongside the basin of water. She had one wash cloth and one towel. NA #1 told Resident #6 she was going to clean her up and untaped her brief. When she pulled the brief away from her body it was noted that she had a very large amount of loose yellowish stool in the brief. Stool was noted to cover the entire perineal	F 312	deficiency is accurate. Further, Premier Nursing and Rehabilitation Center 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. Resident # 6 received a bed bath per resident preference on 10/30/2014 by assigned CNA. Certified Nurse Assistant # 1 was in-serviced on 10/31/2014 on the proper procedure for performing incontinence care thoroughly cleansing the resident's skin with hands on demonstration by Staff Facilitator. A 100% observation of incontinence care will be done for all CNA□s on all shifts by Staff Facilitator, DON, ADON, Unit Supervisor, MDS nurse, TX nurse, and/or QI nurse completed by 11/6/2014. All CNA□s will be retrained immediately by Staff Facilitator, DON, ADON, Unit Supervisor, MDS nurse, TX nurse, and/or QI nurse for all identified areas of concern. 100% in-servicing of all CNAs will be provided by the Staff Facilitator on the proper procedure for performing incontinent care, thoroughly cleansing the resident's skin, with return demonstration and will be completed by 11/06/2014. All newly hired staff will be in-serviced upon hire by Staff Facilitator.	

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F 312	Continued From page 2 area extending up to and in the abdominal skin folds. Stool was noted to be outside the brief and on the bed pad. The skin folds as well as both groins and pubic area were very reddened in appearance. NA #1 used the brief to remove some of the stool. While she was cleansing the stool from her skin, Resident #6 requested the bed pan. NA #1 asked her to roll onto her right side so she could place the bedpan. She wiped away some of the stool from the perineum and the back part of the body with a disposable wipe and rolled the soiled bed pad underneath her buttocks. She asked Resident #6 to roll back onto her back while she obtained the bed pan. NA #1 placed the bed pan underneath Resident #6. After approximately 5 minutes Resident #6 stated she was finished with the bedpan. NA #1 removed the bed pan and flushed the contents in the commode. She removed her gloves, washed her hands and donned a clean pair of gloves. NA #1 told Resident #6 she was about to clean away the rest of the stool. She took the wash cloth and placed it in the water. She sprayed the no rinse soap onto the wash cloth and proceeded to remove the remaining stool from the abdominal folds. NA #1 flipped the edges of the wash cloth several times as she removed stool from the groins and the perineal area. She rinsed the soiled wash cloth out in the basin of water and continued to wash the stool from Resident #6's skin. She did not empty the basin of water nor did she use a clean wash cloth to continue cleansing. She asked Resident #6 to spread her legs. She used the same wash cloth to remove the stool from the vaginal area and rinsed the cloth out into the basin of water. She asked Resident #6 to roll onto her right side and she used the same wash cloth to remove the remaining stool residue from her buttocks. She	F 312	Incontinence care will be monitored by Staff Facilitator, DON, ADON, Unit Supervisor, MDS nurse, TX nurse, and/or QI nurse for 10% of resident population to include resident # 6 and CNA # 1 weekly x 4 weeks and monthly x 2. Using a resident care audit QI tool. Retraining will be conducted immediately for any identified areas of concern by Staff Facilitator, DON, ADON, Unit Supervisor, MDS nurse, TX nurse, and/or QI nurse. The Executive QI Committee will meet monthly x 3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	

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F 312	Continued From page 3	F 312		

dried her skin with a towel and placed a clean brief underneath her buttocks. NA #1 asked her to roll back onto her back. She reached into the drawer of the night stand and obtained a container of powder and squirted the powder onto the reddened areas of her skin. She taped the clean brief into place.

During an interview with NA #1 on 10/30/14 at 1:10 PM. She stated she had been trained to knock to gain entrance into the resident's room. She stated she should tell the resident what she was about to do and wash her hands. NA #1 stated she should gather all of the necessary supplies for care and wear gloves. NA #1 reported she should always wash in a front to back manner when cleansing the resident. She stated she would change the bed pad if it was soiled. NA #1 commented that she was taught to use wipes to clean the perineal area and to use as many as needed to properly clean the resident. NA #1 stated the facility provided a peri-wash cleanser as well as a no rinse soap for staff to use for personal care. When questioned about using a wash cloth that was soiled with stool to cleanse Resident #6's skin, she stated she probably should have had more than one wash cloth in the room. NA #1 stated she didn't leave the room to get more because she didn't want to leave her in the room alone without a brief. NA #1 stated she should not have placed the stool soiled wash cloth back into the basin of water and should have used a clean cloth.

During an interview with the Director of Nurses (DON) on 10/30/14 at 5:15 PM, she stated the resident's dignity should be preserved while providing incontinent care. She stated staff should knock before entering the room and

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F 312	Continued From page 4 identify themselves to the resident. The DON stated the aide should gather all of the necessary supplies and wash their hands before donning gloves. She commented staff have been educated to use disposable wipes or soap and water to thoroughly cleanse a resident's skin. The DON stated staff should remove all stool residue from the skin. The DON remarked that random audits were performed to observe staff while providing personal care. She stated it was not acceptable for staff to rinse a wash cloth that was soiled with stool into the basin of water and continue to use that water and the same cloth to clean the resident's skin. The DON stated that the aide could have covered the resident up and left the room to obtain more wash clothes. She reported that during orientation aides were given intense training and were paired with a trained preceptor for several days before being able to provide care independently. The DON stated all staff had to be checked off before being allowed to work on the floor.	F 312		