PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	<u> </u>	01702/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 001 SS=F	S403.748, §416.54, § §482.15, §483.73, §4 §485.542, §485.625, §486.360, §491.12  The [facility, except f must comply with all and local emergency The [facility, except f must establish and m emergency prepared requirements of this s preparedness progra limited to, the followin  * (Unless otherwise i the terms "facility" or refers to all provider this appendix. This i lieu of the specific pr the regulations. For specific regulation for noted as well.)  *[For hospitals at §48 comply with all applic local emergency prep The hospital must de comprehensive emer program that meets t section, utilizing an a emergency prepared but not be limited to,  *[For CAHs at §485.6 with all applicable Fe	ndicated, the general use of "facilities" in this Appendix and suppliers addressed in a generic moniker used in ovider or supplier noted in varying requirements, the rethat provider/supplier will be \$2.15:] The hospital must cable Federal, State, and paredness requirements.	E 00	,		7/27/24
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/26/2024

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.

**Electronically Signed** 

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETION	
E 001	program, utilizing an emergency prepared but not be limited to, This REQUIREMEN by: Based on record reviacility failed to main Emergency Prepared failed to provide annuemergency training process the emergency community-based exemply include: On the facility's 2024 the Emergency Prepared to the emergency Prepared to the facility's 2024 the Emergency Prepared to the emergency Prepa	nd maintain a rgency preparedness all-hazards approach. The ness program must include, the following elements: Γ is not met as evidenced riew and staff interviews, the tain a comprehensive dness (EP) plan. The facility ual education for the program to the staff and failed	E 00	,	or EP ment.	
	A review of the facility's Emergency Preparedness plan was conducted on 6/14/2024 revealed the following:  a. There was no documentation regarding annual education of the EP plan to all their staff or providers.  b. There was no documentation of an annual full scale community-based exercises was conducted for EP testing.  In a phone interview on 7/1/2024 at 1:23 pm with Medication Aide #5, who had worked at the facility 3 years, did not know what the Emergency Preparedness Plan was when asked. When explained it was a plan how staff would respond to emergency events such as fire emergencies or			Home Administrator (LNHA) educate Maintenance Director on the importar of ensuring annual EP education is provided to all staff.  On 7/18/2024, the LNHA educated the Maintenance Director on ensuring documentation is completed regarding annual EP education that is provided staff.  On 7/18/2024, the LNHA educated the Maintenance Director on the important of annual documentation of full-scale community-based exercises being conducted for EP plan testing.  The LNHA, Maintenance Director, or	nce ng all to all ne nce	

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			A. BUILDIN	G			
		345185	B. WING _		0:	C // <b>02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>		
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
E 001	Continued From page	e 2	E 0	01			
	stated the facility had and she was not awa plan in the event of a could not recall receipolicies and procedu. Preparedness in the received an education the last year to compute In an interview with Mast 6 years) with the 6/14/2024 at 5:00 pm conducted fire drills at the staff scheduled to not conducted EP tra	last year and had not nal competency checklist for lete related to the EP plan.  Maintenance Director (for the Administrator present on		Designee will educate all staplan by 8/5/2024. After 8/5/2 hired staff will be educated oby the LNHA, Maintenance I Designee during their new horientation.  Beginning 7/27/2024, weekly weeks, the LNHA, Maintena or Designee will interview 3 across various shifts to valid knowledge of the EP plan.  Beginning 7/27/2024, once (minimum) for 12 months the Maintenance Director, or Deensure annual EP education	2024, newly on the EP plan Director, or ire employee  y for 12 nce Director, staff members ate their  (1) a month (at LNHA, ssignee will		
	the facility had not co community-based tra recertification survey	nducted a full scale ining since the last		all staff and the education co be documented regarding the Beginning 7/27/2024, the LN	onducted will se EP plan.		
In an interview with the Administrator or 6/14/2024 at 5:00 pm, she explained six resignation one month ago of Nurse #2 had worked at the facility for the last six was the person responsible for EP train updating the EP manual, she (the Admi		n, she explained since the th ago of Nurse #22, who cility for the last six years and onsible for EP training and		Maintenance Director, or De ensure annual full-scale con exercises are conducted for testing and the exercises co be documented regarding the	signee will nmunity-based EP plan nducted will		
	was the responsible   She stated the facility scale community-bas she was unable to loc educational training t say all staff had recei year on EP policies a	person of the EP manual.  I had not participated in a full sed EP training, and since cate documentation of EP or all the staff, she could not lived EP training in the last		The audits will be reviewed Maintenance Director, or De the results of the audits will the monthly Quality Assuran Performance Improvement (Meeting monthly for 3 month Committee will review the aumake recommendations as ensure ongoing compliance	signee, and be reviewed in ce and QAPI) ns. The QAPI udits and necessary to		
	At the end of the surv	ey on 7/2/2024, the facility P educational training		The facility will utilize this pla correction to ensure complia mandated regulation by 8/6/	an of ince under the		

Facility ID: 923415

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			l	C <b>02/2024</b>
	ROVIDER OR SUPPLIER	NTER		106	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMERON STREET IKE WACCAMAW, NC 28450	, <u> </u>	02/2024
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E 001	Continued From page records that had beer recertification survey	n conducted since the last on April 2023.	E 0		audits will continue for the specified timeframe as described in this correctivaction.	⁄e	
	conducted onsite from 06/14/24. Onsite vali jeopardy removal plan 6/19/24. Addtional in remotely on 6/26/24 t	dation of the immediate					
	NC00215202, NC002 NC00216128, NC002 NC00216522, NC002 NC00217555, NC002 NC00218317, NC002	214039, NC00214303, 215973, NC00216122, 216401, NC00216423, 216980, NC00217469, 217685, NC00218316, 218320, and NC00218322.					
	Intakes NC00217685 NC00216423, NC002 NC00218317, NC002 resulted in immediate	16401, NC00218316, 118320, and NC00218322 jeopardy.					
	CFR 483.12 at tag F6 of (K) CFR 483.25 at tag F6 of (K)	600 at a scope and severity 697 at a scope and severity 755 at a scope and severity					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
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		345185	B. WING _			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	Ī		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 000	of (K)  The tags F600, F697 Substandard Quality Immediate Jeopardy F755 on 5/9/24 and w Immediate Jeopardy and was removed on Immediate Jeopardy and was removed on on Immediate Jeopardy and was removed on Immediate Jeopardy and Immediate Jeopardy	760 at a scope and severity  , and F760 constituted of Care.  began for F580, F697, and was removed on 6/16/24.  began for F600 on 3/14/24 6/16/24.  began for F760 on 3/14/24 6/15/24.	FO	000			
F 550 SS=D	self-determination, ar access to persons an outside the facility, in this section.  §483.10(a)(1) A facility with respect and dignaresident in a manner promotes maintenancher quality of life, receindividuality. The facility promote the rights of §483.10(a)(2) The face access to quality care severity of condition, must establish and m	Rights. (2)(b)(1)(2)  Rights. ght to a dignified existence, and communication with and and services inside and cluding those specified in  ty must treat each resident with and care for each and in an environment that the ce or enhancement of his or ognizing each resident's lity must protect and	F 5	550			7/27/24

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0	110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 550	residents regardless §483.10(b) Exercise The resident has the rights as a resident of or resident of the Un §483.10(b)(1) The faresident can exercise interference, coercio from the facility. §483.10(b)(2) The re free of interference, or reprisal from the faci rights and to be supplexercise of his or hel subpart. This REQUIREMENT by: Based on record rev interviews, the facility (Resident #50) with or nurse refused to leav request and when th out of the shower whe expressed feelings or was for 1 of 1 resident Findings included: Resident #50 was ac 10/06/23. Diagnoses below the knee ampo	under the State plan for all of payment source.  of Rights. right to exercise his or her if the facility and as a citizen ited States.  cility must ensure that the ensure that ensure the ensure that ensure	F 5	Resident Rights were violated for #50 when nurse #12 did not exit the when asked to do so. On 6/12/202 nurse #12 was terminated. The revoiced satisfaction with the intervence No negative outcome occurred.  All residents residing in the facility been identified as having the pote be affected by the alleged deficient practice.  The Licensed Nursing Home Administrator (LNHA) and Directo Nursing (DON) met with the Region Ombudsman on 7/11/2024 to scheme Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to be given by the Resident Rights education and presentation to the province of the pr	he room 24, esident ention.  have ential to nt  r of onal edule a	

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		345185	B. WING _				02/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	06 CAMERON STREET		
PREMIER	LIVING AND REHAB C	ENTER		L	AKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 550	Continued From pag	ne 6	F!	550			
	behaviors.	,	, ,	300	Ombudsman. The Regional Ombudsm	an	
	beliaviors.			completed this education in-person on	all		
	1a Review of an inv	estigation report submitted to			7/25/2024 for all staff. Any staff who we	ere	
		ealth and Human Services			not in attendance will be educated by the		
		for an abuse allegation on			LNHA, DON, or Designee by 8/5/2024.		
	, ,	Resident #50 reported that the			After 8/5/2024 newly hired staff will be		
		Nurse #12) "hit" his leg three			educated on Residents Rights by the		
		ally aggressive towards him			LNHA, DON, or Designee during their i	าew	
	while attempting to g	give him his medication. No			hire employee orientation.		
	physical or mental in	jury was reported. This was					
		e and Department of Social			The LNHA, DON, or Designee, will		
	Services (DSS) on 0	2/15/24.			educate all staff by 8/5/2024 on Reside	nt	
				Rights, Dignity, and Respect.			
		report dated 02/15/24 stated,					
	_	0] stated that the offender			Beginning 7/27/2024, the LNHA, DON,		
		im on the leg 3 times and			Social Worker, or Designee will conduc	π	
		y aggressive towards him.			an interview with 3 alert and oriented residents per week x 12 weeks to ensure	-	
		got verbally aggressive with fender stated that she shook			Resident Rights are being followed by		
	the leg of resident to				staff members. The questions asked m		
	_	not strike him. No injuries			include but are not limited to asking if s		
	were noted at time o	•			members enter/leave the resident's roo		
	Word Hotel at time o	r reperung.			when asked. If a resident has a concer		
	A summary of the fac	cility investigation dated			the Social Worker or Designee will writ		
		Concerns were reported to			grievance regarding the concern,		
	l	the resident [Resident #50].			investigate the concern, and implemen	t	
	It was determined th	at the allegation of physical			an intervention to rectify the grievance.		
		intiated, however it was			The LNHA, DON, or Designee will ensi	ıre	
		employee [Nurse #12] placed			if a staff member is involved in the		
		sident [Resident #50] shaking			concern the staff member will be		
	him when asking if h				re-educated and employee disciplinary		
	medications. It was determined the employee action will be taken if necessary.		action will be taken if necessary.				
		bally aggressive to the			D		
		ed him before exiting room.			Beginning 7/27/2024, the audits will be		
		2] admitted to not leaving his			reviewed by the LNHA or DON, and the		
	room when asked ar	nd continued to provoke him."			results of the audits will be reviewed in monthly Quality Assurance and	uie	
	An interview with Do	sident #50 was conducted on			Performance Improvement (QAPI)		
		. Resident #50 stated Nurse			Meeting monthly for 3 months. The QA	PI	
	55, 15, = 1 at 1.00 1 W		- 1			• •	

Facility ID: 923415

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NAME OF B	ROVIDER OR SUPPLIER	343103	1 2:	STREET ADDRESS, CITY, STATE, ZIP C		102/2024	
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PREMIER	LIVING AND REHAB CE	NTER		106 CAMERON STREET			
				LAKE WACCAMAW, NC 28450			
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F 550	Continued From page	e 7	F 55	50			
F 3300	#12 had come into hi 9:30 PM, had hit his him he needed to tak #50 told Nurse #12 to hit his leg again, insis answer if he was goin Resident #50 stated get out of his room an and insisted again the answer if he was goin Resident #50 stated covered his head with he pressed the call him member to come in a him and refusing to le Nurse Aide (NA) #7 of trying to get Nurse #1 she kept insisting on Resident #50 stated no answer, but by hir times, Nurse #12 sho refusal to take his medications angry when she was asked her to leave se stated he felt like Nur a child.  A phone interview with at 12:35 PM revealed standing at the nurse she had heard Nurse #50 and heard Resid out, get out of my roo NA #6 they needed to see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going of the standing at the see what was going the see what wa	leg and woke him and told leg at out of his room and she sting she needed a yes or no leg to take his medications. The again told Nurse #12 to leave him alone, but leg at third time leg at she needed a yes or no leg to take his medications. The told her to get out and he leght to get another staff leght witness Nurse #12 hitting leave the room. He stated came into the room and was 12 to leave him alone, but		Committee will review the a make recommendations as assure ongoing compliance. The facility will utilize this progrection to ensure complimandated regulation by 8/6 audits will continue for the stimeframe as described in taction.	necessary to e is sustained. It is sustained and it is sustained ance under the size of the specified		

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F 550	until you say yes or n #50 continued to tell Nurse #12 continued answer. She stated I over his head and sh going to ask one mor to leave the room." N entered the room she #50 to take his medic refusal to leave the ro requested and the ins medications went on stated she never saw #50. She added, Nur one hand and the me hand. NA #7 stated he was getting louder kept refusing to leave there was a lot of nar #12 and Resident #5 each other names su  An interview with NA 02/15/24 Nurse #12 N	d "I am not going anywhere to." NA #7 stated Resident Nurse #12 to leave, and to demand a yes or no Resident #50 had the covers e heard Nurse #12 say "I am the time and he said I told you NA #7 stated when she e tried to encourage Resident stations. She stated the pom as Resident #50	F 5	,		
	the nurse's station whaway from the nursin could hear Resident; out of the room and Nare you going to take stated the back and f Resident #50 and Numinutes. She and Nand she noticed Nursione hand and the methand. NA #6 stated she	2 and Resident #50 yelling at nich was about 4 rooms g station. She stated she #50 telling Nurse #12 to get Nurse #12 saying "Yes or no your medications?" NA #6 forth arguing between arse #12 went on for a few A #7 went down to the room see #12 had a cup of water in edication cup in the other she did not see Nurse #12 dent #50, but she was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY IPLETED
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F 550	Continued From pag	e 9 room when he asked her to	F 5	550		
	and Resident #50 wa	as getting angry and upset ot leaving when asked to.				
	on 06/14/24 at 4:27 F 02/15/24 she was try medications and he t stated he did not out telling her to get out estated the last time F medication he accus medications when he them. She added, shanswer to accurately the medications. Nu up "gingerly" by shak did not touch him mohad the sheet over higet out of his room. when she arrived in the state of the state of the state of the sheet over high the sheet	as conducted with Nurse #12 PM. Nurse #12 stated on ing to give Resident #50 his old me to leave. Nurse #12 wardly refuse, he just kept of his room. Nurse #12 desident #50 refused his ed her of not giving him his e actually refused to take he wanted a yes or no document that he refused rse #12 stated she woke him ring his leg one time and she re than once. She stated he is head and was telling her to She stated he was upset he room and he did not or while she was in the room,				
	but he was yelling at yes or no answer and stated, in looking bac room and accepted h room" as a refusal ar of "yes" or "no", but s going to report her to did not bring in his m	her while she persisted for a discalling her a liar. She ck, she should have left the nim stating "get out of my and documented that instead she was concerned he was management stating she edications. Nurse #12 ent #50 stupid or crazy.				
	Administrator stated investigation it had be #12 did not physically she did refuse to leave	nducted with the 14/24 at 5:00 PM. The after she conducted the een determined that Nurse y abuse Resident #50 but we his room when asked led to treat the resident with				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Administrator added, regarding dignity and early February 2024. of correction for this in accepted as it did corcomponents.  1b. Review of an incirevealed the resident asked to get a showe was visiting. Nurse A hall took resident to s Resident stated he was 20 minutes before the came in and assisted Camera footage was call light sounded and 23 seconds before Noback to the shower to back into his wheelch Review of the camera incident report dated following:  10:42 AM Resident # and NA #8 followed Find the shower room 10:46 AM Nurse Aide 10:48 AM Nurse Aide 10:49 AM Nurse Aide 11:00 AM Call light in 11:16 AM Nurse Aide room 11:20 AM Nurse Aide room	whonoring his request. The she had three in services respect since she started in The facility provided a plan incident but it was not nationall the required  dent report dated 05/17/24 [Resident #50] reported he rearly because his family ide [NA #8] from another hower and then left. as left in shower room for 15 he same Nurse Aide [NA #8] him back to his wheelchair. reviewed and confirmed the diwas on for 15 minutes and curse Aide [NA #8] came assist Resident in getting air.  a footage time line on an 05/17/24 revealed the  50 entered the shower room desident #50 and entered the  #8 exited the shower room  #8 reentered the shower	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>7/02/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 106 CAMERON STREET LAKE WACCAMAW, NC 28450		710212024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	1:00 PM revealed unattended in the He stated prior to smoking porch an shower early on the coming. Resident said he was not o would get him stated no one can turned the water a washed himself at to answer the call to yell for someon one came. Resid did not have wheen not able to move i reach a towel and prosthetic leg and continued to yell, #50 stated he the from the shower cobanged his leg and himself safely. Refine the shower of the him to his wheeld was very angry ar	Resident #50 on 06/14/24 at on 05/17/24, he was left shower for over 15 minutes. the shower he was on the d stated he wanted to get a his day because he had family to #50 stated Nurse Aide (NA) #8 in her assignment, but that she red in the shower. He used the red help when he was done. He had after a few minutes so he again to keep himself warm and gain while waiting for someone bell. He stated he then started he to come and help him, but no cent #50 stated the shower chair els like his wheelchair so he was to easily, but he was able to dry off and reached his put it on. He stated he but still no one came. Resident in attempted to transfer himself shair to the wheelchair but he d was not able to transfer esident #50 stated after about a finally came back and helped shower chair and transferred hair. Resident #50 stated he had frustrated that he was left and wait so long to get	F	550	Y)		
	06/14/24 at 2:35 F she was on the sr and he reported h his aides from the	conducted with NA #8 on PM. NA #8 reported on 05/17/24 noking porch with Resident #50 e wanted a shower. He stated 100 hall were busy so she told t him in the shower. NA #8					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLETION	
F 550	helped transfer Res from his wheelchair his clothes and his purned on the water shower. NA #8 stat was assigned to the was assigned to the to the store to get so the street and only it they were back with when they came ba going off and Nurse computer at the nur went into the shower was still in the shower getting dressed and shower room. She angry and wanted to in the shower room.  An interview was consolidated and stated he him today and he wis said she would give Resident #50 in the was in the shower; that we were leaving across the street to #50 was in the show they could reported they were and when they cam the shower room. In the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was the shower room to shower. Nurse #7 responses to the street was	gned to the 200 hall, but she ident #50 to a shower chair and assisted with removing prosthetic leg. She then and he began to take his ed that she and Nurse #7 who a 200 hall told Nurse #9 who a 100 hall that they were going pap which was located across minutes away. NA #8 stated in 15 minutes or less and ck, they saw the shower light #9 was sitting at the se's station. She stated she er room and saw Resident #50 yer. She assisted him with brought him out of the stated Resident #50 was very to know why his aides left him	F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01102/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 550	assist him.  An interview was conphone on 06/13/24 at reported she was the hall on 05/17/24 when She stated she was son 05/17/24 when Reand asked where his Resident #50 was vebeing left in the show was answering the castated Resident #50 thim in the shower and had learned from NA left the building to go until they returned. Nurse #7 reported was in the shower the store. Nurse #9 shearing the call light of An interview was confon 06/18/24 at 10:39 had worked at the factor about 8 weeks. Sto Resident #50 on the H4 reported she did in happened on 05/17/2 Resident #50 in the store were doing resident considered were doing resident considered was years.	ducted with Nurse #9 via 2:19 PM. Nurse #9 nurse assigned to the 100 re Resident #50 resided. ritting at the nurse's station resident #50 came to the desk resident #50 came to one resident #50 came to the desk resident #8 that she and Nurse #9 stated she resident #9 stated neither NA red to her that Resident resident #60 came to the first the store, but it was not red to her that Resident resident #60 came to the first fir	F 55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			07/	02/2024
	IDER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
An Nu DO alvers	ursing (DON) on 06/DN reported that a revays be with a resident and a shower. The ow NA #8 and Nursident telling anyone pectation of nursing shower room should be reported assistance with the was sounding seded assistance with the resident set with the resident site in injury and has a significant change and the was sedent involved the seded to discontinue set the seded to discontinue seded to discontinue set the seded to dis	ducted with the Director of 14/24 at 11:00 AM. The nursing staff member should lent whenever they were a DON stated she did not be #7 left the building on to to kay for them to leave.  She stated her a staff was that the call bell do have been responded to a she stated Resident #50 th getting dressed and ower room for 15 minutes assed was too long.  ury/Decline/Room, etc.)  O(i)-(iv)(15)  Cation of Changes.  Cediately inform the resident; cent's physician; and notify, ther authority, the resident in there issing the resident which cas the potential for requiring graph in the resident's physical, all status (that is, a in mental, or psychosocial eatening conditions or graph in the state of the state		550			7/27/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 580	(14)(i) of this section all pertinent informat is available and prov physician. (iii) The facility must resident and the resi when there is- (A) A change in room as specified in §483. (B) A change in resident in section (iv) The facility must update the address (phone number of the representative(s).  §483.10(g)(15) Admission to a computat is a composite of §483.5) must disclosits physical configural locations that compripart, and must speciroom changes between under §483.15(c)(9). This REQUIREMENT by:  Based on record revent in the section of the section interviews physician interviews physician that the section interviews physicia	the facility must ensure that son specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or lent rights under Federal or lons as specified in paragraph in.  The record and periodically mailing and email) and resident  Toosite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various see the composite distinct by the policies that apply to len its different locations  To is not met as evidenced riew, and staff, resident, and the facility failed to notify the	F 58	The facility failed to notify the physic that the scheduled medication gabap was not administered.  Resident #51 was prescribed gabape 800 milligrams (mg) four times daily f nerve pain. Resident #51 missed a to 21 doses of the medication from 5/8/2 through 5/13/2024 and had complain constant pain up to a 10 (on a scale of to 10 with the 10 being the worst pair	entin entin or otal of 2024 ts of of 0	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345185	B. WING			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 16	F	580			'
	· -	le), numbness in her legs,			possible), numbness in her legs, and		
		physician was not notified of			spasms and the physician was not noti	fied	
		as prescribed gabapentin			of this.		
	800 mg two times dai						
	_	tified that Resident #46			Resident #46 was prescribed gabapen	tin	
	missed 14 doses of the	ne medication from 5/10/24			800 mg two times daily for nerve pain.		
	through 5/17/24 resul	ting in trouble sleeping,			The physician was not notified that		
		usea, and being unable to			Resident #46 missed 14 doses of the		
		routine due to pain in her			medication from 5/10/2024 through		
	legs. Additionally, the facility failed to notify the				5/17/2024 resulting in trouble sleeping,		
	physician that 14 dos				anxiety, irritability, nausea, and being		
	_	as administered to Resident			unable to complete her normal routine		
	#39 instead of the an				due to pain in her legs.		
		ate 875 mg-125 mg) that hysician on discharge from			Additionally, the facility failed to notify t	he	
		ficient practice affected 3 of			physician that 14 doses of the antibiotic		
	10 residents reviewed	•			Amoxicillin 875 mg was administered to		
					Resident #39 instead of the antibiotic		
	Immediate Jeopardy	began for Resident #51 on			Augmentin (Amoxicillin-Clavulanate 87	5	
		lent reported a pain scale of			mg-125 mg) that was ordered by the		
	10, had not been rece	eiving gabapentin, and the			physician on discharge from the hospit	al.	
	physician was not not	tified, and on 5/12/24 for					
	Resident #46 when the	ne resident had increased			This deficient practice affected 3 of 10		
		ıg, had not been receiving			residents reviewed for notification. All		
	gabapentin, and the p	ohysician was notified.			residents residing in the facility have be	en	
		was removed on 6/16/24			identified as having the potential to be		
		emented an acceptable plan			affected by the alleged deficient practic	e.	
		dy removal. The facility			luura dieta la ananda banan fan Dasida	_4	
		iance at a lower scope and			Immediate Jeopardy began for Reside	זנ	
			#51 on 5/9/2024 when the resident reported a pain scale of 10, had not be	on			
		ducation is completed and			receiving gabapentin, and the physicia		
		out in place are effective.			was not notified, and on 5/12/2024 for	•	
		d at scope and severity "D."			Resident #46 when the resident had		
					increased pain, difficulty sleeping, had	not	
	Findings included:				been receiving gabapentin, and the physician was notified.		
	1. Resident #51 was	admitted on 10/19/23 with			, ,	ĺ	
		ded in part: chronic pain			Upon identification of the severity of the	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION  a. BUILDING		(X3) DATE SURVEY COMPLETED	
		245405	B WING			С	
		345185	B. WING _			07/02/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
PREMIER	LIVING AND REHAB	CENTER		106 CAMERON STREET			
I IXLIMILIX	LIVING AND INCIDAD	OLIVI LIK		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From pa	age 17	F 5	80			
F 580	syndrome, chronic arthritis, pressure u (a disorder that car stiffness, tightness the lower extremition Review of Residen revealed an 11/21/milligrams (mg) 4 to the May 2024 Med (MAR) indicated Rescheduled to be ac PM, 5:00 PM and 9 medication administ Resident #51's gat on 5/8/24 at 5:00 PM, 5:00 PM.  A pain assessment by Nurse #9. The Resident #51 had pain rating of 10 ar sleep and day to depain.  A nursing progress indicated Resident too much pain.  An interview was compared to the manufactured was compared to the manuf	back pain, rheumatoid alcers, and spastic paraplegia uses progressive weakness, pain and muscle spasms of es).  It #51's physician orders 23 order for gabapentin 800 imes per day for nerve pain.  Idication Administration Record esident #51's gabapentin was liministered at 9:00 AM, 12:00 estration notes revealed expentin was not administered and 9:00 PM and on 5/9/24, 1/12/24 and 5/13/24 at 9:00 AM,	F 5	alleged deficient practices, to Nursing Home Administrator wrote the Immediate Jeopar Plan and submitted the Remapproval. The Immediate Jeremoved on 6/16/2024 where implemented an acceptable Immediate Jeopardy removed terminated the agency Direct (DON) during extended survice 6/19/2024. The LNHA hired experienced non-contractuate 6/19/2024 to ensure future of the facility has also hired not including RNs and LPNs to compliance.  The DON or Designee will remove MARs) from March 2024 to residents receiving pain mere well as antibiotics, to ensure missing doses. All missing of reported to the provider and documentation will follow to compliance by 8/5/2024.  The DON or Designee will enurses and medication aides on the steps to follow when is not in stock, as well as predocumentation that describe that were taken to ensure the receives their medications a	r (LNHA) rdy Removal rdy Removal rhoval Plan for repardy was in the facility plan of al. The LNHA ctor of Nursing rey on an il DON on compliance. ursing staff ensure future  review all records reducate all respectively and reducate all respectively solution respec		
	Resident #51's gab 5/9/24 and 5/10/24 9:00 AM, 12:00 PM	00 PM. Nurse #9 stated papentin was not available on for the scheduled doses at 1 and 5:00 PM. Nurse #9 #51 refused her shower on		ensure compliance. After 8/s hired nursing staff will be ed DON or Designee during the employee orientation.	ucated by the		

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		345185	B. WING _	·····	07	/02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB	CENTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page 18 5/9/24 which was not normal for her, reporting she was in too much pain. Nurse #9 stated she was not aware that she should have notified the physician of Resident #51's increased pain and the ordered medication gabapentin that was not administered.			80 Beginning 7/27/2024, the I	OON or		
				Designee will audit pain me administrations 5 times per weeks to ensure all pain me given as ordered. Any miss administrations will result in with the appropriate staff near the control of the control	edication r week for 12 nedications are sed n re-education		
	An interview was conducted via phone on 6/13 at 5:12 PM with Nurse #8. Nurse #8 stated sh was assigned to Resident #51 on 5/8/24 and 5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 increased pain when she did not receive her gabapentin. Nurse #8 indicated she did not not the physician that Resident #51 had not receive			employee disciplinary action if necessary.  Beginning 7/27/2024, the End Designee will audit all antike medication administrations week for 12 weeks to ensure missing doses. Any missed	DON or biotic s 5 times per ire there are no		
	did not realize that physician that the r and not administere stated she did not r	apentin. Nurse #8 stated she she should have notified the nedication was not available as ordered. Nurse #8 report Resident #51's ne physician.		administrations will result in with the appropriate staff nemployee disciplinary action if necessary.  Beginning 7/27/2024, the a	nembers and on will be taken audits will be		
	increased pain to the physician.  A nursing progress note by Nurse #13 on 5/10/24 at 3:24 AM stated Resident #51 reported her legs were numb. The note stated the nurse informed Resident #51 there were no interventions for that and offered emergency room evaluation. Resident #51 declined to be sent to the emergency room.  Attempts were made to interview Nurse #13 via phone with messages left on 6/13/24 and 6/14/24 with no return call received.  An in-person interview was conducted with Unit Manager #1 on 6/13/24 at 8:00 AM. Unit Manager #1 revealed she was assigned to Resident #51 on 5/11/24 from 7:00 AM to 3:00 PM and she documented the medication			reviewed by the LNHA or Described by the audits will be monthly Quality Assurance Performance Improvement Meeting monthly for 3 monto Committee will review the amake recommendations as assure ongoing compliance. The facility will utilize this procorrection to ensure complimandated regulation by 8/6 audits will continue for the timeframe as described in action.	reviewed in the e and t (QAPI) of this. The QAPI audits and s necessary to e is sustained. Dan of liance under the 6/2024 and the specified		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	doses at 9:00 AM and #1 stated she did not medication gabapential administered and had Manager #1 was una not notify the physicial medication gabapential Resident #51.  A progress note writte at 3:48 AM indicated pain and spasming at emergency room. Resoriented and stated the gabapentin withdrawa.  An Emergency Depart 5/12/24 at 6:11 AM in evaluated due to acut gabapentin. The disc take prescription medincluding gabapentin to not stop taking presuddenly.  An interview was con #2 on 6/14/24 at 2:24 was an agency nurse from 7:00 PM to 7:00 Resident #51 on 5/11 recalled sending Res 5/12/24 due to uncon her prescribed gabap Resident #51 kept co shift and was shaking	available for the scheduled of 12:00 PM. Unit Manager notify the physician that the in was not available and not it increased pain. Unit ble to explain why she did an that the ordered in was not administered to the property of the propert	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 580	resident's change in be sent to the hospit the hospital per her Attempts were made phone with message with no return call rethe facility through at the facility through at A progress note write 2:40 AM revealed on urse was called to #51 complained of wover" and requested department. 911 was emergency room. It facility having receivemergency room stage of the emergency room stage of the emergency room stage of the emergency room.	e notified the provider of the condition and requested to tal. Resident #51 was sent to request.  e to interview Nurse #14 via es left on 6/13/24 and 6/14/24 eccived. Nurse #14 worked at	F 580			
	Gabapentin 800mg pharmacy. Resider at 9:41 PM.  An ED Summary da Resident #51 was e Resident #51 receive emergency room ar physician sent a new to the pharmacy.  An in-person intervir Director of Nursing The DON stated she	ta a new prescription for four times per day to facility in t#51 returned to the facility ted 5/13/24 indicated valuated due to acute pain. ed gabapentin in the d the emergency room w prescription for gabapentin ew was conducted with the (DON) on 6/12/24 at 2:00 PM. edid not know why the atin was not available for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0//02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLETION	
F 580	notified. The DON nurses to notify the were not available for the would be available for the physician. The staff did not have a understanding of with the medication was administration.  An interview via phore the physician on 6/18/2 indicated she was in since 6/7/24. The Figabapentin ordered a high dose of medication due to the severe pain. The Physician of the physician so they ordered and if the ordered and if the ordered and if the ordered and if the ordered and physician so they ordered the physician of the physician so they ordered and if the ordered and physician so they ordered the physician so the physician so the physician so the physician so they ordered the physician so th	why the physician was not stated she expected the physician when medications or administration.  ew was conducted with the 14/24 at 4:10 PM. The d she expected medications and administered as ordered he Administrator stated nursing comprehensive hat to do when they identify	F 580			
	2. Resident #46 wa diagnosis which inc	s admitted on 12/6/23 with luded diabetes and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 580	revealed a 12/6/23 milligrams (mg) 2 till Resident #46's May Administration Recogabapentin 800 mg 9:00 AM and 9:00 F 5/10/24 at 9:00 PM 5/13/24, 5/14/24, 5/9:00 AM and 9:00 F documented the galadministered.  An interview was considered to Reside and 5/12/24 from 7: stated she documented the mach stated she documented she	# 46's physician orders order for gabapentin 800 mes per day for nerve pain.  # 2024 Medication ord (MAR) indicated was to be administered at PM. The MAR revealed on and on 5/11/24, 5/12/24, 15/24, 5/16/24 and 5/17/24 at PM, the nursing staff	F 580	,		
	several months. Nu assigned to Reside and documented 9 scheduled 9:00 AM #6 stated the medic	rse #6 stated she was int #46 on 5/12/24 and 5/13/24 on the electronic MAR for the doses of gabapentin. Nurse sation was not available on the I she did not notify the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	0770272024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	aware that she was physician.  An interview was corp PM with Nurse #17. worked at the facility 6 weeks. Nurse #17 to Resident #46 on 5 from 7:00 PM to 7:00 did not notify the phyadminister the scheed 5/14/24 and 5/15/24 explanation why she An interview was corporated with the series of 13/24 at 11:30 AM an agency nurse at Nurse #7 was assign 5/14/24 and 5/15/24 Nurse #7 stated she ordered dose of gab 5/15/24 at 9:00 AM of Nurse #7 recalled gaon the medication caphysician. Nurse #7 upset and had increareceive the ordered unable to explain why physician of Resider gabapentin not admincreased pain.	e #6 stated she was not supposed to notify the inducted on 6/13/24 at 3:47 Nurse #17 stated she inducted she was assigned 5/13/24, 5/14/24 and 5/15/24 indicated she was assigned 5/13/24, 5/14/24 and 5/15/24 inducted with a she did not duled gabapentin on 5/13/24, Nurse #17 did not have an edid not notify the physician.  Inducted with Nurse #7 on Nurse #7 revealed she was the facility since March, and to Resident #46 on from 7:00 AM to 7:00 PM. did not administer the apentin on 5/14/24 and due to it not being available art, but she did not notify the fatted Resident #46 was assed pain when she did not gabapentin. Nurse #7 was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The stated Resident #46 was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not gabapentin. Nurse #7 was as the facility since March. The was assed pain when she did not notified the int #46's medication inistered and resident's	F 5	·			
	on 6/13/24 at 8:15 A she was assigned to from 7:00 AM to 3:00 stated gabapentin w	nducted with Unit Manager #2 M. Unit Manager #2 indicated Resident #46 on 5/16/24 DPM. Unit Manager #2 as unavailable for Resident 00 AM as ordered, resident					

NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED	
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 580  Continued From page 24 had increased pain and she did not notify the physician.  An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses.  An interview was conducted via phone with Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/124 form 7:00 PM to 7:00 AM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/124 form 7:00 PM to 7:00 AM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/124 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the			345185	B. WING _			07/02/2024
F 580  Continued From page 24 had increased pain and she did not notify the physician.  An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses.  An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses.  An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the			ENTER		106 CAMERON STREET		0110212024
had increased pain and she did not notify the physician.  An interview was conducted with Nurse #5 on 6/14/24 at 9:00 AM. Nurse #5 stated she was assigned to Resident #46 on 5/17/24 for the 7:00 AM to 7:00 PM shift. Nurse #5 stated she did not administer the scheduled gabapentin on 5/17/24 at 9:00 AM. Nurse #5 stated she did not notify the physician the medication was unavailable or of the missed doses.  An interview was conducted via phone with Nurse #2 on 6/14/24 at 2:25 PM. Nurse #2 stated she was the nurse assigned to Resident #46 on 5/17/24 from 7:00 PM to 7:00 AM. Nurse #2 stated gabapentin was not available for the	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
she did not notify the physician.  Attempted to interview Nurse #11, nurse assigned to Resident #46 on 5/16/24 7:00 PM to 7:00 AM.  Messages were left on 6/11/24 and 6/12/24 with no return call received.  An interview was conducted with Resident #46 on 6/13/24 at 9:30 AM. Resident #46 stated she had gone without gabapentin for days at a time on several occasions. Resident #46 reported staff stated the medication was coming from the pharmacy and then it didn't come in. Resident indicated she was familiar with her medications and gabapentin was prescribed for nerve pain. Resident #46 stated she had increased pain, trouble sleeping, was anxious, irritable, nauseous and unable to get up out of bed or complete her usual routine during the time when she did not	F 580	had increased pain physician.  An interview was co 6/14/24 at 9:00 AM. assigned to Reside AM to 7:00 PM shift administer the sche at 9:00 AM. Nurse the physician the m of the missed doses.  An interview was co #2 on 6/14/24 at 2:2 was the nurse assig 5/17/24 from 7:00 F stated gabapentin v prescribed dose for she did not notify the Attempted to intervit to Resident #46 on Messages were left no return call received. An interview was co 6/13/24 at 9:30 AM. gone without gabapseveral occasions. stated the medication pharmacy and then indicated she was fand gabapentin was Resident #46 stated trouble sleeping, was and unable to get uniterview of the sleeping, was and unable to get uniterview was considered to get uniterview was fand gabapentin was Resident #46 stated trouble sleeping, was and unable to get uniterview was considered she was fand gabapentin was Resident #46 stated trouble sleeping, was and unable to get uniterview was considered she was fand gabapentin was Resident #46 stated trouble sleeping, was and unable to get uniterview.	and she did not notify the onducted with Nurse #5 on Nurse #5 stated she was at #46 on 5/17/24 for the 7:00 at Nurse #5 stated she did not duled gabapentin on 5/17/24 #5 stated she did not notify edication was unavailable or stated she did not notify edication was unavailable or stated she graded to Resident #46 on and to 7:00 AM. Nurse #2 was not available for the Resident #46 on 5/17/24 and e physician.  Bew Nurse #11, nurse assigned 5/16/24 7:00 PM to 7:00 AM. on 6/11/24 and 6/12/24 with red.  Bonducted with Resident #46 on Resident #46 stated she had bentin for days at a time on Resident #46 reported staff on was coming from the ait didn't come in. Resident amiliar with her medications as prescribed for nerve pain. It is she had increased pain, as anxious, irritable, nauseous pout of bed or complete her	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	, 3770212021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	Continued From pag	e 25	F 580		
	Resident #46 stated	atil the medication came in. she was not aware if the ed of her medication not being ered.			
	Nursing (DON) on 6/ the nurses on the me to notify the physicia available and admini stated she started at March 2024. The DO the physician was no expected the nurses changes in condition medications not adm transferred to the ho An in-person intervie	to notify the physician of including uncontrolled pain, inistered, and residents			
	to be notified when n available and admini Administrator stated understand what to o medication was not a	she expected the physician nedications were not istered as ordered. The nursing staff did not do when they identified a available for administration tification of the physician for			
	Physician on 6/18/24 stated she had been The Physician indica ordered, 800 mg twic of medication and it abruptly stop taking of withdrawal and incomplete symptoms can occur	nducted by phone with the lat 1:20 PM. The Physician in the position since 6/7/24. Ited the dose of gabapenting per day was a high dose was not recommended to the medication due to the risk creased pain. Withdrawal within 12 hours and can be an stated increased pain was			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
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F 580	scheduled gabapent was the responsibility physician when a so available.  Attempts were made previous physician wat 3:33 PM and 6/13 call received.  The Administrator was Jeopardy on 6/13/24.  The facility provided allegation of immediate likely to suffer, as a result of the noncontract the multiple doses.  Resident #51 was not administered the multiple doses.  Resident #51 was not administered the multiple doses.  Resident #51 was not administered the multiple doses.  Resident #51 was not that if medication was not that if medication was days, then she woulf facility Unit Manager gabapentin not being what happened or was available.	the to not receiving the cin as ordered. She stated it by of the facility to notify the sheduled medication was not be via phone to interview the with messages left on 6/12/24 by 24 at 3:00 PM with no return as notified of Immediate at 2:15 PM.  The following credible ate jeopardy removal:  The serious adverse outcome as simpliance:  Inotify the provider when two #51 and Resident #46) were sir ordered gabapentin for the administered her routine at 800 mg 4 times a day from 2024. A licensed nurse stated as not available for a few dicall the pharmacy. The reflection of the gavailable but did not recall that she did about obtaining	F 5	80		
	allegation of immedial ldentify those recipies are likely to suffer, as a result of the noncomposition of the facility failed to residents (Resident not administered the multiple doses.  Resident #51 was not order for gabapentin 05/08/2024 - 05/13/3 she did not notify the medication was not that if medication was not that if medication was days, then she woul facility Unit Manager gabapentin not being what happened or with medication. The electronic health recomposition of the sufficient of the suffing sufficient of the sufficient of the sufficient of the sufficie	ents who have suffered, or serious adverse outcome as impliance:  notify the provider when two #51 and Resident #46) were sir ordered gabapentin for  ot administered her routine a 800 mg 4 times a day from 2024. A licensed nurse stated a physician when the available. The nurse stated as not available for a few d call the pharmacy. The refit was aware of the gavailable but did not recall				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag		F 5	580		
	due to too much pain #51 complained of he 05/12/2024 Resident spasming in which R to the Emergency Roreturned from the ER treated for acute pain the hospital. In the ex Resident #51 compladue to not receiving go to the ER. Reside in the ER. The physic prescription for gaban Resident #46 was no order for gabapentin 05/10/2024 - 05/17/2 there had been delay gabapentin and resid ordered gabapentin. The physician. Resident #46 had a paduring the time the faradminister the medic complained of not rewhich caused her mosleep. Resident #46 being anxious, and nelt well and had not to participate in activioutine due to pain in Residents with misse conditions, and resid documented risk man	ceiving pain medication ore pain and made it hard to complained of irritability, ausea. Resident #46 had not been able to get out of bed ties and perform a daily her legs.  Independent who have had a magement report are at a sysician not being notified.				

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F 580	Managers (UMs) cor	ne 28 For of Nursing, and Unit Impleted an audit for the past Ints in the facility who had	F 580		
	missed medications, and/or a documented ensure the physician 06/15/2024 it was de the physician had no missed medication, of	changes in conditions, d risk management report to had been notified. On etermined by this audit that of been notified of every change in condition, and			
	concerns were ident physician to ensure id documented risk ma that a nurse complet incidents such as me	nagement report. The ified and reported to the the notification of change. A nagement report is a report tes to document resident edication errors, falls, skin			
	that occurs in the fac electronic health rec details of the inciden incident, any stateme	rs, etc. Any resident incident cility is documented in the ord. It includes general at, a description of the ents from the resident or collow-up action to be taken by			
	process or system fa	e entity will take to alter the allure to prevent a serious om occurring or reoccurring will be complete:			
	Floor Nurses and Ur process to notify the missed medications, and/or a resident wh management report. physician immediate on-call service provioursing station. This nurse is working in the	Director of Nursing educated nit Managers (UMs) on the physician when there are changes in conditions, o has a documented risk Nurses will notify the ly via phone call to the der that is posted at each process will happen if the he facility and witnesses a change in condition, and/or if			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07702/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 580	management report of Nursing and Unit person education of and medication aide full-time, part-time, This education will notifying the physic medications, changed documented risk materials. The series of medications of the folial of the foli	s a documented risk c on any resident. The Director Managers (UMs) will begin in n 06/13/2024 with all nurses es which will include all as needed, and agency staff. De on the importance of an of any missed es in conditions, and anagement reports.  ation aides will work after ey have received the above the Director of Nursing will be bing up with those nurses and no have and have not been actor of Nursing is responsible education or assigning the UM totation for any staff who has by 06/13/2024. The UMs were consibility on 06/13/2024 by ing. The Director of Nursing for tracking the education and teted so that the facility has an colace to ensure staff notify the e are missed medications, ans, and/or if a resident has a consideration of this 2/13/2024 by the Administrator.	F 58		

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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				ഥ	AKE WACCAMAW, NC 28450		
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F 580	each nursing station. Nurses and UMs will communication log defor why the provider sas for a sick visit, read orders to be signed, at the resident's families changes in conditions management reports. Floor Nurses and UM ensuring this provide updated daily. The Flootified of their respothe Director of Nursing will be responsible for ensuring it is complet effective system in ple provider when there a changes in conditions.	located in a white binder at in the facility. The Floor utilize this provider aily to document any reason should see a resident such dmission, new admission, at the resident's request, at a request, medication refills, s, and/or documented risk. Effective as of 06/13/2024 Is will be responsible for recommunication log is oor Nurses and UMs were insibility on 06/13/2024 by ag. The Director of Nursing retracking the education and ted so that the facility has an acce to ensure staff notify the are missed medications, s, and/or a resident who has an agement report. The	F	580			
	All newly hired nurses (full-time, part-time, a be educated as noted completed by the Director of Nursing w up with new hires wheducated. The Direct for completing the ed Director of Nursing w responsibility on 06/1	ector of Nursing. The ill be responsible for keeping o have and have not been or of Nursing is responsible ucation with new hires. The					

The removal plan of the Immediate Jeopardy was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE		
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01702	1202-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	all residents who had changes in condition management report been notified was verified dentified concerns with physician. A sample Administrator, Unit Medication aides we services they receive practice. All staff into been in serviced regnotifying the physicial medications or chan removal date of 06/3. Resident #39 was 05/02/24 with a diagnification (UTI).  The hospital dischar revealed the following Amoxicillin-Clavulan oral every 12 hours of Amoxicillin-Clavulan penicillin-type antibio variety of bacterial in the facility MAR (Medicates for May 202 administered Amoxicillin-Clavulan penicillin-type antibio variety of bacterial in the facility MAR (Medicates for a total of 105/05/24, 05/06/24, and 05/10/24.  Review of an admission admission of the facility of an admission of the facility of the facility Mark (Medicates for a total of 105/05/24, 05/06/24, and 05/10/24.	4. The audit conducted for d missed medications, as, and/or a documented risk to ensure the physician had erified and confirmed any overe reported to the of staff including the Manager, nurses and are interviewed regarding in ed related to the deficient erviewed stated they had arding the process of an when there are missed ges in condition. The IJ 16/24 was validated.  • admitted to the facility on mosis of a urinary tract  ge summary dated 05/02/24 to physician order: ate 875 mg-125 mg tablet for 7 days, (Augmentin). ate is a combination offic used to treat a wide	F 58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ENTER	10	TREET ADDRESS, CITY, STATE, ZIP CODE D6 CAMERON STREET AKE WACCAMAW, NC 28450	1 01/02/2024
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F 580	indwelling urinary corecent genitourinary organs of the body) care. He was admir Review of the Cons Medication Regime revealed the following resident was admitt Amoxicillin/Clavular for 7 days. This was Amoxicillin 875 MG sent. Please notify the error to clarify if any needed. Please rev	ge 32  ntact cognition. He had an atheter. He had undergone a surgery (refers to the urinary that required skilled nursing nistered antibiotic medication.  ultant Pharmacist 's n Review dated 05/27/24 ng recommendation: "This ed with an order for nate 875 MG BID (twice a day) is entered into the computer as a This is what the pharmacy the provider of the medication of additional treatment is iew with the nurses to ensure refully and double check	F 580		
	6/12/24 at 9:50 AM between Amoxicillin was that the Clavula Amoxicillin work betwere affected by the would have expected report the medicatic additional treatments. In an interview with on 06/12/24 at 4:40 followed up on the pand had not notified antibiotic had been to determine if furth. In an interview with 06/19/24 at 9:30 AM	the Consultant Pharmacist on she stated the difference and Amoxicillin-Clavulanate anate drug helped the tter and more types of bacteria addition of Clavulanate. She addition of Clavulanate. She addition of Clavulanate if twas necessary.  the Director of Nursing (DON) PM she stated she had not charmacy recommendation if the provider that the wrong administered to Resident #39 er treatment was necessary.  the facility physician on if the stated she had not been the stated sh			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345185	B. WING _			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE D6 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 SS=K	last week and was no occurred. However, s Resident #39 yesterd any symptoms of a U feel any further interv stated she would exp there was a pharmac	she started at the facility t his doctor when this she reported she had seen ay and he was not having TI at this time. She did not ention was required. She ect to be notified whenever y recommendation or a nat it could be addressed		580			7/27/24
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's metal the resident's metal state of the facility \$483.12(a) (1) Not use physical abuse, corporativoluntary seclusion; This REQUIREMENT by:  Based on record reviresident, staff, Consu Quality Assurance Sp Physician, and Wounfacility failed to protective of neglect when the significant medication.	involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ew and interviews with Itant Pharmacist, Pharmacy			The facility failed to protect the resider right to be free of neglect when the faci failed to obtain significant medications, administer significant medications, noti the physician that scheduled medicatio for nerve pain that was not to be stoppe abruptly was not administered, and provide effective pain management.	lity fy n	

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930 <del>-</del> 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
						(	С
		345185	B. WING _			l	02/2024
NAME OF P	ROVIDER OR SUPPLIER		'	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				10	06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	INTER		L	AKE WACCAMAW, NC 28450		
()(1) ID	CHMMADV CT	TATEMENT OF DEFICIENCIES	I		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 34	F	300			
		nt #269, Resident #51,					
		ent #419, Resident #39,			The facility failed to protect Residents		
		ent #10, Resident #50, and			#46, #51, #269, and #419 from neglec	as	
		he physician that scheduled			evidenced by the following deficient		
		pain that was not to be			practices:		
		not administered (Resident			1		
		6), and provide effective pain			F580: The facility failed to notify the		
	I .	ent #51 and Resident #46).			physician when two residents (Resider	nt	
	`	dministered 6 doses of			#51 and #46) were not administered th		
	haloperidol (antipsycl	hotic medication) 20			ordered gabapentin for multiple doses.		
	milligrams (mg) inste	ad of the ordered dosage of					
	2 tablets of 2 mg at b	edtime and was not			F697: The facility failed to effectively		
	administered carvedi	lol (a medication used to			manage Resident #51's and Resident		
	treat heart failure, hig	gh blood pressure and chest			#46's pain.		
	pain) for 25 of the ord	dered doses. Resident #269					
	experienced an eleva	ated pulse and shortness of			F755: The facility failed to ensure routi	ne	
		rgency Department (ED)			pain medication was obtained and		
		1. Resident #51's scheduled			available for administration for Resider	nt	
		obtained and administered			#51 and Resident #46.		
	for 21 doses resulting						
		enced by complaints of			F760: The facility failed to prevent		
		10 (on a scale of 0 to 10			significant medication errors for Reside		
	with the 10 being the				#269, Resident #419, Resident #51, au	ıa	
	numbness in her legs	s, and spasms. The tified. Resident #51 was			Resident #46.		
	1	twice on 5/12/24 where she			All regidents regiding in the facility have	_	
		pain with gabapentin and			All residents residing in the facility have been identified as having the potential		
		y. Resident #46's scheduled			be affected by the alleged deficient	lo	
	1	obtained and administered			practice.		
	for 14 doses resulting				practice.		
		enced by increased pain,			Immediate Jeopardy began on 3/14/20	24	
	_	iety, irritability, nausea, and			when the facility neglected to administr		
		olete her normal routine due			Resident #269's haloperidol and carve		
		ne physician was not notified.			as ordered and the resident required E		
	1 -	ot administered 6 doses of			evaluation due to shortness of breath a		
	intravenous (IV) (deli				an elevated pulse. Immediate Jeopard		
	Rocephin (antibiotic)	· · · · · · · · · · · · · · · · · · ·			was removed on 6/16/2024 when the		
	1	ic) for treatment of his			facility implemented an acceptable plan	n of	
		al (triangular bone at the			Immediate Jeopardy removal.		

NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)  (X5) B. WING O7/02/202  STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450  (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  (X6) COMPLETED TO THE APPROPRIATE DEFICIENCY)			345185	B. WING _			C 7/02/2024
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ENTER		106 CAMERON STREET		77027202-7
F 600 Continued From page 35	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
	F 600			F 6	00		
base of the spine) pressure ulcer. The resident was hospitalized and the discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteorwyelltis (bone infection). This deficient practice affected 9 of 10 residents reviewed for neglect.  Immediate Jeopardy began on 3/14/24 when the facility neglected to administer Resident #269's haloperidol and carvedilol as ordered and the resident required ED evaluation due to shortness of breath and an elevated pulse. Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy was removed on 6/16/24 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. Residents #8, #10, #32, #39, and #50 were cited at scope and severity "E".  The findings included:  The findings included:  F580: Based on record review, and staff, resident, and Physician interviews, the facility failed to notify the physician that the scheduled medication gabapentin, a medication ordered for nerve pain that is not to be stopped abruptly, was not administered. Resident #51 missec abroad to gabapentin 800 milligrams (mg) four times daily for nerve pain. Resident #51 missed at lot of 21 doses of the medication from 5/8/24 through		was hospitalized and indicated they suspel likely centered arour ulcer with likely chro infection). This defic residents reviewed for limmediate Jeopardy facility neglected to a haloperidol and carving resident required ED of breath and an electrony jerile of breath and an electrony jerile of breath and an electrony jerile of limmediate Jeopardy was removed facility implemented limmediate Jeopardy remains out of composeverity of "E" (no hamore than minimal higopardy) to ensure monitoring systems Residents #8, #10, # at scope and severity. The findings included This tag is cross referenced in the property of the property pain that is no not administered. Regabapentin 800 milligitor nerve pain. Residents.	d the discharge summary ected Resident #419's sepsis and his large stage 4 pressure nic osteomyelitis (bone cient practice affected 9 of 10 for neglect.  To began on 3/14/24 when the administer Resident #269's redilol as ordered and the overaluation due to shortness wated pulse. Immediate wed on 6/16/24 when the an acceptable plan of the removal. The facility eliance at a lower scope and farm with the potential for farm that is not immediate reducation is completed and put in place are effective. #32, #39, and #50 were cited by "E".  d:  d:  d:  d:  d:  d:  d:  d:  d:  d		alleged deficient practices, the Nursing Home Administrator (I wrote the Immediate Jeopardy Plan and submitted the Removapproval. The Immediate Jeopremoved on 6/16/2024 when the implemented an acceptable planted and acceptable planted and acceptable planted the agency Director (DON) during extended survey 6/19/2024. The LNHA hired an experienced non-contractual E 6/19/2024 to ensure future contraction of the facility has also hired nursincluding RNs and LPNs to encompliance.  The DON or Designee will revious Medication Administration Recontraction of the steps will be reported provider and documentation wensure compliance by 8/5/2024. The DON or Designee will edunurses and medication aides be on the steps to follow when a ris not in stock, as well as proposition of the steps to ensure the receives their medications as a ensure compliance. After 8/5/2026.	e Licensed LNHA)  / Removal  val Plan for  pardy was  he facility  an of The LNHA  or of Nursing  / on  DON on  mpliance.  sing staff  sure future  iew all  cords  uly 2024 for  cations to  oses. All  I to the  //ill follow to  //4.  ucate all  by 8/5/2024  medication  er  all the steps  resident  ordered to  2024 newly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				0 <b>2/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER		<del>                                     </del>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024	
TO THE OT TH	TO VIDER OR OUT FILER							
PREMIER	LIVING AND REHAB CE	NTER			106 CAMERON STREET			
					LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	∍ 36	F 6	300				
	· -	le), numbness in her legs,						
		physician was not notified of			The DON or Designee will educate all			
		as prescribed gabapentin			nurses by 8/5/2024 on the importance	of		
		ily for nerve pain. The			completing pain assessments daily for			
		tified that Resident #46			residents that are receiving pain	a.i.		
		he medication from 5/10/24			medications to ensure compliance. After	er		
		Iting in trouble sleeping,			8/5/2024 newly hired nursing staff will			
		usea, and being unable to			educated by the DON or Designee dur			
		routine due to pain in her			their new hire employee orientation.	J		
	legs. Additionally, the	facility failed to notify the						
	physician that 14 dos	es of the antibiotic			Beginning 7/27/2024, the DON or			
	Amoxicillin 875 mg w	as administered to Resident			Designee will audit pain medication			
	#39 instead of the an	tibiotic Augmentin			administrations 5 times per week for 12	2		
		ate 875 mg-125 mg) that			weeks to ensure all pain medications a	re		
		hysician on discharge from			given as ordered. Any missed			
	-	ficient practice affected 3 of			administrations will result in re-education			
	10 residents reviewed	d for notification.			with the appropriate staff members and			
					employee disciplinary action will be tak	en.		
		rd review, staff, resident,			if necessary.			
		st, and Physician interview,			D : : 7/07/0004 // DOM			
	the facility failed to pr				Beginning 7/27/2024, the DON or			
	_	nage symptoms of withdraw			Designee will interview 3 residents per			
		Resident #51 and Resident			week x 12 weeks to ensure his/her pai			
		n management. Resident			being managed effectively. Any missed administrations will result in re-educations			
	(mg) four times daily	gabapentin 800 milligrams			with the appropriate staff members and			
	, -,	vailable to administer and			employee disciplinary action will be tak			
		21 doses of the prescribed			if necessary. Any pain that a resident	.CII		
		histered from 5/8/24 through			expresses that is not being managed			
	5/13/24. Resident #5				effectively will be reported to the provide	ler		
		o a 10 (on a scale of 0 to 10			onedavely will be reperted to the provide			
	with the 10 being the				Beginning 7/27/2024, the audits will be	<u> </u>		
		s, and spasms. She was			reviewed by the LNHA or DON, and the			
		ergency Department (ED)			results of the audits will be reviewed in			
		12/24 in the middle of the			monthly Quality Assurance and			
	1 -	treated for acute pain with			Performance Improvement (QAPI)			
	_	ned to the facility the same			Meeting monthly for 3 months. The QA	·ΡΙ		
		issed 3 more doses of			Committee will review the audits and			
	gabapentin on 5/12/2	4 and returned to the ED			make recommendations as necessary	to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345185	B. WING _		07/	02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB	CENTER		LAKE WACCAMAW, NC 2845	60		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From parthat evening per hemuscle spasms. Spain with gabapen where she proceed the medication prior medication for administer on 5/10 14 doses of the medication gradinister on 5/10/14 doses of the medication for administer on 5/10/14 doses of the medication gradinister on 5/17/24 resulting in 8-9 pain level, trounausea, and being routine due to pain F755: Based on reconsultant Pharma Assurance Special the facility failed to was obtained and 3 of 10 residents (I and Resident #8) resident #51 was milligrams (mg) for The medication was pharmacy and Residoses of the medication was doses of the medication	age 37 er request for worsening he was again treated for acute tin and returned to the facility ded to miss 4 more doses of or to the facility obtaining the ninistration. Resident #46 was ntin 800 mg two times daily for edication was not available to //24 and Resident #46 missed edication from 5/10/24 through in increased pain at a sustained ble sleeping, anxiety, irritability, unable to complete her normal	F	DEFICIE	nce is sustained. s plan of npliance under the 8/6/2024 and the ne specified	DAIL	
	constant pain up to with the 10 being to numbness in her let transferred to the E on 5/12/24 in the numbness of the meacute pain with galfacility the same damore doses of gab	that complaints of the action of the worst pain possible), ags, and spasms. She was a semergency Department (ED) and the missing addication. She was treated for papentin and returned to the ay. Resident #51 missed 3 apentin on 5/12/24 and that evening for worsening					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			D 14/11/0			I		
		345185	B. WING			07/	02/2024	
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		1	BTREET ADDRESS, CITY, STATE, ZIP CODE  06 CAMERON STREET  LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	where she proceeded the medication prior to medication for administered gabapenti nerve pain. The mediform the pharmacy are doses of the medication 5/17/24 resulting in the irritability, nausea, and her normal routine du Additionally, Residen Oxycodone/Acetamin 10/325 mg and this moreon from the pharmacy redoses of the medication of the medication of the pharmacy redoses of haloperido (pharmacy library) in the pharmacy redoses of haloperido	and returned to the facility If to miss 4 more doses of to the facility obtaining the istration. Resident #46 was n 800 mg two times daily for cation was not obtained nd Resident #46 missed 14 on from 5/10/24 through ouble sleeping, anxiety, d being unable to complete le to pain in her legs. t #8 was prescribed lophen (opioid medication) nedication was not obtained resulting in multiple missed	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 ti Boile	_		، ا	c
		345185	B. WING				02/2024
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024
	(0.1.52.1.5.1.5.1.1.2.1.1				106 CAMERON STREET		
PREMIER	LIVING AND REHAB C	ENTER			_AKE WACCAMAW, NC 28450		
					,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag	ge 39	F	600			
		ble), numbness in her legs,					
		ras transferred to the ED					
		ere she was treated for acute					
	pain with gabapentir	n and returned to the facility.					
	Resident #46 was no	ot administered 14 doses of					
	gabapentin (prescrib	oed for nerve pain) 800 mg					
		n 5/17/24 resulting in					
		ble sleeping, anxiety,					
		nd being unable to complete					
		ue to pain in her legs.					
		not administered 6 doses of					
	intravenous (IV) (del						
	Rocephin (antibiotic)						
		tic) for treatment of his ral (triangular bone at the					
	_	ressure ulcer. The resident					
		4/5/24 and the 4/26/24					
	=	indicated they suspected					
		sis likely centered around his					
		re ulcer with likely chronic					
		infection). In addition, the					
	facility: administered	I 14 doses of Amoxicillin					
	(antibiotic) to Reside	ent #39 instead of the ordered					
	Amoxicillin-Clavulan	ate; did not administer 34					
	doses of Resident #	32's ordered mirtazapine					
	' '	lication); did not administer					
		nt #10's ordered tetrabenazine					
	=	eatment of tardive dyskinesia					
		ents such as tongue thrusting,					
	, ,	epetitive chewing, that can					
		psychotropic use); did not					
	-	rs indicated in the physician's					
	order for Resident #	in 8 doses not administered					
		not administer 12 doses of					
		odone/Acetaminophen (opioid					
	pain medication), 3 (						
		ation), 1 dose of Glipizide					
		ation), and 1 dose of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	ı	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Physician on 6/18/24 indicated it was the provide the services  An interview was co Director of Nursing (The DON indicated services needed to the neglect. She indicated nursing staff to educate services the residen.  The Administrator was jeopardy on 6/13/24.  The facility provided jeopardy removal play in the provided jeopardy removal play in the facility failed to the facility failed to the facility failed to the facility failed when two residents not administered the multiple doses.  697: The facility failed Resident #51's and 755: The facility failed medication was obtained.	agulant).  Inducted via phone with the 4 at 1:20 pm. The Physician facility's responsibility to necessary for the residents.  Inducted in person with the DON) on 6/14/24 at 4:10 PM. It is that staff not providing he resident was a form of ed education was provided to rate them on providing the required.  It is notified of immediate at 5:00 PM.  It is following immediate an:  In it is that staff not providing the resident was a form of education was provided to resident was a form of education was provided to required.  In it is that staff not providing the required of immediate and the following immediate and t	F 6			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				02/2024	
	ROVIDER OR SUPPLIER	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 600		I to prevent significant	F 6	600				
	#419, Resident #51, a							
	neglect allegation wa Care Personal Regist	nt #51 on 06/13/2024. The s reported to the Health rry on 06/14/2024 and has enforcement and Adult						
	neglect allegation wa Care Personal Regist	nt #46 on 06/13/2024. The s reported to the Health rry on 06/14/2024 and has enforcement and Adult						
	neglect allegation wa Care Personal Regist	nt #269 on 06/13/2024. The s reported to the Health rry on 06/14/2024 and has enforcement and Adult						
	neglect allegation wa Care Personal Regist	nt #419 on 06/13/2024. The s reported to the Health rry on 06/14/2024 and has enforcement and Adult						
		d Director of Nursing ent residents have the ed by this deficient practice.						
	process or system fai	entity will take to alter the lure to prevent a serious n occurring or reoccurring						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 600	Nursing, Social Work (UMs) began educate abuse and neglect proon the importance of residents have a right that failing to provide services to residents will have a comprehe following are necess obtaining and adminiordered by provider, and notifying the phy to include any issues significant medication. Administrator, Direct and Unit Managers (education on 06/13/2 include all full-time, prontract staffing department of the proof of Norsing and have not been enthe Director of Nursing for completing the edincluding any staff with by 06/13/2024. The Uresponsibility on 06/2 Nursing. The Social Nursing will be responsed to the proof of the social staffing and ensur facility has an effective or the proof of the social staffing and ensur facility has an effective or significant medical staffing and the social staffing a	dministrator, Director of ter, and Unit Managers ing all staff on the facility olicy. This education will be staff understanding that all at to be free of neglect and the necessary care and constitutes neglect. All staff ensive understanding that the ary care and services: stering medications as effectively managing pain, sician of significant changes with administering in as ordered. The or of Nursing, Social Worker, UMs) will begin in person 2024 with all staff which will part-time, as needed, artments, and agency staff.  Work after 06/13/2024 until the education. The Social of Nursing will be and up with staff who have ducated. The Social Worker, and, and UMs are responsible	F 6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		_	C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STA 106 CAMERON STREET LAKE WACCAMAW, NC	·	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORREC' CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 600	services that are need the Director of Nursin responsibility on 06/1  All newly hired staff (fineeded, contract staff agency) will be educated will be completed by the Resources Coordinated Nursing. The Social Will Coordinator, and the responsible for keeping have and have not be Worker, Human Resources Coof Nursing are the education with ne Human Resources Coof Nursing were notified 06/13/2024 by the Addinated on 06/13/2024 by the Addinated on 06/19/24 including the Administed and medication aides in-services they receip practice. All staff interes of neglect and un provide the necessary residents constitutes and administering memanaging pain, and residents constitutes and staff in the part of the provide the necessary residents constitutes and administering memanaging pain, and residents constitutes and administering memanaging pain, and residents constitutes and staff in the part of the providents constitutes and administering memanaging pain, and residents constitutes and staff in the part of the part	ded. The Social Worker and g were notified of this 3/2024 by the Administrator.  full-time, part-time, as fing departments and ted as noted above. This he Social Worker, Human for, and/or Director of Worker, Human Resources Director of Nursing will be an up with new hires who be ne educated. The Social worces Coordinator, and the responsible for completing whires. The Social Worker, coordinator, and the Director ed of this responsibility on ministrator.  Idiate jeopardy removal:  The Immediate Jeopardy was a sample of staff trator, Unit Manager, nurses were interviewed regarding wed related to the deficient reviewed stated they had arding the importance of staff residents have a right to be inderstood that failing to a care and services to neglect such as obtaining dications as ordered, of the IJ removal date of	F	600		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345185	B. WING _		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	01102/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 609 F 609			F 6		7/27/24
SS=E		o(i)(A)(B)(c)(1)(4) se to allegations of abuse, or mistreatment, the facility			
	involving abuse, neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not rest the administrator of tofficials (including to adult protective servifor jurisdiction in long accordance with Starprocedures.	ng injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides geterm care facilities) in the law through established			
	designated represen accordance with Star Survey Agency, with incident, and if the all appropriate corrective This REQUIREMENT by:  Based on record reverselisting failed to submineglect to Adult Protection and the process of the protection of the	the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified a action must be taken. It is not met as evidenced view and staff interviews, the left a report of an allegation of active Services (APS) and win the required time frame Resident #46, #51, #269 and alleget. The facility was		The facility failed to submit a repo allegation of neglect that was alleg during an annual recertification su and complaint investigation to Adu Protective Services (APS) and law enforcement within the required tir	ged rvey Ilt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D		343163	D. WING _	OTDEET ADDRESS SITY STATE		7/02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
PREMIER	LIVING AND REHAB	CENTER		106 CAMERON STREET			
				LAKE WACCAMAW, NC 28	i450		
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F 609	F 609 Continued From page 45						
	PM when an imme issued. The facility enforcement within following notification. Findings included:	neglect on 06/13/24 at 2:15 diate jeopardy template was y did not notify APS or law the required time frame on.  ity provided initial allegation /24 regarding Residents #46,		frame for 4 of 4 reside #51, #269 and #419) of for neglect. The facility notified of neglect on 6 PM when an immediat was issued to the Lice Administrator (LNHA).  Review of the state agrevealed the facility su	who were reviewed y was officially 6/13/2024 at 2:15 te jeopardy template ensed Nursing Home		
	#51, #269, and #4 of APS being notific enforcement notific  During an annual r complaint investigat notified of neglect	19 revealed no documentation ed and no record of law cation.  ecertification survey and ation, the facility was officially on 06/13/24 at 2:15 PM and an		report to the State Age required time frame fo notification of neglect. documentation supported did not notify APS or la 6/16/2024.	ency within the ollowing the However, rted that the facility aw enforcement until		
	Administrator. The was signed by the Administrator was information regard neglect. Review o revealed the facility the State Agency of following the notific documentation supports the State Agency of the sta	y template was issued to the elimmediate jeopardy template Administrator and the verbally informed of the ing the situation involving if the state agency records y submitted an initial report to within the required time frame cation of neglect, however opported that the facility did not ment or APS until 06/16/24.		All residents residing i been identified as hav be affected by the alle practice.  The Licensed Nursing Administrator (LNHA) review all facility allegatives 7/27/2024, since Marchael validate that APS and were notified timely.	ring the potential to eged deficient  Home or Designee will ations of abuse by ch of 2024, to		
	Administrator on 00 she submitted an i State Agency rega provided on the tel on 06/13/24. She identified by the streceived a templat she was confused	erview with the facility 6/17/24 at 4:30 PM, she stated nitial allegation report to the rding the neglect information mplate which she had received stated since the neglect was ate surveying staff and she e for the immediate jeopardy as to whether or not she would APS and law enforcement. She		The LNHA or Designe DON, Social Worker, a staff members by 8/5/2 allegations timely and time frame per the reg 8/5/2024 newly hired s by the LNHA, DON, or their new hire employed Beginning 7/27/2024,	and other involved 2024 on reporting within the required gulation. After staff will be educated r Designee during ee orientation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			l	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE  16 CAMERON STREET  AKE WACCAMAW, NC 28450		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 F 636 SS=E	template and the initial 06/16/24 when she re	she was reviewing the all allegation report on ealized she should notify law and on 06/16/24 she essments & Timing (2)(i)(iii)		609	Designee will audit all allegations of ab for 12 weeks to ensure there is timely reporting to APS and law enforcement. there are any concerns that were not reported to APS or law enforcement, the will be reported immediately, and re-education will be completed.  Beginning 7/27/2024, the audits will be reviewed by the LNHA or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustaine. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this correctivaction.	If ey the to d. the	7/27/24
	The facility must cond a comprehensive, acc	duct initially and periodically					
	A facility must make a assessment of a residuals, life history and	ent Assessment Instrument.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET .AKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	the following: (i) Identification and of (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavi (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritio (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass include direct observa with the resident, as v licensed and nonlicer members on all shifts §483.20(b)(2) When it timeframes prescribe chapter, a facility mus assessment of a resid timeframes specified through (iii) of this se- prescribed in §413.32 apply to CAHs.	demographic information demogr	F	636			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 636	significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii)Not less than once This REQUIREMENT by:  Based on record reversible for MDS assessment #17, Resident #9, Referred timeframe for MDS assessment #16).  Findings included:  a. Resident #269 was Resident #269's adm (MDS) dated 3/14/24  An interview was corron 6/11/24 at 1:57 Pland been in training taking online MDS correquirements for the #2 stated since she was Remote MDS Nurse assessments. MDS told the MDS assess	ons in which there is no the resident's physical or or purposes of this section, is a return to the facility of absence for hospitalization of every 12 months. It is not met as evidenced fiew and staff interviews, the olete the comprehensive of MDS) assessments within the or 5 of 29 residents reviewed of (Resident #269, Resident of (Resident #24 and Resident of (Resident #24 and Resident of (Resident #24 and Resident of (Resident #25) of (Resident #26) of (R	F 63	The facility failed to complete the comprehensive Minimum Data Set (Nassessments within the required timeframe for 5 of 29 residents review for MDS assessments (Resident #26 Resident #17, Resident #9, Resident and Resident #16).  All comprehensive MDS assessment have been identified as having the potential to be affected by the alleged deficient practice.  The Director of Nursing (DON) or Designee, will review the comprehen MDS assessments for all residents, f March of 2024, to ensure they are all completed timely by 8/5/2024.  The DON or Designee will educate the MDS Coordinator and all staff who as responsible for completing sections of MDS assessment by 8/5/2024 on the regulation related to "Resident Assessment" and on the importance timely completion of MDS assessment ensure they are completed in the requiremer they are completed in the requiremer and After 8/5/2024 newly hired	wed 9, #24 s d sive rom ne re on the of ints to uired
	since she started in I	February. The Administrator e MDS assessments were		staff will be educated by the DON or Designee during their new hire emplo	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				0 <b>2/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024	
				10	06 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	NTER		L	AKE WACCAMAW, NC 28450			
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F 636	Continued From page	e 49	F 6	636				
		the regulatory timeframe, for a solution.			orientation.			
	on 6/14/24 at 4:10 PN that the MDS assess a timely manner due to DON stated the experassessments would be manner.  b. Resident #17 was at Resident #17's annuassessment dated 5/6/12/24.  An interview was conon 6/11/24 at 1:57 PN had been in training staking online MDS corequirements for the at #2 stated since she will Remote MDS Nurse to assessments. MDS Noted the MDS assessments. MDS Noted the MDS assessments in the role of since she started in First stated she was aware not completed within and she was looking to An interview with the on 6/14/24 at 4:10 PN had been in training staking online MDS assessments. MDS Noted the MDS assessments assessments. MDS Noted the MDS assessments are completed within and she was looking to MI interview with the on 6/14/24 at 4:10 PN had been in training stated she was aware not completed within and she was looking to MI interview with the on 6/14/24 at 4:10 PN had been in training stated she was aware not completed within and she was looking to MI interview with the on 6/14/24 at 4:10 PN had been in training staking online MDS corequirements for the at #2 stated since she within the stated she was aware not completed within and she was looking the more manufactured that the more more manufactured that the more manufactured that the more more more manufactured that the more more more more more more more mor	Director of Nursing (DON)  If revealed she was aware ments were not completed in to staffing changes. The ctation was that MDS per completed in a timely admitted on 12/29/22.  If Minimum Data Set (MDS) 1/24 was completed on May urse to learn the assessments. MDS Nurse was still learning it was the chat completed the Nurse #2 stated she was ments were behind.  Administrator on 6/14/24 at the had been personnel of MDS Nurse several times the regulatory timeframe, for a solution.  Director of Nursing (DON)  If revealed she was aware			Beginning 7/27/2024, the DON or Designee will audit all "In Progress" comprehensive MDS assessments on weekly basis for 4 weeks (Monday – Friday) to ensure all comprehensive M assessments are completed within the required timeframe. Any issues with lat submissions of comprehensive MDS assessments will result in re-educating the appropriate staff members and additional training.  Beginning 7/27/2024, the DON or Designee will audit all "In Progress" comprehensive MDS assessments monthly for three months.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hon Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	DS te the the to the the the		
		ments were not completed in to staffing changes. The						

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING	<del> </del>		C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636	Continued From pag		F 63	36		
		ectation was that MDS be completed in a timely				
	c. Resident #9 was a	dmitted on 12/28/16.				
		Minimum Data Set (MDS) 26/24 was completed on				
	on 6/11/24 at 1:57 PI had been in training staking online MDS correquirements for the #2 stated since she will Remote MDS Nurse	assessments. MDS Nurse vas still learning it was the that completed the Nurse #2 stated she was				
	4:41 PM revealed the changes in the role of since she started in Firstated she was awar	Administrator on 6/14/24 at ere had been personnel of MDS Nurse several times be rebruary. The Administrator e MDS assessments were the regulatory timeframe, for a solution.				
	on 6/14/24 at 4:10 Pl that the MDS assess a timely manner due DON stated the expe	Director of Nursing (DON) M revealed she was aware ments were not completed in to staffing changes. The ectation was that MDS be completed in a timely				
	d. Resident #24 was	admitted on 5/4/23.				
	Resident #24's annu	al Minimum Data Set (MDS)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	<u> </u>	0110212024	
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F 636	An interview was cor on 6/11/24 at 1:57 Pl had been in training taking online MDS or requirements for the #2 stated since she Remote MDS Nurse assessments. MDS told the MDS assess  An interview with the 4:41 PM revealed the changes in the role of since she started in 8 stated she was awar not completed within and she was looking  An interview with the on 6/14/24 at 4:10 Pl that the MDS assess a timely manner due DON stated the expeasessments would manner.  e. Resident #16's admit (MDS) assessment on 5/27/24.  An interview was cor	Inducted with MDS Nurse #2 M. MDS Nurse #2 stated she since she started in May burses to learn the assessments. MDS Nurse was still learning it was the that completed the Nurse #2 stated she was ments were behind.  Administrator on 6/14/24 at ere had been personnel of MDS Nurse several times February. The Administrator is MDS assessments were the regulatory timeframe, for a solution.  Director of Nursing (DON) in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes. The extation was that MDS be completed in a timely in the staffing changes.	F6	36			
		M. MDS Nurse #2 stated she shince she started in May burses to learn the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING		-		0 <b>2/2024</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638 SS=E	requirements for the a #2 stated since she w Remote MDS Nurse t assessments. MDS N told the MDS assessr  An interview with the 4:41 PM revealed the changes in the role of since she started in F stated she was aware not completed within and she was lokking to  An interview with the on 6/14/24 at 4:10 PN that the MDS assess a timely manner due DON stated the expensessessments would b manner. Qrtly Assessment at L CFR(s): 483.20(c)  §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CMS once every 3 months. This REQUIREMENT by: Based on record revifacility failed to compl within the required 14 residents reviewed fo assessments. (Reside	assessments. MDS Nurse vas still learning it was the that completed the Nurse #2 stated she was ments were beind.  Administrator on 6/14/24 at the had been personnel for MDS Nurse several times bebruary. The Administrator of MDS assessments were the regulatory timeframe, for a solution.  Director of Nursing (DON) of the revealed she was aware ments were not completed in the staffing changes. The contact of the thick was that MDS are completed in a timely because Every 3 Months  Review Assessment a resident using the timent specified by the State of the short of the staff interviews, the end at a staff interviews, the ete quarterly assessments and staff interviews, the ete quarterly mDS and the staff of the staf			The facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required 14-day timeframe fo 14 of 29 residents reviewed for quarterl MDS assessments (Resident #20, Resident #36, Resident #51, Resident #22, Resident #38, Resident #61,	s r	7/27/24

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
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PREMIER	LIVING AND REHAB CI	ENTER		LAKE WACCAMAW, NC 28450	
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 638	Continued From pag	ne 53	F 638	3	
		ent #47, Resident #7, ent #26, and Resident #58).		Resident #63, Resident #5, Resident Resident #47, Resident #7, Resident Resident #26, and Resident #58).	
	Findings included:			All quarterly MDS assessments have been identified as having the potenti	
	(MDS) assessment of	terly Minimum Data Set dated 5/1/24 was listed as in		be affected by the alleged deficient practice.	
	progress and was in			The Director of Nursing (DON) or Designee, will review the quarterly	
	b. Resident #36 was admitted to the facility on 2/8/24.			assessments for all residents, from I of 2024, to ensure they were all	March
		terly Minimum Data Set dated 5/15/24 was completed		completed timely by 8/5/2024.	h.
	011 6/11/24.			The DON or Designee will educate t MDS Coordinator and all staff who a	
	c. Resident #51 was	admitted on 10/19/23.		responsible for completing sections	on the
		terly Minimum Data Set		MDS assessment by 8/5/2024 on the	
	(MDS) assessment on 6/4/24.	dated 4/4/24 was completed		importance of timely completion of N assessments to ensure they are	
	d. Resident #22 was	admitted on 9/8/17.		completed in the required timeframe 8/5/2024 newly hired staff will be ed	
		terly Minimum Data Set dated 3/29/24 was completed		by the DON or Designee during their hire employee orientation.	rnew
	D : 1 / #00			Beginning 7/27/2024, the DON or	
		admitted on 8/14/20.		Designee will audit all quarterly MDS	
	•	terly Minimum Data Set		assessments on a weekly basis for	
	<b>`</b>	dated 4/22/24 was completed		weeks (Monday – Friday) to ensure	all
	on 6/11/24.			quarterly MDS assessments are completed within the required timefront	ame
	f. Resident #61 was	admitted on 1/11/2/		Any issues with late submissions of	ame.
		terly Minimum Data Set		quarterly MDS assessments will res	ult in
		dated 4/18/24 was completed		re-educating the appropriate staff members and additional training.	MIC III
	g. Resident #63 was	admitted on 2/1/24.		Beginning 7/27/2024, the DON or	
		terly Minimum Data Set		Designee will audit all "In Progress"	
	(MDS) assessment of	dated 5/3/24 was completed		quarterly MDS assessments monthly	/ for

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ONSTRUCTION		PLETED
		345185	B. WING			1	0 <b>2/2024</b>
	ROVIDER OR SUPPLIER	NTER		106	EET ADDRESS, CITY, STATE, ZIP CODE  CAMERON STREET  KE WACCAMAW, NC 28450	<u>,                                    </u>	OLI LOLT
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638	on 6/13/24.  h. Resident #5 was a Resident #5's quarter assessment dated 4/6/11/24.  i. Resident #21 was Resident #21's quarter (MDS) assessment don 6/4/24.  j. Resident #47 was Resident #47's quarter (MDS) assessment don 6/13/24.  k. Resident #7 was a Resident #7's quarter assessment dated 4/6/5/24.  l. Resident #14 was a Resident #14's quarter assessment dated 4/6/5/24.  l. Resident #14 was a Resident #14's quarter (MDS) assessment don 6/13/24.  m. Resident #26 was Resident #26's quarter (MDS) assessment don 6/11/24.  n. Resident #58 was Resident #58's quarter (MDS) dated 5/24/24 and was not completer An interview was considered was consider	dmitted on 12/17/20.  Ily Minimum Data Set (MDS)  15/24 was completed on  admitted on 4/19/21.  Ily Minimum Data Set  ated 4/8/24 was completed  admitted on 12/13/21.  Ily Minimum Data Set  ated 5/3/24 was completed  admitted on 10/12/10.  Ily Minimum Data Set (MDS)  Ily Minimum Data Set (MDS)  Ily Minimum Data Set (MDS)  Ily Minimum Data Set  ated 5/2/24 was completed  admitted on 5/26/16.  Ily Minimum Data Set  ated 5/2/24 was completed  admitted on 8/29/23.  Ily Minimum Data Set  ated 4/11/24 was completed  admitted on 12/6/23.  Ily Minimum Data Set  admitted on 12/6/23.  Ily Minimum Data Set  was listed as in progress	F 6		three months.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hon Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this correctivaction.	the to ed.	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	01/0E/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLETION
F 638	was aware that MDS completed within the The Remote MDS Nu contracted on 04/30/2 assessments and the assessments when s  An interview was con on 6/11/24 at 1:57 PN started in May and was MDS courses to learn assessments. MDS I was still learning it was that completed assess	assessments were not state designated time frame. It is stated she was 24 to complete MDS facility was behind on the started.  ducted with MDS Nurse #2 M. MDS Nurse #2 stated she as training taking online in the requirements for the Nurse #2 stated since she as the Remote MDS Nurse sments since she started. If she was told the MDS	F 63	38	
F 640 SS=D	since February of this stated there had been Nurse several times is Administrator stated of personnel, the MDS a and were not comple.  An interview with the 6/14/24 at 4:10 PM rewith the MDS Assess in a timely manner due Encoding/Transmittin CFR(s): 483.20(f)(1)-  §483.20(f) Automated requirement- §483.20(f)(1) Encoding	/24 at 1:42 PM. The she had been in the position by year. The Administrator in changes in the role of MDS since she started. The due to the changes in assessments were behind the died in a timely manner.  Director of Nursing on evealed there was a problem ments not being completed the to staffing changes.  In the position of the pos	F 64	40	7/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	<u> </u>	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 640	facility must encode to each resident in the form (i) Admission assessing (ii) Annual assessmed (iii) Significant chang (iv) Quarterly review (v) A subset of items reentry, discharge, and (vi) Background (face is no admission asses §483.20(f)(2) Transmafter a facility complet a facility must be caped CMS System information contained in the MDS standard record layou and that passes standed that passes standed that passes standed accurate, and the State.  §483.20(f)(3) Transmafter a facility encoded, accurate, and the CMS System, incomplete (ii) Admission assessment (ii) Annual assessment (iii) Significant correct (v) Significant correct assessment.  (vi) Quarterly review.  (vii) A subset of items reentry, discharge, and (viii) Background (face)	the following information for acility: ment. Int updates. e in status assessments. assessments. upon a resident's transfer, and death. e-sheet) information, if there ssment.  Initing data. Within 7 days tes a resident's assessment, able of transmitting to the ation for each resident is in a format that conforms to ats and data dictionaries, dardized edits defined by  Initial requirements. Within by completes a resident's or must electronically transmit and complete MDS data to a luding the following: a ment. Int. Int. Int. Int. Int. Int. Int. I	F	540			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C <b>07/02/2</b>	024
NAME OF PROVIDE	ER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, 1 106 CAMERON STREET LAKE WACCAMAW, NC 284		01/02/2	<u> </u>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) MPLETION DATE	
§483 trans for a by C appr This by: Bas facili Data 26 re Find Resi 12/1 Resi quar signo trans An ir PM v state Data trans state trans An ir AM v Minii	smit data in the for State which has SMS, in the formatoved by CMS. REQUIREMENT and the formatoved by CMS. REQUIREMENT and Set within the resident assessment ings included: Indent #5 was admitted within the feet as completed smission date of the for Resident was aware and Set for Resident smitted within the feet she knew Resimitted late.  Interview was conwith the Administrative was conwithed was considered with the was conwithed was considered with the was conwithed was considered with the was conwithed with the was conwithed was conwithed was conwithed was conwithed with the was conwithed was	rmat. The facility must brimat specified by CMS or, an alternate RAI approved it specified by the State and is not met as evidenced iew and staff interviews the mit the quarterly Minimum equired time frame for 1 of ents reviewed (Resident #5).  In record revealed his eata Set dated 04/15/24 was on 04/15/24 with a 06/11/24.  Inducted on 06/17/24 at 1:37 in Data Set Coordinator. She is that the quarterly Minimum it #5 had not been in designated time frame. She ident #5's MDS was inducted on 06/14/24 at 11:15 trator. She indicated that all should be transmitted in a	F 6	The facility failed to tra Minimum Data Set (MD within the required time resident assessments r #5).  All quarterly MDS asse been identified as havin be affected by the alleg practice.  The Director of Nursing Designee, will review the assessments for all rese of 2024, to ensure they transmitted timely by 8/  The DON or Designee MDS Coordinator and a responsible for complete MDS assessment by 8/  importance of timely transmitted in timeframe. After 8/5/20 staff will be educated be Designee during their morientation.  Beginning 7/27/2024, the Designee will audit all cassessments on a wee	os) assessment of frame for 1 of 2 reviewed (Resident of 2) reviewed (Resident of 2) reviewed (Resident of 2) (DON) or the quarterly MDS of 2) will educate the all staff who are ting sections on 1/5/2024 on the ansmission of the ments to ensure the required of 24 newly hired by the DON or new hire employed the DON or quarterly MDS	6 ent 0 Sch	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	, <u></u>	<b>Y</b>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 640	Continued From page	÷ 58	F	weeks (Monday - Friday) to ensure a quarterly MDS assessments are transmitted within the required timefr Any issues with late transmission of quarterly MDS assessments will resure-education with the appropriate stamembers and additional training.  Beginning 7/27/2024, the DON or Designee will audit all "In Progress" quarterly MDS assessments monthly three months to ensure timely transmission of the assessments.  Beginning 7/27/2024, the audits will reviewed by the Licensed Nursing He Administrator (LNHA) or DON, and the results of the audits will be reviewed monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The Committee will review the audits and make recommendations as necessal assure ongoing compliance is sustain The facility will utilize this plan of correction to ensure compliance und mandated regulation by 8/6/2024 and audits will continue for the specified timeframe as described in this correctation.	t in f  for  e me e n the API / to ed. or the the	
F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 6	641		7/27/24
	resident's status.	of Assessments.  t accurately reflect the  is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION   A. BUILDING			(X3) DATE SURVEY COMPLETED	
		2454.05	B. WING				С	
		345185	B. WING _			07/	02/2024	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER	LIVING AND REHAB CE	NTER			06 CAMERON STREET			
				L	AKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 59	F 6	341				
	Based on record revi facility failed to accura Data Set (MDS) asse	iew and staff interviews, the ately code the Minimum			The facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 26 residents reviewed (Resident #50, Resident #61, and Resident #8).	s		
	Findings included:				All MDS assessments have been identified as having the potential to be affected by the alleged deficient practic	e.		
	1. Resident #50 was admitted to the facility on 10/06/23. Diagnoses included peripheral vascular disease, and diabetic foot ulcer.				The Director of Nursing (DON), MDS coordinator, or Designee will review all assessments scheduled after 7/1/2024	for		
	01/22/24 and 02/15/2	consultant notes written on 4 revealed the resident had c foot infection and chronic			current residents to ensure proper codi was completed accurately by 8/5/2024			
	inflammatory polyneu	•			The DON or Designee will educate the MDS coordinator by 8/5/2024 on the			
	The Minimum Data S				importance of MDS assessment coding	-		
	assessment dated 03				accuracy. After 8/5/2024 newly hired s			
	I .	as having a venous or			will be educated by the DON or Design	ee		
		ving a diabetic foot ulcer.  an dated 03/08/24 revealed			during their new hire employee orientation.			
	mellitus with intervent daily for open areas, blisters, edema or rec potential pressure are	lan of care for diabetes tions to include inspect feet sores, pressure areas, dness; and a plan of care for ea related to decreased al vascular disease with de monitor/document			Beginning 7/27/2024, the DON or Designee will audit all MDS assessment to ensure all MDS assessments are coded accurately. Any issues of coding accuracy will result in re-education and additional training for the MDS coordinand any other appropriate staff members.	) I ator		
	location, size and trea abnormalities, failure of infection to physicia documentation to incl area of skin breakdow of tissue and exudate	atment of skin injury, report to heal, signs or symptoms an and weekly treatment ude measurement of each vn, width, length, depth, type and other notable changes			Beginning 7/27/2024, the DON or Designee will audit all MDS assessment monthly for 3 months to ensure they have been coded accurately.	nts ave		
	or observations.  A review of the physic	cian's order written on			Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hon Administrator (LNHA) or DON, and the	ne		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE COMP	SURVEY LETED
		345185	B. WING _				02/2024
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024
					AMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			WACCAMAW, NC 28450		
				LANE	WACCAMAW, NC 28430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	e 60	F 6	41			
F 641	10/23/23 revealed an topically with a topical Wednesday and Frida was discontinued on A phone interview wa MDS nurse on 06/18/ she was a contract er the facility since April worked remotely and electronic medical rec the assessments bas the look back period. physician orders, diagnotes and nursing as accurately code the Not do any actual face stated she was able to about the resident by documentation. The reviewed Resident #5 time and confirmed the diabetic foot ulcer and for this wound since a MDS nurse stated she was able to diabetic foot ulcer and for this wound since a MDS nurse stated she was always and the word of the wound since a MDS nurse stated she was always and the word of the word	order to cleanse left heel I medication every Monday, ay for wound healing. This 05/10/24.  Is conducted with the remote 24 at 12:59 PM revealed imployee and had been at 30, 2024. She stated she she had access to the cords so she could complete ed on the documentation in She stated she reviewed gnoses, nursing progress sessments in order to IDS. She added, she did to to face assessments. She to retrieve the information reviewing the remote MDS nurse to's medical record at this that he was admitted with a d was receiving treatments admission. The remote the should have coded him as fulcer.  Is conducted on 06/19/24 at	F6	re: mm Pe Mi Co ma ass Th co ma au tin	sults of the audits will be reviewed in onthly Quality Assurance and erformance Improvement (QAPI) eeting monthly for 3 months. The QAD mittee will review the audits and ake recommendations as necessary issure ongoing compliance is sustained facility will utilize this plan of prection to ensure compliance under andated regulation by 8/6/2024 and sudits will continue for the specified meframe as described in this correctivation.	to d. the	
	facility. Diagnoses inc the immune system a	admitted on 1/11/2024 to the sluded a condition in which ttacks the nerves and pain.					
	A review of the physic	an s orders recorded an					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 641	medication) 5 milligra day for pain was writt #61.  The April 2024 Medic (MAR) recorded Resi Methadone HCL twick The quarterly Minimu assessment dated 4/#61 was cognitively in opioids (pain relieving Resident #61's care pincluded a focus for padministering analger pain) per physician of effectiveness in reliev The June 2024 MAR continued to receive a day.  On 6/19/2024 at 11:1 with the Remote MDS explained based on hResident #61's electromagnetic when completing the #61 was not on any of MDS Nurse reviewed stated Resident #61 an opioid, daily when dated 4/18/2024 was missed coding Reside for opioid. She explais stroke of the computer stroke of the computer with the service was missed to the computer stroke of the computer stroke of the computer with the service was missed to the computer stroke of the computer stroke of the computer stroke of the computer was missed to the computer stroke of the computer s	HCL (a long acting opioid ms (mg) two tablets twice a en on 2/1/2024 for Resident ation Administration Record dent #61 was receiving a day.  Im Data Set (MDS)  18/2024 indicated Resident stact and was not receiving medications).  Isolan dated 6/11/2024 ain. Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications that relieve reders and to evaluate the ring pain.  Interventions included sics (medications).	F 64		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		DATE SURVEY COMPLETED
		345185	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	due to the inconsisted in the facility, the facility, the facility, the facility has a most of the facility oversaw MDS assessed of opioids. The facility oversaw MDS assessed ov	Aursing (DON), she explained ency of having a MDS nurse illity was using a Remote ete MDS assessments. She tee MDS Nurse used MR that could lead to sessment of Resident #61 DON stated she had not toring related to the accuracy ssessments by the Remote 25 p.m in a phone interview or, she stated the DON sments to ensure completed ent #61's MDS assessment the use of opioids.  admitted to the facility on ses which included chronic which included chronic es which included chronic atrial 8/19/23.  ation Administration Record and indicated she received by mouth daily since she was the one 8/19/23.  artly Minimum Data Set (MDS) /24/24 indicated Resident #8 ceiving anticoagulants on a	F 64			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
		345185	B. WING			C / <b>02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC  X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR  DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 641	She also indicated it of for anticoagulant use	assessments remotely. could have been not coded in error. ne Administrator on 6/17/24 sated the MDS should be	F	641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)  §483.21 Comprehens Planning §483.21(a) Baseline §483.21(a) Baseline that includes the instreffective and personthat meet professiona The baseline care plati) Be developed with admission.  (ii) Include the minimulation necessary to properly including, but not limi (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services  (E) Social services.  (F) PASARR recomm	care Plans cility must develop and care plan for each resident cuctions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's  care for a resident ted to- d on admission orders.	F	655		7/27/24
		ments set forth in paragraph cepting paragraph (b)(2)(i) of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345185	B. WING _				C / <b>02/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	02/2024
DDEMIED	LIVING AND REHAB CE	NTED		10	06 CAMERON STREET		
FREINIER	LIVING AND REHAB CE	NIER		L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		EFICIENCY MUST BE PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	÷ 64	Fé	655			
	this section).						
	§483.21(a)(3) The faresident and their report the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on record revifacility failed to developerson-centered base forty-eight hours of activity and their report of the comprehensive that the comprehe	treatments to be acility and personnel acting y. mation based on the details care plan, as necessary. is not met as evidenced ew and staff interviews, the pan individualized eline care plan within dmission for 2 of 26 r care planning (Resident			The facility failed to develop an individualized person-centered baseling care plan within forty-eight hours of admission for 2 of 26 residents reviewed for care planning (Resident #16 and Resident #319).		
	4/26/2024 with diagno	as admitted to the facility on oses including stroke. s dated 4/26/2024 included			All individualized person-centered baseline care plans within forty-eight hours of a residents admission have be identified as having the potential to be affected by the alleged deficient practic		
	an order for rivaroxab				The Director of Nursing (DON) or		
	medication that preve	nts or break down blood			Designee, will review the individualized		
	,	ng) via gastrostomy tube			person-centered baseline care plans for	or	
	(G-Tube) in the eveni	ng for anticoagulation.			all residents, from March of 2024, to		
	Decident #401= Armil 6	2024 Madigation			ensure they were all completed timely	by	
	Resident #16's April 2				8/5/2024.		
	Administration Record	ams (mg) was administered			The DON or Designee will educate the		
	4/27/2024, 4/28/2024	, -,			MDS coordinator and all staff who are responsible for completing sections on	the	

	DF DEFICIENCIES CORRECTION			OATE SURVEY OMPLETED		
		345185	B. WING			C 07/02/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		07/02/2024
				106 CAMERON STREET	-	
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450		
240.15	CLIMMADY CT	TATEMENT OF DEFICIENCIES			NDDECTION .	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	Continued From page	e 65	F 6	55		
	There was no individu	ualized person-centered		MDS assessment by 8/5/2024	4 on the	
		cated in Resident #16's		importance of timely completi	ion of the	
	medical record for the	e 4/26/2024 admission.		individualized person-centere	ed baseline	
				care plans to ensure they are	completed	
	Nursing documentation	on dated 4/29/2024 at 8:25		in the required timeframe. Aft	ter 8/5/2024	
		nt #16 was coughing up		newly hired staff will be educa	•	
		rofusely from the nose.		DON or Designee during thei	r new hire	
		Services (EMS) was called to		employee orientation.		
	transport Resident #1	16 to the hospital.				
				Beginning 7/27/2024, the DO		
		re-admitted to the facility on		Designee will audit individual		
	5/9/2024.			person-centered baseline car	•	
	The F day admission	Minimum Data Sat (MDS)		ensure all individualized pers		
	-	Minimum Data Set (MDS) 15/2024 indicated Resident		baseline care plans are comp the required timeframe. Any i		
		paired cognitively and was		late submissions will result in		
	not coded for receivir			with the appropriate staff mer		
	1100 00000 101 10001111	ig annocagaiante.		additional training.	nboro ana	
	Resident #16's May 2	2024 Medication		additional training.		
	Administration Recor			Beginning 7/27/2024, the DO	N or	
		rams (mg) was restarted on		Designee will audit all individe		
		stered every evening from		person-centered baseline car		
		4 except for 5/29/2024.		monthly for 3 months to ensu	•	
				transmission of the assessme	ents.	
	Resident #16's June	2024 MAR recorded				
		as administered every		Beginning 7/27/2024, the aud		
		2024, to June 13, 2024		reviewed by the Licensed Nu	-	
		and 6/9/2024 when Resident		Administrator (LNHA) or DON		
	#16 was out of the fa	cility.		results of the audits will be re		
				monthly Quality Assurance ar		
		ualized person-centered		Performance Improvement (C		
	•	cated in Resident #16's		Meeting monthly for 3 months		
	medical record for the	e 5/9/2024 admission.		Committee will review the aud		
	On 6/10/2024 at 11:1	Q a m in a phone interview		make recommendations as n assure ongoing compliance is	•	
		9 a.m. in a phone interview S Nurse for the facility, she		The facility will utilize this plan		
		red by the facility to work		correction to ensure compliar		
		olete MDS assessments.		mandated regulation by 8/6/2		
		ng staff at the facility were		audits will continue for the sp		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			1	0 <b>2/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
					06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			AKE WACCAMAW, NC 28450		
					ARE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	e 66	F 6	355			
F 655	responsible for complete person-centered base and the individualized care plan was active completed the compressated Resident #16 to on admission, and an person-centered base been completed within of admission.  On 6/19/2024 at 10:2 interview with the Direstated the MDS Nurse responsible for complete person-centered base explained there had in Nurse at the facility since the stated there was individualized personplans were not being MDS Nurse was work log of MDS assessment Resident #16 should person-centered base two hours of admission.  On 6/19/2024 at 12:2 interview with the Admalthough the MDS Nurse person-centered base admission, licensed in individualized personplan. She further explants	eting individualized eline care plans for residents I person-centered baseline until the MDS Nurse ehensive care plan. She was receiving anticoagulants individualized eline care plan should have in the first forty-eight hours  2 p.m. during a phone ector of Nursing (DON), she e located at the facility was eting the individualized eline care plans. The DON not been a consistent MDS note before March 2024. only one MDS Nurse, and centered baseline care completed because the king on completing the back ents. The DON stated have had an individualized eline care plan started within on to the facility.  5 p.m. during a phone ministrator, she explained arse at the facility was the o complete the individualized eline care plan after	F 6	855	timeframe as described in this corrective action.	/e	
		to start resident's -centered baseline care alizing the transition had not					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING				02/2024
	ROVIDER OR SUPPLIER	NTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET LAKE WACCAMAW, NC 28450	1 011	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	4/23/24 with diagnose Diabetes Mellitus, ap a cerebral vascular a hemiplegia (loss of st weakness on one sid A review of Resident Record (EMR) reveal Review of Resident # Data Set (MDS) reveacompleted on 5/1/24.  During an interview won 6/17/24 at 10:08 a assessments were coprevious nurse could further indicated she assessments remoted During a phone interview on 6/17/24 at 10:08 a complete on 5/1/24.	s admitted to the facility on es which included type 2 hasia, and a recent history of ecident (stroke) with rength or almost complete e of the body).  #319's Electronic Medical ed no baseline care plan.  #319's admission Minimum aled admission assessment  with the Remote MDS nurse im she revealed that completed late because the not get caught up. She was completing MDS	F	655			
F 656 SS=E	further stated she did completed upon Resi In a phone interview of 6/18/24 at 9:03 am sh admission MDS asse completed within the	not know why this was not dent #319's admission.  with the Administrator on the stated Resident #319's sament should have been regulatory time frame.  Comprehensive Care Plan (3)	F	656			7/27/24
			1				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345185	B. WING			1	02/2024
	ROVIDER OR SUPPLIER	NTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET LAKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identif assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized significant to the reunder §483.10 including the findings of the PASAF rationale in the resider (iv) In consultation with resident's representationale in the resident's representational	cility must develop and densive person-centered sident, consistent with the sth at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial died in the comprehensive exprehensive care plan must great to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse at 10(c)(6).  Between the furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse at 10(c)(6).  Between the furnished to attain ent's medical record. In the resident and the tive(s)-als for admission and deference and potential for desired and any referrals to seed and any referrals to seed and or other appropriate	F	656			

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————		(X3) DATE SURVEY COMPLETED		
	345185	B. WING		C 07/02/2024
ROVIDER OR SUPPLIER	ENTER	1	06 CAMERON STREET	1 0.1.02.202.
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
section. §483.21(b)(3) The s by the facility, as out care plan, must- (iii) Be culturally-con This REQUIREMEN by: Based on record refacility failed to deve person-centered cor indicated by the Min area assessment to psychosocial wellbe communication, presactivities of daily livin #11), at risk for nutri and Resident #34), a daily living, nutrition, (Resident #52); and comprehensive care anticoagulant medic (Resident #16). This reviewed.  Finding included:  1. Resident #11 was 08/11/23 with diagno dementia, hearing lo accident (CVA).  The Minimum Data 3 assessment dated 0 #11 had moderately	ervices provided or arranged tlined by the comprehensive inpetent and trauma-informed. T is not met as evidenced view, and staff interviews the elop and implement a imprehensive care plan as imum Data Set (MDS) care include: the areas of ing, falls, nutrition, vision, assure ulcers, dental, pain, and, and dehydration (Resident tional status (Resident #219 assistance with activities of and urinary incontinence for not developing a plan for a resident receiving ation (blood thinner) is was for 5 of 26 residents.  Set (MDS) admission 8/17/23 revealed Resident impaired cognition. He had	F 656	The facility failed to develop and implement a person-centered comprehensive care plan as indicated the Minimum Data Set (MDS) care assessment to include: the areas of psychosocial wellbeing, falls, nutritivision, communication, pressure uldental, pain, activities of daily living dehydration (Resident #11), at risk nutritional status (Resident #219 ar Resident #34), assistance with activity of daily living, nutrition, and urinary incontinence (Resident #52); and for developing a comprehensive care paresident receiving anticoagulant medication (blood thinner) (Resident This was for 5 of 26 residents reviewall person-centered comprehensive plans have been identified as having potential to be affected by the alleg deficient practice.  The Director of Nursing (DON) or Designee will review the person-ce comprehensive care plans for all residents, from March of 2024, to expressions.	area  f on, cers, , and for nd vities or not blan for nt #16). wed. e care ng the ed  ntered  nsure
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF	CORRECTION  JA5185  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69 section.  §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #11), at risk for nutritional status (Resident #219 and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed.  Finding included:  1. Resident #11 was admitted to the facility on 08/11/23 with diagnoses including in part; dementia, hearing loss, and cerebral vascular	A BUILDING  345185  B. WING  B. WING  B. WING  B. WING  B. WING  COVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69  section.  \$483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:  Based on record review, and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #11), at risk for nutritional status (Resident #219 and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed.  Finding included:  1. Resident #11 was admitted to the facility on 08/11/23 with diagnoses including in part; dementia, hearing loss, and cerebral vascular accident (CVA).  The Minimum Data Set (MDS) admission assessment dated 08/17/23 revealed Resident #11 had moderately impaired cognition. He had	A BUILDING  345185  STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 69 section.  \$483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:  Based on record review, and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan as indicated by the Minimum Data Set (MDS) care area assessment to include: the areas of psychosocial wellbeing, falls, nutrition, vision, communication, pressure ulcers, dental, pain, activities of daily living, and dehydration (Resident #21) and activities of daily living, and dehydration (Resident #21) and and Resident #34), assistance with activities of daily living, nutrition, and urinary incontinence (Resident #52); and for not developing a comprehensive care plan for a resident receiving anticoagulant medication (blood thinner) (Resident #16). This was for 5 of 26 residents reviewed.  1. Resident #11 was admitted to the facility on 08/11/23 with diagnoses including in part; dementia, hearing loss, and cerebral vascular accident (CVA).  The Minimum Data Set (MDS) admission assessment do agent and the preson-ce comprehensive care plan for a resident receiving ancident (CVA).  The Minimum Data Set (MDS) admission assessment do admission assessment do agent review the person-ce comprehensive care plan for a resident receiving ancident (CVA).  The Minimum Data Set (MDS) admission assessment do admission assessment do agent review the person-ce comprehensive care plan for all residents, from March of 2024, to ecomprehensive care plans for all residents, from March of 2024, to ecomprehensive care plans for all residents, from March of 2024, to ecomprehensive care plans for all residents, from March of 2024, to ecomprehens

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDI			Ι,	С
		345185	B. WING				02/2024
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024
					06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER		L	AKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	e 70	F	656			
	broken teeth and rece	eived pain medication. He			responsible for completing sections on	the	
		vith activities of daily living.			MDS assessment by 8/5/2024 on the		
	The care area assess	sment dated 08/17/23			importance of developing and		
		are plans in the following			implementing the person-centered		
		wellbeing, falls, nutrition,			comprehensive care plans to ensure		
		n, pressure ulcers, dental,			residents are receiving quality care. Af		
	pain, activities of daily	y living, and dehydration.			8/5/2024 newly hired staff will be educated		
					by the DON or Designee during their n	∋W	
		t11's electronic medical			hire employee orientation.		
		n on 08/11/23 through			Danisasia a 7/07/0004 tha DON		
		care plan in place for			Beginning 7/27/2024, the DON or Designee will audit all person-centered		
		ess psychosocial wellbeing, communication, pressure			comprehensive care plans to ensure the		
		activities of daily living, or			are all completed. Any issues with late		
	dehydration.	delivities of daily living, of			submissions will result in re-education		
	2011) 41 41 51 11				with the appropriate staff members and	ı	
	During a phone interv	view on 06/19/24 at 2:05 PM			additional training.		
		d she worked for an agency			9		
	that was contracted v				Beginning 7/27/2024, the DON or		
	completed MDS asse	essments and care plans			Designee will audit all person-centered		
	remotely. She began	working for the facility on			comprehensive care plans monthly for		
	04/30/24. She indicat	ted although she was not the			three months to ensure the developme	nt	
		onsible for creating the initial			and implementation of the		
		plan for Resident #11, the			person-centered comprehensive care	olan	
	-	ve been completed from the			assessments.		
		ered on the MDS admission			D : : 7/07/0004 // // //		
		iewed the MDS and care			Beginning 7/27/2024, the audits will be		
		and agreed a care plan			reviewed by the Licensed Nursing Hon		
		plemented in the areas of ng, falls, nutrition, vision,			Administrator (LNHA) or DON, and the results of the audits will be reviewed in		
	· •	sure ulcers, dental, pain,			monthly Quality Assurance and	uie	
	activities of daily living	· •			Performance Improvement (QAPI)		
	asariass of daily fivility	g, 3011, 41.41.0111			Meeting monthly for 3 months. The QA	PI	
	During an interview o	on 06/14/24 at 4:00 PM the			Committee will review the audits and		
	_	OON) stated she was not			make recommendations as necessary	to	
		s were not implemented for			assure ongoing compliance is sustaine		
		ated there had been staff			The facility will utilize this plan of		
		S nurses. She indicated care			correction to ensure compliance under	the	
		eloped and implemented			mandated regulation by 8/6/2024 and t		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345185	B. WING				C <b>(02/2024</b>
	ROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMERON STREET AKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	according to the requivalence of the Administrator staff turnover with the MD MDS nurse was respiplans and care plans for Resident #11. She utilized an agency MI remotely, and she plaback in the facility as 2. Resident #219 was 05/22/24 with diagnor left lower limb and dia The MDS admission revealed Resident #2 She received wound The care area assess indicated to initiate a nutritional status.  Review of Resident #2 record from admission 06/19/24 revealed not Resident #219 to add measurable goals an During a phone intervithe MDS nurse stated initiating the comprehence initiating the care planadmission assessme She stated it was dor	view on 06/19/24 at 4:00 PM ted there had been staff S nurses. She reported the onsible for developing care should have been initiated e reported they currently DS nurse who worked anned to get an MDS nurse soon as possible.  Is admitted to the facility on sis including cellulitis of the abetes.  assessment dated 05/28/24 at 19 was cognitively intact. care and a therapeutic diet. sment dated 05/28/24 care plan that included  1219's electronic medical in on 05/22/24 through a care plan in place for dress Nutritional status with d interventions.  12 view on 06/19/24 at 2:05 PM and she was responsible for the ensive care plan for eported that she missed in as indicated on the MDS ant in the area of nutrition.	F	656	audits will continue for the specified timeframe as described in this correctivaction.	/e	

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450		07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTIVE ACTIVE)  CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	Director of Nursing (I aware that care plans Resident #219. She sturnover with the MD plans should be deve according to the required Medicare & Medicaid During a phone intervithe Administrator stat turnover with the MD MDS nurse was respilans and care plans for Resident #219. Slutilized an agency MI remotely, and she plans back in the facility as 3. Resident #52 was 05/02/24. Diagnoses	OON) stated she was not swere not implemented for stated there had been staff S nurses. She indicated care eloped and implemented ired CMS (Centers for ) guidelines.  View on 06/19/24 at 4:00 PM ted there had been staff S nurses. She reported the onsible for developing care should have been initiated the reported they currently DS nurse who worked anned to get an MDS nurse	F	356		
	#52 was severely cogrequired assistance vand was occasionally frequently incontinen weight was recorded were no nutritional appeare area assessment to initiate care plans activities of daily livin nutritional status.  Review of Resident # record from admission 06/19/24 revealed the	5/09/24 revealed Resident				

AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP COD 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	daily living, or urinary An interview was con PM with the Director DON stated she was were not implemente stated there had been nurses. She indicated developed and imple required CMS (Cente guidelines.  A phone interview wa 2:05 PM with the MD stated she worked fo contracted with the fa assessments and cal began working for the indicated although sh was responsible for comprehensive care care plans should ha care areas that trigge assessment. She rev plan for Resident #52 should have been im nutritional status, acti urinary incontinence.  A phone interview wa 4:00 PM with the Adr Administrator stated of with the MDS nurses nurse was responsible and care plans shoul Resident #52. She re an agency MDS nurses	ducted on 06/14/24 at 4:00 of Nursing (DON). The not aware that care plans d for Resident #52. She in staff turnover with the MDS d care plans should be mented according to the ers for Medicare & Medicaid)  as conducted on 06/19/24 at S nurse. The MDS nurse in a gency that was acility and completed MDS re plans remotely. She is facility on 04/30/24. She is was not the person that creating the initial plan for Resident #52, the ve been completed from the ered on the MDS admission in iewed the MDS and care is and agreed a care plan plemented in the areas of vities of daily living and its conducted on 06/19/24 at its con	F 6	556		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		345185	B. WING		07/02/2024	
	ROVIDER OR SUPPLIER	ENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 656	Continued From pag	e 74	F 656			
	02/01/24. Diagnose anxiety and depress kidney, and demention.  The MDS admission revealed Resident #3	assessment dated 02/08/24				
		on a mechanically altered				
	revealed Resident #: cognitively impaired. coughing or choking swallowing medication as 139 pounds. Res	Resident #34 was coded as during meals or when ons and weight was recorded sident #34 had a weight loss last month or a loss of 10% on this and was on a				
	record from admission	#34's electronic medical on on 02/01/24 through ere was no care plan in place I status.				
	06/14/24 at 4:00 PM (DON) stated she wanutritional care plan Resident #34. She sturnover with the MD plans should be deviaccording to the required Medicare & Medicaio	•				
		as conducted on 06/19/24 at OS nurse. The MDS nurse				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED			
		345185	B. WING		O7/02	2/2024
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	contracted with the far assessments and carbegan working for the indicated although shas responsible for comprehensive care care plans should had care area that trigger assessment. She reviplan for Resident #34 should have been important to the MDS nurses nurse was responsible and the care plan should had care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurse was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the MDS nurses nurses was responsible and the care plan should have been important to the more nurses nurses was responsible and the care plan should have been important to the more nurses nurses and the care plan should have been important to the more nurses	r an agency that was acility and completed MDS re plans remotely. She is facility on 04/30/24. She he was not the person that creating the initial plan for Resident #34, the ve been completed from the red on the MDS admission riewed the MDS and care 4 and agreed a care plan plemented for nutritional as conducted on 06/19/24 at ministrator. The there had been staff turnover . She reported the MDS le for developing care plans bulld have been initiated for eported they currently utilized se who worked remotely, and in MDS nurse back in the	F 6	56		
	4/26/2024 with diagn Physician's orders da order for Xarelto (an that prevents or brea	admitted to the facility on oses including stroke.  ated 4/26/2024 included an anticoagulant medication k down blood clots) 20 astrostomy tube (G-Tube) in pagulation.				
		2024 Medication rd (MAR) recorded Xarelto ered 4/27/2024, 4/28/2024				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 017021202-1
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F 656	Continued From pag	ge 76	F 650	3	
	8:25pm reported Re blood and bleeding   Emergency Medical transport Resident #	ischarged to the hospital on			
	4/29/2024 and was i 5/9/2024.	re-admitted to the facility on			
	assessment dated 5 #16 was severely im	n Minimum Data Set (MDS) 1/15/2024 indicated Resident apaired cognitively. The S was not coded for receiving			
		prehensive care plan dated clude a focus for the use of			
		R from 5/9/2024 through Resident #16 received dered.			
	with the Remote MD was responsible for comprehensive care MDS assessment. Sphysician's order an administration of the anticoagulants shou	e plans after completing the She stated based on the d documentation of exarelto daily, the use of ld have been included on the e plan for Resident #16. She			
	with the Director of I	22 am in a phone interview Nursing (DON), she explained ırse or MDS Nurse at the			

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING		0.	C 7/02/2024	
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP ( 106 CAMERON STREET LAKE WACCAMAW, NC 28450		702/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	#16's comprehensive of anticoagulants and have been care plant anticoagulants. The Dresignations of previor 2024 and a back log complete, the MDS in dedicate sufficient time comprehensive care.  On 6/19/2024 at 12:2 with the Administrator Nursing was responsionaries completed Recare plan to included Care Plan Timing and CFR(s): 483.21(b)(2). §483.21(b)(2) A complete (i) Developed within the comprehensive a (ii) Prepared by an iniculded but is not lime (A) The attending phy (B) A registered nurse resident.  (C) A nurse aide with resident.  (D) A member of food (E) To the extent practite resident and the resident and the resident record if the	ble for updating Resident care plan to include the use distated Resident #16 should ned for the use of DON explained due to bus MDS nurses since March of MDS assessments to urses were unable to ne in developing a plan for Resident #16.  5 pm in a phone interview r, she stated the Director of ible to ensure the MDS esident #16's comprehensive anticoagulants. di Revision (i)-(iii)  ensive Care Plans prehensive care plan must didys after completion of essessment. terdisciplinary team, that nited to ysician. e with responsibility for the did and nutrition services staff. citicable, the participation of resident's representative(s). be included in a resident's participation of the resident bresentative is determined		657		7/27/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1 01/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 657	disciplines as deterr or as requested by to (iii)Reviewed and reteam after each assocomprehensive and assessments. This REQUIREMEN by:  Based on record retresident representation interviews, the facility and/or the responsity care planning proces. Resident #16), to retwith new fall interved develop a care plan completion of the confersident #319). The facility of 26 residents revied Findings included:  1. a. Resident #61 with 1/11/2024.  The quarterly Minimal assessment dated 4 with 461 was cognitively. There was no docur a care plan meeting Resident #61's Reprimedical record.  On 6/10/2024 at 2:0 Resident #61, he state facility he had not the complete of the confersion	e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review  T is not met as evidenced view, resident interviews, ive interviews, and staff by failed to ensure the resident ble party was involved in the ses (Resident #61 and vise a resident's care plan intions (Resident #47), and to within 7 days after imprehensive assessment is deficient practice affected 4 ewed for care planning.  I was admitted to the facility on um Data Set (MDS) 1/18/2024 indicated Resident	F 65	The facility failed to ensure the res and/or the responsible party was in in the care planning process (Resident #16), to revise a resident's care plan with new fall interventions (Resident #47), and to develop a care plan within 7 days a completion of the comprehensive assessment (Resident #319). This deficient practice affected 4 of 26 residents reviewed for care plannin All residents residing in the facility I been identified as having the poten be affected by the alleged deficient practice.  The Director of Nursing (DON) or Designee will review the care plans residents, from March of 2024, to e the resident and/or the responsible was involved in the care planning p care plans have been revised to en new interventions are developed, c planned, and implemented, and to timely completion of the care plans ensure they are completed in the retimeframe by 8/5/2024.	avolved dent  or after  g. have tial to dent  s for all ensure party process, asure eare ensure to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		345185	B. WING _			07	/02/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
				106	CAMERON STREET		
PREMIER	LIVING AND REHAB	CENTER		LAK	E WACCAMAW, NC 28450		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 657	Continued From pa	age 79	F 6	657			
	discuss a plan of c	are to prepare him for a		-	The DON or Designee will educate th	е	
	discharge to the co				MDS coordinator and all staff who are		
		•			responsible for completing sections o	n the	
	On 6/14/2024 at 1	1:23 am in an interview with the			MDS assessment by 8/5/2024 on the		
	Social Worker, she	e explained she and the former		i	mportance of resident and/or respons	sible	
	MDS Nurse in the	facility provided dates each			party involvement when developing th	ie	
	month to the recep	tionist to schedule initial care		(	care plan. After 8/5/2024 newly hired	staff	
		r residents were admitted to			will be educated by the DON or Desig	nee	
		ited she could not recall having			during their new hire employee		
	•	g with Resident #61 and did		(	orientation.		
		dent #61's initial admission					
		was not conducted in January			The DON or Designee will educate th		
	•	ed the facility did not have a			MDS coordinator and all staff who are		
		d indicating who was			responsible for completing sections o		
		ident care plan meetings and a MDS Nurse located in the			MDS assessment by 8/5/2024 on the importance of revising care plans to		
		barrier in communicating			ensure new interventions are develop	had	
		eetings were to be conducted.			care planned, and implemented. After		
		#61's quarterly care plan			8/5/2024 newly hired staff will be edu		
		ccurred because care plan			by the DON or Designee during their		
	_	being conducted at the facility			hire employee orientation.		
		a consistent MDS Nurse.			1 ,		
				-	The DON or Designee will educate th	е	
	On 6/14/2024 at 3:	14 pm in an interview with the			MDS coordinator and all staff who are		
	Director of Nursing	, she said she could not recall			responsible for completing sections o	n the	
	attending a care pl	an meeting for Resident #61			MDS assessment by 8/5/2024 on the		
	and was unable to	locate documentation in		i	mportance of timely completion of the	<b>;</b>	
	Resident #61's me	dical record that a care plan			care plan to ensure they are complete		
	meeting was condi	ucted.			the required timeframe. After 8/5/2024		
					newly hired staff will be educated by t		
		as admitted to the facility on		- 1	DON or Designee during their new hir	e	
		ged from the facility on		•	employee orientation.		
		ospital, and readmitted on		1.	D		
	5/9/2024 to the fac	ility.		- 1	Beginning 7/27/2024, the DON or		
	The E day adva::	on Minimum Data Cat (MDC)			Designee will audit all care plans to	oible	
		on Minimum Data Set (MDS)			ensure the resident and/or the respon		
		5/15/2024 indicated Resident			party was involved in the care planning	-	
	# 10 was severely (	cognitively impaired.			process, care plans have been revise ensure new interventions are develop		
	I		1	(	ensure new interventions are develop	≂u,	1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING			l	02/2024
NAME OF P	ROVIDER OR SUPPLIER		<del> </del>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	077	02/2024
NAME OF T	TO VIDER OR OUT FIER				, , ,		
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				LAI	KE WACCAMAW, NC 28450		
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F 657	Continued From page	÷ 80	F 6	657			
F 657	There was no docume meeting with Resident Resident #16's medic On 6/10/2024 at 3:33 with Resident #16's Refacility had not conduction as a plan of care Representatives. She was not able to common On 6/14/2024 at 11:25 Social Worker, she examples after resident with the facility. She stated a care plan meetings after restricted a care plan meeting with Resident #16's Representatives at the facility did not have indicating who was replan meetings and standicating when be conducted. She sa admission care plan meconducted at the facili consistent MDS Nurse	entation of a care plan It #16's Representative in al record.  In pm in a phone interview It the presentative, she said the It the core with Resident #16's It is reported that Resident #16 In inicate his needs.  If is a m in an interview with the It is provided dates each Inist to schedule initial care It is ident #16 or It is entatives. She explained It is a process established It is provided as a barrier in It is a process established It is a p	F 6		care planned, and implemented, and to ensure timely completion of the care pl to ensure they have been completed in the required timeframe. If any issues an identified the appropriate staff member will be re-educated and additional train will be provided.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hom Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustaine The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this correctivaction.	ans Te s ing the the the the he	
	Director of Nursing, s attending a care plan with Resident #16's R unable to locate docu medical record that a	pm in an interview with the he said she could not recall meeting for Resident #16 or lepresentative and was mentation in Resident #16's care plan meeting was a individualized plan of care					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		) DATE SURVEY COMPLETED
		345185	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	l	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	On 6/13/2024 at 5:55 Social Worker, Direct Administrator present care plan meetings w resident's medical red Worker) or the MDS I MDS Nurse was not a plan meetings. The D Nurse working remote not held. The Administresponsible for ensur conducted as schedu  In a follow-up intervie by phone on 6/19/202 explained since Marc the facility, there had the facility consistent meetings with the So  On 6/19/2024 at 12:2 with the Administrator coordinator was resp- scheduling and comn interdisciplinary team resident representativ were to be conducted when she started at there was not a clear plan meetings. She re searching for staff to since she had not be MDS Nurse. She sai was responsible for the ensuring care plan m discussed with reside representatives the d	pm in an interview with the or of Nursing (DON) and to the Social Worker stated the Ford by herself (Social Nurse, and the Remote at the facility to conduct care to No stated due to the MDS tely, care plan meetings were strator stated the DON was ing care plan meeting were alled.  The word conducted with the DON 24 at 10:22 am, she than 2024 when she started at not been a MDS Nurse in the strate of the MDS consible for coordinate care plan meeting were, she explained the MDS consible for coordinating, nunicating to the members, residents and the facility in February 2024, process for conducting care apported she had been busy fill the MDS vacant position and let of find a permanent of the Director of Nursing the MDS department and the Director of Nursing the MDS department and the certification and individualized person	F 6	57		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 657	Continued From pag	e 82	F 65	77		
	2. Resident #47 was 12/13/2021.	s admitted to the facility on				
	#47 was cognitively from a sitting to a state independently could self-propel a manual A review of Resident dated 4/16/2024 and following:  On 4/16/2024 the renew intervention was Programs of All-Inclu (PACE) to perform a On 5/29/2024 the renew intervention was	1/2024 indicated Resident ntact, required assistance anding position and walk up to fifty feet and wheelchair.  1/2024 indicated the reports 1/29/2024 indicated the resident sustained a fall and a simplemented to request for resive Care for the Elderly medication review.  1/2024 indicated the resident sustained a fall and a simplemented to remind as implemented to remind from the wheelchair alone				
	On 6/11/2024, the que with an Assessment	uarterly MDS assessment Reference Date (ARD) of ed as still in process.				
	last reviewed on 6/1: #47 had a history of falling that could resi impaired mobility and medications (medica chemicals involved in Interventions include position, keeping the encouraging Resider request assistance to	plan dated 12/14/2021 and 1/2024 indicated Resident falling and was at risk for all in an injury due to duse of psychotropic tions that affect the brain mental health disorders). In mental health disorders and health disorders are call bell within reach and health the call bell to be get out of the bed. The ed free of injury and free of				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
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(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
falls until next review indicated on the inc and 5/29/2024 falls plan that was last review for the incompleted composition of the incompleted and sent explained Resident #47's care interventions. The Fishe didn't see where had been updated a documentation in Riedical record, she for falls on 6/13/202 On 6/19/2024 at 10 with the Director of MDS Nurse in the faheld after the clinical discuss falls, and the responsible for updated a fall was repoimplemented. She signal individual record in the faheld after the clinical discuss falls, and the responsible for updated a fall was repoimplemented. She signal in the individual record in the faheld after the clinical discuss falls, and the responsible for updated a fall was repoimplemented. She signal in the faheld after the clinical discuss falls, and the responsible for updated a fall was repoimplemented. She signal in the faheld after the clinical discuss falls, and the responsible for updated a fall was repoimplemented. She signal in the faheld after the clinical discuss falls, and the responsible for updated and the fall was repoimplemented. She signal in the faheld after the clinical discuss falls, and the responsible for updated and the fall was repoimplemented. She signal in the fall was repoimplemented. She signal in the fall was repoimplemented.	w date. The interventions ident reports for the 4/16/2024 were not included on this care eviewed on 6/11/2024.  It was interventions from the 1/2024 falls were added to 1/2024 falls were care plans after the 1/2024 falls was 2/2024 falls was 2/2024 was 2/2024 falls were all falls was 2/2024 falls were added to 1/2024 falls w	F 65	7		
	ROVIDER OR SUPPLIER  LIVING AND REHAB C  SUMMARY S (EACH DEFICIEN REGULATORY OF SILL ATORY OF SILL A	F CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 83 falls until next review date. The interventions indicated on the incident reports for the 4/16/2024 and 5/29/2024 falls were not included on this care plan that was last reviewed on 6/11/2024.  On 6/13/2024, the new interventions from the 4/16/1024 and 5/29/2024 falls were added to Resident #47's care plan.  On 6/19/2024 at 11:19 am in a phone interview with Remote MDS Nurse, she stated she updated or completed comprehensive care plans after the MDS assessment was completed, and Resident #47's comprehensive care plan for falls was updated on 6/13/2024 after the quarterly assessment with an ARD date of 5/3/2024 was completed and sent for processing. She explained Resident #47's comprehensive care plan was a live documentation tool and nursing staff at the facility was responsible for updating Resident #47's care plan to record falls and new interventions. The Remote MDS Nurse stated she didn't see where Resident #47's care plan had been updated and based on the documentation in Resident #47's care plan for falls on 6/13/2024.  On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she stated the MDS Nurse in the facility attended a risk meeting held after the clinical morning meetings to discuss falls, and the MDS Nurse was responsible for updating Resident #47's care plan after a fall was reported and new interventions implemented. She said the MDS Nurse and herself (the DON) updated resident care plans. She explained that due to the inconsistency of a	ROWIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL (EACH OBRECTIVE ACTION SHOUL) REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 83 falls until next review date. The interventions indicated on the incident reports for the 4/16/2024 and 5/29/2024 falls were not included on this care plan that was last reviewed on 6/11/2024.  On 6/13/2024, the new interventions from the 4/16/1024 and 5/29/2024 falls were added to Resident #47's care plan.  On 6/19/2024 at 11:19 am in a phone interview with Remote MDS Nurse, she stated she updated or completed comprehensive care plans after the MDS assessment with an ARD date of 6/3/2024 was completed and sent for processing. She explained Resident #47's comprehensive care plan for falls was updated on 6/13/2024 after the quatertly assessment with an ARD date of 6/3/2024 was completed and sent for processing. She explained Resident #47's comprehensive care plan fall she will be sufficient #47's comprehensive care plan fall she will be sufficient #47's care plan to record falls and new interventions. The Remote MDS Nurse stated she didn't see where Resident #47's care plan had been updated and based on the documentation in Resident #47's care plan for falls on 6/13/2024.  On 6/19/2024 at 10:22 am in a phone interview with the Director of Nursing (DON), she stated the MDS Nurse in the facility attended a risk meeting held after the clinical morning meetings to discuss falls, and the MDS Nurse and herself (the DON) updated resident care plans. She explained that due to the inconsistency of a	

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION  G	(X:	(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	I	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	MDS assessments the MDS Nurse had not be in Resident #47's car not updated Resident new interventions on and did not provide a care plan. She also seem communicated with the make revisions to Resident of the MDS assessments the most approved the MDS process and MDS assessments the staff nurses to help were vision of resident can had not occurred.  3. Resident #319 was 4/23/24 with diagnose Diabetes Mellitus, ap a cerebral vascular and hemiplegia (loss of stweakness on one sident the most approved assessment completed A review of Resident #Data Set (MDS) reveals and (EMR) reveals until 6/13/24.	at needed completed, the been able to make revisions e plan. She stated she had the 47's care plan with the 4/16/2024 and 5/29/2024 reason for not updating the tated she had not the Remote MDS Nurse to sident #47's fall care plan.  5 pm in a phone interview or, she stated the Director of she explained the MDS ork in the facility was learning the working on the back log of the at needed to be completed DON was transitioning the with the development and the transition are plans, but the transition admitted to the facility on the swhich included type 2 thasia, and a recent history of the cident (stroke) with the rength or almost complete the of the body).	F 63	57		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C / <b>02/2024</b>
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ( (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	previous nurse could further indicated she wassessments remoted  During a phone intervious nursing (DON) on 6/1 the MDS nurse was rethe care plans. She fiknow why this was not #319.  In an interview with that 11:07 am she indicated	om she revealed that completed late because the not get caught up. She was completing MDS	Fé	557		
F 684 SS=E	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident that residents received accordance with professor practice, the compreheare plan, and the resident professor plan, and the resident professor plan, and the resident, staff, and Winterviews the facility wound care treatment foot ulcer and implement (a specific boot to receive part of the foot to allow the staff of	are Indamental principle that Int and care provided to Interest and care provided to Interest and care provided to Interest and care in	Fé	The facility failed to 1) perform daily wound care treatments to a non-pres diabetic foot ulcer and implement a hoff-loading boot according to the Wor Care Physicians' orders for 1 of 3 residents (Resident #50) observed for wound care; and 2) follow physician orders to change an intravenous (IV)	ind Ind r	7/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				C / <b>02/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
					6 CAMERON STREET		
PREMIER	LIVING AND REHAB C	ENTER			KE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	Continued From pag	ge 86	F 6	584			
	for 1 of 3 residents (wound care; and 2) change an intravence to provide an intervence for a resident ordered antibiotic therapy for	Resident #50) observed for follow physician orders to ous (IV) site every 3 days and ention to establish IV accessed to receive long term or 1 of 1 resident reviewed for histration (Resident #419).			every 3 days and to provide an intervention to establish IV access for resident ordered to receive long term antibiotic therapy for 1 of 1 resident reviewed for IV medication administrat (Resident #419).		
	Findings included:	( " ',			The facility responded to the above-mentioned issues as follows for Resident #50; the hind off-loading boo		
	10/06/23. Diagnose	s admitted to the facility on es included right below the eripheral vascular disease, left abetic foot ulcer.			was ordered on 6/26/2024 and was delivered on 6/28/2024 when the new Director of Nursing (DON) was hired. Resident #419 was discharged from the	ne	
	was cognitively intac behaviors. Residen	3/08/24 revealed resident of and demonstrated no t #50's was not coded as lcer, venous and arterial ulcer			facility on 4/5/2024; therefore, no furth action could be taken as of 7/27/2024.  All residents residing in the facility hav been identified as having the potential be affected by the alleged deficient practice.	re	
	revealed Resident # diabetes mellitus wit part, inspect feet da pressure areas, blis a plan of care for po to decreased mobilit disease with interve monitor/document lo skin injury, report ab	ocation, size and treatment of onormalities, failure to heal,			The DON or Designee will educate all nursing staff by 8/5/2024 on the importance of following providers orde as they are given to ensure all wounds cared for appropriately, and to ensure residents receive antibiotic therapy as ordered. After 8/5/2024 newly hired nursing staff will be educated by the D or Designee during their new hire employee orientation.	are all	
	weekly treatment do measurement of eac width, length, depth, and other notable ch	of infection to physician and ocumentation to include the area of skin breakdown, type of tissue and exudate nanges or observations.			Beginning 7/27/2024, the DON or Designee will audit all dressing change times per week for 12 weeks to ensure providers orders are being followed as given and to ensure all wounds are ca for appropriately. Any missed dressing	e red	
	I TO VICAN OI THE MOUTH	u u caunoni assessinonis			ioi appropriatery. Arry misseu dressing	j	I

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345185	B. WING _			C <b>07/02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	2.2.2.2	<del>                                     </del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
	10115211 011 001 1 21211				06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER					
					AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684	Continued From page 87 revealed the following measurements and wound orders for the diabetic wound of the left heel for Resident #50:		F 6	F 684			
					changes will result in re-education and additional training for the appropriate nursing staff.		
	were recorded as 2.0 (cm) with indication the The treatment was sil agent), and xeroform	surements to the left heel X 2.0 X 0.2 centimeters he wound was improving. It is a sorb gel (antimicrobial (a pad applied to a wound and protect the wound from kerlix.			Beginning 7/27/2024, the DON or Designee will audit all antibiotic usage times per week for 12 weeks to ensure missed doses occur. Any missed antibiotic administration will result in re-education and additional training wit the appropriate nursing staff.	no h	
	On 05/07/24 the measurements to the left heel were recorded as 2.6 X 2.6 X 0.2 (cm) with indication that the wound was unchanged. The treatment was to apply Medi honey (helps prevent bacteria from growing), silver alginate (antimicrobial) and cover with gauze daily.  Review of the Wound Care Physicians' wound evaluation and management summary for diabetic wound of left foot dated 05/20/24 revealed the measurements to the left heel were recorded as 2.8 X 2.8 X 0.3 (cm) with 40% slough and 60 % granulation tissue (healthy tissue) with a surface area of 7.84 (cm). The note indicated the wound was surgically debrided at this time and as a result of the procedure the wound bed decreased from 40 percent to 10 percent. The recommendations were to order a hind off-loading boot and apply Santyl (helps remove dead skin tissue and aides in wound healing) with xeroform and cover with gauze daily.				Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hon Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	the PI to d. the	
	A review of the physic 05/21/24 revealed to saline, apply Santyl w	cian's orders written on cleanse wound with normal vith xeroform and secure ere was no order for a hind					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 106 CAMERON STREET LAKE WACCAMAW, NC 28450	E	01/02/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 684	Continued From page 88		F 6	84		
	for May 2024 reveal treatment order was by nursing initials or there was no order of Administration Record to left heel wound.  Record review reveal documentation to sucheel wound was characteristic wound of level wound of the revealed the measure recorded was 3.0 x 2 granulation tissue (harea of 6.60 (cm). Twas improving as events was proving as events was not order to the revealed the measure recorded was 3.0 x 2 granulation tissue (harea of 6.60 (cm). Twas improving as events was not order to the revealed the measure recorded was 3.0 x 2 granulation tissue (harea of 6.60 (cm). Twas improving as events was not order to the revealed the measure recorded was 3.0 x 2 granulation tissue (harea of 6.60 (cm). The revealed the r	aled there was no pport the dressing to the left inged on Saturday 05/25/24.  d Care Physicians' wound agement summary for ft foot dated 05/27/24 rements to the left heel were 2.2 X 0.1 (cm) with 100 % ealthy tissue) with a surface the note indicated the wound ridenced by decreased ommendation for a hind				
	(UM) #1 on 06/14/24 revealed she was as #50 resided on 05/2 was nothing charted administration record that the treatment when she was not aware confiling boot for F	d on 05/25/24 then it meant as not done. UM #1 reported of an order for a hind Resident #50.				
	evaluation and mana diabetic wound of le revealed the measu	d Care Physicians' wound agement summary for ft foot dated 06/03/24 rements to the left heel were 8 X 0.1 (cm) with indication				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		10	REET ADDRESS, CITY, STATE, ZIP CODE  6 CAMERON STREET  AKE WACCAMAW, NC 28450	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 684	changed to cleanse leapply calcium alginate with gauze daily. The was surgically debride result of the procedur from 20 percent to 0. to order a hind off-load. A review of the physic revealed an order to saline, apply calcium and wrap with gauze. Review of the Treatm for June 2024 revealed treatment order was reby nursing initials or a An interview and observed her was boot and when he incomposed from the boot. Resident #50 on 06/1 #50 reported he was boot and when he incomposed from the boot. Resident #50 revealed heel and added, the result of the surgice of the surgic	anged. The treatment was eft heel with normal saline, and Medi honey and wrap anote indicated the wound ed at this time and as a e the wound bed decreased. The recommendation was ding boot.  Sian orders dated 06/03/24 cleanse left heel with normal alginate and Medi honey daily.  The recommendation was ding boot.  Sian orders dated 06/03/24 cleanse left heel with normal alginate and Medi honey daily.  The recommendation was ding boot.  Sian orders dated 06/03/24 cleanse left heel with normal alginate and Medi honey daily.  The recommendation was ding honey daily.	F	684	DEFICIENCY)		
	was dated 06/08/24.  Observation of the woon Resident #50 with Nurse was conducted The wound was not	24. The wound dressing bund dressing to the left heel the Wound Treatment on 06/12/24 at 2:30 PM. heasured at this time. There ptoms of infection such as sident #50 had no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF C  X (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From pag	e 90	F	684		
	Treatment Nurse on Wound Treatment No Resident #50's left h Wound Care Physici treatment was change wound was debrided it was worsening with size which was due to up the wound bed.  An interview was cornon 06/14/24 at 2:00 lows assigned to Resishe should have changed as the condered to his left hen urse overseeing the her responsible to do medications aides wound care. Unit Manot aware of an order for his left heel.  A phone interview was assigned to the condered to his left heel.	anducted with the Wound 06/12/24 at 2:30 PM. The burse stated the wound to eel was debrided by the an on 06/03/24 and the ged. She stated whenever a late, the wound may appear that in increased measurement to the debridement opening anducted with Unit Manager #2 PM. UM #2 reported she sident #50 on 06/09/24 and langed the dressing as el. She stated she was the elemedication aide and it was a wound care since the ere not allowed to perform anager #2 reported she was ar for a hind off loading boot eas conducted with the ele Physician on 06/17/24 at				
	1:00 PM revealed he #50 and his chronic would have to refer to stated based on what the wound was chronalightly better but not Care Physician was interview and stated he reviewed the median	e was familiar with Resident heel wound. He stated he back to his records but he at he could recall he felt that hic and it was the same or t getting worse. The Wound hot able to complete the he would return the call after				
	the Wound Treatmer	terview was conducted with hit Nurse on 06/17/24 at 2:11 eatment Nurse reported that				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0110212024
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F 684	and she would enter medical record. The stated she was award order for the hind off not sure why it was a classified the left her since he was admitted acquired from his unperipheral vascular of Treatment Nurse and Director of Nursing (recommendation for she did not follow up to see what the state was or when it was or When it was of the was of the was or when it was of the was and was working the did not know who was and was working where to order this to supply companies.  A follow up call was Wound Care Physician's message was left	are Physicians put in they were considered orders in the orders into the electronic at Wound Treatment Nurse are that Resident #50 had an folloading boot, but she was not ordered. The Wound ated the physician had all wound as a diabetic ulcer and to the facility and was accontrolled diabetes and adisease. The Wound ded, she recalled letting the DON) know about the the hind off-loading boot, but to with the Director of Nursing as of the hind off-loading boot going to be ordered.  Inducted with the Director of 6/14/24 at 5:00 PM. The would expect wound ting according to the prevent infection or further and wound. The DON stated that a "hind off-loading" boot go on trying to figure out the placed to the previous and no 06/18/24 at 1:57 PM.	F 684		
	evaluation and mana diabetic wound of le revealed the measur	agement summary for ft foot dated 06/20/24 rements to the left heel were 1 X 0.1cm with a surface			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			1	02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, OF THE		1 017	02/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	92	F 6	884			
	be at 100% with a no healing as evidenced surface area and 100 tissue within the would	noted for a hind off-loading					
	Nursing Supervisor of The Nursing Supervisor of The Nursing Supervisor of The Nursing Supervisor of Supervisor of Previous DON were to of boot this was by rewound supply companever heard of it. Shourrent Wound Care clarify the order for the this physician sent he was and where to order	n 06/26/24 at 11:00 AM. sor stated she was made and Treatment Nurse about 2 and off loading boot was #50. She stated she and the rying to figure out what type is earching on line with local nies because they had be stated she spoke to the Physician on 06/25/24 to be hind off-loading boot and for a link as to what the boot der it. She stated the current 06/19/24 will be ordering the					
	via phone on 06/26/2 had started on 06/19/ attention on 06/25/24 Supervisor that Resid off-loading boot. The been ordered by the	lent #50 needed the hind DON stated it should have previous DON. She added, off-loading boot today and it					
	Physician on 06/27/24 had been attending the	h the current Wound Care 4 at 9:30 AM revealed she ne facility since 06/14/24 and e Wound Treatment Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/0	) )2/2024
NAME OF PROVIDER OF PREMIER LIVING AN				STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	J2/2024
, , , , , , , , , , , , , , , , , , , ,			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
that the for Resistype of the speak to ordered sent a list purchase boot wo worsenis She state boot for but it she extra properties was ord dressing wound in the second s	dent #50. Shoot or difficular as to why it.  The Wound have the hoot. So wild not contributed despite the past more ould be ordered to tection. Add an stated Reserved daily an agree to 108/07/23.  Jent #419 was on 08/07/23.  Jent #419 was on 08/07/23.	Ing boot should be ordered the stated it was not a unique all to find and she could not took so long for the boot get of Care Physician stated she sing Supervisor of where to she added, not having the bute to the wound dered as a protective device. The resident not having the onth, his wound was healing ared and utilized to add that ditionally, the Wound Care sident #50's wound dressing dishe would expect the ged daily for continued.  In part, a sacral stage 4 memiplegia and hemiparesis erebral infarction) affecting	F 6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	'	01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Interventions included medication as ordere monitor and documer effectiveness, and an infection related to the 2a. The March 2024 Record (MAR) reveal order: Change IV (in shift every 3 day(s) for 03/01/24; End date 0 coded "5" on 03/04/2 change was held) and Review of the progress revealed Agency Nursite change was to be nurse would change in an interview with A at 12:10 PM she state not to change Reside Registered Nurse would change and did not kendinge and did not kendinge and did not kendinged the next day Review of the progres 03/05/24 revealed no site for Resident #418. In an interview with N stated she was familia could not remember to 03/10/24 or changing She stated that she was stated that	d administering antibiotic d by the physician and to at any side effects, the y signs of secondary e antibiotic therapy.  Medication Administration ed the following physician travenous) site every day or infection control-Start date 3/23/24. The MAR was 4 (indicating the IV site d was left blank on 03/10/24.  Ses notes dated 03/04/24 see #6 documented the IV e held and that another the IV site the following day.  In the IV site the following day.  In the IV site because a wild be at the facility the next mange the IV site. She could lid her to hold the IV site now if the site had been of the IV e had been changed.  It is notes and MAR for a documentation that the IV e had been changed.  It is notes and MAR for a documentation that the IV e had been changed.	F 6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE  106 CAMERON STREET  LAKE WACCAMAW, NC 2		01/02/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTI' CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 684	2b. Resident #419 ha 2/23/24 for IV antibio  A progress note writt 3/15/24 at 3:38 pm d IV had infiltrated (car fluid into the surround able to give the 1:00 made two unsuccess  A progress note writt at 12:28 am document to place an IV in Reswas unsuccessful.  Progress notes writte 03/16/24 at 11:24 am Resident #419 did not medications because A progress note writt 03/17/24 at 4:36 pm acquired and the antifor 03/17/24 indicated were not documented would have indicated administered.  A progress note writte 03/20/24 at 6:49 pm s IV had not been woth the shift. She attemptimes and the charge	ad physician orders dated	F	584		
	PM she stated while stopped working and	lurse #3 on 6/12/24 at 1:55 she was working the IV site she tried to restart the IV ommented that Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 684	to start his IV). Anoth tried and could not ge passed on in report to unsuccessful attempt noted the nursing supstart the IV and could names of the other two were also from an ag Resident #419 on 03/A progress note writte 03/22/24 at 3:51 pm of start an IV for Reside unsuccessful.  In an interview with A at 1:50 PM she stated had tried to restart his cared for Resident #403/22/24.  A progress note writte documented Resident antibiotics because hold In an interview with the 06/12/14 at 12:30 PM Practitioner (NP) was noted the NP was suffacility and restart the #419 on 03/23/34.  In an interview with N 10:10 am she stated #419 on 03/16/24, 03	ck" (meaning it was difficult er agency nurse on duty at the IV started. She to the next nurse the sit to restart the IV. She pervisor on duty also tried to not. She did not know the vonurses but thought they ency. She cared for 19/24 and 03/20/24.  The pervisor on duty also tried to not. She did not know the vonurses but thought they ency. She cared for 19/24 and 03/20/24.  The pervisor on duty also tried to not she had tried to not #419, but the attempt was gency Nurse #2 on 6/12/24 dishe was not sure if she is IV access or not. She is IV access or not. She is IV access or not. She is IV access.  The Wound Care Nurse on I she stated the Nurse aware the IV was out. She is IV. She cared for Resident IV. She cared for Resident when it is the had cared for Resident is the had cared for Resident in 19/24, and 03/21/24. She sessed him to start an IV	F 68	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 684	Multiple unsuccessful contact the NP on 06, PM. She had been e March 2024. An addi 06/13/24 at 3:07 PM attempts were made different surveyors or survey week with no e Multiple unsuccessful 06/12/14 at 1:50 PM aphysician employed a An additional attempt 3:00 PM with no resp made to contact the p surveyors on the team week with no response In an interview with the (Director of Nursing) attacted she became et 03/25/24. She common employed when the fe establish IV access, start the IV herself an have called the provide PICC line and would	attempts were made to 12/14 at 1:48 PM and 3:36 imployed at the facility in tional attempt was made on with no response. Other to contact the NP by the team throughout the response.  attempts were made on and 3:33 PM to contact the tit the facility in March 2024. was made on 06/13/24 at onse. Other attempts were obscience by different in throughout the survey see.  The current Agency DON on 06/12/24 at 1:05 PM she imployed at the facility on ented if she had been accility nurses could not the would have first tried to diffunctional times and the resident out to dished within 24 hours of the	F 684		
F 686 SS=D		rity	F 686	6	7/27/24
	Based on the compre resident, the facility m	hensive assessment of a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	'	
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	Continued From pag		F 6	86		
	pressure ulcers and ulcers unless the ind demonstrates that the (ii) A resident with pronecessary treatment with professional star promote healing, prenew ulcers from deverthis REQUIREMENT by:  Based on record rever Practitioner (NP) interested and communicate absoresses, obtain physicand communicate absoresses (Reservice) and provided for 1 of 5 repressure ulcers (Rese	vent infection and prevent eloping.  T is not met as evidenced riew, and staff and Nurse erviews, the facility failed to cian orders for treatment, rout the new pressure ulcer treatments could be sidents reviewed for ident #119).  pital admission note dated sident with pressure ulcer of t was present on admission.  Idmitted from the hospital to 24. The diagnoses included heart disease, end stage ibrillation, and hypertension.  In o-toe skin assessment for 04/04/24 done by Nurse #2, ented a "Sacrum - small, my prominence, pressure		The facility failed to assess, obto physician orders for treatment, a communicate about a new press so assessments and treatments provided for 1 of 5 residents revipressure ulcers (Resident #119)  Resident #119 received wound of 4/5/2024 which included cleaning normal saline and the application dressing per nursing progress now was dated on 4/5/2024. The word nurse for the facility received an start Calmoseptine twice a day of 4/6/2024 and it was entered into Treatment Administration Record Resident #119 was discharged facility to home per family requed 4/10/2024. Resident #119 was discharged with a referral to a wound care pand with a hospice referral. The was discharged with an appoint wound care provider with the apbeing on 4/16/2024.  All residents residing in the facility to home per family requed with an appoint wound care provider with the apbeing on 4/16/2024.	and sure ulcer could be iewed for . care on g with n of a ote that und care order to on the d (TAR). from the st on discharged provider resident ment to a pointment	
	Nurse #10 revealed l	Resident #119 admitted to rom hospital during day shift.		been identified as having the po be affected by the alleged deficie	tential to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING				02/2024
NAME OF D	ROVIDER OR SUPPLIER	0.10.100		- C-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
NAME OF FI	NOVIDER OR SUFFLIER						
PREMIER	LIVING AND REHAB CE	NTER			06 CAMERON STREET		
				L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 686	Continued From page	e 99	F	686			
		was able to verbalize needs.			practice.		
		a noted to bony prominence			The Director of Nursing (DON) or		
		vas cleansed with normal			Designee, will review all current pressu		
	saline and new dress	ing applied.			wounds to ensure orders and treatmen	ts	
	A talambana intansia	a anadustad with Numan			are being followed and will check the	4	
		was conducted with Nurse 0:35 AM. Nurse #10 stated			weekly skin checks from March of 2024	+,	
	she completed the ini				to ensure any new wounds have been identified and are being treated by		
	•	lent #119 on 04/04/24.			8/5/2024.		
		she noticed Resident #119			0/0/2024.		
		ce from the hospital on her			The DON or Designee will ensure all		
		looked like an open split			current pressure wounds have been		
	, ,	ock crack near the sacrum.			assessed, physician orders for treatme	nt	
	There was no drainag	ge or odor. She said she			have been obtained, and communication		
	removed the old dres	sing, cleaned the site with			has been completed regarding any nev	V	
	normal saline. She a	lso said she did not recall			pressure ulcers; so assessments and		
		ption of her observation, but			treatments can be provided by 8/5/202	4.	
		nformed the day nurse of					
		dressing change and let the			The DON or Designee will educate all		
	wound treatment nurs	se know of the site.			nursing staff by 8/5/2024 on the		
		04/05/04 + 4.00 DM			importance of skin checks upon		
		04/05/24 at 1:36 PM by			admission, as well as routine weekly sl		
		rse went to assess Resident and left facility to go to			checks, to ensure all new skin issues a documented, reported, and treatment	ire	
	dialysis and would be				orders are obtained so treatment begin		
	dialysis and would be	back later tills I W.			After 8/5/2024 newly hired nursing staf		
	Review of the April 20	124 Treatment			will be educated by the DON or Design		
		d (TAR) for Resident #119			during their new hire employee		
	revealed the resident				orientation.		
		ock with each incontinent					
	•	day at night shift and to start			The DON or Designee will educate all		
	04/06/24 at 7:00 PM.				nursing staff by 8/5/2024 on the		
	documented treatmer	nt for the coccyx pressure			importance of off-loading residents to		
	ulcer.				prevent the skin from breaking down.		
					After 8/5/2024 newly hired nursing staf		
	The admission Minim	, ,			will be educated by the DON or Design	iee	
		/10/24 revealed Resident			during their new hire employee		
	#119 had no cognitive	e impairments. She required			orientation.		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING		0	C 7/ <b>02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET		1702/2024	
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686	mobility, transfers, and She was always inconfrequently incontinent. Resident #119 was doubled to the correct of the correct o	chysical assistance with bed and activities of daily living. Intinent of bowel and to foliadder.  discharged to her home on ducted on 06/12/24 at 10:00 of Nursing (DON). The DON ocumented an observation of to bony prominence of the area with normal new dressing. She was no documenation about exyx ulcer from admission charge on 04/10/24.  ducted on 06/12/24 at 3:45 or #2 (previous treatment ager stated on 04/05/24 the red report from Nurse #10  Resident #119's sacral	F 68	Beginning 7/27/2024, the DON of Designee will audit weekly skin of 5 residents per week x 12 weeks ensure any new skin breakdown identified. Any missed skin issue missed weekly skin checks will rere-education and additional training appropriate nursing staff.  Beginning 7/27/2024, the DON of Designee will audit all new admissional assessments to ensure all skin is identified upon arrival to the facility missed skin issues or missed new admission skin assessments will re-education and additional training appropriate nursing staff.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursin Administrator (LNHA) or DON, at results of the audits will be reviewed.	checks on a to has been so or esult in ang for the sistens are ity. Any we result in ang for the will be g Home and the		
	An interview was con AM with the Administ expectation that Resi coccyx pressure ulce identified, treated, an nursing staff.  An interview was con 10:20AM with the Nu stated it was her expeday nurse assigned to the American American treatment of the American American treatment of the American American Technology (1) and the Administration of the American Technology (1) and the Administration of the Administration of the American Technology (1) and the Administration of the Administration of the Administration of the American Technology (1) and the Administration of the American Technology (1) and the Administration of the American Technology (1) and the American	ducted on 06/13/24 at 10:50 rator. She said it was her dent #119's admission r should have been d tracked more closely by  ducted on 06/14/24 at rse Practitioner (NP). She ectation that on 04/05/24 the o Resident #119 should have pressure ulcer to the wound		monthly Quality Assurance and Performance Improvement (QAP Meeting monthly for 3 months. To Committee will review the audits make recommendations as nece assure ongoing compliance is su The facility will utilize this plan of correction to ensure compliance mandated regulation by 8/6/2024 audits will continue for the specifit timeframe as described in this coaction.	he QAPI and ssary to stained. under the and the ied		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING	<u>-</u>	C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 689 SS=D	nursing staff are resp wounds timely to the obtain appropriate ord stated it was important nurse to know what wand what treatments had not happened in Free of Accident Hazic CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(2)(1)(2)(3)(2)(3)(3)(4)(4)(4)(4)(4)(4)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	d not. The NP said all onsible for reporting all treatment nurse so she can ders and start treatment. NP into the rand the treatment rounds were in the facility were being utilized, which this case.  ards/Supervision/Devices (2)   are that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent  is not met as evidenced ons, record review, resident the facility failed to supervise (Resident #50) when he shower room on the shower taff to answer the call light the for 1 of 7 residents	F 68		on to  ed  ative ot ng in kin	
		ressure, chronic kidney ive heart failure.		with no new skin issues reported. The resident did not report any additional occurrences and did not report any pafrom the incident.		

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		07/02/2024
	STREET ADDRESS, CITY, STATE, ZIP CODE	
1	06 CAMERON STREET	
L	AKE WACCAMAW, NC 28450	
PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR		
	DEFICIENCY)	
F 689	All residents residing in the facility have been identified as having the potential to the affected by the alleged deficient practice.  The Licensed Nursing Home Administrator (LNHA), Director of Nursi (DON), Social Worker, or Designee, will educate all nursing staff by 8/5/2024 or the importance of staying with residents for the entire Activities of Daily Living (ADLs) process to ensure resident safe and quality of care is being provided. A 8/5/2024 newly hired staff will be educate by the LNHA, DON, or Designee during their new hire employee orientation.  Beginning 7/27/2024, the LNHA, DON, Social Worker, or Designee, will intervied a alert & oriented dependent residents week x 12 weeks to ensure they feel sawhen in the shower room while utilizing shower chair, to ensure they are not lef alone in the shower room during their showers, and to ensure their call lights being answered in a timely manner. If a resident has a concern the Social Worker or Designee will write a grievance regarding the concern, investigate the concern, and implement an interventior rectify the grievance. The LNHA, DON, Designee will ensure if a staff member	ng I n s ty fter nted I ew per nfe a t are er n to or is
	ID REFIX TAG	REFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)  All residents residing in the facility have been identified as having the potential to be affected by the alleged deficient practice.  The Licensed Nursing Home Administrator (LNHA), Director of Nursi (DON), Social Worker, or Designee, will educate all nursing staff by 8/5/2024 or the importance of staying with residents for the entire Activities of Daily Living (ADLs) process to ensure resident safe and quality of care is being provided. At 8/5/2024 newly hired staff will be educate by the LNHA, DON, or Designee during their new hire employee orientation.  Beginning 7/27/2024, the LNHA, DON, Social Worker, or Designee, will intervice 3 alert & oriented dependent residents week x 12 weeks to ensure they feel sawhen in the shower room while utilizing shower chair, to ensure they are not lef alone in the shower room during their showers, and to ensure their call lights being answered in a timely manner. If a resident has a concern the Social Work or Designee will write a grievance regarding the concern, investigate the concern, and implement an interventior rectify the grievance. The LNHA, DON, Designee will ensure if a staff member involved in the concern the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I NI IMBED:		CONSTRUCTION	' '	ATE SURVEY DMPLETED
		345185	B. WING				C
NAME OF DE	ROVIDER OR SUPPLIER	3-3103	1 2:		TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	07/02/2024
NAIVIE OF PF	ROVIDER OR SUPPLIER						
PREMIER	LIVING AND REHAB	CENTER			06 CAMERON STREET		
				L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 103	F	689			
	·	hower room sounds			reviewed by the Licensed Nursing Ho	me	
	_	de #8 entered the shower			Administrator (LNHA) or DON, and th		
	room	do no officioa the chewer			results of the audits will be reviewed i		
		de #8 and Resident #50 exited			monthly Quality Assurance and		
		vent to Nurse #9 and were			Performance Improvement (QAPI)		
	telling her somethir				Meeting monthly for 3 months. The Q	API	
	3	3			Committee will review the audits and		
	An interview with R	esident #50 on 06/14/24 at			make recommendations as necessar	/ to	
	1:00 PM revealed of	on 05/17/24, he was left			assure ongoing compliance is sustain	ed.	
	unattended in the s	hower for over 15 minutes.			The facility will utilize this plan of		
		n the smoking porch and			correction to ensure compliance unde		
		get a shower early on this			mandated regulation by 8/6/2024 and	the	
		d family coming. Resident			audits will continue for the specified		
		ide (NA) #8 said he was not			timeframe as described in this correct	ive	
	_	but that she would get him			action.		
		er. Resident #50 stated NA #8 wer and assisted with					
		the shower chair from his					
		sisted him with getting					
		ed his prosthetic leg and turned					
		sident #50 stated he					
		himself and washed his hair.					
	· ·	ell to alert for help when he was					
		o one came after a few					
	minutes so he turne	ed the water again to keep					
	himself warm and v	vashed himself again while					
	waiting for someon	e to answer the call bell. He					
	stated he then start	ted to yell for someone to					
		, but no one came. Resident					
		wer chair did not have wheels					
		so he was not able to move it					<b> </b>
	•	able to reach a towel and dry					
		prosthetic leg and put it on.					
		nued to yell, but still no one					
		50 stated he then attempted to					
		m the shower chair to the panged his leg and was not					
		iself safely. Resident #50					
		5 minutes, NA #8 finally came					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRU			(X3) DATE SURVEY COMPLETED			
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		0770272024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From page back and helped him and transferred him?  An interview was core 2:35 PM. NA #8 reports with Resident wanted a shower. He shower. No assigned to the 200 Resident #50 to a she wheelchair and assist clothes and his prosted on the water and he not have assigned to the was assigned to the was assigned to the was assigned to the to the store to get so the street and only make the street and only make the was assigned to the to the store to get so the street and only make the was assigned to the to the store to get so the street and only make the was assigned to the to the store to get so the street and only make the ward and not see the street and only make the was still in the shower was still in the shower was still in the shower getting dressed and	e 104 I get out of the shower chair to his wheelchair. Inducted NA #8 on 06/14/24 at orted she was on the smoking #50, and he reported he e stated his aides from the o she told him she would get A #8 stated she was hall, but she helped transfer ower chair from his sted with removing his hetic leg. She then turned began to take his shower. e and Nurse #7, who was 200 hall, told Nurse #9 who 100 hall that they were going ap which was located across ninutes away. NA #8 stated in 15 minutes or less and k, they saw the shower light	F6	DEFICIENCY)		
	room. NA #8 stated of Nursing after it all not stay with a reside do not give the show leave it to the assign shower. NA #8 state Resident #50 alone is resident should be legetting a shower for Resident #50 could	s left him in the shower she was told by the Director happened that if she could ent while in the shower, then er to the resident and to ed nurse aides to do the ed she should not have left in the shower because no ft alone while they were safety reasons. She stated wash and dress himself, but e with dressing, and he				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	•	3110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag	e 105	F 6	89		
	shower chair to his w Resident #50 needed out of the shower and alone.	ulling himself out of the helchair. NA #8 added, d someone there to get him d he was not safe to be left adducted with Nurse #7 on				
	assigned to Resident Resident #50 was ou stated he had family and he wanted a sho	M. Nurse #7, who was not the #50, reported on 05/17/24, at on the smoking porch and coming in to see him today over and NA #8 said she NA #8 assisted Resident				
	#50 in the shower. S shower, she and NA were leaving the faci the street to get soap	the stated after he was in the #8 told Nurse #9 that they lity to go to the store across and that Resident #50 was ther to let his aides know so				
	they could get him ou were at store for abo came back, the call li	at. Nurse #7 reported they ut 15 minutes and when they ight was on to the shower vas sitting at the nurse's				
	NA #8 went to the sh Resident #50 out of t Nurse #9 did not tell	he shower. Nurse #7 stated the aides that were assigned				
	she did not answer the #7 stated anytime and shower, the nursing s	he was in the shower and ne light when it rang. Nurse y resident was getting a staff was to supervise the shower to prevent any				
	accidents and she sh	nould have made sure vising Resident #50 before				
	phone on 06/13/24 a reported she was the	nducted with Nurse #9 via t 2:19 PM. Nurse #9 nurse assigned to the 100 re Resident #50 resided.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			1	02/2024
	ROVIDER OR SUPPLIER	NTER		106 CAM	ADDRESS, CITY, STATE, ZIP CODE ERON STREET VACCAMAW, NC 28450	<u>,                                    </u>	VEIZUZT
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 689	left in the shower rooi answering the call ligit Resident #50 told her the shower and left. I learned from NA #8 th building to go to the streturned. Nurse #9 streturned. Nurse #9 stated she clight going off.  An interview was condon 06/18/24 at 10:39 had worked at the factor about 8 weeks. Sto Resident #50 on the #4 reported she did in happened on 05/17/2 Resident #50 in the sinform her or NA #5 vin Resident #50. NA #4 Nurse #9 approached were doing resident cresident #50 was yell the shower, but they were in another #4 stated whenever shower, she would as removing his prosther from the wheelchair to stated she would probathe himself, but the for the resident, she warea and leave the restated no resident she	#50 was upset about being m and that no one was ht to assist him. She stated that NA #8 had put him in Nurse #9 stated she had nat she and Nurse #7 left the store, but it was not until they tated neither NA #8 nor her that Resident #50 was they were going to the store. did not recall hearing the call ducted with NA #4 via phone AM. NA #4 reported she cility as agency nurse aide he stated she was assigned in 100 hall on 05/17/24. NA	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			(	С
		345185	B. WING			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  06 CAMERON STREET  AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Nursing (DON) on 06. DON reported that a ralways be with a residence getting a shower. The know NA #8 and Nursing was not okay for them anyone. She stated he staff was that residence shower alone becaus accident. The DON amobility risk due to his required supervision of Nutrition/Hydration St CFR(s): 483.25(g)(1)-\$483.25(g) Assisted reportulation (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a residence \$483.25(g)(1) Maintait of nutritional status, see demonstrates that this preferences indicate of \$483.25(g)(2) Is offer maintain proper hydratic status and status and status and status are sidenced when the status are sidenced when the status are status and status are status are status and status are status are status and status are status and status are status and statu	ducted with the Director of /14/24 at 11:00 AM. The nursing staff member should dent whenever they were e DON stated she did not se #7 left the building and it in to leave without telling her expectation of nursing its should not be left in the e of the potential for an idded Resident #50 had a simpairment and he while in the shower. Status Maintenance (3)  nutrition and hydration. It and gastrostomy tubes, indoscopic gastrostomy and its on a resident's issment, the facility must it.  In acceptable parameters such as usual body weight or it range and electrolyte esident's clinical condition is is not possible or resident otherwise;		689	,		7/27/24
	§483.25(g)(3) Is offer						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 692	Continued From page		F 6	92			
	provider orders a the This REQUIREMENT by: Based on record rev Dietitian and Facility facility failed to obtain weights for 4 of 6 res and wound care eval Resident #38, Reside failed to address a R recommendation for appetite for 2 of 6 res (Resident #36, Resident #36, Resident #36, Resident #36 was diagnoses which incl swallowing), chronic disease and diabetes Resident #36's elect a 2/8/24 physician or then weekly for 3 wemonthly or as specific Resident #36's weig following:  2/9/2024 10:13 AM 1 2/16/2024 No weight 2/23/2024 No weight 3/3/2024 7:06 PM 12	rapeutic diet.  T is not met as evidenced  iew, staff, Registered Physician interviews, the in physician ordered weekly idents reviewed for nutrition uation (Resident #36, ent #219, Resident #52) and egistered Dietitian a medication to stimulate sidents reviewed for nutrition lent #38).  Is admitted on 2/8/24 with uded dysphagia (difficulty obstructive pulmonary is.  I cronic health record included der for weight on admission eks (4 weights total); then ed by the physician.  Intercord contained the  18.7 pounds (lbs.)  recorded.  It recorded.  I Dietitian (RD) note indicated		The facility failed to obtain physordered weekly weights for 4 of residents reviewed for nutrition care evaluation (Resident #36, I #38, Resident #219, Resident # failed to address a Registered E recommendation for a medicatic stimulate appetite for 2 of 6 resireviewed for nutrition (Resident Resident #38).  Resident #36 was admitted on 2 with an admission weight of 118 was identified that weekly weigh not obtained for Resident #36. It his next monthly weight on 3/3/2 121.0lbs. The next monthly weight on showed a weight loss of 23.0lbs 4/5/2024. However, it was ident on-site note by the Primary Care (PCP) who was also the active IDirector of the facility that the winot changed, which was inaccur 4/9/2024, the Registered Dietitatic that the weight on 4/5/2024 was and also showed a 19% weight one month. The Registered Dietitatic the recommendations, however, dietitatic first recommendations, however, dietitatic first recommendations were profite PCP. As of 7/31/2024, the Linuxing Home Administrator (LN Director of Nursing (DON) identiced	and wound Resident 52) and Dietitian on to dents #36,  2/8/2024 3.7lbs. It ats were However, 2024 was ght s on iffed in an e Provider Medical eight had rate. On an noted s 98.0lbs loss in titian listed I not note ovided to cicensed NHA) and iffed that		
	consumed 25-100 pe carbohydrate-control	viewed. Resident # 36 ercent of a led diet. RD recommended a and cueing with meals and		Resident #36 is still undergoing loss. The DON has implemented weights to monitor Resident #36 nutritional status.	d weekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING				02/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2024
					06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			AKE WACCAMAW, NC 28450		
	0.11.11.12.7.4.2.7.2.2.7.2.2.7.2.2.7.2.2.7.2.2.2.2	ATEMENT OF REFIGIENCIES			· T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	<u>-</u> 109	F	692			
	a fortified foods diet.	3 100	'	032			
	a fortified foods diet.				Resident #38 was admitted on 8/14/20	20	
	Δ nhysician order dat	ed 4/4/24 indicated weekly			with an admission weight of 130.0lbs.		
		onitoring and regular fortified			was identified that on 8/19/2020, Resid		
	food diet.	onitering and regular fortilled			#38 weighed 135.5lbs. It was identified		
					that Resident #38 has had weight		
	A 4/9/2024 Registered Dietitian (RD) note				fluctuations from the time of admission	to	
	indicated Resident #36 was reviewed for weight				current. As of 4/23/2024, the Registere	d	
	loss. The note stated resident's current weight on				Dietitian listed recommendations,		
	4/5/24 was 98 lbs. Re	esident #36's weight was 121			however, did not note if the		
	lbs. on 3/3/24 which v	was a weight loss of 19			recommendations were provided to the		
	·	Γhe RD indicated Resident			PCP. As of 7/31/2024, LNHA and DON		
		of a mechanical soft diet			identified that Resident #38 is still		
	1	e following recommendations			undergoing weight loss. The DON has		
	I .	eweigh to verify current			implemented weekly weights to monito	r	
		t x 4 weeks, medication to			Resident #38's nutritional status.		
		I add protein supplement			Resident #219 was admitted on 5/22/2	024	
	three times per day.				with an admission weight of 191.8lbs. (		
	Resident #36's weigh	t record indicated the			6/25/2024 Resident #219 weighed	J11	
	following weights:	it record indicated the			176.0lbs. It was identified that weekly		
	Tollowing Wolgino.				weights have not been obtained upon		
	4/5/2024 98.0 Lbs.				admission and Resident #219 has		
	4/12/2024 No weight	recorded.			experienced weight loss. As of 6/27/20	24,	
	4/19/2024 No weight				the Registered Dietitian listed	•	
	4/20/2024 98.2 Lbs.				recommendations, however, did not no	te	
	4/27/2024 No weight	recorded.			if the recommendations were provided	to	
	5/4/2024 106.4 Lbs.				the PCP. As of 7/31/2024, the LNHA a	nd	
	5/11/2024 No weight				DON identified that Resident #219 is st	ill	
	5/18/2024 No weight				undergoing weight loss. The DON has		
	5/25/2024 No weight				implemented weekly weights to monito	r	
	6/1/2024 No weight re				Resident #219's nutritional status.		
	6/9/2024 No weight re	ecorded.			Resident #219 frequently leaves the		
	Λ 5/7/2024 Pagistara	d Dietitian note stated in part			facility on Therapeutic Leave and is		
	_	d Dietitian note stated in part hts were reviewed with a			non-compliant with medications and health care routine while on Therapeut	ic	
		nth and a loss of 10.3% in 3			Leave.	10	
	•	not indicate a reason for			Louve.		
	the weight fluctuation				Resident #52 was admitted on 5/2/202	4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING _			07/	/02/2024
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				106	CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER		LA	KE WACCAMAW, NC 28450		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 692	Continued From page	÷ 110	F 6	692			
F 692	Resident # 36's care indicated a nutrition a weight loss with interper orders, fortified for record.  Resident # 36's quart (MDS) assessment direction assessment direction for 106 lbs. and prescribed weight gail.  An interview was con PM with the Agency Date of 100 stated weight obtained. The DON stated weight gail. The DON stated she experience on admission and we admission. The DON expected physician or obtained. Without the RD and physician are	plan revised on 5/14/24 t risk problem related to ventions to obtain weights ods, and monitor intake and  erly Minimum Data Set ated 5/15/24 revealed e cognitive impairment, d was on a physician in program.  ducted on 6/12/24 at 2:15 Director of Nursing (DON). this were not consistently tated the facility required a aining weights and recommendations. The ected staff to obtain weights ekly for 3 weeks following	F 6		with an admission weight of 193.0lbs. 06/14/2024 Resident #52 weighed 192.6lbs. It was identified that weekly weights have not been obtained upon admission and Resident #52 has experienced weight loss. As of 7/18/20 the Registered Dietitian listed recommendations, however, did not not if the recommendations were provided the PCP. As of 7/31/2024, the LNHA a DON identified that Resident #52 is still undergoing weight loss. The DON has implemented weekly weights to monito Resident #52's nutritional status.  All residents residing in the facility have been identified as having the potential be affected by the alleged deficient practice.  The DON or Designee, reviewed all weight orders on 7/26/2024 to ensure the staff has a correct list of residents who require weekly and monthly weights.	24, te to nd I r	
		ducted on 6/12/24 at 2:45			nursing staff by 8/5/2024 on the importance of following provider orders	s in	
		ed Dietician (RD). The RD			regard to obtaining weights and to ens		
	_	supposed to be obtained			those identified residents nutrition		
	_	s of the month and that was			statuses are being monitored		
		RD stated she informed the			appropriately per recommendations fro	m	
	_	N several times over the			the Registered Dietitian. After 8/5/2024		
		sident weights were a			newly hired nursing staff will be educat		
	•	ing obtained and this had			by the DON or Designee during their n		
	· ·	) indicated Resident # 36's			hire employee orientation.		
	•	ained weekly on admission			, ,		
	_	RD stated weights were			Beginning 7/27/2024, the DON or		
		commendations, evaluate			Designee will audit ordered weekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>	
NAME OF D	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP	CODE	07/02/2024	
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				LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	D 4.T.E.	
F 692	Continued From pag	ge 111	F 6	592			
F 692	the resident's nutritic current interventions and obtaining weekl stated it was difficult Resident # 36's weight A follow up interview Director of Nursing The DON stated we and accurately. The through an agency a implemented a proceed but indicated it was resident's care and the resident's conditional through an interview was concerned by the facility's responsive to the facility's responsive valuate the resident Facility Physician further be obtained as order recommendations in Dietitian should be and the Registered should have been a Attempts were made Physician who was until 6/6/24. Messaguntil 6/6/24. Messaguntil 6/6/24. Messaguntil 6/6/24.	onal needs and evaluate s. Without accurate weights y weights as ordered, the RD to determine the cause of ght changes.  was conducted with the (DON) on 6/14/24 at 4:10 PM. ights were not obtained timely DON stated she was hired a few months ago and had not ess for obtaining weights yet an important part of the was necessary to evaluate ion.  Inducted with the Facility 4 at 1:24 PM. The Facility e started in the position on monitoring of weights was sibility and was important to nt's nutritional status. The orther stated weights were to red and the made by the Registered evaluated and addressed. an stated Resident #36's e been obtained as ordered Dietitian recommendations	F 6	weights x 12 weeks to ensorders are being followed in weight is reported to the immediately. Any missed will result in re-education training for the appropriate Beginning 7/27/2024, the Designee will audit weekly Dietitian recommendation ensure the recommendation ensure the recommendation addressed and followed umissed Registered Dietitia recommendations will resure-education and additionappropriate nursing staff.  Beginning 7/27/2024, the reviewed by the Licensed Administrator (LNHA) or Eresults of the audits will be monthly Quality Assurance Performance Improvement Meeting monthly for 3 more Committee will review the make recommendations a assure ongoing compliant. The facility will utilize this correction to ensure complimated regulation by 8 audits will continue for the timeframe as described in action.	and any chane provider weekly weight and additional enursing staff  DON or y Registered s x 12 weeks to ons are being to on. Any an ult in all training for the audits will be Nursing Homo DON, and the ereviewed in the end of (QAPI) on this. The QAF audits and as necessary to be is sustained plan of oliance under the specified	to  the  e the  o d. the he	
		e to interview the previous NP) who was in the position at					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	Continued From pag	e 112	F 6	92			
		4. Messages were left on nd 6/13/24 at 3:07 PM with d.					
		admitted on 8/14/20 with ided stroke and dementia.					
	loss with the following physician or Nurse P failure to thrive, fortific supplement and constitutions.	of at nutritional risk for weight g interventions included ractitioner to evaluate for					
	Resident # 38's weig	ght record indicated:					
	12/30/23 91.2 pound 1/8/2024 89.0 lbs. 1/21/2024 102.0 lbs. 2/5/2024 105.0 lbs. 3/3/2024 89.5 lbs.	s (lbs.).					
	Resident # 38's phys order for regular diet	ician orders indicated an with fortified foods.					
	indicated Resident # loss trend. A weight on 9/6/23 which indic loss over 6 months. It to obtain a reweigh d weekly weight for 4 v.  Resident # 38's phys	ician orders indicated a ekly weights for weight					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OF THE	D BE COMPLETION	
F 692	3/19/2024 89.0 lbs. 3/26/24 no weight r 4/5/2024 93.0 lbs. 4/12/24 no weight r 4/20/2024 83.0 lbs. Resident # 38's 4/2 Set (MDS) indicated weight loss of 5 per or loss of 10 percer An RD progress no Resident # 38 was Current weight 4/20 lbs. on 10/11/23 indover 3 months, and months. Resident # of a regular fortified protein supplement medication to help if weekly weights for failure to thrive and due to weight loss a RD did not indicate Resident # 38's weights for a second weekly weights for failure to thrive and due to weight loss a RD did not indicate Resident # 38's weights for failure to thrive and due to weight loss a RD did not indicate Resident # 38's weights.	ght record indicated:  ecorded.  2/24 quarterly Minimum Data d a weight of 83 lbs. and cent or more in the last month in the last 6 months.  te dated 4/23/2024 indicated reviewed for weight loss.  1/24 83 lbs. A weight of 113 licated a loss of 18.6 percent a loss of 26.5 percent over 6 as 38 consumed 0-50 percent foods diet and received a . Recommendations included: increase appetite, obtain 4 weeks and evaluate for protein calorie malnutrition and decreased appetite. The a root cause analysis of	F 69			
	order dated 4/23/24 increase appetite.  A physician note da # 38's weight loss a	for a medication to help  ted 5/3/24 indicated Resident and the 4/23/24 Registered dation for medication to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING				02/2024
	ROVIDER OR SUPPLIER	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET .AKE WACCAMAW, NC 28450		02/202-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	dated 5/20/24 indicate 4/23/24 Registered D medication to increase addressed.  Resident # 38's electra Registered Dietitian 5/30/2024. The program 38 was reviewed for weight 5/2/24 92 lbs. Weight on 11/2/23 was 12.3 lbs. weight loss percent loss over 6 mincluded: medication and physician evalual protein calorie malnum.  Resident #38's physician evalual protein calorie malnum.  Resident #38's electron physician progress 5/30/24 Registered Date a medication to increase for diagnosis of failure malnutrition.	re not addressed.  Int record indicated:  Int record indicated.  Int record included.  Int recommendation for the alth record included the progress note dated the appetite were not the indicated Resident to the indicated are something in a months and 17.8 the indicated are something in a months. Recommendations to help increase appetite the indicated in a months. Recommendations to help increase appetite the indicated in a months. Increase appetite the indicated in a months and 17.8 the indicated in a months. Increase appetite the indicated in a month increase appetite the increase appetite.  In record indicated:  In record indicated:  In record included in included in progress note dated in a month indicated are in a m	F	692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _				0 <b>2/2024</b>	
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450				
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F 692	Physician who was M Messages were left of 6/13/24 at 3:00 PM was Attempts were made Nurse Practitioner (N facility until 6/6/24. M 6/12/24 at 3:36 PM a no return call received An interview was con PM with the Registers stated weights were to ten days of the month done. The RD indicates regarding the accurate reweights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the sover the past 3 weights were not obtain the source of the so	ledical Director until 6/6/24. In 6/12/24 at 3:33 PM and ith no return call received.  Ito interview the previous P) who was employed at the lessages were left on and 6/13/24 at 3:07 PM with d.  Iducted on 6/12/24 at 2:45 and Dietitian (RD). The RD of the obtained within the first and that was not being and that was not being and the weights and obtained when there was a RD stated she informed the process of Nursing several months that resident ained and there was no D indicated Resident #38's ained as ordered or as is made it difficult to make valuate the resident's evaluate current D stated that the nutritional	F6	92				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 106 CAMERON STREET LAKE WACCAMAW, NC 28450	ODE	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 692	documentation require the other orders option over to the MAR to in weekly weight was doweight order also didweight order also didweight order report all were not done. Unit Malist of weights that wassistants (NAs), but them to ensure they was A follow up interview Agency Director of National Agency Director	ed." She stated by selecting on, the order would not carry form the nursing staff that a u.e. She stated the weekly not populate on the weekly not populate on the weekly not that was why the weights Manager #2 stated she gave were needed to the Nursing she did not follow up with were obtained.  was conducted with the ursing (DON) on 6/14/24 at tated weights were not being fown in the process. The excted weights would be accurately. The DON further ed through an agency, had cion of DON at the facility for d not yet implemented a ghts. The DON indicated artant part of the resident's re necessary to evaluate the ducted with the Facility had only been in the position	F	592			
		imulate appetite should have					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 692	Continued From pag	e 117	F 692			
		s admitted to the facility on sis including cellulitis of the abetes.				
	#219 revealed to obt	lated 05/22/24 for Resident ain weight on admission then ks, then monthly or as sician.				
		lated 05/28/24 for Resident ain weekly weights for evaluation.				
	#219 was cognitively care and a therapeut 191.8 lbs. (pounds).	5/28/24 revealed Resident intact. She received wound tic diet. The weight was There was no weight loss or assessment indicated to				
	record from admission 06/19/24 revealed ar	#219's electronic medical on on 05/22/24 through n admission weight recorded ight was 191.8 lbs. (pounds). weights recorded.				
	Nurse Aide #3 stated in the facility and was Resident #219. She the beginning of the needed monthly weight was right her know. She stated obtain Resident #219	on 06/14/24 at 10:23 AM I she recently started working Is the assigned Nurse Aide for stated she was given a list at month of residents that ghts. She stated if a weekly needed the nurse would let I she had not been told to D's weight. She indicated she st of residents who needed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024		
	ROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		, 0.7.2.2.2.		
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F 692	Nurse #6 stated she 400 hall and to Res nurse aides obtaine weights were given electronic medical r not aware Resident weights because no electronic medical r weekly weight was During an interview Nurse Aide #4 state a list of names each needed weights. She of names at different times she would ge beginning of the motthe list of names for She stated she didnate weights were weights were given nurse entered the weights were given nurse entered the weights a list of names each needed weights. She stated she didnate weights were given nurse entered the weights were given nurse entered the weights she weights were given nurse entered the weights. She stated a list of names each needed weights. She stated she weights. She stated she weights. She stated she weights. She she weights.	<u>-</u>	F 69				
	She indicated when month the weights we nurse and the nurse	her if a weight was needed. weights were obtained each were given to the assigned e entered the weight into the ecord. She stated she didn't					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY  COMPLETED	
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIA	5.475	
F 692	Resident #219 had of During an interview of Registered Dietician with getting weights. Nursing, and the Adnissue, and it was beint Assurance meetings. #219 was admitted of an abscess on the grown wound care to the arrown supplements three ting Resident #219's BMI elevated, and the we evaluate her nutrition. She stated she was a were not getting done Administration. She obtained according to Wound Nurse indicated Resident #219 had a assess her nutritional evaluation. She state followed by the wound the facility and the weight indicated the weekly Medication Administration and the weight indicated the weekly Medication Administration. During an interview of Manager #2 indicated weights. She stated seach month and gave she stated she did not seen and the stated she did not seen and the stated she did not seen and the seen and th	oh hall and was not aware riders for weekly weights.  on 06/14/24 at 12:30 PM the stated there had been issues. She stated the Director of innistrator were aware of the ing discussed in their Quality. She reported that Resident in 05/22/24 with cellulitis and ion. She received daily ea and received nutritional mes a day. She reported (body mass index) was ekly weights were ordered to a for wound assessments. In aware the weekly weights are and had reported this to expected weights to be to the physician's order.  on 06/14/24 at 1:18 PM the red she was not aware in order for weekly weights to I needs for wound as ad care physician weekly in bound was improving. She weight order was not on the ation Record (MAR) or the ation Record (TAR) and	F	592			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		_	C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STA 106 CAMERON STREET LAKE WACCAMAW, NC	·	01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)	
F 692	Continued From page	e 120	F 6	92		
	reviewed weights. Sh given the list of reside to obtain weights for	the Registered Dietician he indicated that she had not ent names to the nurse aides the current month and she esident #219 had orders for				
	Director of Nursing (I were to be done by the weekly weights should day of the week. She obtaining weights was staff responsible for of developed bad habits	and there had been no tated more work was needed				
	stated monitoring of waresponsibility and waresident's nutritional sindicated that weights ordered and the reco	as conducted with the at 1:24 PM. The Physician weights was the facility's important to evaluate the status. The Physician is were to be obtained as immendations made by the should be evaluated and				
	4. Resident #52 was 05/02/24.	admitted to the facility on				
	#52 revealed to obtai	ated 05/02/24 for Resident n weights on admission then ks, then monthly or as ician.				
	record from admissio	#52's electronic medical n on 05/02/24 through admission weight recorded				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3	B) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1 07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 692	on 05/02/24 which wawere no other weight  The Minimum Data Sdated 05/09/24 reveaseverely cognitively in or clean up assistance was on a regular diet recorded as 193 pour loss or gain. The car indicated to initiate a for nutritional status.  An interview was condicated Resident #5 obtained weekly as oweights were necess recommendations, evenutritional needs and interventions. The RD determine the cause changes without obtained weights were reported it to Administ An interview was cond6/13/24 at 11:45 AM nurse aides obtained weights were given to electronic medical remot aware Resident # weights because not electronic medical reweekly weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served which weight weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served which weight weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not admitted residents should be a served weight was not a	et admission assessment led Resident #52 was mpaired and required set up e with eating. Resident #52 and her weight was nds. There was no weight e area assessment care plan with interventions ducted with the Registered 12/24 at 2:45 PM. The RD 52's weights were not redered. The RD stated ary to make valuate the resident's evaluate current 0 stated it was difficult to of Resident # 52's weight ining weekly weights as ted she was aware the not getting done and had tration.  ducted with Nurse #7 on I. Nurse #7 reported the the monthly weights and the othe nurse to enter into the cord. She stated she was 52 had an order for weekly	F6	592			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 692	Continued From pag		F 69	02	
	#8 on 06/14/24 at 1: was usually given a month of residents w NA #8 added, if a nu weight she would let had not been told to and had not received needed monthly weigstated when the weiggive them to the assibelieved they would medical record.  An interview was cor (UM) #2 on 06/14/24 she was responsible monthly weights wernew admissions, par was to initiate batch She stated the order she entered into the entered correctly to padministration record weight was due. UM the weekly weight or	nducted with Nurse Aide (NA) 11 PM. NA #8 reported she list at the beginning of the who needed a monthly weight. It is needed a weekly or daily her know. NA #8 stated she obtain Resident #52's weight If a list of residents who ghts as of this time. She ghts were obtained she would ligned Nurse and she enter them in the electronic  Inducted with Unit Manager If at 2:00 PM. UM #2 stated for ensuring the weekly and the obtained. She stated with the of the admission process orders for weekly weights. If or the weekly weights that electronic record was not copulate to the medication If to alert nursing staff that a If #2 added due to this error, der also did not populate on report so she was not aware			
	An interview was con Nursing (DON) on 06 stated weights were accurately. The DON through an agency a implemented a proce but indicated it was a	eded weekly weights for 3 why they were not done.  Inducted with the Director of 6/14/24 at 4:10 PM. The DON not obtained timely and I stated she was hired few months ago and had not less for obtaining weights yet an important part of the was necessary to evaluate			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.			(	c
		345185	B. WING _			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE D6 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692 F 697 SS=K	the resident's condition  An interview was complysician on 06/18/24 Physician stated she 06/07/24 and indicate the facility's responsible evaluate the resident's Facility Physician furtible obtained as ordered Pain Management	ducted with the Facility I at 1:24 PM. The Facility started in the position on d monitoring of weights was bility and was important to s nutritional status. The ner stated weights were to		692			7/27/24
	provided to residents consistent with profes the comprehensive per and the residents' goard This REQUIREMENT by: Based on record revictorsultant Pharmacisthe facility failed to promanagement and ma for 2 of 10 residents (#46) reviewed for pair #51 was prescribed g (mg) four times daily for medication was not at resulted in a total of 2 medication not admin 5/13/24. Resident #5 constant pain at up to with the 10 being the numbness in her legs transferred to the Emitage and the resident was not at the second profession of the second profession was not at the second profession of the second p	ire that pain management is who require such services, sional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced  ew, staff, resident, st, and Physician interview, ovide effective pain nage symptoms of withdraw Resident #51 and Resident management. Resident abapentin 800 milligrams for nerve pain. The vailable to administer and 1 doses of the prescribed istered from 5/8/24 through 1 had complaints of a 10 (on a scale of 0 to 10			The facility failed to provide effective p management and manage symptoms of withdraw for 2 of 10 residents (Resident #51 and Resident #46) reviewed for parmanagement.  Resident #51 was prescribed gabapent 800 milligrams (mg) four times daily for nerve pain. The medication was not available to administer and resulted in a total of 21 doses of the prescribed medication not administered from 5/8/2024 through 5/13/2024. Resident had complaints of constant pain at up to 10 (on a scale of 0 to 10 with the 10 be the worst pain possible), numbness in legs, and spasms. She was transferred	of nt nt iin tin - a #51 o a eing her	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G			
		345185	B. WING _		0.	C 7/ <b>02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP		702/2024	
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	NTER					
				LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From page	e 124	F 6	97			
	night where she was	treated for acute pain with		the Emergency Departme	ent (FD) per her		
		ned to the facility the same		request on 5/12/2024 in the			
		issed 3 more doses of		night where she was trea			
		4 and returned to the ED		pain with gabapentin and			
	that evening per her r			facility the same day. Res			
	<b>.</b>	was again treated for acute		missed 3 more doses of g			
	-	and returned to the facility		5/12/2024 and returned to			
	where she proceeded	I to miss 4 more doses of		evening per her request for	or worsening		
	-	o the facility obtaining the		muscle spasms. She was			
	medication for admini	istration. Resident #46 was		for acute pain with gabap	entin and		
	prescribed gabapenti	n 800 mg two times daily for		returned to the facility wh	ere she		
	nerve pain. The medi	cation was not available to		proceeded to miss 4 more	e doses of the		
		and Resident #46 missed		medication prior to the fac			
		cation from 5/10/24 through		the medication for admini	stration.		
	_	creased pain at a sustained					
		sleeping, anxiety, irritability,		Resident #46 was prescri			
	_	nable to complete her normal		800 mg two times daily fo			
	routine due to pain in	her legs.		The medication was not a			
				administer on 5/10/2024 a			
		began when the facility		#46 missed 14 doses of t			
		tive pain management for		from 5/10/2024 through 5			
		24 resulting in a pain level of Resident #46 on 5/12/24		resulting in increased pair			
	when the resident ha			8-9 pain level, trouble sle irritability, nausea, and be			
		mediate Jeopardy was		complete her normal rout	_		
	removed on 6/16/24 v			her legs.	ine due to pain in		
		ptable plan of Immediate		Tier legs.			
		he facility remains out of		All residents residing in the	ne facility have		
		r scope and severity of "E"		been identified as having			
		ential for more than minimal		be affected by the alleged			
	,	ediate jeopardy) to ensure		practice.	. 4011010111		
		ed and monitoring systems		practice.			
	put in place are effect	<u> </u>		Immediate Jeopardy bega	an when the		
	1			facility failed to provide ef		<b> </b>	
	Findings included:			management for Residen			
	. mango moradoa.			resulting in a pain level of			
	Gabapentin is an anti	convulsant medication		and for Resident #46 on 5		<b> </b>	
	prescribed for seizure			resident had increased pa			
		ions indicated gabapentin		sleeping. Immediate Jeop	_		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 7/02/2024	
NAME OF D	ROVIDER OR SUPPLIER	040100	1	STREET ADDRESS, CITY, STATE, ZIP COD		7/02/2024	
NAME OF T	NOVIDEN ON SOIT LIEN				<i>,</i> L		
PREMIER	LIVING AND REHAB CE	NTER		106 CAMERON STREET			
				LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From page	e 125	F 69	7			
	caused physical depe	endence and stopping the		removed on 6/16/2024 when	the facility		
		withdrawal symptoms.		implemented an acceptable p			
		stopping gabapentin,		Immediate Jeopardy removal			
		s may start and may be					
	severe. Withdrawals	symptoms include nausea,		Upon identification of the sev	erity of the		
	insomnia, anxiety, tre	emors, body aches,		alleged deficient practices, th	e Licensed		
	increased pain, hallu	cinations and seizures.		Nursing Home Administrator	(LNHA)		
				wrote the Immediate Jeopard	ly Removal		
		admitted on 10/19/23 with		Plan and submitted the Remo			
	_	ıded in part: chronic pain		approval. The Immediate Jeo			
	syndrome, chronic ba			removed on 6/16/2024 when	,		
	· •	ers, and spastic paraplegia		implemented an acceptable p			
		a disorder that causes progressive weakness, Immediate Jeopardy removal. The LNH					
		pain and muscle spasms of		terminated the agency Direct			
	the lower extremities	).		(DON) during extended surve	•		
	Daview of Decident 4	4541a mbyraiaian andam		6/19/2024. The LNHA hired a			
		#51's physician orders Border for gabapentin 800		experienced non-contractual 6/19/2024 to ensure future co			
		es per day for nerve pain.		The facility has also hired nur	•		
	mingrams (mg) 4 um	es per day for herve pain.		including RNs and LPNs to e			
	Review of Resident #	#51's physician orders		compliance.	risure future		
		ted 4/10/24 for methadone 5		compilatios.			
		or pain and an order dated		The DON or Designee will rev	view all		
		20 mg 3 times per day for		Medication Administrator Rec			
	muscle spasms.	3 1 7		for residents receiving pain m	` ,		
	'			ensure there are no missing of			
	Review of Resident #	‡51's care plan revealed a		missing doses will be reporte			
		of pain due to chronic back		provider and documentation			
	pain. The goal indica	ated resident's pain will be		ensure compliance by 8/5/20	24.		
	relieved with use of p	pain medications.					
		d provide/ administer pain		The DON or Designee will ed			
		ed, monitor for complaint of		nurses and medication aides	•		
	pain and report the n	eed for further interventions.		on the steps to follow when a			
				is not in stock, as well as pro			
		#51's quarterly Minimum		documentation that describes			
	, ,	d 4/4/24 indicated resident		that were taken to ensure the			
		t The MDS assessment was		receives their medications as			
		cheduled and as needed pain		ensure compliance. After 8/5/	-		
	⊢medication. The nain	interview was not assessed.		hired nursing staff will be edu	icated by the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345185	B. WING _		<del></del>	07	7/02/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	LIVING AND DEHAD	CENTER		106	CAMERON STREET			
PREIMIER	LIVING AND REHAB	CENTER		LA	KE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
							1	
F 697	Continued From p	page 126	F	697				
		-9			DON or Designee during their new hir	ro.		
	The pharmacy rec	cords indicated a supply of 120			employee orientation.	C		
		he pharmacy records indicated a supply of 120 paper in pills was sent to the facility for			employee orientation.			
		4/25/24. The pharmacy record			The DON or Designee will educate all	I		
	indicated the 92 gabapentin pills from the 4/25/24				nurses by 8/5/2024 on the importance			
	_	nt #51 were returned to the			completing pain assessments daily fo			
		esident #51 was in the hospital			residents that are receiving pain			
	from 5/5/24 throug				medications to ensure compliance. At	ter		
	`			8/5/2024 newly hired nursing staff will				
	The hospital disch	arge summary dated 5/8/24			educated by the DON or Designee du			
	indicated Residen 5/5/24 through the			their new hire employee orientation.				
	1	summary indicated the order			Beginning 7/27/2024, the DON or			
	for gabapentin for	Resident #51 was unchanged			Designee will audit pain medication			
	when she returned	d on 5/8/24.			administrations 5 times per week for 7	12		
					weeks to ensure all pain medications	are		
	· -	edication Administration Record			given as ordered. Any missed			
	, , , <del>,</del>	abapentin 800 mg was			administrations will result in re-educate			
		dministered at 9:00 AM, 12:00			with the appropriate staff members ar			
	PM, 5:00 PM and				employee disciplinary action will be ta	ken		
		a "9" indicated to see the is MAR did not include routine			if necessary.			
	monitoring of pain	using a 0-10 pain scale rating.			Beginning 7/27/2024, the DON or			
	This MAR and the	medication administration			Designee will interview 3 residents pe	:r		
		e following related to Resident			week x 12 weeks to ensure his/her pa			
	#51's gabapentin:				being managed effectively. Any misse			
					administrations will result in re-educate			
	5/8/24				with the appropriate staff members ar			
		0 PM indicated Nurse #8			employee disciplinary action will be ta			
		and the corresponding			if necessary. Any pain that a resident			
		ord note at 5:23 PM indicated			expresses that is not being managed			
		vaiting the arrival of gabapentin			effectively will be reported to the prov	iuei.	<b> </b>	
	800 mg from the p	onarmacy. 0 PM indicated Nurse #8			Beginning 7/27/2024, the audits will b			
	documented a "9"				reviewed by the Licensed Nursing Ho			
	corresponding nu				Administrator (LNHA) or DON, and th			
	5/9/24	any note.			results of the audits will be reviewed i			
		0 AM indicated Nurse #9			monthly Quality Assurance and		<b> </b>	
	documented a "9"				Performance Improvement (QAPI)			

Facility ID: 923415

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345185	B. WING _		<del></del>	07	/02/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	LIVING AND DELIAD OF	NTED		10	06 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	NIER		L	AKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From page corresponding nursing - The MAR for 12:00 documented a "9" and corresponding nursing - The MAR for 5:00 P documented a "9" and corresponding nursing - The MAR for 9:00 P documented a "9" and corresponding nursing - The MAR for 9:00 P documented a "9" and corresponding nursing - The MAR for 9:00 P documented a "9" and corresponding nursing - The page and corresponding nursing - The page and sessident #51 had pagin rating of 10 and sleep and day to day pain.  A nursing progress not indicated Resident #51 had page and community and sessident #51 had page and sessident #51 had page and sessident #512 PM with Nurse was assigned to Resi 5/9/24. Nurse # 8 state Resident #51. Nurse reported increased page her gabapentin. Nurse was frustrated about	g note. PM indicated Nurse #9 d there was no g note. M indicated Nurse #9 d there was no g note. M indicated Nurse #9 d there was no g note. M indicated Nurse #8 d there was no g note.  ated 5/9/24 was completed in assessment indicated n almost constantly with a the pain made it hard to activities were limited due to  but by Nurse #9 on 5/9/24 for refused a shower due to  ducted via phone on 6/13/24 for #8. Nurse #8 stated she dent #51 on 5/8/24 and ted she was familiar with for #8 stated Resident #51 for receiving the medication Nurse #8 stated she did not for the receiver for the receiver for the receiving the medication Nurse #8 stated she did not for the receiver for the re		697		API to ed. the the	DATE	
	for why she did not re A nursing progress no 5/10/24 at 3:24 AM in	d not have an explanation port the concerns.  ote written by Nurse #8 on						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 697	were no intervention emergency room evideclined to be sent.  The MAR and the motes revealed the file #51's gabapentin: 5/10/24  The MAR for 9:00 documented a "9" a corresponding nursi. The MAR for 12:00 documented a "9" a corresponding nursi. The MAR for 5:00 documented a "9" a corresponding nursi. The MAR for 9:00 documented a "9" a corresponding nursi. The MAR for 9:00 documented a "9" a administration recort the facility was await 800 mg from the ph.  An interview was count # 9 on 6/13/24 at 2: assigned to Resider from 7:00 AM to 7:00 Resident # 51's gab 5/9/24 and 5/10/24 9:00 AM, 12:00 PM revealed she documedication was not Nurse # 9 stated she medication for Resider reported pain in her	) informed Resident #51 there as for this and offered aluation. Resident #51 to the emergency room.  Inedication administration following related to Resident  AM indicated Nurse # 9 and there was no ng note.  D PM indicated Nurse # 9 and there was no ng note.  PM indicated Nurse # 9 and there was no ng note.  PM indicated Nurse # 9 and there was no ng note.  PM indicated Nurse # 13 and the corresponding d note at 10:12 PM indicated ting delivery of gabapentin	F 69	7		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	MPLETED
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	#13 on 6/27/24 at 12 she was assigned to from 7:00 PM to 7:00 the ordered medicat unavailable for the s Nurse #13 recalled t did not complain of prom her suprapubic through the abdome bladder).  The MAR and the motes revealed the fe #51's gabapentin: 5/11/24  - The MAR for 9:00 processed the fermal for the mark of the fermal for fermal for the fermal for fermal for fermal for fermal for fermal fermal for fermal fermal fermal for fermal ferm	nducted via phone with Nurse 2:50 PM. Nurse #13 revealed 3 Resident #51 on 5/10/24 3 AM. Nurse #13 indicated 3 ion gabapentin 800 mg was 3 cheduled dose at 9:00 PM. 3 hat Resident #51 normally 3 bain other than discomfort 3 catheter (a tube inserted 3 in to drain urine from the  4 edication administration 5 collowing related to Resident  4 AM indicated Unit Manager  4 and there was no 6 ng note.  5 PM indicated Unit Manager  6 and there was no 7 and there was no 8 ng note.  6 PM indicated Nurse #14 8 nd the corresponding 8 11/24 at 4:15 PM indicated 9 was pending from the 9 urse pass on information to 9 oc.  6 PM indicated Nurse #2 9 nd there was no	F 69	97		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024	
	ROVIDER OR SUPPLIER	NTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 01/02/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 697	medication for Reside Resident #51 for pair she was in the role of and prior to that she was and prior to that she was that Resident #51 rar required emergency increased pain but didetails of the situation she did not recall if shobtaining the medicar #51.  A progress note writte at 3:48 AM indicated pain and spasming at the emergency room, and oriented and stat to gabapentin withdrate to gabapentin withdrate An Emergency Depart 5/12/24 at 6:11 AM in evaluated for a chief had been out of her gate days and now she was cramps. The ED Sur presented to the ED or reported she had not thought she was in gain the ED, at 4:43 AM was administered gald discharge instructions 800 mg 4 times per deprimary care physicial prescription medications.	y attempt to obtain the ent #51 and did not assess in Unit Manager #1 stated if Unit Manager for 3-4 weeks worked the 7:00 PM to 7:00 per #1 stated she was aware in out of gabapentin and room evaluation due to do not recall any further in. Unit Manager #1 stated he had been involved in the had requested to be sent to Resident #51 was alert the had been involved in the	F 69	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		0770272024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	#2 on 6/14/24 at 2:2-was an agency nurse from 7:00 PM to 7:00 was assigned to Res 5/12/24. Nurse #2 roto the hospital during uncontrolled pain an gabapentin on hand kept complaining of shaking and stating: #2 stated it looked lill exhibiting withdrawarequested to be sent and to receive her programmer of gabapentin for pain. The provider and sent hospital. Nurse #2 strequently not availabeen told by other not able to recall which in wait until the medical pharmacy and there done about the medical pharmacy and there done about the medical from the hospital at a Manager #1 was made Resident #51's gabatthe facility and the remergency room durobtain it.  The MAR for 5/12/24 inaccurately document 12:00 PM, and 5:00 gabapentin which incomplete in the sent and sent	nducted via phone with Nurse 4 PM. Nurse #2 stated she e at the facility and worked 0 AM. Nurse #2 stated she sident #51 on 5/11/24 into ecalled sending Resident #51 of the night on 5/12/24 due to d not having her prescribed in the facility. Resident #51 oain during the shift and was she did not feel well. Nurse we Resident #51 was I symptoms. Resident #51 to the hospital for evaluation	F 6	97		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			1	C <b>02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		106 CAMER	DRESS, CITY, STATE, ZIP CODE RON STREET CCAMAW, NC 28450	1 077	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 697	#14's progress note] a dose of gabapentin w Attempts were made #14, a nurse that wor needed. Messages le with no return call red An ED Summary date indicated Resident #5 spasms and reported gabapentin prescription facility and was havin Medication Administratindicated Resident #5 gabapentin 800 mg o Resident #51 was dis on 5/12/24 at 9:41 PN continue with gabape A progress note writte 2:40 AM revealed on nurse was called to re #51 complained of wo over" and requested to department. 911 was emergency room. Refacility having receive emergency room staff Gabapentin at the fact go to the emergency supposed to get it or emergency room phy prescription for Gabal	mately 8:00 AM [per Nurse and the next scheduled as due at 9:00 AM).  Via phone to interview Nurse ked through an agency as left on 6/13/24 and 6/14/24 eived.  In d 5/12/24 at 8:50 PM In presented with muscle she was unable to get her on refilled at the nursing gobreakthrough pain. The lation Record for the ED in was administered in 5/12/24 at 9:12 PM. In the lation Record for the facility in with instructions to latin 800 mg 4 times per day.  In by Nurse #8 on 5/13/24 at 5/12/24 at 7:50 PM the lation in the lation in the lation in the latin in	Fé	97				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	
		345185	B. WING		07/02	2/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01702	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 697	Continued From pag	je 133	F 69	97		
	The MAR and the m notes revealed the fe #51's gabapentin: 5/13/24  - The MAR for 9:00 documented a "9" at administration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and ministration record the facility was awai 800 mg from the phater and minist	AM indicated Nurse # 15 and the corresponding d note at 10:05 AM indicated ting delivery of gabapentin armacy. D PM indicated Nurse # 15 and the corresponding d note at 1:41 PM indicated ting delivery of gabapentin armacy. PM indicated Nurse # 15 and the corresponding d note at 1:41 PM indicated ting delivery of gabapentin armacy. PM indicated Nurse # 15 and there was no ang note. PM indicated Nurse # 11 and the corresponding d note at 10:52 PM indicated ting delivery of gabapentin armacy andicated a supply of 120 a sent to the facility for night of 5/13/24.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		7770212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	gabapentin but stated pain so running out of cause increased pain.  An interview was con Nursing Assistant (NAN #1 stated she was NA #1 stated Resider times, but this was not an interview was con on 6/27/24 at 4:40 PM #51 complained of legal A follow up interview with Nurse #8 on 6/27 stated she was aware withdrawal and adver may sustain because doses of gabapentin, aches and spasms was was and spasms was an interview by phone Consultant Pharmaci. The Consultant Phar	ducted via phone with A) #1 on 6/27/24 at 4:17 PM. Is familiar with Resident #51. In t#51 complained of pain at ot common for her.  ducted via phone with NA #9 M. NA #9 stated Resident g pain at times.  was conducted via phone #8 of the potential for se effects that Resident #51 of not receiving the ordered Nurse #8 stated muscle ere signs of withdrawal.  e was conducted with the st on 6/12/24 at 9:14 AM. macist indicated not as ordered could cause rawal symptoms, and hythm problem causing The Consultant Pharmacist symptoms may start within severe.  W was conducted with the DON) on 6/12/24 at 2:00 PM.	F 69	97		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NIER			LAKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 697	Continued From page	e 135	F	697	7		
		regarding the requirements	'	001			
		gabapentin and she did not					
	_	rements herself. The DON					
	·	ant Pharmacist had informed					
		th gabapentin running out					
		DON position, she had not					
		em. The DON stated a					
	system was required	in the facility to track					
	medication refills, esp	pecially medications for pain.					
	An in-person interview Administrator on 6/14	w was conducted with the					
	Administrator stated s						
		inistered as ordered by the					
		istrator stated nursing staff					
	did not have a compre	ehensive understanding of					
	what to do when they	identified a medication was					
	not available for admi	nistration.					
	-	e was conducted with the					
		at 1:20 PM. The Physician					
		gabapentin ordered, 800 mg					
		a high dose of medication					
		nended to abruptly stop due to the potential for					
		e pain. The Physician stated					
		definite concern due to not					
	•	ed gabapentin as ordered					
		in 12 hours. The Physician					
	further indicated it wa						
	medication from a res						
	potential for adverse	outcome. The Physician					
	revealed Resident #5	1 being sent to the hospital					
		increased pain was the					
		ring the scheduled doses of					
		entin as ordered by the					
	· •	it was the responsibility of					
		ne medications, especially they could be administered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 011022224
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 697	Continued From pagas ordered.  2. Resident #46 wadiagnosis which inclineuropathy.  Review of Resident revealed a 12/6/23 cmilligrams (mg) 2 tirces Aphysician order da Resident #46 had a hydrocodone acetar (mg) every 6 hours a Resident #46's quar (MDS) assessment resident was cognitive received scheduled medication, pain into and resident reported days.  A review of the Med	ge 136  s admitted on 12/6/23 with uded diabetes and  # 46's physician orders order for gabapentin 800 nes per day for nerve pain.  ated 1/18/24 indicated PRN (as needed) order for ninophen 5-325 milligrams as needed for pain.  terly Minimum Data Set dated 3/12/24 indicated vely intact. Resident #46 and as needed pain erview should be conducted, and no pain in the previous 5	F 69	,	
	Resident #46 was a hydrocodone acetar highest pain level re mg was administere through 5/9/24.  An interview was co 6/13/24 at 1:45 PM. through an agency at the facility on 5/6/24 Nurse #3 stated she #46. Nurse #3 indic was delivered for Resident acetar was stated as the part of th	ough 5/9/24 revealed dministered the PRN ninophen 10 doses with the corded as 8. Gabapentin 800 d twice per day from 5/1/24 nducted with Nurse #3 on Nurse #3 stated she worked and was assigned to work at from 7:00 PM to 7:00 AM. was assigned to Resident ated a card of gabapentin esident #46 on 5/6/24 but the lave a controlled substance			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONS			PLETED
		345185	B. WING _				C / <b>02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		106 CAN	ADDRESS, CITY, STATE, ZIP CODE MERON STREET NACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	do. Nurse #3 indicate card of gabapentin for pharmacy with the destated she did not inf Director of Nursing (I medication was return would have done this An interview was core 6/14/24 at 2:25 PM. on 5/6/24 from 7:00 In not assigned to Resident #46 on some controlled drug sheets was told by some recall who, to return a pharmacy with the decontrolled drug sheet not inform the Unit M that the medication with the nurse assigned to The May 2024 Medic (MAR) indicated gaba administered at 9:00 specified the docume see the nursing note medication administration.	e asked Nurse #2 what to ed Nurse #2 returned the or Resident #46 to the elivery driver. Nurse #3 form the Unit Manager, DON), or pharmacy that the med as she thought Nurse #2 s.  Inducted with Nurse #2 on Nurse #2 stated she worked PM to 7:00 AM but she was dent # 46. Nurse #2 recalled delivered from the pharmacy 5/6/24 but it did not have a tattached. Nurse #2 stated eone, but she could not the medication to the elivery driver due to not. Nurse #2 indicated she did lanager, DON or pharmacy was returned as she thought to Resident #46 would do it.  Cation Administration Record apentin 800 mg was to be AM and 9:00 PM. The MAR entation of a "9" indicated to s. This MAR and the ation notes revealed the	F	697	DEFICIENCY		
	documented a "9" an corresponding nursin - The MAR at 9:51 P	PM indicated Nurse # 3 d there was no					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	I	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 697	documented the PF 5/11/24  - The MAR for 9:00 documented as the - The MAR for 9:00 documented a "9" a corresponding nurs - The MAR indicate administered a PRN hydrocodone acetal Nurse #3 documented effective. 5/12/24  - The MAR for 9:00 documented a "9". note at 9:09 AM indicate administered a PRN hydrocodone acetal Nurse #3 documented a "9" a corresponding nurs - The MAR indicate administered a PRN hydrocodone acetal Nurse #3 documented effective. 5/13/24  - The MAR for 9:00 documented a "9". note at 9:44 AM indicated at 9:44 AM indicated at 10:50 PM. The colors PN Indicated pharmacy.  - The MAR indicated pharmacy.  - The MAR indicate administered a PRN indicated at 10:50 PM. The colors PN Indicated pharmacy.	25 mg for pain. Nurse #3 RN dose was effective.  AM indicated Nurse #6 medication was administered. PM indicated Nurse #3 and there was no ing note. d at 9:43 PM Nurse #3 N dose of 5-325 mg minophen for a pain level of 7. ted the PRN dose was  AM indicated Nurse #6 The corresponding nursing licated awaiting pharmacy atin. PM indicated Nurse #3 and there was no ing note. d at 9:37 PM Nurse #3 N dose of 5-325 mg minophen for a pain level of 9. ted the PRN dose was  AM indicated Nurse #6 The corresponding nursing licated awaiting pharmacy atin. PM indicated Nurse #6 The corresponding nursing licated awaiting pharmacy atin. PM indicated Nurse #17 A pain level of 8 was recorded corresponding nursing note at the medication on order from  d at 9:50 PM Nurse #17	F 6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET .AKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	documented a "9" and corresponding nursin - The MAR for 9:00 P documented a "9" and corresponding nursin - The MAR indicated administered an as not hydrocodone acetam documented the PRN 5/15/24 - The MAR for 9:00 A documented a "9" and corresponding nursin - The MAR for 9:00 P documented a "9" and corresponding nursin 5/16/24 - The MAR for 9:00 A #2 documented a "9" note at 9:17 AM indicting gabapentin from phan - The MAR for 9:00 P documented a "9". Tote on 5/17/24 at 12 medication delivery for 5/17/24 - The MAR for 9:00 A documented a "9". A 5/17/24 at 10:09 AM medication delivery opharmacy The MAR for 9:00 P documented a "9". The MAR for 9:00 P documented a "9". A 5/17/24 at 10:09 AM medication delivery opharmacy The MAR for 9:00 P documented a "9" and source an	I dose was effective.  M indicated Nurse # 7 d there was no g note. M indicated Nurse # 17 d there was no g note. at 9:25 PM Nurse # 17 eeded dose of 5-325 mg inophen. Nurse #17 I dose was effective.  M indicated Nurse #7 d there was no g note. M indicated Nurse # 17 d there was no g note. M indicated Unit Manager The corresponding nursing ated waiting for delivery of macy. M indicated Nurse # 11 he corresponding nursing ated waiting for delivery of macy. M indicated Nurse # 11 he corresponding nursing ated waiting for delivery of macy. M indicated Nurse # 5 n administration note dated indicated awaiting f gabapentin from M indicated Nurse #2 d there was no g note. A pain level of 7 was	F	697			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	OATE SURVEY COMPLETED
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	· ·	0110212021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	6/13/24 at 1:45 PM. assigned to Resident and 5/12/24 from 7:00 stated she document and 5/12/24 at 9:00 For gabapentin and incomposition of administered due Nurse #3 stated Resignable to sleep when medication gabapent did not relay Resident pain to the physician.  An interview was con 6/13/24 at 12:30 PM. an agency nurse that several months. Nurse assigned to Resident and documented 9 or scheduled 9:00 AM due #6 stated the medical medication cart. Nurse #46 was upset about gabapentin due to ha #6 did not report the pain and did not have An interview was con PM with Nurse #17. worked at the facility 6 weeks. Nurse #17. Resident #46 from 7:5/13/24, 5/14/24, and she looked for the medications were free free free free free free free	ducted with Nurse #3 on Nurse #3 stated she was #46 on 5/10/24, 5/11/24, 20 PM to 7:00 AM. Nurse #3 ed 9 on 5/10/24, 5/11/24, 20 PM for the scheduled doses dicated the medication was to it being unavailable. It dent #46 had pain and was she did not receive the in. Nurse #3 reported she to #46's reports of increased to was had worked at the facility for se #6 stated she was had worked at the facility for se #6 stated she was #46 on 5/12/24 and 5/13/24 in the electronic MAR for the oses of gabapentin. Nurse tion was not available on the se #6 indicated Resident not receiving her scheduled ving increased pain. Nurse resident's concerns about an explanation for why.  ducted on 6/13/24 at 3:47 Nurse #17 stated she through an agency for about stated she was assigned to 900 PM to 7:00 AM shift on 5/15/24. Nurse #17 stated edication on the medication in not see it, she documented	F 6	97		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 697	gabapentin was pres #46 exhibited increas anxiety from not rece #17 did not report Re the physician or adm an explanation for whan explanation for	cribed for pain and Resident red pain, irritability and iving the medication. Nurse sident #46's symptoms to inistration and did not have by.  ducted on 6/13/24 at 3:47 Nurse #16 was assigned to 6/24, 5/14/24 and 5/15/24 AM. Nurse #16 stated she through an agency for about stated 9 on the electronic redication was not available. She documented "9" for rent #46's MAR on 5/13/24, at 9:00 PM for the scheduled Nurse #16 stated cribed for pain and Resident red pain and inability to sleep	F 69		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		MPLETED
		345185	B. WING _			C )7/ <b>02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		7170212024
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F 697	Continued From pag	je 142	F 6	97		
	the medication would increased pain. Nur why she did not report pain from not receiving gabapentin.	erve pain and not receiving d cause the resident to have se #7 was unable to explain ort Resident #46's increased ing the scheduled doses of				
	on 6/13/24 at 8:15 A indicated she was as 5/16/24 from 7:00 Al #2 stated gabapentii Resident #46 on 5/1 resident reported ind #2 stated she did no	M. Unit Manager #2 ssigned to Resident #46 on M to 3:00 PM. Unit Manager n was unavailable for 6/24 at 9:00 AM as ordered, creased pain. Unit Manager thing about Resident #46's g available and did not have				
	6/14/24 at 9:00 AM. problem with running administration was a medication not comi Nurse #5 stated she #46 on 5/17/24 for th Nurse #5 stated she scheduled gabapent did not call the pharm stated Resident #46	nducted with Nurse #5 on Nurse #5 stated there was a g out of medications and ware of the problem with ng in from pharmacy. was assigned to Resident ne 7:00 AM to 7:00 PM shift. did not administer the in on 5/17/24 at 9:00 AM and macy to obtain it. Nurse #5 reported increased pain. the medication was on order, pt to obtain it.				
	#2 on 6/14/24 at 2:2 was the nurse assign 5/17/24 from 7:00 PI stated gabapentin w prescribed dose for	nducted via phone with Nurse 5 PM. Nurse #2 stated she ned to Resident #46 on M to 7:00 AM. Nurse #2 as not available for the Resident #46 on 5/17/24 and d pain. Nurse #2 stated she				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	343103	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CO		07/02/2024	
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PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From page	e 143	F 6	697			
	gabapentin for Reside medications were free was informed by othe not recall which nurse until the medications and there was nothing						
	to Resident #46 on 5/	w Nurse #11, nurse assigned /16/24 7:00 PM to 7:00 AM. n 6/11/24 and 6/12/24 with d.					
	6/13/24 at 9:30 AM. facility frequently had medications. Resident without medications froccasions. Resident state the medication of pharmacy and then it indicated she was far and gabapentin was president #46 stated strouble sleeping, was and unable to get up usual routine during the receive her gabapent was horrible and the shave to wait it out untured. An interview was con Nursing Assistant (NA) NA #1 stated she was	nt #46 stated she had gone or days at a time on several #46 reported staff would was coming from the didn't come in. Resident miliar with her medications prescribed for nerve pain, she had increased pain, anxious, irritable, nauseous out of bed or complete her he time when she did not in. Resident #46 stated it staff told her she would just ill the medication came in.  ducted via phone with A) #1 on 6/27/24 at 4:17 PM. In a familiar with Resident #46. In the world would be set a familiar with Resident #46. In the world staff told her she would just ill the medication came in.					
		ducted via phone with NA #9 Λ. NA #9 stated Resident #					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING _				02/2024	
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	DE	, , ,		
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F 697	Continued From page	e 144	F 6	597				
	normal routine was to wheelchair and attend	a #9 stated Resident #46's get up out of bed to the dactivities daily.						
	#5 on 6/27/24 at 6:44 was aware that sudde could lead to withdraw insomnia, nausea, tre	ducted via phone with Nurse PM. Nurse #5 stated she enly stopping gabapentin wal symptoms including emors and anxiety. Nurse #5 Resident #46 reported could I symptoms.						
	by the Consultant Phamedication error was electronic health recogabapentin was mark in May 2024. The Phameter that she checked found the pharmacy smedication gabapentic Communication was and 5/16/24 that the roughly 5/6/24 and would be please review with st	identified in Resident #46's and. The note indicated and out of stock for 13 doses armacist indicated on the difference of the pharmacy records and sent a 30-day supply of the in on 5/6/24.  Is sent to the facility on 5/11/24 medication was filled on refilled again on 5/30/24.  See was conducted with the st on 6/12/24 at 9:14 AM.						
	receiving gabapentin increased pain, withd tachycardia (a heart relevated heart rate). indicated withdrawal 12 hours and may be	as ordered could cause rawal symptoms, and hythm problem causing The Consultant Pharmacist symptoms may start within						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLEMIER LIVING AND REP			STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	<u> </u>
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
medications we depleted. The Resident #46 of twice per day food DON stated short March and control aware Resider gabapentin. The problems with while and that problem. The would be moniphysician would medication was ordered by stated nursing understanding a medication with the fax material affected comments with the fax material area affected comments. An interview were done of gabap day was a high recommended medication due.	tion cart were expected to reorder ithin 5-7 days of the supply being DON stated she was aware did not receive Gabapentin 800 mg from 5/10/24 through 5/17/24. The started at the facility at the end did not recall when she became at #46 did not receive the ordered The DON stated there had been the fax machines in the facility for a may have contributed to the DON expected that resident's pain tored and addressed, and the did be notified if a prescribed pain is unavailable.  as conducted with the on 6/14/24 at 4:10 PM. The stated she expected that pain ould be available and administered the physician. The Administrator staff did not have a comprehensive of what to do when they identified was not available for administration. After stated there were problems archines in the facility and that had nunication between the facility and	F 69	7	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	0	7/02/2024	
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F 697	not right to withhold and it had the potent Physician revealed I having increased pain daily activities was receiving the schedugabapentin. She stathe facility to obtain the administered as of the Administrator was Jeopardy on 6/13/24. The facility provided Jeopardy removal plus Identify those recipies are likely to suffer, as a result of the noncomplete the facility failed to (Resident #51 and Incomplete the facility failed to (Resident #51 and Incomplete facility failed to (Resident #51 complete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete facility failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a result of the noncomplete failed to not administering a resul	cian further indicated it was medication from a resident cial for adverse outcome. The Resident # 46 not feeling well, in being unable to participate a direct result of not alled pain medication ted it was the responsibility of the medications so they could ordered.  The sent of the medication so they could ordered.  The following Immediate at 2:15 PM.  The following Immediate an:  The sent of the whole suffered, or serious adverse outcome as mpliance:	F 69	97			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		702/2024		
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F 697	Continued From pag		F 6	97				
	Resident #51 receive facility failed to mana not administering a to	ested to go to the ER. ed gabapentin in the ER. The age Resident #51's pain by otal of 21 doses of 05/08/2024 and 05/13/2024.						
	pain by not administe gabapentin 800 mg 2 dates of 05/10/2024 Resident #46 had a p during the time the fa	ering a routine order of 2 times a day between the -05/17/2024 (Resident #46). Doain level of 8 or 9 constantly acility failed to manage her						
	pain medication which made it hard to sleep of irritability, being ar #46 had not felt well	omplained of not receiving ch caused her more pain and o. Resident #46 complained nxious, and nausea. Resident and had not been able to get ate in activities and perform o pain in her legs.						
	by not administering	manage Resident #46's pain a total of 14 doses of 05/10/2024 and 05/17/2024.						
	that all residents hav adverse and/or serio the deficient practice Minimum Data Set (Managers (UMs) will assessments on all r unmet pain needs/ch intact residents will b cognitively impaired for signs or symptom completed by 06/15/2 concerns identified, t	birector of Nursing identified e the potential to experience us outcomes as a result of . The Director of Nursing, MDS) Coordinator, and Unit begin completing pain esidents to identify any sange in pain. Cognitively e interviewed, and residents will be assessed as of pain. This will be 2024. If there are any he concerns will be reported ediately to ensure the facility						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	NTER		106 CAME	DDRESS, CITY, STATE, ZIP CODE ERON STREET ACCAMAW, NC 28450	1 017	02/2024	
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F 697	Continued From page	e 148	F	697				
	process or system fa adverse outcome from and when the action. The Director of Nursi (UMs) will begin in per 06/14/2024 with all numbers will include all needed, and agency on the importance of per the physician's or pain management to pain, if the resident's physician must be call and if the medication call the physician to gavailable per physician medication aides will they have received the Nursing will be responsible for confuse assigning the UM to a language of the system of the sys	ng and Unit Managers erson education on urses and medication aides full-time, part-time, as staff. This education will be providing pain medications ders, ensuring appropriate control the resident's level of pain is not controlled the lled for further treatment, is not available, they must get alternate treatment that is an's orders. No nurses or work after 06/14/2024 until he education. The Director of nsible for keeping up with dication aides who have and ted. The Director of Nursing hpleting the education or complete the education for						
	aides which will inclu needed, and agency symptoms of pain to aides beginning immo nurse aide will work a has been received. T	ation begin for all nurse de all full-time, part-time, as staff on reporting signs and nurses and/or medication ediately on 06/14/2024. No at the facility until education he Director of Nursing will eping up with those nurse						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	I	07/02/2024	
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F 697	The Director of Nursin completing the educate complete the education been educated by 06 notified of their responsibility of the Director of Nursing with the completed by Director of Nursing with the physician order, et acility staff to include MDS Coordinator and pain assessment audany unmet pain or chimpaired residents with the educated of the pain or chimpaired residents were successful to the educated of the pain of the physician order, et acility staff to include MDS Coordinator and pain assessment audany unmet pain or chimpaired residents were possible to the edicate the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the edicate the pain or chimpaired residents were provided to the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the pain or chimpaired residents were provided to the education of the provided to the education of the pain or chimpaired residents were provided to the education of the provided to the education of the pain or chimpaired residents were provided to the education of the provided to the edu	nave not been educated. Ing is responsible for attion or assigning the UM to on for any staff who has not /14/2024. The UMs were insibility on 06/14/2024 by ing.  Is, medication aides, and and atted as noted above. This interest of Nursing. The ill be responsible for keeping on have and have not been for of Nursing is responsible ucation with new hires. The as notified of this 4/2024 by the Administrator.  In the Immediate Jeopardy was in the Immediate Jeopardy was in A sample of staff including it Manager, Nurses, in Nursing Assistants were in in-services they received in practice. All staff by had been in-serviced ain medications according to ensuring pain management	F6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 712 SS=D	complained of new parand/or symptoms of reshould be completed, be notified for any nestaff stated if there we medications available the emergency medication was available they were to notify the date of 6/16/24 was were	aff stated if a resident ain or was showing signs new pain, a pain assessment and the physician should w interventions. Nursing ere no ordered pain e, they would need to check cation system to see if the able and if not available, e provider. The removal ralidated. uency/Timeliness/Alt NPP		712		7/27/24	
	physician at least one 90 days after admissi 60 thereafter.  §483.30(c)(2) A phys timely if it occurs not date the visit was required.  §483.30(c)(3) Except (c)(4) and (f) of this size wisits must be made at the size wisits must be made at the size wisits in SNF alternate between perior and visits by a physic practitioner or clinical accordance with para	sidents must be seen by a see every 30 days for the first ion, and at least once every ician visit is considered later than 10 days after the uired.  as provided in paragraphs ection, all required physician by the physician personally.  option of the physician, is, after the initial visit, may resonal visits by the physician iian assistant, nurse					
	Based on record rev	iew and staff interviews, the e a physician visit occurred		The facility failed to ensure a phy visit occurred for a resident within			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING_			С	
		345165	B. WING_			<u> </u>	07/02/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRFMIFR	LIVING AND REHAB	CENTER		1	06 CAMERON STREET		
				L	AKE WACCAMAW, NC 28450		
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F 712	Continued From pa	ge 151	F 7	712			
		n 30 days from admission for 1 ents reviewed for physician l8).			from admission for 1 of 8 sampled residents reviewed for physician visits (Residents #48).		
	Findings included:				Resident #48 received a medication regimen review by the Primary Care		
		admitted to the facility on			Provider who was the facility's Medical		
		noses included congestive			Director on 5/7/2024. Resident #48 wa		
	heart failure, dementia, depression, anxiety, pain,				seen on 5/14/2024 by the facility Nurse	Э	
	seizures, hallucinat	ions, and edema.			Practitioner (NP). Resident #48 is on		
	The second and a Mineira	D-t- O-t (MDO) d-t- d			hospice services and received a hospi	ce	
	' '	num Data Set (MDS) dated Resident #48 had moderate			comprehensive assessment on		
	cognitive impairmen				6/20/2024. Resident #48 was seen on 6/21/2024 by the current facility Nurse		
	cognitive impairmen	111.			Practitioner (NP). Resident will be see		
	Review of Resident	t #48's Electronic Medical			the current Primary Care Provider who	-	
		ealed she was not seen by the			the facility's Medical Director on 8/6/20		
					All residents residing in the facility hav	е	
	Review of Resident	t #48's EMR revealed she was			been identified as having the potential	to	
	seen by Nurse Prac	ctitioner (NP) on 05/14/24.			be affected by the alleged deficient practice.		
	An interview was co	onducted on 06/14/24 at 11:15					
		strator. She stated their past			The Licensed Nursing Home		
		ID) was not personally visiting			Administrator (LNHA) who became the	<b>;</b>	
	-	n as he should have. The			LNHA at the facility in February 2024,		
		tated reason for switching MD			recognized that the physician who was		
	1	r that reason, MD was not			appointed as the active Medical Direct		
	visiting on site as o	ften as needed.			for the facility in November 2023 was t		
					active primary care physician (PCP) fo		
		onducted on 06/14/24 at 3:45			the facility. The LNHA identified that the		
		or of Nursing (DON). She			active Medical Director who was also t	пe	
		Medical Director (MD) was illity as often as he should			PCP was not visiting residents as expected per the regulations and the		
		vealed Resident #48 was			expected per the regulations and the expectation of quality of care was not		
		24 and had only been seen by			being met.		
		but never personally by her			Joing Met.		
	attending physician				The LNHA recognized that the PCP was not communicating with the Director of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345185	B. WING		C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 712	Continued From pag	e 152	F 71	Nursing (DON) or other contractual providers who provide medical service the facility such as the mental health providers and consultant pharmacist necessary.  The LNHA recognized the need for continuous effective and efficient quacare for all residents. The LNHA submitted a 30-day written termination notice on May 7th, 2024, to the medigroup that the active Medical Director was also the PCP was contracted with The active Medical Director who was the PCP and all other medical providiand medical services obtained from facility as of June 7th, 2024, with adherence to the 30-day written termination notice that the LNHA initiper the agreed contract that was sign prior to the LNHA taking over the LNH position at the facility in February 202.  The LNHA initiated contact with a difference also included services from would also serve as the PCP. The contract also included services from medical providers such as a Nurse Practitioner to visit the facility and meservices to be utilized in the facility. The services offered under the contract consist of but are not limited to telemedicine sessions, visits to the faciliminum of three times a week on which includes a visit the PCP who is under active Medical Directorship, ar hours/7 days a week/365 days a year.	when  dity of  an cal r who ch. also ers he the ated aed HA 24.  derent ct who other edical che acility e of s also ad 24		

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245405	B. WING			С	
		345185	B. WING_			07/0	02/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRFMIFR	LIVING AND REHAB CE	NTFR		10	06 CAMERON STREET		
				L	AKE WACCAMAW, NC 28450		
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F 712	Continued From page	e 153	F	712	an on-call provider. This contract begand on June 7th, 2024.  The LNHA or Designee will educate the newly contracted PCP who is also under active Medical Directorship for the faciliand the assigned facility Nurse Practitioner by 8/5/2024 on the regulation regarding timely resident visits upon admission. After 8/5/2024 if there are an newly hired Medical Directors, PCPs, on Nurse Practitioners they will be educated by the LNHA or Designee upon their himals. Beginning 7/27/2024, the LNHA, DON, Designee will audit all new admissions 12 months to verify that the PCP has visited each new resident in a timely manner. Any new admission identified not being seen by the PCP within the required timeframe will be communicated to the PCP. The expectation is that the PCP visits the resident within 24 hours being notified to correct the action and ensure compliance. If the PCP does not see a new admission within the required timeframe it will result in re-education with appropriate medical provider and we communicated to the medical group that the PCP is contracted under, and disciplinary action will be taken if necessary.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hom Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI)	e er ity on ny red re. or for as ed of with ill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345185	B. WING _			07/	02/2024
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	LIVING AND REHAB CE	NTER		10	06 CAMERON STREET		
				L/	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 712 F 726 SS=E	Continued From page  Competent Nursing S  CFR(s): 483.35(a)(3)  §483.35 Nursing Serv.	Staff (4)(c) vices		712	Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustaine. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and to audits will continue for the specified timeframe as described in this correctivaction.	to d. the he	7/27/24
	The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).						
	licensed nurses have and skill sets necessareds, as identified the assessments, and de §483.35(a)(4) Providi limited to assessing, of	cility must ensure that the specific competencies ary to care for residents' nrough resident escribed in the plan of care.  In g care includes but is not evaluating, planning and at care plans and responding					
	§483.35(c) Proficience	ey of nurse aides.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			07/02/2024	
NAME OF P	ROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STATE, ZIP COL	DE I	0110212024	
PREMIER	LIVING AND REHAB CE	NTER		106 CAMERON STREET LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	Continued From page	e 155	F 7	726			
F 720	The facility must ensite to demonstrate complete to demonstrate to demonstrate to demonstrate the proof of the pharmacy form the pharmacy procedure. Findings included:  1a. Resident #51 was Review of Resident # revealed an 11/21/23 milligrams (mg) 4 times. The May 2024 MAR gabapentin was not a 5/8/24 through 5/13/2 being obtained from the pharmacy form the pharmacy procedures. The may 2024 MAR gabapentin was not a 5/8/24 through 5/13/2 being obtained from the pharmacy form the phar	ure that nurse aides are able setency in skills and y to care for residents' hrough resident escribed in the plan of care. is not met as evidenced siew and staff interview, the e staff were trained and cess to obtain medications or 10 of 10 staff (Nurse #8, Nurse #6, Nurse #17, Nurse Manager #1, Unit Manager of Nursing) reviewed for so for obtaining medications.		The facility failed to ensure strained and competent in the obtain medications from the properties of 10 of 10 staff (Nurse #8, Nurse #3, Nurse #6, Nurse #17, Nurse #7, Unit Manager #1, Warrend #2, and the Director of Nursing for pharmacy procedures for medications).  All residents residing in the fabeen identified as having the beaffected by the alleged depractice.  The Director of Nursing (DON Designee, will review all nurse competencies to ensure they date by 8/5/2024.  The DON or Designee will ensure they date by 8/5/2024 on policy/procedure for obtaining from the pharmacy. After 8/5, hired staff will be educated by Designee during their new his orientation.	process to obarmacy for se #9, Nurse rse #16, Unit Manager ng) reviewed obtaining acility have potential to ficient  N) or se are up to ducate all the g medications /2024 newly y the DON or		
	nurses, although she	did not recall which nurses, as not available, they just		Beginning 7/27/2024, the DC Designee will audit nurse cor ensure all education is given Any missing competencies w	npetencies to annually.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY PLETED
		345185	B. WING		C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		702/2027
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	#9 on 6/13/24 at 2:15 assigned to Resident Nurse #9 stated she medication for Reside process for obtaining  An interview was con on 6/13/24 at 8:00 AN revealed she was ass 5/11/24. Unit Manage about the requiremer  An interview was con #2 on 6/14/24 at 2:24 was an agency nurse assigned to Resident Nurse #2 stated she nurses, although she nurses, that they just medications came in there was nothing the medications not being indicated she was no the facility for orderin medications.  1b. Resident #46 was Review of Resident #4 was revealed a 12/6/23 or milligrams (mg) 2 tim Resident #46's May 2 Administration Recorgabapentin was not as	ducted via phone with Nurse  PM. Nurse #9 was #51 on 5/9/24 and 5/10/24. did not attempt to obtain ent #51 and did not know the gabapentin.  ducted with Unit Manager #1 M. Unit Manager #1 signed to Resident #51 on er #1stated she was unclear ets for reordering gabapentin.  ducted via phone with Nurse PM. Nurse #2 stated she e at the facility and was #51 on 5/11/24 into 5/12/24. had been told by other was not able to recall which had to wait until the from the pharmacy and et could be done about the gavailable. Nurse #2 t familiar with the process at g and reordering  s admitted on 12/6/23.  4 46's physician orders der for gabapentin 800 es per day for nerve pain.  2024 Medication d (MAR) indicated idministered as ordered from /24 due to the medication	F 726	re-education and additional trait appropriate nursing staff.  Beginning 7/27/2024, the audit reviewed by the Licensed Nurs Administrator (LNHA) or DON, results of the audits will be reviewed by the audits will be reviewed by the audits will be reviewed by the audits will provide the reviewed by the audits and Performance Improvement (QA Meeting monthly for 3 months. Committee will review the audit make recommendations as new assure ongoing compliance is a The facility will utilize this plan correction to ensure compliance mandated regulation by 8/6/202 audits will continue for the specifimeframe as described in this action.	s will be sing Home and the ewed in the d API) The QAPI ts and cessary to sustained. of ee under the 24 and the cified	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		07/02/2024		
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	· · · · · ·	3110212024	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 726	#3 on 6/13/24 at 1:4 was assigned to Res 5/11/24, and 5/12/24 unaware of the proc and she did not inque. An interview was co 6/13/24 at 12:30 PM an agency nurse that several months. She on 5/11/24, 5/12/24, stated she was not a obtaining a medicati. An interview was co at 3:47 PM with Nurshe worked at the fa about 6 weeks. Nur assigned to Resider and 5/15/24. Nurse the process for obtainessidents.  An interview was co at 3:47 PM with Nurse the process for obtain residents.  An interview was co at 3:47 PM with Nurse assigned to Resider to Reside	ge 157 Inducted via phone with Nurse 5 PM. Nurse #3 stated she sident #46 on 5/10/24, If Nurse #3 stated she was less to obtain the medication wire about how to obtain it.  Inducted with Nurse #6 on If Nurse #6 stated she was less thad worked at the facility for exercise worked with Resident #46 and 5/13/24. Nurse #6 aware of the process for on that was not available.  Inducted via phone on 6/13/24 are #17. Nurse #17 stated incility through an agency for se # 17 stated she was lat #46 on 5/13/24, 5/14/24, #17 stated was not aware of ining medications for Inducted via phone on 6/13/24 are #16. Nurse #16 was lat #46 on 5/13/24, 5/14/24 are #16 stated she worked at the	F 72	,			
	Nurse #16 stated sh process to obtain m An interview was co 6/13/24 at 11:30 AM an agency nurse at Nurse #7 was assig	nducted with Nurse #7 on  Nurse #7 revealed she was the facility since March. ned to Resident #46 on  Nurse #7 stated she was ess for obtaining a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			106	REET ADDRESS, CITY, STATE, ZIP CODE CAMERON STREET KE WACCAMAW, NC 28450	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page An interview was con	e 158 ducted with Nurse #5 on	F7	726			
	6/14/24 at 9:00 AM. know the process for did not know if a writte was needed to reorde	Nurse #5 stated she did not obtaining gabapentin and en or electric prescription er gabapentin. Nurse #5 ned to Resident #46 on					
	#2 on 6/14/24 at 2:25 was the nurse assign 5/17/24. She indicate	ducted via phone with Nurse PM. Nurse #2 stated she ed to Resident #46 on d she did not know the and reordering medications.					
	on 6/13/24 at 8:00 AM she was in the role of weeks. Unit Manage gabapentin required a	r #1 stated she thought a written or electronic lled but it had been a while					
	on 6/13/24 at 8:15 AN she thought a written	ducted with Unit Manager #2 M. Unit Manager #2 stated or electronic prescription n a refill of gabapentin, but					
	Nursing (DON) on 6/1 indicated there was c requirements to order	ducted with the Director of 12/24 at 2:00 PM. The DON onfusion regarding the rand reorder gabapentin rstand the requirements					
		ducted with the d/24 at 4:10 PM. She stated have a comprehensive					

NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CONTROL OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	2/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
	(X5) COMPLETION DATE
F 726 Continued From page 159 understanding of what to do when they identified a medication was not available for administration. F 727 RN 8 Hrs/7 days/Wk, Full Time DON F 728 SS=E CFR(s): 483.35(b) (Registered nurse §483.35(b) (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily cocupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 17 of 130 days reviewed for sufficient staffing (218/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/31/2024, 3/	7/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345185	B. WING _	B. WING		07/02	2/2024
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DDEMIED	LIVING AND DELIAD CE	NTED		106 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	NIEK		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  CIENCY MUST BE PRECEDED BY FULL  YOR LSC IDENTIFYING INFORMATION)  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			_	(X5) COMPLETION DATE	
F 727	27 Continued From page 160		F 7	27			
	A review of the daily census posting sheets for the months of February 2024 to June 9, 2024, reported a constant census greater than 60 residents in the facility and no RN coverage for eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024.  A review of the daily nursing staffing sheets for the months of February 2024 to June 9, 2024, indicated there was no RN scheduled for at least eight consecutive hours for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024,			Nursing (DON) had already prior to the cited deficiency that there has been a trend failure for the facility not ha Registered Nurse (RN) sch least eight consecutive hou seven days a week; specific on weekends for a minimur when investigating this ider.  The LNHA and DON also ide to the cited deficiency being there has been a trending particular for current and previous taying clocked into the for at least eight consecutive working as the dedicated Refore example, 7.62 continued.	Administrator (LNHA) and Director of Nursing (DON) had already determined prior to the cited deficiency being given that there has been a trending pattern of failure for the facility not having a Registered Nurse (RN) scheduled for at least eight consecutive hours per day seven days a week; specifically trending on weekends for a minimum of two years when investigating this identified issue.  The LNHA and DON also identified prior to the cited deficiency being given that there has been a trending pattern of failure for current and previous hired RNs not staying clocked into the work system for at least eight consecutive hours when working as the dedicated RN coverage.		
	There was no RN recorded as working eight consecutive hours on the timecard records reviewed for the following dates: 2/18/2024, 3/10/2024, 3/12/2024, 3/16/2024, 3/17/2024, 3/23/2024, 3/24/2024, 3/30/2024, 3/31/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 5/4/2024, 5/5/2024, 6/8/2024 and 6/9/2024.  In a phone interview with Unit Manager #2 on 6/19/2024 at 11:57 am, she explained she had been responsible for the schedule since April 30, 2024 and knew there was to be a RN scheduled daily for eight consecutive hours. She explained she tried to ensure a RN was scheduled for at least eight hours a day and would call staff to attempt to cover the days when a RN was not scheduled. She stated when she was unable to schedule an RN for eight consecutive hours for a			worked, or 7.98 continuous hours worked.  The LNHA and DON are continuing to actively search for RNs to work at the facility and are proceeding with hiring RNs for the facility to ensure compliance. Since the survey, 2 RNs have been hired. The facility is attempting to continue the ongoing seeking of RNs to hire additional staff to ensure compliance with the staffing regulation. The LNHA and DON have hired a Minimum Data Set (MDS) RN, Staff Development Coordinator (RN), and agency RNs to assist in ensuring compliance. The LNHA, DON, Staff Development Coordinator (RN), and Human Resources Coordinator continue to utilize newspaper ads, fliers, job fairs, local community college nursing program			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING _			07	/02/2024	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
DDEMED	LIVING AND DELLAD OF	-NTED		10	6 CAMERON STREET			
PREMIER	LIVING AND REHAB C	ENTER		L/	AKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 727	7 Continued From page 161		F 7	727				
	day, the Director of N	lursing (DON) and			engagement to recruit RN staff to ensu	re		
		nformed, and the unit			compliance is achieved.			
	managers (who were	e not RNs) covered shifts if			•			
	needed.	· ·			The DON, RN Nursing Supervisor, and			
					Unit Manager who assist with nursing			
	In a phone interview	with the DON on 6/19/2024			scheduling are aware of the requireme	nt		
	at 10:22 am, she sta	ted when she started at the			for RN coverage at least eight			
		there was not a sufficient			consecutive hours per day seven days	а		
	number of registered nurses on the schedule to				week. The facility will attempt to sched	ule		
	cover the required eight consecutive hours per				RN staff accordingly to ensure the			
	day of RN coverage. She said due to the census				deficient practice does not recur.			
	_	lents consistently, she was						
		the RN coverage and there			The LNHA or Designee will educate the			
		aily when not in the facility.			DON, RN Nursing Supervisor, and Unit			
		nistrative team was aware of			Manager by 8/5/2024 on the regulation			
		age for the eight consecutive			related to the requirement for RN	uro		
	_	due to not having a Minimum se in the facility and RN not			coverage at least eight consecutive ho	uis		
	, ,	ekends. She explained the			per day seven days a week.			
		e problem and had worked			The DON or Designee will educate all			
		nurses and had been using			RNs that work at the facility by 8/5/202	4		
	agency RN staff.	idises and flad been asing			on the regulation related to the	•		
	agonoy ravolan.				requirement for RN coverage at least			
	In a phone interview	with the Administrator on			eight consecutive hours per day seven			
		m, she explained the daily			days a week to ensure the RNs are			
		s ultimately the DON			staying clocked in for the eight			
		ire there was a RN that			consecutive hours during their shifts. A	fter		
	•	utive hours daily in the facility			8/5/2024 newly hired RNs will be			
	_	ruary when she started at			educated by the DON or Designee duri	ing		
		aware there was an issue			their new hire employee orientation.	-		
	-	eight consecutive hours daily			-			
	in the facility. She ful	ther explained the			The LNHA or Designee will educate the	9		
	resignation of MDS N	Nurses and the DON's			DON, RN Nursing Supervisor, and Unit	t		
	inability to serve as t	he RN coverage due to a			Manager by 8/5/2024 on the			
		s greater than 60 residents			communication of all RN staffing			
		s inability to provide RN			needs/challenges, RN vacant positions	, or		
	•	onsecutive hours daily. The			additional coverage needs being			
		she hired a MDS Nurse,			communicated to the LNHA as necessar	ary.		
	registered nurses and agency registered nurses				After 8/5/2024 newly hired staff will be			

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING			С		
NAME OF D	ROVIDER OR SUPPLIER	343103	1		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	02/2024	
NAIVIE OF FI	NOVIDER OR SUFFLIER				06 CAMERON STREET			
PREMIER LIVING AND REHAB CENTER		NTER			AKE WACCAMAW, NC 28450			
		ATEMENT OF DEFICIENCIES			· T		0.47)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE		
F 727	F 727 Continued From page 162		F	727				
	to help cover the RN for eight consecutive hours issue and continued to use newspaper ads, fliers and job fairs to recruit RN staff due to				educated by the LNHA, DON or Design during their new hire employee orientation.	ee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _	B. WING		C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		100	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMERON STREET AKE WACCAMAW, NC 28450	<u>,                                    </u>	02/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 727	7 Continued From page 163		F 7	730	hours and did not fulfill this requirement it will result in re-education and additional training for the appropriate nursing staff.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Home Administrator (LNHA) or DON, and the results of the audits will be reviewed in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAPI Committee will review the audits and make recommendations as necessary to assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under the mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.		7/27/24
SS=D	CFR(s): 483.35(d)(7) §483.35(d)(7) Regular The facility must come of every nurse aide at months, and must proceducation based on the reviews. In-service the requirements of §483 This REQUIREMENT by: Based on record revifacility failed to complete every 12 months for 10 (NAs) reviewed to addressed and the reviews designed and the reviews designed to addressed and the reviews designed and the r	ovide regular in-service ne outcome of these aining must comply with the		30	The facility failed to complete a performance review every 12 months for 5 nursing assistants (NAs) reviewed ensure in-service education was design to address the outcome of the performance reviews (Medication Aide	to	1121124

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		(X3) DATE SURVEY COMPLETED	
245195	B WING		С	
345165			07/02/2024	
CENTER	1	106 CAMERON STREET		
		LAKE WACCAMAW, NC 28450		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETION	
age 164	F 730	#5).		
e of hire of 11/8/2019. The dedication Aide #5 did not performance review had been to Medication Aide #5's date of was conducted on 7/1/2024 at cation Aide #5. During the con Aide #5 stated her annual ation was due in November received a performance st year.  Was conducted on 6/19/24 at Director of Nursing (DON). We, the DON stated since ty in March 2024, she had not mance review for Medication did not provide a reason as to conducted an annual of the for Medication Aide #5.  Was conducted on 6/19/24 at Administrator who stated the ble for conducting the annual of for Medication Aide #5 and ON had not conducted the		The Director of Nursing (DON), Staff Development Coordinator Registered Nurse (RN), or Designee will review education that has been provided to nurse aides from, January 2024, unticurrent by 8/5/2024 to ensure ongoin education is being provided. The Lick Nursing Home Administrator (LNHA) DON have determined that there has been a trending pattern of failure for facility not having a full-time Staff Development Coordinator Registered Nurse (RN) for at minimum of one year when investigating this identified issued However, the LNHA has hired a full-staff Development Coordinator RN.  The LNHA, DON, or Designee will educate the Staff Development Coordinator RN.  The LNHA, DON, or Designee will educate the Staff Development Coordinator RN.  The LNHA is provided at the facility will educate on assisting in the formation and completion of an annual educatic calendar that will be available for all as of 8/5/2024. After 8/5/2024 newly staff will be educated by the DON or Designee during their new hire emploorientation.  Beginning 7/27/2024, the LNHA, DOD Designee will audit employee educating records monthly for 12 months to enongoing education is being complete on ongoing education is being complete.	d the the the the il and sensed and sensed and sensed and sensed and sensed and sense decrease.	
	IDENTIFICATION NUMBER:  345185  CENTER  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	A BUILDING  345185  B. WING  CENTER  STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)  Age 164  F 730  TAG  TAG  TAG  F 730  TAG  TAG  F 730  TAG  TAG  TAG  TAG  TAG  TAG  TAG  TA	The Director of Nursing (DON), Staff Development Coordinator Registered Nurse (RN), or Designee will educate the Stated her annual ation was due in November eceived a performance st year.  Was conducted on 6/19/24 at Director of Nursing (DON), w, the DON stated since ty in March 2024, she had not mance review for Medication did eff. awas conducted an annual w for Medication Aide #5.  Was conducted on 6/19/24 at Administrator who stated the bib for or onducting the annual w for Medication Aide #5 and ON had not conducted the	

		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>		
	ROVIDER OR SUPPLIER			s <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE D6 CAMERON STREET AKE WACCAMAW, NC 28450	<u>  0770</u>	02/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755 SS=K	S483.45 Pharmacy S The facility must prov drugs and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accur- dispensing, and admi	cedures/Pharmacist/Records (1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed		730	appropriate staff member. If there are a newly hired nursing staff to begin working at the facility they will also be audited.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hom Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	ne the PI to d. the he	7/27/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 50.25.	_	<del></del>	С	
		345185	B. WING			07/02/2024	
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	017	02/2024
					06 CAMERON STREET		
PREMIER LIVING AND REHAB CENTER		NTER			AKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 755	Continued From page	e 166	F ·	755			
		onsultation. The facility					
		n the services of a licensed					
	pharmacist who-						
	•						
	§483.45(b)(1) Provide						
		on of pharmacy services in					
	the facility.						
	\$492 45(b)(2) Establi	shes a system of records of					
		n of all controlled drugs in					
	sufficient detail to ena	•					
	reconciliation; and						
		nines that drug records are in					
		ount of all controlled drugs					
	is maintained and per	•					
		is not met as evidenced					
	by: Based on record revi	iew staff resident			The facility failed to ensure scheduled		
	Consultant Pharmacis				medication was obtained and available	for	
		, and Physician interview,			administration for 3 of 10 residents		
		sure scheduled medication			(Resident #51, Resident #46, and		
	was obtained and ava	ailable for administration for			Resident #8) reviewed for medications.		
		sident #51, Resident #46,					
	,	ewed for medications.			All residents residing in the facility have		
		escribed gabapentin 800			been identified as having the potential	io l	
	milligrams (mg) four t The medication was r	imes daily for nerve pain.			be affected by the alleged deficient		
		ent #51 missed a total of 21			practice.		
	T	on from 5/8/24 through			Resident #51 was prescribed gabapen	tin	
	5/13/24. Resident #5				800 milligrams (mg) four times daily for		
		10 (on a scale of 0 to 10			nerve pain. The medication was not		
	with the 10 being the	•			obtained from the pharmacy and Resid	ent	
		, and spasms. She was			#51 missed a total of 21 doses of the		
		ergency Department (ED)			medication from 5/8/2024 through		
		dle of the night after missing			5/13/2024. Resident #51 had complain		
		cation. She was treated for			of constant pain up to a 10 (on a scale		
		pentin and returned to the			0 to 10 with the 10 being the worst pair	1	
	tacility the same day.	Resident #51 missed 3			possible), numbness in her legs, and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES				Ol	OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024	
NAME OF P	ROVIDER OR SUPPLIER		<del> </del>	STREET ADDRESS, CITY, STATE, ZIP COD	<b>_</b>	0110212024	
				106 CAMERON STREET	_		
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450			
				LARE WACCAWAW, NC 20450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	e 167	F 7	55			
	more doses of gabap		' '	spasms. She was transferred	to the		
		at evening for worsening		Emergency Department (ED)			
		was again treated for acute		5/12/2024 in the middle of the			
	-	and returned to the facility		missing 14 doses of the medi			
		I to miss 4 more doses of		was treated for acute pain wit		in I	
		o the facility obtaining the		and returned to the facility the	• .		
	_ ·	istration. Resident #46 was		Resident #51 missed 3 more	•		
		n 800 mg two times daily for		gabapentin on 5/12/2024 and			
		cation was not obtained		the ED that evening for worse			
	-	nd Resident #46 missed 14		spasms. She was again treate			
		on from 5/10/24 through		pain with gabapentin and retu			
		ouble sleeping, anxiety,		facility where she proceeded			
		d being unable to complete		more doses of the medication			
	her normal routine du			facility obtaining the medication	•		
	Additionally, Residen			administration. Her medication		1	
	Oxycodone/Acetamin	ophen (opioid medication)		prescription to be faxed to the	pharmacy.		
	10/325 mg and this m	nedication was not obtained		A note was left for the provide	r on 5/11		
	from the pharmacy re	sulting in multiple missed		requesting a prescription to be	e signed.		
	doses of the medicati	on.		Resident #51 requested this r	nedication		
				and was told by he nurse that	they were		
	Immediate Jeopardy			waiting for the prescription to	•	у	
		ne facility failed to obtain the		the provider, and she verbaliz			
	ordered medication g	•		understanding of this process			
		a reported pain scale of 10		#51 requested to be sent bac			
	_	Jeopardy began on 5/12/24		ED on 5/12 and returned to the	,		
		n the facility failed to obtain		approximately 4 hours later. S		i	
		on gabapentin from the		the prescription would be sign			
	, ,	increased pain and difficulty		Monday (5/13) and would be		•	
	. •	Jeopardy was removed on		pharmacy to be filled. On 5/13			
	6/16/24 when the faci			#51 requested to be sent bac			
		mediate Jeopardy removal.		and stated she would keep re	. •		
	•	ut of compliance at a lower		go out to the ED until her pres			
		"E" (no harm with the		filled. She returned to the faci			
	I -	n minimal harm that is not		with a prescription sent to the	pnarmacy		
		to ensure education is		from the ED doctor.			
		oring systems put in place		Decident #40 was pressilled	aaba===+!		
		e #3 was cited at scope and		Resident #46 was prescribed			
	severity "E".			800 mg two times daily for ne	rve pain.	[	

The medication was not obtained from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NI IMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
						С		
	DOLUBER OF CLIEBULES	345165	D. WING _		•	07/02/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
PREMIER	LIVING AND REHAB CE	NTER		106 CAMERON STREET				
			LAKE WACCAMAW, NC 28450					
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 755	Continued From page	e 168	F 7	55				
	Findings included:			pharmacy and Resident #46	missed 14			
	T mam go moladod.			doses of the medication fron				
	1. Resident #51 was	admitted on 10/19/23 with		through 5/17/2024 resulting	in trouble			
	diagnosis which inclu	ıded in part: chronic pain		sleeping, anxiety, irritability,	nausea, and			
	syndrome, chronic ba	ack pain, rheumatoid		being unable to complete he	er normal			
		ers, and spastic paraplegia		routine due to pain in her leg				
	(a disorder that causes progressive weakness,			has scheduled pain assessn				
	stiffness, tightness, pain and muscle spasms of			completed by the nurses to				
	the lower extremities	).		pain is now being managed	effectively.			
	Review of Resident #	‡51's physician orders		Additionally, Resident #8 wa	s prescribed			
		order for gabapentin 800		Oxycodone/Acetaminophen	(opioid			
	milligrams (mg) 4 tim	es per day for nerve pain.		medication) 10/325 mg, and	this			
				medication was not obtained				
		\$51's quarterly Minimum		pharmacy resulting in multip				
	` ,	d 4/4/24 indicated resident		doses of the medication. On				
		t and exhibited no behaviors.		3/27, the NP notes indicated				
		nt was coded as received		resident had no complaints of	•			
	pain interview was no	eded pain medication. The		DON has scheduled pain as be completed by the nurses				
				pain is being managed effect				
	1 -	ds indicated a supply of 120			5/0/0004			
		oills was sent to the facility for		Immediate Jeopardy began				
		5/24. The pharmacy record		for Resident #51 when the fa				
		ntin pills from the 4/25/24 \$51 were returned to the		from the pharmacy resulting				
		dent #51 was in the hospital		pain scale of 10 out of 10. In				
	from 5/5/24 through 8	•		Jeopardy began on 5/12/202				
	nom ororz r unough c	5/0/21.		Resident #46 when the facili				
	The hospital dischard	ge summary dated 5/8/24		obtain the ordered medication				
		51 was hospitalized from		from the pharmacy resulting				
		orning of 5/8/24. The		pain and difficulty sleeping.				
		e order for gabapentin for						
	I .	changed when she was		Upon identification of the se				
	discharged on 5/8/24	l.		alleged deficient practices, the				
				Nursing Home Administrator				
		ote written by Nurse #8 on		wrote the Immediate Jeopar	•			
	5/8/24 at 4:22 PM rev			Plan and submitted the Rem				
returned to the facility from the hospital on 5/8/24			approval. The Immediate Je	opardy was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345185	B. WING _			0	7/02/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	LIVING AND REHAB CE	INTED		10	06 CAMERON STREET		
PREWIER	LIVING AND REHAD CE	ENTER		L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG			(X5) COMPLETION DATE				
F 755	Continued From pag	e 169	F 7	755			
F 755	Tontinued From page 169 at 2:40 PM.  Resident #51's May 2024 Medication Administration Record (MAR) indicated there was no routine pain monitoring.  The May 2024 MAR indicated Resident #51's gabapentin was scheduled to be administered at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM and specified the documentation of a "9" indicated to see the nursing notes. This MAR and the medication administration notes revealed the following related to Resident #51's gabapentin:  5/8/24  The MAR for 5:00 PM indicated Nurse #8 documented a "9" and the corresponding administration record note at 5:23 PM indicated the facility was awaiting the arrival of gabapentin 800 mg from the pharmacy.  The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note.  5/9/24  The MAR for 9:00 AM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.  The MAR for 12:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.  The MAR for 5:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.  The MAR for 9:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.  The MAR for 9:00 PM indicated Nurse #9 documented a "9" and there was no corresponding nursing note.  The MAR for 9:00 PM indicated Nurse #8 documented a "9" and there was no corresponding nursing note.		F	755	removed on 6/16/2024 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The LNHA terminated the agency Director of Nursing (DON) during extended survey on 6/19/2024. The LNHA hired an experienced non-contractual DON on 6/19/2024 to ensure future compliance. The facility has also hired nursing staff including RNs and LPNs to ensure future compliance.  The DON or Designee will review all Medication Administration Records (MARs) for residents receiving medications by 8/5/2024 to ensure there are no missing doses. All missing doses will be reported to the provider and documentation will follow to ensure compliance by 8/5/2024.  The DON or Designee will educate all		
					is not in stock, as well as proper documentation that describes all the s that were taken to ensure the resident receives their medications as ordered ensure compliance. After 8/5/2024 new hired nursing staff will be educated by DON or Designee during their new hire employee orientation.  The DON or Designee will educate all nurses by 8/5/2024 on the importance completing pain assessments daily for	to wly the e	
	pain assessment dat	on to the facility on 5/8/24, a ed 5/9/24 was completed by assessment indicated			residents that are receiving medication ensure compliance. After 8/5/2024 new hired nursing staff will be educated by	wly	

Facility ID: 923415

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345185	B. WING _		0	7/02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB	CENTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From page 170			55			
	pain rating of 10 ar	pain almost constantly with a and the pain made it hard to ay activities were limited due to		DON or Designee during the employee orientation.  Beginning 7/27/2024, the DO			
	A nursing progress	note by Nurse #9 on 5/9/24 #51 refused a shower due to		Designee will audit medication administrations 5 times per was weeks to ensure all medication as ordered. Any missed administrations as well a	on veek for 12 ons are given inistrations		
	at 5:12 PM with Nu was assigned to Re	onducted via phone on 6/13/24 urse #8. Nurse #8 stated she esident #51 on 5/8/24 and utated she was familiar with		will result in re-education with appropriate staff members at disciplinary action will be tak necessary.	nd employee		
	5/9/24. Nurse #8 stated she was familiar with Resident #51. Nurse # 8 stated Resident #51 had increased pain when she did not receive her gabapentin. Nurse #8 stated "9" documented on the MAR indicated the medication was not available. If a medication was not available, she stated she would wait a few days and then notify Unit Manager #1. Nurse #8 indicated she did not			Beginning 7/27/2024, the DC Designee will interview 3 res week x 12 weeks to ensure heing managed effectively. A administrations will result in with the appropriate staff me employee disciplinary action	idents per his/her pain is hny missed re-education mbers and will be taken		
	the pharmacy and nurses, although si that if a medication	or obtaining medications from had been informed by other ne did not recall which nurses, was not available, they just		if necessary. Any pain that a expresses that is not being n effectively will be reported to	nanaged the provider.		
	had to wait for it to come in. Nurse #8 stated she did not recall when, but she knew she notified Unit Manager #1 that Resident #51's gabapentin was not available. Nurse #8 stated frequently medications were not available. Nurse #8 stated a written or electronic prescription was not			Beginning 7/27/2024, the audited reviewed by the Licensed Nu Administrator (LNHA) or DOI results of the audits will be remonthly Quality Assurance a Performance Improvement (Meeting monthly for 3 monthly	ursing Home N, and the eviewed in the nd QAPI)		
	Resident #51 was the medication gab A nursing progress at 3:24 AM indicate	note by Nurse #13 on 5/10/24 ed Resident #51 reported her		Committee will review the aumake recommendations as rassure ongoing compliance in The facility will utilize this pla correction to ensure complia	dits and necessary to s sustained. in of nce under the		
	legs were numb. The note indicated the nurse informed Resident #51 there were no interventions for this and offered emergency			mandated regulation by 8/6/2 audits will continue for the sp timeframe as described in th	ecified		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 755	The MAR and the menotes revealed the for #51's gabapentin: 5/10/24  - The MAR for 9:00 A documented a "9" an corresponding nursin.  - The MAR for 12:00 documented a "9" an corresponding nursin.  - The MAR for 5:00 F documented a "9" an corresponding nursin.  - The MAR for 5:00 F documented a "9" an corresponding nursin.  - The MAR for 9:00 F documented a "9" an administration record the facility was awaiti. 800 mg from pharma.  An interview was con. #9 on 6/13/24 at 2:15 assigned to Resident from 7:00 AM to 7:00 Resident #51's gabapent from 7:00 AM, 12:00 PM are revealed she documented and time was in stated the facility free medications and did time. Nurse #9 state obtain medication for	edication administration llowing related to Resident  M indicated Nurse #9 d there was no g note. PM indicated Nurse #9 d there was no g note. PM indicated Nurse #9 d there was no g note. PM indicated Nurse #9 d there was no g note. PM indicated Nurse #13 d the corresponding note at 10:12 PM indicated ng delivery of gabapentin cy.  Inducted via phone with Nurse S PM. Nurse #9 was s #51 on 5/9/24 and 5/10/24 PM. Nurse #9 stated Dentin was not available on or the scheduled doses at and 5:00 PM. Nurse #9 ented "9" which indicated the available for the doses. desident #51 refused her ich was not normal for her, atoo much pain. Nurse #9	F 755	action.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETION	
F 755	Continued From page	e 172	F 75	55		
	phone with message with no return call red					
	notes revealed the for #51's gabapentin: 5/11/24	edication administration Illowing related to Resident				
	#1 documented a "9" corresponding nursing	g note.				
	#1 documented a "9" corresponding nursin - The MAR for 5:00 F	g note. PM indicated Nurse #14				
	gabapentin 800 mg v	1/24 at 4:15 PM indicated was pending from the irse pass on information to				
	next shift to follow up - The MAR for 9:00 F documented a "9" an corresponding nursin	PM indicated Nurse #2 d there was no				
	Manager #1 on 6/13/	w was conducted with Unit 24 at 8:00 AM. Unit I she was assigned to				
	PM and she docume	1/24 from 7:00 AM to 3:00 nted the medication available for the scheduled				
	#1 stated she did not	d 12:00 PM. Unit Manager recall if she made any medication for Resident				
		dering gabapentin and did				
	Attempts were made	to interview Nurse #14 via				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP OF 106 CAMERON STREET  LAKE WACCAMAW, NC 28450	CODE	<b>3170</b>	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 755	A progress note writte at 3:48 AM indicated pain and spasming at emergency room. Re oriented and stated th gabapentin withdrawa. An Emergency Depat 5/12/24 at 6:11 AM in evaluated for a chief had been out of her gays and now she was cramps. The ED Surpresented to the ED or reported she had not thought she was in gain the ED, at 4:43 AM was administered galdischarge instructions 800 mg 4 times per diprimary care physicial prescription medicatic Resident #51 was dison 5/12/24 at 6:11 AM An interview was con #2 on 6/14/24 at 2:24 was an agency nurse from 7:00 PM to 7:00 Resident #51 on 5/11 recalled sending Res 5/12/24 due to uncon her prescribed gabap Resident #51 kept co	seleft on 6/13/24 and 6/14/24 serived.  en by Nurse #2 on 5/12/2024 Resident #51 complained of and requested to be sent to esident #51 was alert and ant symptoms were due to al.  entment (ED) Summary dated dicated Resident #51 was complaint that the facility pabapentin for a couple of as experiencing full body anary stated Resident #51 on 5/12/24 at 4:22 AM and had her gabapentin and abapentin withdrawal. While I on 5/12/24 Resident #51 on 5/12/24 Resident #	F7	755			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	COMF	COMPLETED		
		345185	B. WING			C / <b>02/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 017	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE	
F 755	Nurse #2 stated she sent Resident #51 to stated medications win the facility. Nurse is by other nurses, althorecall which nurses, the medications came there was nothing the medications not being A progress note writt 5/12/24 at 10:09 AM returned from the host AM. Unit Manager #7 5/11/24 that Residen medications from the #1 wrote down the medications from the #1 wrote down the medications from the pharmacy. emergency room lass:  The MAR for 5/12/24 inaccurately docume 12:00 PM, and 5:00 ligabapentin which incomplete the hospital. (Reside on 5/12/24 at approximately docume 12:00 PM, and 5:00 ligabapentin which incomplete the hospital. (Reside on 5/12/24 at approximately dose of gabapentin which incomplete the facility through and A progress note writt 2:40 AM revealed on the facility through and A progress note writt 2:40 AM revealed on the facility through and	n and to receive her n gabapentin for pain. notified the provider and the hospital. Nurse #2 vere frequently not available #2 stated she had been told bugh she was not able to that they just had to wait until e in from the pharmacy and at could be done about the g available.  en by Agency Nurse #14 on indicated Resident #51 spital at approximately 8:00 was made aware on the #51 had not received her pharmacy. Unit Manager edication that was needed The resident was sent to the tringht to obtain gabapentin.  revealed Nurse #14 need a "6" for the 9:00 AM, PM doses of Resident #51's licated the resident was in ent #51 returned from the ED imately 8:00 AM [per Nurse and the next scheduled was due at 9:00 AM).  to interview Nurse #14 via as left on 6/13/24 and 6/14/24 derived. Nurse #14 worked at	F 75	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	COMPLE	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 07702	172024
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	over" and requested department. 911 was emergency room. Refacility having receive emergency room. Femergency room stated Gabapentin at the fago to the emergency supposed to get it or room physician sent Gabapentin 800mg findicated Resident # spasms and reported gabapentin prescript facility and was havin Medication Administrindicated Resident # gabapentin 800 mg or Resident #51 was dion 5/12/24 at 9:41 P continue with gabapentin: 5/13/24  The MAR and the monotes revealed the for #51's gabapentin: 5/13/24  The MAR for 9:00 Adocumented a "9" ar administration record the facility was await 800 mg from the phand The MAR for 12:00 documented a "9" ar ar ar and the mand the mand the mand the monotes revealed the for #51's gabapentin: 5/13/24  The MAR for 9:00 Adocumented a "9" ar administration record the facility was await 800 mg from the phand The MAR for 12:00 documented a "9" ar ar and mand the mand t	to go to the emergency or called for transfer to the esident #51 returned to the ed Gabapentin at the Resident #51 told the ff that until she received her cility, she would continue to room every time she was at least daily. Emergency a new prescription for our times per day to facility to the facility to facility th	F 75	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	,
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 755	the facility was await 800 mg from the pha - The MAR for 5:00 F documented a "9" an corresponding nursin - The MAR for 9:00 F documented a "9" an administration record the facility was await 800 mg from the pha Pharmacy records in gabapentin pills was Resident #51 on the A 6/7/24 nursing prog Resident #51 was trato a change in condit in the hospital as of 6 for interview.  An in-person intervie Manager #1 on 6/13/ Manager #1 stated s Manager for 3-4 wee she thought gabaper electronic prescription been a while since show and signed for was aware that Resignal gabapentin and requievaluation due to incomben or how she bed #1 indicated she did	ing delivery of gabapentin rmacy.  PM indicated Nurse #15 d there was no g note.  PM indicated Nurse #11 d the corresponding I note at 10:52 PM indicated ing delivery of gabapentin rmacy  dicated a supply of 120 sent to the facility for night of 5/13/24.  gress note indicated inserved to the hospital due ion. Resident #51 remained ion. The was in the role of Unit in the was not in the refilled but it had the ordered it so she was not in the raccotic locked in the narcotic locked Unit Manager #1 stated she	F 75	5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		07/02/2024	
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		0110212024
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLÉTIO	
F 755	Manager #2 on 6/13/ Manager #2 stated selectronic prescription refill of gabapentin, be Manager #2 stated the receiving refills of gamonths and Resident medication. Unit Marif Resident #51 had proposed papapentin. Unit Marcontacted the pharm medication gabapentin. Unit Marcontacted the pharm medication gabapentin. An interview by phore Consultant Pharmace The Cons	w was conducted with Unit 24 at 8:15 AM. Unit he thought a written or n was required to obtain a but she was not sure. Unit here had been delays in bapentin for the past several at #51 had gone without hager #2 was unable to recall boain due to not receiving hager #2 stated she had not acy to obtain the ordered in for Resident #51.  The was conducted with the list on 6/12/24 at 9:14 AM. In macist indicated there was a lem with the facility and the ing of medications, including insultant Pharmacist stated in the facility regarding the	F 7			
	Director of Nursing (I at the facility (DON s March) and made he Consultant Pharmac gabapentin as ordere pain, withdrawal symheart rhythm problemate). The Consultan withdrawal symptom and may be severe. indicated the pharma	DON) came into the position tarted position in the end of r aware of the concerns. It indicated not receiving ed could cause increased uptoms, and tachycardia (and causing elevated heart to the Pharmacist indicated is may start within 12 hours. The Consultant Pharmacist increased gabapentin and for storage and accounting.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>7/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		110212024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	Pharmacy Quality As 6/12/24 at 11:50 AM Assurance Specialist treated gabapentin at terms in the storage stated a written or el required to obtain the pharmacy. The Phastated the process formedication gabapen refill sticker via fax of the computer.  An in-person intervied Director of Nursing (The DON stated shemedication gabapen Resident #51. The It confusion regarding and reorder gabapen understand the requirevealed the Consultation of the problem available. Being new had not investigated stated a system was track medication refile.  An in-person intervied Administrator on 6/1 Administrator stated would be available as	and for refills.  Inducted by phone with the surrance Specialist on and accounting for it. She ectronic prescription was not e medication from the rmacy Assurance Specialist or obtaining a refill of the tin was the facility sent the recompleted a refill request in each was not available for DON indicated there was the requirements to order in and she did not irements herself. The DON tant Pharmacist had informed at at the facility at the end of a with gabapentin not being to the DON position, she the problem. The DON required in the facility to the March 2018.  The polyment of the surrange of the was conducted with the end of a with gabapentin not being to to the DON position, she the problem. The DON required in the facility to the March 2019. The she expected medications and administered as ordered	F 75	55		
	Administrator on 6/1 Administrator stated would be available a by the physician. The staff did not have a contract of the	4/24 at 4:10 PM. The she expected medications nd administered as ordered e Administrator stated nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	345185		B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	•	5770272024
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Continued From pag	e 179	F 7	55		
	that a medication wa administration.	s not available for				
	Physician on 6/18/24 indicated the dose of 4 times per day was and it was not recommand taking the medication withdrawal and seve increased pain was a receiving the scheduland it could start with further indicated it was medication from a repotential for adverse revealed Resident #5 for evaluation due to outcome of not receive the medication gabal physician. She stated the facility to obtain the be administered as of	outcome. The Physician 51 being sent to the hospital increased pain was the ving the scheduled doses of pentin as ordered by the d it was the responsibility of the medications so they could ordered.				
	diagnosis which incluneuropathy.	admitted on 12/6/23 with uded diabetes and				
	revealed a 12/6/23 o	# 46's physician orders rder for gabapentin 800 les per day for nerve pain.				
	(MDS) assessment of resident was cognitive Resident #46 received pain medication, pair	erly Minimum Data Set lated 3/12/24 indicated rely intact with no behaviors. red scheduled and as needed in interview should be lent had no pain in the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
		345185	B. WING			C 07/02/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 106 CAMERON STREET LAKE WACCAMAW, NC 28450	DE	07/02/2024		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 755	Continued From pag	e 180	F 7	55				
	Resident #46 had a	ted 1/18/24 indicated PRN (as needed) order for ninophen 5-325 milligrams as needed for pain.						
	(MAR) for 5/1/24 thro	ninophen 10 doses with the						
	6/13/24 at 1:45 PM. on 5/6/24 from 7:00 assigned to Residen card of gabapentin w #46 on 5/6/24 but the controlled substance asked Nurse #2 wha Nurse #2 returned th	nducted with Nurse #3 on Nurse #3 stated she worked PM to 7:00 AM and was t #46. Nurse #3 indicated a vas delivered for Resident e medication did not have a e sign out sheet, so she t to do. Nurse #3 indicated the card of gabapentin for pharmacy with the delivery						
	driver. Nurse #3 sta Unit Manager, Direct pharmacy that the m	ted she did not inform the for of Nursing (DON), or edication was returned as 2 would have done this.						
	6/14/24 at 2:25 PM. on 5/6/24 from 7:00 on 5/6/24 from 7:00 on the gabapentin was for Resident #46 on controlled drug shee she was told by som recall who, to return pharmacy with the decontrolled drug shee	nducted with Nurse #2 on Nurse #2 stated she worked PM to 7:00 AM but she was dent #46. Nurse #2 recalled delivered from the pharmacy 5/6/24 but it did not have a t attached. Nurse #2 stated eone, but she could not the medication to the elivery driver due to no t. Nurse #2 indicated she did lanager, DON or pharmacy						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345185	B. WING		07/02/2024		
	ROVIDER OR SUPPLIER  LIVING AND REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	- OHOLIZOLY		
(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 CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE COMPLETION		
F 755	that the medication the nurse assigned  Review of a Control #46 revealed the las gabapentin delivere Nurse #7 on 5/10/24 count to 0 pills remarked as the count to 0 pills remarked to 0 pill	was returned as she thought to Resident #46 would do it.  led Drug Record for Resident st dose from the supply of don 4/8/24 was signed out by at at 8:00 AM bringing the sining.  2024 Medication and (MAR) indicated was to be administered at M. The MAR further no routine monitoring of level.  specified the documentation see the nursing notes. This ation administration notes and related to Resident #46's  PM indicated Nurse #3 and there was no nong note.  PM indicated Nurse #3 and dose of hydrocodone was administered.  AM indicated Nurse #6 medication was administered.  PM indicated Nurse #3 and there was no nong note. A pain level of 7 was 1. dose of 5-325 mg	F 755				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B WING	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	343163	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	02/2024
	LIVING AND REHAB CE	NTER		1	06 CAMERON STREET  AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	documented a "9". T note at 9:09 AM indic delivery of gabapentii - The MAR for 9:00 P documented a "9" and corresponding nursin recorded at 9:37 PM.  - The MAR indicated administered a PRN of hydrocodone acetam 5/13/24  - The MAR for 9:00 A documented a "9". T note at 9:44 AM indic delivery of gabapentii - The MAR for 9:00 P documented a "9". A at 10:50 PM. The cor 10:53 PM indicated the pharmacy.  - The MAR indicated administered a PRN of hydrocodone acetam 5/14/24  - The MAR for 9:00 A documented a "9" and corresponding nursin - The MAR for 9:00 P documented a "9" and corresponding nursin - The MAR indicated administered an as no hydrocodone acetam 5/15/24	M indicated Nurse #6 he corresponding nursing ated awaiting pharmacy n. M indicated Nurse #3 d there was no g note. A pain level of 9 was at 9:37 PM Nurse #3 dose of 5-325 mg inophen. M indicated Nurse #6 he corresponding nursing ated awaiting pharmacy n. M indicated Nurse #17 pain level of 8 was recorded responding nursing note at he medication on order from at 9:50 PM Nurse #17 dose of 5-325 mg inophen for pain. M indicated Nurse #7 d there was no g note. M indicated Nurse # 17 d there was no g note. at 9:25 PM Nurse #17 eeded dose of 5-325 mg inophen. M indicated Nurse #17 eeded dose of 5-325 mg inophen. M indicated Nurse #7 d there was no	F	755			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 755	- The MAR for 9:00 P documented a "9" and corresponding nursing 5/16/24 - The MAR for 9:00 A #2 documented a "9" note at 9:17 AM indict gabapentin from phare - The MAR for 9:00 P documented a "9". The mode on 5/17/24 at 12 medication delivery for 5/17/24 - The MAR for 9:00 A documented a "9". A 5/17/24 at 10:09 AM imedication delivery opharmacy The MAR for 9:00 P documented a "9" and corresponding nursing recorded at 9:04 PM.  An interview was con 6/13/24 at 1:45 PM. In assigned to Resident and 5/12/24 from 7:00 stated she documented and 5/12/24 at 9:00 P of gabapentin and incompared in the medication obtain the medication of the med	M indicated Nurse #17 d there was no g note.  M indicated Unit Manager The corresponding nursing ated waiting for delivery of macy. M indicated Nurse #11 ne corresponding nursing:40 AM indicated awaiting om pharmacy.  M indicated Nurse #5 n administration note dated ndicated awaiting f gabapentin from  M indicated Nurse #2 d there was no g note. A pain level of 7 was  ducted with Nurse #3 on Nurse #3 stated she was #46 on 5/10/24, 5/11/24, D PM to 7:00 AM. Nurse #3 ed 9 on 5/10/24, 5/11/24, M for the scheduled doses to it was unaware of the process on and she did not follow up on. Nurse #3 stated n and was unable to sleep from the norm when she did	F 755		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345185	B. WING			C <b>07/02/2024</b>	
			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET		110212024	
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
6/13/24 at 12:30 PM an agency nurse that several months. Nurse administered the pre on 5/11/24 at 9:00 Al medication delivery son the medication cat told by someone, unagave the dose from to delivery system that was not the correct of medication delivery some assigned to Resident and documented 9 of scheduled 9:00 AM of the stated the medication cart and semergency medication cart and semergency medication cart and semergency medication cart and semergency medication that was not available. An interview was cor PM with Nurse #17. worked at the facility 6 weeks. Nurse #17. worked for the medications were free from the medication was referenced to the medication	Nurse #6 stated she was thad worked at the facility for se #6 stated she scribed dose of gabapentin M from the emergency system as it was not available at. Nurse #6 stated she was able to recall who, after she he emergency medication she was not to do so since it lose. The emergency system contained gabapentin Resident #46's physician g. Nurse #6 stated she was the #46 on 5/12/24 and 5/13/24 in the electronic MAR for the doses of gabapentin. Nurse ation was not available on the she did not obtain it from the on delivery system on lurse #6 stated she was not a for obtaining a medication be.  Inducted on 6/13/24 at 3:47  Nurse #17 stated she through an agency for about a stated she was assigned to 100 PM to 7:00 AM shift on 15/15/24. Nurse #17 stated bedication on the medication of not see it, she documented urse #17 indicated quently missing and ran out cart. Nurse #17 stated she immacy or the provider that not available. Nurse #17	F 79	55			
	SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag 6/13/24 at 12:30 PM an agency nurse that several months. Nur administered the pre on 5/11/24 at 9:00 AI medication delivery s on the medication ca told by someone, una gave the dose from to delivery system that was not the correct of medication delivery s 100 mg tablets and F order was for 800 mg assigned to Resident and documented 9 o scheduled 9:00 AM of #6 stated the medicat medication cart and semergency medication 5/12/24 or 5/13/24. N aware of the process that was not available  An interview was cor PM with Nurse #17. worked at the facility 6 weeks. Nurse # 17. Resident #46 from 7: 5/13/24, 5/14/24, and she looked for the me cart and when she di it 9, not available. No medications were free from the medication was r revealed gabapentin	TORRECTION SUPPLIER  345185  ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she administered the prescribed dose of gabapentin on 5/11/24 at 9:00 AM from the emergency medication delivery system as it was not available on the medication cart. Nurse #6 stated she was told by someone, unable to recall who, after she gave the dose from the emergency medication delivery system contained gabapentin 100 mg tablets and Resident #46's physician order was for 800 mg. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24 and documented 9 on the electronic MAR for the scheduled 9:00 AM doses of gabapentin. Nurse #6 stated the medication was not available on the medication cart and she did not obtain it from the emergency medication delivery system on 5/12/24 or 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available.  An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse #17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated she looked for the medication on the medication cart and when she did not see it, she documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication was not available. Nurse #17 revealed gabapentin was prescribed for pain and	ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 184 6/13/24 at 12:30 PM. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she was an agency nurse that had worked at the facility for several months. Nurse #6 stated she was bid by someone, unable to recall who, after she gave the dose from the emergency medication delivery system as it was not available on the medication cart. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 at 9.00 AM from the emergency medication delivery system contained gabapentin 100 mg tablets and Resident #46's physician order was for 800 mg. Nurse #6 stated she was assigned to Resident #46 on 5/12/24 and 5/13/24, and someoned she she was not available on the medication cart and she did not obtain it from the emergency medication delivery system on 5/12/24 or 5/13/24. Nurse #6 stated she was not aware of the process for obtaining a medication that was not available.  An interview was conducted on 6/13/24 at 3:47 PM with Nurse #17. Nurse #17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated she worked at the facility through an agency for about 6 weeks. Nurse #17 stated she was assigned to Resident #46 from 7:00 PM to 7:00 AM shift on 5/13/24, 5/14/24, and 5/15/24. Nurse #17 stated she looked for the medication on the medication cart and when she did not be eit, is documented it 9, not available. Nurse #17 indicated medications were frequently missing and ran out from the medication on as not available. Nurse #17 revealed gabapentin was prescribed for pain and	TONITION OF SUPPLIER  105 CAMERON STREET LAKE WACCAMAW, NC 28450  106 CAMERON STREET LAKE WACCAMAW, NC 28450  107 STREET ADDRESS, CITY, STATE, 2IP CODE  108 CAMERON STREET  108 CAMERON STREET  108 CAMERON STREET  108 CAMERON STREET  109 PROVIDERS PLAN CORRECTION  109 (EACH ORDRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  109 CONTINUED TO THE APPROPRIATE  100 CONTINUED TO THE APPROPRIATE  100 CONTINUED TO THE APPROPRIATE  100 CONTINUED TO THE APPROPRIATE  101 CANES AND THE APPROPRIATE  102 CONTINUED TO THE APPROPRIATE  103 CAMERON STREET  104 CANES AND THE APPROPRIATE  105 CAMERON STREET  106 CAMERON STREET  107 CANES AND THE APPROPRIATE  107 CANES AND THE APPROPRIATE  108 CAMERON STREET  109 CAMERON STREET  100 CAMERON S	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	01702/2024	
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F 755	An interview was cor PM with Nurse #16. Resident #46 on 5/13 from 7:00 PM to 7:00 the electronic MAR in not available. Nurse documented "9" for u MAR on 5/13/24, 5/1 for the scheduled do stated gabapentin was for Resident #46, Nuthe facility through an Nurse #16 stated me missing from the me stated she did not camedication. Nurse # prescribed for pain a medication caused F An interview was cor 6/13/24 at 11:30 AM an agency nurse at the Nurse #7 was assign 5/14/24 and 5/15/24 Nurse #7 stated she ordered dose of gaba 5/15/24 at 9:00 AM on Nurse #7 stated she electronic MAR on 5. Nurse #7 recalled gas on the medication caused for the med	nducted on 6/13/24 at 3:47 Nurse #16 was assigned to 3/24, 5/14/24 and 5/15/24 O AM. Nurse #16 stated 9 on indicated the medication was #16 indicated she unavailable on Resident #46's 4/24 and 5/15/24 at 9:00 PM se of gabapentin. Nurse #16 as not on the medication cart was #16 stated she worked at in agency for about 6 weeks. Edications were frequently dication cart. Nurse #16 will the pharmacy to obtain the #16 stated gabapentin was	F 7	55			
	when she did not red Nurse #7 stated she was prescribed for n	ceive the ordered gabapentin. was aware that gabapentin erve pain and not receiving d cause the resident to have					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		١,	C <b>)7/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1/102/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	increased pain and sil Nurse #7 was unawa obtaining a medication on 6/13/24 at 8:15 AN indicated she thought prescription was requigabapentin. Unit Mail been delays in receive she did not know why without the medication indicated she was as 5/16/24 from 7:00 AN #2 stated gabapentin Resident #46 on 5/16 resident had increase attempt to obtain it. Undid nothing about Resident #46 on 6/14/24 at 9:00 AM. problem with running medications not being available.  An interview was con 6/14/24 at 9:00 AM. problem with running medications not being she used the computibut they frequently dinot know why. Nurse was aware of the procoming in from pharm did not know if a writt was needed to reorde stated she was assig 5/17/24 for the 7:00 A #5 stated she did not gabapentin on 5/17/2 pharmacy to obtain the Resident #46 to have	hould be monitored for this. re of the process for in that was not available.  ducted with Unit Manager #2 if a written or electronic sired to obtain a refill of mager #2 stated there had ing refills of gabapentin, but if and Resident #46 had gone in. Unit Manager #2 signed to Resident #46 on it to 3:00 PM. Unit Manager	F 75	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
	345185		B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 07/02/2024	
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F 755	attempt to obtain it.  An interview was cor #2 on 6/14/24 at 2:25 was the nurse assign 5/17/24 from 7:00 PM stated gabapentin was prescribed dose for Fresident had increased did not call the pharm gabapentin for Residemedications were frewas informed by othe not recall which nursuntil the medications and there was nothin Attempted to intervie to Resident #46 on 5 Messages were left on return call received An interview was cor 6/13/24 at 9:30 AM. facility had trouble of Resident #46 stated medications for days occasions. Resident medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication was comit then it didn't come in familiar with her medication. Resident was not of bed or complet the time when she digabapentin. Resider	aducted via phone with Nurse of PM. Nurse #2 stated she hed to Resident #46 on M to 7:00 AM. Nurse #2 as not available for the Resident #46 on 5/17/24 and hed pain. Nurse #2 stated she hacy to obtain the prescribed hent #46. Nurse #2 stated quently unavailable, and she her nurses, although she did hes, that they just had to wait came in from the pharmacy g that could be done.  We Nurse #11, nurse assigned M/16/24 7:00 PM to 7:00 AM. On 6/11/24 and 6/12/24 with decent with Resident #46 on Resident #46 stated the obtaining medications. She had gone without at a time on several #46 reported staff stated the ng from the pharmacy and and Resident indicated she was ications and gabapentin was pain. Resident #46 stated ain, trouble sleeping, was useous and unable to get up the her usual routine during	F 75	5		

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY LETED	
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		345185	B. WING			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
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FIXEWILK	LIVING AND KLIIAD CL	NIEK		L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 755	by the Consultant Phamedication error was electronic health recogabapentin was mark in May 2024. The Phamote that she checked found the pharmacy smedication gabapentic Communication was and 5/16/24 that the resultant 5/6/24 and would be resultant Please review with standard An interview was concentrated by the storage and accompleted are fill of the was the facility faxed completed a refill requestion of the storage and accompleted a refill of the was the facility faxed completed a refill requestion of the storage and accompleted a refill requesting a pharmacy QA Special gabapentin for Reside pharmacy on 5/6/24 who wever the delivery folder for follow up so did not investigate the the usual process not the facility. The Pharmacy was not the pharmacy was not the storage and	Medication Record Review armacist indicated a identified in Resident #46's ord. The note indicated ared out of stock for 13 doses armacist indicated on the d the pharmacy records and sent a 30-day supply of the in on 5/6/24. Sent to the facility on 5/11/24 medication was filled on refilled again on 5/30/24. aff.  ducted by phone with the surance (QA) Specialist on The Pharmacy QA ne pharmacy treated rolled medication in terms of unting for it. She stated a prescription was not required ion from the pharmacy. The allist stated the process for the medication gabapentin	F	755			
		pentin that was returned on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	I	STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		0	7/02/2024
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F 755	5/6/24. The pharmac from the facility for ga on 5/11/24 and 5/16/2 sent via fax to the facilindicating it was too egabapentin for Resid not respond to the faregarding the refill reinvestigated, found the gabapentin was returned replacement supply.  An interview was con Consultant Pharmacist The Consultant Pharmacist The Consultant Pharmacist of faxes probereordering of medical when the current Direstarted, the Consultant Pharmacist indications for admin meeting, the pharmamachines for the facing of faxes not being recontinued. The Consultanted in the Consultanted in the Consultanted in the pharmamachines for the facing faxes not being recontinued. The Consultanted in the Consultanted with drawal 12 hours and may be Pharmacist indicated gabapentin a controll and accounting purpowritten or electronic purpower in the facility of the facility	y received refill requests abapentin for Resident #46 24. Communication was sility on 5/11/24 and 5/16/24 early to obtain a refill of ent #46. When the facility did xed communication quests, the pharmacy net the 5/6/24 supply of ned and then sent a ducted by phone with the st on 6/12/24 at 9:14 AM. macist indicated there was a lem with the ordering and tions in the facility. In March ector of Nursing (DON) and Pharmacist stated she and reordering of nistration. Following the cry provided new fax lity to alleviate the problem ceived, however the problem ceived and	F 75			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED			
		345185	B. WING _	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP CODI 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	01102/2024	
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F 755	Continued From page	e 190	F 7	55			
	gabapentin was not a The DON stated a sy facility to track medic medications were rec being depleted.  A follow up in-person Nursing (DON) on 6/ the nurses on the me to reorder medication supply being deplete aware Resident #46 800 mg twice per day 5/17/24. The DON st facility at the end of N recall when she beca not receive the order stated there had bee machines in the facility						
	Administrator on 6/14 Administrator stated medications would be as ordered by the phistated nursing staff dunderstanding of what a medication was not The Administrator state with the fax machines affected communication the pharmacy.  An interview was communication of the pharmacy.	w was conducted with the I/24 at 4:10 PM. The she expected that a available and administered ysician. The Administrator id not have a comprehensive at to do when they identified available for administration. Inted there were problems in the facility and that had ion between the facility and inducted by phone with the at 1:20 PM. The Physician					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING	B. WING		C 07/02/2024		
	ROVIDER OR SUPPLIER	NTER	•	10	REET ADDRESS, CITY, STATE, ZIP CODE 16 CAMERON STREET AKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	twice per day was a hit was not recommend the medication due to increased pain. Without within 12 hours and of stated increased pain to not receiving the so ordered. The Physici not right to withhold mand it had the potentic stated it was the respobtain the medication administered as ordered. The Administrator was Jeopardy on 6/13/24. The facility provided to Jeopardy removal pland Identify those recipier are likely to suffer, as a result of the noncord. The facility failed to emedication was obtain administration (Residual The facility failed to emedication was obtain administration (Residual routine order for garday. The medication was obtain administration. This receiving the medications supply of 120 pills on	gabapentin ordered, 800 mg high dose of medication and ded to abruptly stop taking to the risk of withdrawal and drawal symptoms can occur an be severe. The Physician was a definite concern due cheduled gabapentin as an further indicated it was medication from a resident all for adverse outcome. She onsibility of the facility to as so they could be red.  Is notified of Immediate at 2:15 PM.  The following Immediate an:  This who have suffered, or serious adverse outcome as impliance:  Insure routine pain med and available for ent #51 and Resident #46).  Insure routine pain med and available for ent #51). Resident #51 had bapentin 800 mg 4 times a	F	755				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345185	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	I	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	morning of 05/08/202 was sent back to the the hospital. The ord returned to the facilit pharmacy sent a 30-night of 05/13/2024.  Resident #51 comple	24. The supply of medicine pharmacy while she was in er was unchanged when she y on 05/08/2024. The day supply (120 pills) on the ained of pain. On 05/09/2024	F 7	55		
	pain. On 05/10/2024 her legs feeling num #51 complained of p Resident #51 reques Room (ER). Resident where the resident w received gabapentin evening on 05/12/20 of agitation and anxional gabapentin and requesting received Resident #51 received	d a shower due to too much Resident #51 complained of b. On 05/12/2024 Resident ain and spasming in which sted to go to the Emergency at #51 returned from the ER was treated for acute pain and at the hospital. In the 24 Resident #51 complained ety due to not receiving ested to go to the ER. End gabapentin in the ER. The sent a new prescription for armacy.				
	medication was obta administration (Residual administration) (Residual administration). The medication administration. This receiving the medical #46 had a pain level the time the facility fathe medication. Residual receiving pain medicupain and made it har complained of irritab nausea. Resident #4 not been able to get	illed to ensure routine pain ined and available for dent #46). Resident #46 had abapentin 800 mg 2 times in was not available for resulted in the resident not tion as ordered. Resident of 8 or 9 constantly during ailed to obtain and administer dent #46 complained of not ation which caused her more d to sleep. Resident #46 illity, being anxious, and 6 had not felt well and had out of bed to participate in in a daily routine due to pain				

<b>345185</b> B. WING	C 07/02/2024
EMIER LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F755  Continued From page 193 in her legs. The facility failed to obtain and administer a total of 14 doses of gabapentin between 05/10/2024 and 05/17/2024.  On 06/13/2024 the Administrator and Director of Nursing consulted with the facility Consultant Pharmacist to further investigate the medication delays during 05/08/2024 - to 05/17/2024. It was determined by the Consultant Pharmacist to the pharmacy had made an error and not shipped the medication in a timely manner. It was further determined that nursing staff do not have a comprehensive understanding of what to do when they identify that a medication is not available for administration.  On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete by 06/15/2024. If there are any concerns identified, the concerns will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately to ensure the facility is effectively managing pain.  On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete an audit for the past 90 days of all residents in the facility with pain medications are in the facility and available for administration. This will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately to ensure the facility is effectively managing pain.  On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete an audit for	S, CITY, STATE, ZIP CODE
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in her legs. The facility failed to obtain and administer a total of 14 doses of gabapentin between 05/10/2024 and 05/17/2024.  On 06/13/2024 the Administrator and Director of Nursing consulted with the facility Consultant Pharmacist to further investigate the medication delays during 05/08/2024 - to 05/17/2024. It was determined by the Consultant Pharmacist that the pharmacy had made an error and not shipped the medication in a timely manner. It was further determined that nursing staff do not have a comprehensive understanding of what to do when they identify that a medication is not available for administration.  On 06/13/2024 the Director of Nursing and Unit Managers (UMs) began to complete an audit for the past 90 days of all residents in the facility with pain medication orders to identify if there were any additional medications that needed to be ordered. The purpose of this audit is to ensure all pain medications are in the facility and available for administration. This will be completed by 06/15/2024. If there are any concerns identified, the concerns will be reported to the physician immediately to ensure the facility is effectively managing pain.  On 06/13/2024 the Director of Nursing and Unit	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE S COMPLI	
		345185	B. WING		O7/0	2/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0770.	2/2024
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F 755	Continued From pag	e 194	F 75	5		
	process or system faradverse outcome from and when the action.  On 06/13/2024 the DEFloor Nurses and Undaily medication refill by the Floor Nurses are obtained timely manner to predelays. Nurses will identify the pharmacy at least medication running of time depicted on the prior to the medication of Nursing and Unit of Nursing appropriate administration, and if available the physicial treatment, guidance,  No nurses or medication. The Direct responsible for keeping medication aides wheducated. The Direct for completing the edication is not some suring the edication of the prior to the prior to the physicial treatment, guidance, and if the physicial treatment, guidance, the prior to the prior to the physicial treatment, guidance, and the physicial treatment, guidance, the prior to the prior to the physicial treatment, guidance, and the physicial treatment of the physicial treatment, guidance, the prior to the physicial treatment, guidance, and the physicial treatment of the physicial trea	pirector of Nursing educated it Managers (UMs) on the I log that is to be maintained and UMs to ensure sined from the pharmacy in a event further medication dentify needed medications leting medication cart audits. It is to be requested by the red for medication to fill should be requested by the red for medication to fill should be requested by the red for medication card is 5 days on running out. The Director Managers (UMs) will begin in 06/13/2024 with all nurses is which will include all is needed, and agency staff. It is on the importance of its per the physician's orders, medication is available for it the medication is not an must be called for further and/or physician orders.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP 106 CAMERON STREET LAKE WACCAMAW, NC 28450	CODE	0110212024
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F 755	not been educated be notified of their responsible for the Director of Nursing will be responsible for ensuring it is comple effective system in permedications are avaing the Director of Nursing responsibility on 06/2.  All newly hired nurses (full-time, part-time, as be educated as note completed by the Director of Nursing with new hires where ducated. The Director of Nursing with new hires where ducated in the Director of Nursing with new hires where ducated in the Director of Nursing with new hires where ducated in the Director of Nursing with new hires where ducated in the Director of Nursing with new hires where discaled in the facility. The summary from the hours of the discaled in the medischarging hospital in	y 06/13/2024. The UMs were possibility on 06/13/2024 by and the Director of Nursing or tracking the education and ted so that the facility has an lace to ensure ordered lable for administration. In gwas notified of this 13/2024 by the Administrator. It is and medication aides, as needed, and agency) will do above. This will be ector of Nursing. The will be responsible for keeping to have and have not been toor of Nursing is responsible ducation with new hires. The was notified of this 13/2024 by the Administrator. In the was confirmed that the will ensure all nurses and 1-time, part-time, as needed, amprehensive knowledge on action orders for residents. This process will include an efaxing the discharge opening to fax the discharge need Floor Nurse will enter ers and clarify any 1f there is a controlled	F 7	755		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/00/0004
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  06 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 755	Floor Nurse will fax the pharmacy. The assig copy for facility record prescriptions will be snight with the pharma.  Effective as of 06/13/refills of medications medication will be the previously noted. It is recognize the need for need. On 06/13/2024 educate all nurses an (full-time, part-time, at the facility process for newly prescribed medications are avail Director of Nursing whow to put in a medications are avail Director of Nursing whow to put in a medication will access the reside administration record record (EHR). The nut the prescribed medication from the prescribed medication within 48 hours post of communication from notify the UMs and the pharmacy regarding to ordering a prescribed should have written deprogress section of the order processed and any, should be included the UMs will record in the UMs w	ne prescription to the ned Floor Nurse will make a ds and then the original sent to the pharmacy that acy delivery driver.  2024 the facility process for and newly prescribed a same process as imperative the nursing staff or a refill and anticipate the the Director of Nursing will ad medication aides as needed, and agency) on a refills of medications and dication so the facility has an ace to ensure ordered able for administration. The ill educate nursing staff on ation refill request. Nurses not's medication from the electronic health arse will place an order for ation by clicking on order or to populates in the ord (EHR), and the refill be sent to the pharmacy. If on has not been received	F 755		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION  G	COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 755	enable tracking of the medications so that the facility for administration is responsible for corresponsible for corresponsibility on 06/1 Nursing. The Director responsible for tracking ensuring it is comple effective system in properties of this responsibility on 106/1 Nursing. The Director responsible for tracking ensuring it is comple effective system in properties of this responsibility on 106/1 Nursing with the part-time, and the discontinuous ensuring it is completed of this responsibility on 106/1 Nursing with the part-time, and the properties of the proper	refill notification. This will be system of ordered they are available in the tion. The Director of Nursing inpleting the education or complete the education for to been educated by si were notified of their 3/2024 by the Director of or of Nursing will be ing the education and ted so that the facility has an ace to ensure ordered lable in the facility for Director of Nursing was insibility on 06/13/2024 by the  sis and medication aides as needed, and agency) will diabove. This will be ector of Nursing. The fill be responsible for keeping on have and have not been or of Nursing is responsible flucation with new hires. The	F 75		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			1	02/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	<u> </u>
DDEMIED	LIVING AND REHAB CI	ENTED		1	106 CAMERON STREET		
PREWIER	LIVING AND REHAD CI	ENIER		l	LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	medical record, faxe orders from the hosp process for completi Observation of nursi ensure they understo electronic record and the refilled order was nursing staff explaint refill log. Staff report had a remainder of section of the medica a refill was entered in drug information was request form to inclumame of drug, the readministration frequest form the medication cart is second shift nurse rewere ordered from the That nurse was to mon the refill request form the medication. The form was reviewed, a The IJ removal date 3. Resident #8 was a 8/19/23 with diagnostic and the position of the second shift nurse the pharmacy within the medication. The form was reviewed, a Resident #8 was a 8/19/23 with diagnostic states and the second shift nurse the pharmacy within the medication. The form was reviewed, a Resident #8 was a 8/19/23 with diagnostic states and the second shift nurse was to months the pharmacy within the medication. The form was reviewed, a Resident #8 was a 8/19/23 with diagnostic states and the second shift nurse rewards the se	rs the orders in the electronic is the discharge summary potal to the pharmacy, and the ing a medication refill request. Inguitable staff was conducted to bood how to enter orders in the industry of the processed. Additionally, the election of the process of utilizing the sted when the medication card of doses indicated in the blue action care, then an order for in the electronic record. The is also handwritten on the refill inde the name of resident, quired dose, and the ency. This form was kept on in the narcotic book. The exceived the medications that the pharmacy each night, aske sure what was ordered form was delivered. The Unit ine refill request form each	F	755			
	revealed an 2/28/24 Oxycodone/Acetami	ent #8's physician orders order for nophen 10/325 milligrams outh two times a day at 8:00					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 755	am and 8:00 pm for Oxycodone/Acetam by mouth once a da Freeze Professional analgesic apply to a for pain (PRN).  A review of the phatablets of Oxycodon was delivered to the by Nurse #10 and North The April 2024 Med (MAR) indicated Resolved to be add 8:00 pm and specific indicated to see the and the medication the following related Oxycodone/Acetam 4/16/24  - The MAR for 8:00 documented a "9" a corresponding nurs 4/18/24  - The MAR for 8:00 documented a "9" a note at 9:06 am ind the arrival of Oxycomg from the pharma - The MAR for 8:00 documented a "9" a note at 9:36 pm ind the arrival of Oxycomg from the pharma - The MAR for 8:00 documented a "9" a note at 9:36 pm ind the arrival of Oxycomg from the pharma - The MAR for 8:00 documented a "9" a note at 9:36 pm ind the arrival of Oxycomg from the pharma 4/19/24	rpain, inophen 5/325 mg - 1 tablet by at 2:00 pm for pain, and Bio I External Gel 5% topical area every 6 hours as needed rmacy records indicated 30 ne/Acetaminophen 10/325 mg e facility on 3/28/24 and signed durse #18.  ication Administration Record sident #8's inophen 10/325 mg was ministered at 8:00 am and ed the documentation of a "9" nursing notes. This MAR administration notes revealed at to Resident #8's inophen:  pm indicated Nurse #2 nd there was no ing note.  am indicated Nurse #6 nd the corresponding record icated the facility was awaiting done/Acetaminophen 10/325 acy. pm indicated Nurse #9 nd the corresponding record icated the facility was awaiting done/Acetaminophen 10/325 icated the facility was awaiting done/Acetaminophen 10/325	F 755		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/152	345165	D. WING			07/	02/2024
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	LIVING AND REHAB CE	NTER			106 CAMERON STREET		
					LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	note at 12:53 pm indice of the facility with spotential of the facility with spotential of the facility with spotential of the arrival of Oxycodomy from the pharmace 4/20/24  The MAR for 8:00 and documented a "9" and corresponding nursing 4/21/24  The MAR for 8:00 and documented a "9" and corresponding nursing 4/21/24  The MAR for 8:00 and documented a "9" and corresponding nursing 4/22/24  The MAR for 8:00 and documented a "9" and corresponding nursing 4/22/24  The MAR for 8:00 and documented a "9" and note at 9:34 am indicate arrival of Oxycodomy from the pharmace  The MAR for 8:00 pm documented a "9" and note at 8:53 pm indicated and the arrival of Oxycodomy from the pharmace  The MAR for 8:00 pm documented a "9" and note at 9:46 am indicated	d the corresponding record cated Resident #8 was out use and friend for lunch. In indicated Nurse #8 d the corresponding record ated the facility was awaiting one/Acetaminophen 10/325 yy.  In indicated MA# 5 d there was no g note.  In indicated MA# 5 d there was no g note.  In indicated Nurse #6 d the corresponding record ated the facility was awaiting one/Acetaminophen 10/325 yy.  In indicated Nurse #8 d the corresponding record ated the medication was on the indicated Nurse #8 d the corresponding record ated the medication was not in ordered.  In indicated Nurse #8 d the corresponding record ated the medication was not in ordered.  In indicated Nurse #8 d the corresponding record ated the medication was on acey.  In indicated Nurse #8 d the corresponding record ated the medication was on acey.  In indicated Nurse #9 d there was no	F	755			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 755	Continued From page	e 201	F 75	5	
	document used to do administration of come Resident #8's Oxycomm revealed no nurse following:  - 4/16/24 8:00 pm - 4/18/24 8:00 am - 4/19/24 8:00 am - 4/20/24 8:00 am - 4/21/24 8:00 am - 4/22/24 8:00 am - 4/22/24 8:00 am - 4/23/24 8:00 am - 4/23/24 8:00 am - 4/24/24 8:00 am - 4/24/	trolled substances) for done/Acetaminophen 10/325 e signatures for the  Nurse #2 Nurse #6 Nurse #8 Nurse #9 Nurse #8 MA #5 MA# 5 Nurse #6 Nurse #8 Nurse #8 Nurse #8 Nurse #9 Nurse #8 Nurse #19 Nurse #8 Nurse #19 Nurse #9 to interview Nurse #9 via s left on 6/28/24 with no Nurse #9 no longer worked  to interview Nurse #2 by s left on 6/28/24 with no Nurse #2 worked at the			
	Attempts were made	to interview Medication Aide with messages left on			
	with Nurse #8, she in	view on 7/1/24 at 11:51 am dicated Resident #8 did not 3:00 pm Oxycodone 10/325			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345185	B. WING			07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755 F 756 SS=E	awaiting delivery from she did not know which Oxycodone 10/325 m. During a phone intervition 7/1/24 at 3:32 p sent the narcotics (Oxon 3/28/24. The Phaenough Oxycodone/AResident #8. She fur request a refill for the and prior to 4/25/24. Drug Regimen Review CFR(s): 483.45(c)(1)(	24 and 4/23/24. She and documentation she was a the pharmacy. She stated the nurse ordered the g.  The with Pharmacy Tech and she stated the pharmacy eycodone/Acetaminophen) armacy Tech #1 indicated not acetaminophen was sent for the stated the facility did not medication after 3/28/24  W. Report Irregular, Act On 2)(4)(5)  The men Review.		755 756			7/27/24
	must be reviewed at I licensed pharmacist. §483.45(c)(2) This reformed from the resident's media §483.45(c)(4) The pharmacist to the attraction from the second direct and these reports mu (i) Irregularities including that meets the code of this section for a during this review museparate, written reportate and director and director and director of the second from	armacist must report any tending physician and the stor and director of nursing, st be acted upon.  de, but are not limited to, any riteria set forth in paragraph an unnecessary drug.  noted by the pharmacist st be documented on a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 7/ <b>02/2024</b>	
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		770212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	(iii) The attending phresident's medical reirregularity has been action has been take be no change in the physician should doot the resident's medical \$483.45(c)(5) The farmaintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent actio This REQUIREMENT by:  Based on record review Consultant Pharmacifacility failed to act or recommendations for #39, Resident #18, Resident #22, Resident #22, Resident #22, Resident #24, Resident #25, Resident #25, Resident #26, Reviewed for medicate 1. Review of the host dated 05/02/24 for Refollowing physician of 875 MG (Milligram)-12 hours for 7 days for related to a perirectal infection (UTI).	re pharmacist identified. Sysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending rument his or her rationale in all record.  Cility must develop and if procedures for the monthly that include, but are not as for the different steps in as the pharmacist must take record if it is not met as evidenced riew and interviews with ast, Physician, and staff, the in pharmacy if of 10 residents (Resident Resident #50, Resident #47, rent #46 and Resident #8) ions.  Spital discharge summary resident #39 revealed the reder: Amoxicillin-Clavulanate in the pharmacy or diagnoses of sepsis in abscess and a urinary tract is limitted to the facility on	F 75	The facility failed to act on phrecommendations for 7 of 10 or (Resident #39, Resident #18, #50, Resident #47, Resident #8 for medications.  All residents residing in the factor medications.  All residents residing in the factor medications.  The Director of Nursing (DON Designee will review all pharm recommendations from, June 8/5/2024 to ensure all pharmare recommendations are approved provider and changes are upon DON will review pharmacy recommendations for Residert #18, Resident #50, Figure 100.	residents Resident #22, 3) reviewed  cility have potential to icient  ) or nacy of 2024, by acy ed by the lated. The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
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		345185	B. WING _			07/02/2024	
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PREMIER	LIVING AND REHAB	SENIER		LAKE WACCAMAW, NC 28450			
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F 756	Continued From pa	nge 204	F 7	756			
	revealed the follow computer system o	ician orders for Resident #39 ing order was entered into the n admission: Amoxicillin 875 mouth every 12 hours for UTI		#47, Resident #22, Resident Resident #8 by 8/5/2024 to the pharmacy recommendaresident have been acknown addressed with the provide	ensure that ations for each vledged and		
	(MDS) assessment Resident #39 had i indwelling urinary of antibiotic medication Review of the facilit Administration Rec Resident #39 was a MG on 05/03/24, 05	ession Minimum Data Set at dated 05/08/24 revealed entact cognition. He had an eatheter. He was administered entact.  The ty MAR (Medication ord) for May 2024 revealed eadministered Amoxicillin 875 5/04/24, 05/05/24, 05/06/24, 05/09/24, and 05/10/24 for a		The DON or Designee will nursing managers by 8/5/2 procedure for completing a recommendations, to include approval from the provider, communicating with contral as necessary, to ensure all followed. After 8/5/2024 newill be educated by the DO during their new hire employerentation.	024 on the all pharmacy de obtaining , as well as acted providers I orders are ewly hired staff on or Designee		
	Medication Regime revealed the follow "Priority: High": "The an order for Amoxic [twice a day] for 7 computer as Amoxic the pharmacy sent, the medication error treatment is needed nurses to ensure the documentation that reviewed by nursing In an interview with 6/12/24 at 9:50 AM	this pharmacy review was g or the physician.  the Consultant Pharmacist on she stated the difference		The DON or Designee will incoming pharmacy recommendations and training for the anursing staff.  The DON or Designee will pharmacy recommendations. The DON or Designee will pharmacy recommendation 12 months to ensure the pharmacy recommendation are approvider and any changes. Any missing approvals by the result in re-education and a training for the appropriate	mendations ensure all orders to the pharmacy essing order fucation and ppropriate  audit all ens monthly for charmacy roved by the are updated. the provider will additional enursing staff.		
	was that the addition	n and Amoxicillin-Clavulanate on of Clavulanate helped the otter and more types of bacteria		Beginning 7/27/2024, the a reviewed by the Licensed N Administrator (LNHA) or DO	Nursing Home		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	NTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	1 011	<i><b>02:202</b></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	e 205	F 7	756			
	were affected. She was provider to be notified error and determine it necessary.  During an additional in PM with the Consultated during a monthly review building, she emailed report and recomment Director of Nursing (Despected recomments before she returned to review. If she found a been addressed, she recommendation and to try and get the recommendation High" on the Medicatis she would have expe	rould have expected the d to report the medication of additional treatment was additional treatment was additional treatment was a terview on 06/26/24 at 1:17 and Pharmacist she explained ew before she left the the complete pharmacy additions to the Agency DON). Routinely, she dations to be addressed to complete the next monthly a recommendation had not would write another speak to the DON directly commendation addressed. In was identified as "Priority: for Regimen Review and ceted the Agency DON to call the received the report to			results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustaine. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	PI to d. the he	
	06/12/24 at 4:40 PM s followed up on the ph and had not notified the antibiotic had been as to determine if further She stated she had be recommendation and on the recommendation May 2024.  In an interview with the on 06/19/24 at 9:30 A	was responsible for acting on when it was received in ne facility's current physician M she stated she had not					
		sident #39 was given the noted she had just started					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 756	at the facility last were when this occurred. had seen Resident # having any symptom did not feel any furth She stated she would whenever there was recommendation on facility or called if the immediate attention.  2. Resident #18 was recently on 06/23/23  Diagnoses included a disorder.  The physician order 11/08/23 indicated A 0.5 mg every 6 hours agitation. This order  Review of a pharmac "Note to Attending Pl 04/25/24, documente Medicare and Medicastate that PRN [as no only be given x 14 da PRN psychotropic af must provide rationa for the PRN order. Heview of a quarterly assessment dated 09 #18 had moderately received Hospice selexpectancy of less the state of the provide selexpectancy of less the provide selexpectancy of less the provide selexpectancy of less the provide received t	ek and was not his doctor However, she reported she 39 yesterday and he was not s of a UTI at this time. She er intervention was required. d expect to be notified a pharmacy her next routine visit to the e situation required  s admitted to the facility most a generalized anxiety  for Resident #18 dated tivan (antianxiety medication) as a needed for anxiety or had no stop date.  by recommendation titled, hysician/Prescriber", dated ed: "CMS [Centers for aid Services] regulations eeded] psychotropics can ays. If the resident requires a ter 14 days, the physician le and indicate the duration dospice is not exempt."  Minimum Data Set (MDS) 5/13/24 revealed Resident impaired cognition. She rvices and had a life han six months. She did not hedication during this	F 75	56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET .AKE WACCAMAW, NC 28450	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 756	Continued From pag	ge 207	F 756			
		orders for Resident #18 as the PRN Ativan order initiated I in place.				
	(MAR) from January	ation Administration Record 2024 through June 2024 for ed PRN Ativan had been 27/24, 04/09/24 and				
	the Consultant Pharinotified the facility the recommendations of the recommendations of the recommendations of the recommendation or provide and the recommendation for the med had communicated to month that the report were urgent and need also spoke with the pregarding the pharm previous DON never when she spoke with current Agency DON PRN Ativan order, so May 2024 and sent to the recommendation of the recommendati	nonth after month on 1/18/24, 3/25/24, 4/25/24 and ue the PRN psychotropic ationale and indicate the ication. She wrote that she to the previous DON every thad medication issues that eded to be addressed. She previous DON monthly acy reports. She stated the had the reports available in her. She had emailed the I on 4/29/24 regarding the poke with her in person in the another email on 05/28/24 order. She noted hospice				
	06/13/24 at 4:33 PM the 14 day rule for P She stated she was recommendations re had not been able to	the current Agency DON on she stated she was aware of RN psychotropic medication. aware of the pharmacy garding the PRN Ativan but o communicate effectively ysician to get the medication				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS,  106 CAMERON STE  LAKE WACCAMA			
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F 756	Continued From page	e 208	F	56			
	conflict" between thei documented that atte discontinue the medic pharmacy recommen Consultant Pharmaci discontinue the Ativar 2024.	dation. She was aware the st had made the request to n order in April and May					
	06/12/14 at 1:50 PM previous physician. A made on 06/13/24 at Other attempts were physician by different	attempts were made on and 3:33 PM to contact the An additional attempt was 3:00 PM with no response. made to contact the surveyors on the team y week with no response.					
	on 06/19/24 at 9:30 A working at the facility of the 14 day rule for applied even if the reservices. She was not Pharmacist had reconstopped or reviewed stop date. She expect of pharmacy recomm psychotropic medicat date during her routin called if a recommendation.  3. Resident #50 was	ne facility's current physician and she stated she started last week. She was aware PRN psychotropics that sident was on hospice of aware the Consultant mmended the medication be with justification and given a cted the facility to notify her endations and of PRN ions that did not have a stop le visits to the facility or to be dation needed immediate					
	artery disease, high be kidney disease, and de A review of a physicia	included, in part, coronary blood pressure, chronic congestive heart failure.  an's order written on we one tablet of Carvedilol (a					

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION   BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING	B. WING		C 07/02/2024		
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			10	TREET ADDRESS, CITY, STATE, ZIP CODE D6 CAMERON STREET AKE WACCAMAW, NC 28450	077	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 756	milligrams twice daily heart rate less than 6 systolic blood pressur milligrams per mercur with meals.  A review of Resident administration record administer the Carved revealed the following:  05/11/24 the blood pr. 100/59 mm/Hg and th. 59 bpm at 9:00 AM at. Manager #1 05/15/24 the blood pr. 106/68 mm/Hg at 9:00. Nurse #9 05/26/24 the blood pr. 109/63 mm/Hg at 5:30. Unit Manager #1 05/27/24 the blood pr. 103/69 mm/Hg at 5:30. Unit Manager #1 Review of the Consult medication regimen rethrough 05/27/24 reveorder to hold Carvedii heart rate less than 6 as ordered. Please review with nurses."  An interview was conconsultant on 06/11/27. The Pharmacist Conscompleted her medical	aronary artery disease) 12.5 and to hold medication for a 0 beats per minute (bpm) or re (SBP) less than 110 ry (mg/Hg) and administer  #50's medication (MAR) for May 2024 to dilol 12.5 milligrams g: essure recording was ne heart rate recording was ne heart rate recording was no AM and was signed off by essure recording was 0 AM and was signed off by essure recording was 0 PM and was signed off by essure recording was 0 PM and was signed off by	F	756				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345185		1	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		B. WING _			C 07/02/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 106 CAMERON STREET LAKE WACCAMAW, NC 28450		7/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 756	She added, she with regimen to addiconcerns right awas stated a blood premedication and if an order, the experiessure medication the physician's order the parameters. She at risk for increpressure) or brady the medication was an interview was a Nursing (DON) on DON stated the Please the May pharmacy had finished. She actual date she reof this date, she high pharmacy recommendation is medication and was possible.  A phone interview 06/19/24 at 9:30 A expected to be no medication error is when it occurred.  4. Resident #47 with diag disorder (a mental extreme mood swith a state of the same and the	y after she finished her review. ould expect the DON to review dress any high risk medication ay. The Pharmacist Consultant assure medication is a high risk there were parameters given in actation was that the blood on would be held according to der if the reading was outside the stated the resident would assed hypotension (low blood accardia (decreased heart rate) if	F	756			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION  IG	(X3	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS, CITY, STATE, ZIP COD 106 CAMERON STREET LAKE WACCAMAW, NC 28450	DE	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 756	mental health conditi think, feel and behave Resident #47's electrorevealed the last asses Involuntary Movement measures the severificaused by neuroleptical known for their ability and delusions), was reported Resident #4 involuntary movement psychotropic medical A review of Resident physician order dated medicine that treats to a milligrams (mg) and dyskinesia (a drug in that causes involuntate physician order dated HCL (an antipsychotic bipolar disorders and a day for bip	onic medical record (EMR) essment for Abnormal at Scale (AIMS), a scale that y of involuntary movements c medications (medications to attenuate hallucinations dated 11/06/2023 and 7 was not experiencing ats, an adverse side effect to tions.  #47's EMR included a d 2/24/2024 Ingrezza (a dody movement disorders) to bedtime for tardive duced movement disorder ary facial tics), and a d 3/27/2024 for Ziprasidone c medication used to treat schizophrenia) 80 mg twice rder.  ion Regimen Review (MRR) cited by the Consultant a recommendation for an ar Resident #47.  and June 2024 Medication ds (MARs) indicated derived the medications done HCL daily as prescribed	F 7	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
	345185 B. WIN		B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,  106 CAMERON STREET  LAKE WACCAMAW, NC 284		07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 756	completed on resider every six months, and pharmacy recomment assessment for Residenthe Director of Nursin In an interview with L 6/14/2024 at 11:18 and recommendations were Nursing (DON), and supharmacy recommenter receive an AIMS assesstated there was a country to the DON and herself recommendations not fax machine, shredded AIMS assessments in the EMR for nurses not aware Resident # assessment  In an interview with the 6/12/2024 at 10:04 and experiencing internet had not reviewed the recommendation for why AIMS assessment the DON explained A generated through the just learned how to me EMR. She said she had managers training on assessments as she the week this recertification.	atts receiving antipsychotics of she communicated the dations for a AIMS dent #47 through an email to g (DON) on 5/25/2024.  Init Manager #1 on m, she stated pharmacy are sent to the Director of she had not received a dation for Resident #47 to assment from the DON. She ammunication gap between and understood at received were left on the ad or lost. She explained should automatically populate as to complete, and she was a 47 needed an AIMS  The Director of Nursing on m, she explained due to outages in May 2024, she May 2024 pharmacy Resident #47. When asked and had not been completed, IMS assessments were a EMR and stated she had a higrate this information to the ad not provided the unit the process of adding AIMS was planning a training for	F7	756			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 756	revealed a diagnose diagnosis of general Review of the physical revealed an order of milligrams (mg) give tube (a tube surgical provide nourishment every 8 hours as new Review of the Marcon revealed on 3/21/24 administered PRN 4 date of 3/7/24.  Review of a quarter 3/29/24 revealed Reimpaired cognition and medication.  Review of the April revealed on 4/5/24 PRN Ativan 0.5 mg  Review of the May 3 revealed on 5/12/24 administered PRN 4 date of 3/7/24.  Review of Resident record revealed a Corecommendation titt Physician/Prescribe indicated in part: the PRN psychotropic rexempt. If the reside psychotropic after 1 provide rationale are revealed and control of the provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic are revealed and control of the psychotropic after 1 provide rationale are revealed and control of the psychotropic are revealed and control of the psychotropic are revealed and control of the psychotropic and control of the psychotropic are revealed and control of the psychotropic	des report which included a dized anxiety disorder.  Ician orders for Resident #22 ated 3/7/24 for Ativan 0.5 de one tablet via gastrostomy ally placed in the abdomen to at, liquids and medications) deded for anxiety.  In 2024 MAR for Resident #22 determined that had a start was activan 0.5 mg that had a start was administered and received an antianxiety and received an antianxiety and received an antianxiety and start date of 3/7/24.  In 2024 MAR for Resident #22 the resident was administered that had a start date of 3/7/24.  In 2024 MAR for Resident #22 the resident was administered that had a start date of 3/7/24.  In 2024 MAR for Resident #22 the resident was administered that had a start date of 3/7/24.  In 2024 MAR for Resident #22 the resident was activan 0.5 mg that had a start was activan 0.5 mg that h	F 756			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 756	Continued From pa	ge 214	F 75	6			
		lys with a rationale of Hospice.  Id by the previous Physician					
	revealed on 6/3/24,	2024 MAR for Resident #22 6/16/24 and 6/23/24 resident PRN Ativan 0.5 mg that had a					
	06/12/24 at 9:15 AM facility through a ph discontinue the PRI provide a rationale the medication. The stated residents recond exempt from this Pharmacist indicate the facility under the with the recommentate Completed her medicated a copy of Mursing (DON) with The Consultant Phatthe DON to review of the provided that	the Consultant Pharmacist on M she stated she notified the narmacy recommendation to N psychotropic medication or and indicate the duration for a Consultant Pharmacist seiving Hospice services were so regulation. The Consultant and there had been problems in the previous Director of Nursing dations not being addressed. The armacist stated when she incation regimen review, she were review to the Director of the initial and and after she finished. The armacist stated she expected the medication regimen review commendations right away.					
	previous Physician 6/13/24 at 3:00 PM call was received.	e via phone to interview the on 6/12/24 at 3:33 PM and with messages left. No return conducted with the current					
	Director of Nursing PM. The DON statthe facility since the DON stated she was	(DON) on 06/13/24 at 4:33 ed she was in the position at e end of March 2024. The s aware of the 14-day psychotropic medication, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345185			` ′	PLE CONSTRUCTION  G	, , ,	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		C 07/02/2024		
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	communicate with the the medication discording the Consultant Pharm recommendations via reviews were comple was responsible for reconsultant Pharmaci DON stated she saw recommendation for laware that the previous Hospice on the recomprovide a stop date of psychotropic medicat was given to the previous the DON indicate conversation with him.  An interview was consultant Physician stated she on 6/7/24 and was not residents, their orders facility. The Physicia the 14-day regulation that this applied even Hospice services. Shootify her of pharmaci address the recommending that did not physician stated she medication that did not physician stated she recommending that the physician stated she medication stated she recommending that the physician stated she recommending the physician sta	thad not been able to e previous physician to get natinued. The DON indicated nacist sent her the email after her monthly ted. The DON stated she eviewing and addressing the st recommendations. The the 5/27/24 Resident #22 and was us physician indicated mendation and did not rediscontinue the as needed ion. The recommendation ious physician to address dishe had not had a regarding this.  ducted with the current on 6/18/24 at 1:15 PM. The started working at the facility of familiar yet with the enstated she was aware of for PRN psychotropics and if the resident was on the expected the facility to y recommendations, endations as indicated and the deded psychotropic to thave a stop date. The was not made aware the mended Resident #22's and or reviewed with a a stop date.	F 7	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		07/02/2024		
	ROVIDER OR SUPPLIER	ENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	, 0.102.202.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 756	Continued From pag	ge 216 onic health record for	F 756				
		ed a diagnosis report which sis of diabetes and diabetic					
	Resident #46 reveal	onic health record for ed a physician order dated tin 800 milligrams (mg) twice in.					
	Administration Reco medication Gabaper twice per day was re indicated to see nurs notes for both sched	#46's May Medication rd (MAR) revealed the ntin 800 milligrams (mg.) ecorded as "9" which sing administration progress luled doses on 5/10/24, 13/24, 5/14/24, 5/15/24,					
	revealed administrat						
	by the Consultant Pl medication error was electronic health rec	Medication Record Review narmacist indicated a s identified in Resident #46's ord. The note indicated ked out of stock for 13 doses e review with staff.					
	Consultant Pharmac The Consultant Pha completed her medi- emailed a copy of he Nursing (DON) withi	nducted via phone with the cist on 6/12/24 at 9:15 AM. rmacist stated when she cation regimen review, she er review to the Director of n a day after she finished. rmacist stated she expected					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>7/02/2024</b>	
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	01/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 756	the DON to review the and address any me.  An interview was con Nursing (DON) on 6/ was unable to explair as a result of the Codated 5/27/24 that in had been made with The DON stated she medication error with completed a medicar DON stated the Phasthe May pharmacy review on 5/27/24. It knows the actual date DON stated as of this some of the May phanot all of them and suphysician about the soccurred. The DON addressed this recommendations.  An interview was con Physician via phone Physician stated she on 6/7/24. The Physician stated she on 6/7/24. The Physician stated she on 6/7/24. The Physician error of the medication error of the commendations.  7. Resident #8 was a 8/19/23 with diagnostic stated she on the commendation of the error o	ne medication regimen review dication errors right away.  Inducted with the Director of (13/24 at 4:33 PM. The DON in any action that was taken insultant Pharmacist's report indicated a medication error. Resident #46's gabapentin. It had not reviewed the instaff, nor had she it tion error incident report. The intermediations after her incommendations but he had not notified the indicated she should have indicated she should have indicated with the current on 6/18/24 at 1:15 PM. The estarted working at the facility sician stated she expected	F 7	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		,	C 07/ <b>02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 756	Continued From pag	e 218	F 75	56		
	record (EMR) included orders: 9/22/23: Ozempic 0 subcutaneously one type 2 Diabetes Mel 8/19/23: Rivaroxabathe evening for atria 8/19/23: Glipizide 1 times a day for type  A Pharmacy Consult Review (MRR) report Ozempic weekly do doses in April and 1 without medication Montelukast, Rivaromed error), Zotrix, Gerror) not charted 6 pharmacist consultathe errors and review  In an interview with the on 6/12/24 at 11:00 the Pharmacist Consultathe errors and therefore medication errors or nurses.  During a phone interproportion of 12/24 and indications were available of 12/24 and indications with medication with medications were available of the problem with medication	an 5 mg - 1 tablet by mouth in fibrillation 0 mg - 1 tablet by mouth two 2 Diabetes Mellitus cant Medication Regimen t dated 5/26/24 read se marked out of stock x 2 in May. That is 3 weeks				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION IDENTIFICATION NUMBER:  AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF COMPLEX (X3) DATE STATEMENT OF CORRECTION (X3) DATE STATEMENT OF CONFIDENCE (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE STATEMENT OF CONFIDENCE (X6) DATE						
		345185	B. WING				C <b>02/2024</b>
	ROVIDER OR SUPPLIER	NTER	•	106 C	ET ADDRESS, CITY, STATE, ZIP CODE CAMERON STREET E WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	She indicated her cor #8's omissions of the hyperglycemia, increa blood clots, and incre	aware of the concerns.  ncerns regarding Resident  ordered medications was  ased risk for formation of  ased pain.		756			
F 758 SS=E	CFR(s): 483.45(c)(3)( §483.45(e) Psychotro §483.45(c)(3) A psychological affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	opic Drugs. hotropic drug is any drug that s associated with mental rior. These drugs include, drugs in the following	F	758			7/27/24
	psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medicatio	nts who have not used re not given these drugs in is necessary to treat a diagnosed and documented ints who use psychotropic I dose reductions, and was, unless clinically in effort to discontinue these					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
345185	B. WING _		C 07/02/2024	
R		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212021	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
s for psychotropic drugs except as provided in ading physician or elieves that it is order to be extended the should document their medical record and the PRN order.  Is for anti-psychotic that are sident for an elieves the resident for at medication. The elieves the service of the elieves and cannot be adding physician or evaluates the resident for at medication. The elieves the service of the elieves the service of the elieves the e	F 7	The facility failed to limit an as n (PRN) psychotropic medication to (Resident #18 and Resident #22 an appropriate diagnosis for an antipsychotic medication (Resider and monitor for abnormal involunt movements on a resident receivity antipsychotic medication (Resider for 4 of 5 residents reviewed for unnecessary medications.  All residents residing in the facility been identified as having the pothe affected by the alleged deficite practice.  The Director of Nursing (DON) of Designee, will review all antipsychedication usage to ensure all Predications have a 14 day stop of the sident forms.	o 14 days ), provide ent #269), stary ng an ent #47)  by have ential to ent chotic RN	
	345185  ER  MENT OF DEFICIENCIES UST BE PRECEDED BY FULL	A. BUILDIN  345185  B. WING  MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)  S for psychotropic drugs xcept as provided in nding physician or elieves that it is order to be extended ne should document their medical record and he PRN order.  S for anti-psychotic ays and cannot be nding physician or valuates the resident for at medication. not met as evidenced  and Consultant ysician interviews the s needed (PRN) to 14 days (Resident #18 de an appropriate hotic medication nitor for abnormal on a resident receiving an (Resident #47) for 4 of 5 innecessary medications.  hitted to the facility most  art, generalized anxiety  orders for Resident #18	A BUILDING  345185  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  BENT OF DEFICIENCIES  ISTS BE PRECEDED BY FULL  DENTIFYING INFORMATION)  DESTREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450  PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE APP  DEFICIENCY)  DEFICIENCY)  F 758  S for psychotropic drugs  Xcept as provided in  ading physician or  valuates that it is  order to be extended  the should document their  medical record and  the PRN order.  S for anti-psychotic  asys and cannot be  ading physician or  valuates the resident for  at medication.  not met as evidenced  and Consultant  ysician interviews the  s needed (PRN)  to 14 days (Resident #18  de an appropriate  thotic medication  nitor for abnormal  an a resident receiving an  (Resident #47) for 4 of 5  Innecessary medications.  All residents residing in the facility  been identified as having the pot  be affected by the alleged deficie  practice.  The Director of Nursing (DON) or  Designee, will review all antipsyc  medication usage to ensure all P  medications have a 14 day stop  medication have a 14 day stop	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
							С
		345185	B. WING _			0	7/02/2024
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	LIVING AND REHAB	CENTED		106 C	AMERON STREET		
PREWIER	LIVING AND REHAB	CENTER		LAKE	WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	Continued From pa	age 221	F 7	758			
	-	5 mg (Milligram)-give one			ntipsychotic medications have		
		ery 6 hours as needed for			ppropriate diagnoses, and to ensu	re all	
	anxiety or agitation				Ms assessments are completed a		
	anniory or agriculori	•			date. The DON will review all as	na ap	
	Review of the Janu	uary 2024 MAR (Medication			eeded (PRN) psychotropic medica	tions	
		ord) for Resident #18 revealed			r Resident #18, Resident #22, Res		
		ad been administered PRN			269, and Resident #47 by 8/5/2024		
	Ativan 0.5 mg that	had a start date of 11/08/23.			ill ensure the AIMs assessments for		
				R	esident #18, Resident #22, Reside	ent	
	Review of the April	2024 MAR for Resident #18		#2	269, and Resident #47 have been		
	revealed on 04/09/2	24 and 04/23/24 she had been		cc	ompleted by 8/5/2024.		
		Ativan 0.5 mg that had a start					
	date of 11/08/23.				ne DON or Designee will educate	all	
					ursing staff by 8/5/2024 on the		
		rly MDS assessment dated			quirements for PRN antipsychotic		
		Resident #18 had moderately			edications, as well as the importar	nce of	
		She had received scheduled			onitoring the side effects of the		
		n medications during the			edications by completing the AIMs ssessments as scheduled. After	<b>;</b>	
	Hospice services.	ack period. She received			5/2024 newly hired staff will be ed	jugated	
	Tiospice services.				the DON or Designee during thei		
	In an interview with	the Consultant Pharmacist on			re employee orientation.	I IICW	
		M she stated she had notified		'	o employee enemation.		
		pharmacy recommendations		В	eginning 7/27/2024, the DON or		
		to discontinue this PRN			esignee will audit antipsychotic us	age 5	
	psychotropic or pro	ovide a rationale and indicate			nes per week x 12 weeks to ensur		
	' ' ' ' '	medication. She noted			RN medications have a 14 day sto		
	residents who rece	ived Hospice services were		da	ate, and to ensure all antipsychotic	· :	
	not exempt from the	is regulation.		m	edications have appropriate diagn	oses.	
				Th	ne DON or Designee will also audi	t all	
		view was conducted with the			Ms assessments weekly to ensure		
		acist on 06/26/24 at 1:17 pm.			ssessments are completed as sch		
		nmendations on 12/19/23,			r 12 weeks. Any missing stop date		
		, 03/25/24, 04/25/24, and			nd/or AIMs assessments will result		
		the ongoing PRN Ativan			education and additional training	tor the	
		she communicated to the		ap	opropriate nursing staff.		
		(DON) that the pharmacy		_	7/07/0064		
	l '	ation issues that were urgent			eginning 7/27/2024, the audits will		
	i and needed to be a	addressed. She had spoke with	1	re	viewed by the Licensed Nursing F	IUIIIE	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	COMF	
		345185	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		01702/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	She had emailed the and in May she spok person and sent an extreme the use of the PRN A. In an interview with the PM she stated she was aware of the recommendations becommunicate with the Medical Director at the discontinued becaus listen to her. She existed any attemption of the 14 day regulated that applied even if the services. She was not recommended the more reviewed with justifice the sexpected the factor recommendations are medications that did the services. Resident # 22 was recently on 06/22/23 Review of the diagnor.	Agency DON on 04/29/24 e with the Agency DON in email on 05/28/24 regarding stivan.  The DON on 06/13/24 at 4:33 Fas aware of the 14 day sychotropic medication, and expharmacy at had not been able to be physician who was the netime to get the medication eshe stated he would not plained she had not empts to discontinue the stated she started a last week. She was aware ion for PRN psychotropics he resident was on Hospice of aware the pharmacy had edication be stopped or ation and given a stop date.  Stated to the facility most admitted to the facility most	F 75	Administrator (LNHA) or DON, a results of the audits will be revie monthly Quality Assurance and Performance Improvement (QAI Meeting monthly for 3 months. To Committee will review the audits make recommendations as nece assure ongoing compliance is so The facility will utilize this plan of correction to ensure compliance mandated regulation by 8/6/202 audits will continue for the specitimeframe as described in this caction.	PI) The QAPI and essary to sustained. f under the 4 and the fied	
		ian orders for Resident #22 ted 3/7/24 for Ativan 0.5				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01102/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION
F 758	milligrams (mg) give tube every 8 hours in tube every 8 hours in Review of the March revealed on 3/21/24 administered PRN in date of 3/7/24.  Review of a quarter 3/29/24 revealed Review of the April revealed on 4/5/24 PRN Ativan 0.5 mg  Review of the May in revealed on 5/12/24 administered PRN in date of 3/7/24.  Review of Resident record revealed an Physician/Prescribe indicated in part: the PRN psychotropic revempt. If the reside psychotropic after 1 provide rationale and PRN order. The note was signed previous Physician Review of the June in	e one tablet via gastrostomy as needed for anxiety.  In 2024 MAR for Resident #22 If the resident was Ativan 0.5 mg that had a start  If MDS assessment dated esident #22 had moderately and received an antianxiety ent #22 was not coded as ervices.  2024 MAR for Resident #22 resident was administered that had a start date of 3/7/24.  2024 MAR for Resident #22 resident was administered that had a start date of 3/7/24.  2024 MAR for Resident #22 and 5/21/24 resident was Ativan 0.5 mg that had a start  # 22's electronic health lote to Attending or dated 5/27/24 which eresident had an order for a nedication and Hospice is not lent required a PRN 4 days, the physician must dindicate the duration for the te was checked to continue ys with a rationale of Hospice. d as a telephone order by the	F 75	8	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	'	01702/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	start date of 3/7/24.  In an interview with the 06/12/24 at 9:15 AM of facility through a phare discontinue the PRN provide a rationale and the medication. The Costated residents received not exempt from this example of the medication of exempt from this example.  Attempts were made previous Physician or 6/13/24 at 3:00 PM we call was received.  In an interview was conversing (DON) on 06 DON stated she was regulation for PRN possible was aware of the recommendations but communicate with the Medical Director at the discontinued.  In an interview was covia phone on 6/1824 as the stated she started 6/7/24. The Physicial the 14-day regulation that this applied even Hospice services. Shoutify her of pharmace	the Consultant Pharmacist on the stated she notified the macy recommendation to psychotropic medication or dindicate the duration for consultant Pharmacist ving Hospice services were regulation.  In the phone to interview the moducted with the Director of the state of the 14-day such of the state of the services medication, and pharmacy that not been able to ephysician who was the etime to get the medication on the stated she was aware of for PRN psychotropics and if the resident was on the expected the facility to you recommendations and of edications that did not have	F 7	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		345185	B. WING_			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 106 CAMERON STREET LAKE WACCAMAW, NC 28450		07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	Review of Resident # electronic health recotoxic encephalopathy caused by exposure to Review of Resident # summary dated 3/7/2 to receive haloperidol (mg) at bedtime.  Resident #269's admentered in the computincluded haloperidol 2 The dose of 20 mg w. computer in error. The computer by the F (DON).  Review of a Medicatic dated 3/8/24 for Resident #3/8/24 for Resident #4/8/24 for Resident #4/8/24 for the schedurevealed haloperidol 2 administered at 8:00 3/7/24 for the schedurevealed the medications administered on 3/3/11/24, 3/12/24, and Resident #269's adm (MDS) dated 3/14/24 cognitively intact, exhipsymptoms and had no or psychotic disorder.	269's diagnosis report in the ord revealed a diagnosis of (a neurological disorder to toxic substances).  269's hospital discharge 4 indicated the resident was 12 tablets of 2 milligrams  anission physician orders the system on 3/7/24 20 mg at bedtime for mood. The order was entered into the ne order was entered into the ne order was entered into Previous Director of Nursing on Regimen Review (MRR) dent #269 indicated an accompleted with no dations.  269's March 2024 action Record (MAR) 20 mg was scheduled to be PM. The MAR was blank on led 8:00 PM dose. The MAR ion was electronically signed (8/24, 3/9/24, 3/10/24, 3/13/24.  The ission Minimum Data Set indicated the resident was sibited no behavioral or diagnosis of a psychiatric	F 7	758			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	sent to the emergence returned with orders tablets of 2 mg at be Review of Resident; revealed an order damg give 1 tablet at b was entered by the produced discontinued on 3/15.  Review of the March #269 revealed halop bedtime on 3/14/24 awith a "9" indicating of Resident #269's not revealed there was rounded and give 2 tablets at Review of Resident; revealed an order damg give 2 tablets at Review of the March #269 revealed halop bedtime for mood wars 3/16/24, 3/17/24, 3/11.  Review of a nursing indicated Resident #Review of a Home Dindicated dated 3/20 mg take 2 tablets at included in the list of An interview was conforted.	cy room on 3/14/24 and to continue haloperidol 2 dtime.  #269's physician orders ated 3/14/24 for haloperidol 2 dedime for mood. The order orevious DON and was at 8:00 PM was documented to see nurses notes. Review arising progress notes are corresponding note on at 8:00 PM was documented to see nurses notes. Review arising progress notes are corresponding note on at 8:00 PM was documented to see nurses notes. Review arising progress notes are corresponding note on at 8:269's physician orders at 8:04 PM AR for Resident eridol 2 mg give 2 tablets at 8:04 and 3/15/24 for haloperidol 2 progress note dated 3/20/24 and 3/19/24.  Progress note dated 3/20/24 and 3/19/24.	F 75	8	

		(X3) DATE COMP	SURVEY LETED				
		345185	B. WING _			l	02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CIT 106 CAMERON STREE LAKE WACCAMAW	ET	, <u> </u>	<b></b>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	prescribed for specifical The Physician further appropriate indication antipsychotic medical been clarified with the was written.  An interview was compliant of 6/12/2 Consultant Pharmacist on 6/12/2 Consultant Pharmacist usually only prescribe major psychiatric diagram propriate diagnosis medication. The Conthe order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the emergency of the order for haloperic clarified upon admissing from the order for haloperic clarified upon admission from the ord	g haloperidol were only to be copsychiatric diagnoses. In stated mood was not an an an for prescribing an	F	758			
	Director of Nursing (Director	OON) on 6/13/24 at 1:20 PM ous DON stated she entered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 758	admitted to the facil The previous DON is for haloperidol with previous DON indic was not an appropri In an interview with PM she stated she the end of March 20 aware of the regular diagnosis for psych was not in the posit in the facility. The I appropriate diagnos medication.  Attempts were mad previous Physician 6/13/24 at 3:00 PM call was received.  4. Resident #47 was 12/13/21 with diagn disorder (a mental if extreme mood swin highs and lows) and mental health condi think, feel and beha The last Abnormal I (AIMS), a scale that involuntary moveme medications (medic attenuate hallucinat assessment dated	lent #269 when he was ity from the hospital on 3/7/24. It stated she entered the order the incorrect dose. The ated she was not aware mood iate diagnosis for haloperidol.  Ithe DON on 06/13/24 at 4:33 had been in the position since 024. The DON stated she was tion for an appropriate otropic medication, but she ion when Resident #269 was DON stated mood was not an isis for an antipsychotic  e via phone to interview the on 6/12/24 at 3:33 PM and with messages left. No return as admitted to the facility on oses including a bipolar nealth condition that causes gs that include emotional dischizophrenia (a serious tion that affects how people ve).  Involuntary Movement Scale at measures the severity of ents caused by neuroleptic ations known for their ability to ions and delusions), 11/06/2023 in Resident #47's	F 758		
	extreme mood swin highs and lows) and mental health condition think, feel and behat the last Abnormal I (AIMS), a scale that involuntary movemedications (medicattenuate hallucinate assessment dated electronic medical r	gs that include emotional dischizophrenia (a serious tion that affects how people ve).  nvoluntary Movement Scale timeasures the severity of ents caused by neuroleptic ations known for their ability to ions and delusions), 11/06/2023 in Resident #47's ecord (EMR) reported tot experiencing involuntary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 01/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 758	Continued From page psychotropic medical	-	F 758	3		
	2/1/2024 indicated F	•				
	physician order date medicine that treats 80 milligrams (mg) a dyskinesia (a drug i that causes involunt physician order date HCL (an antipsycho	at #47's EMR included a ed 2/24/2024 Ingrezza (a body movement disorders) at bedtime for tardive induced movement disorder tary facial tics), and a ed 3/27/2024 for Ziprasidone of tic medication used to treat indisorder.				
	Reviews (MRRs) co Consultant on 5/25/	othly Medication Regimen onducted by the Pharmacist 24 revealed a r an AIMS assessment for				
	Administration Reco	nd June 2024 Medication ord (MAR) recorded Resident le medications Ingrezza and lily as prescribed by the				
	Consultant on 6/12/ explained AIMS ass completed on reside every six months, a pharmacy recomme assessment for Res	w with the Pharmacist 2024 at 10:44 am, she sessments were to be ents receiving antipsychotics and she communicated the endations for a AIMS sident #47 through an email to ing (DON) on 5/25/2024.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 758	Continued From page		F 75	8		
	assessment for Reside EMR screen when dura message to comple received the pharmace	nit Manager #1 on n, she stated the AIMS lent #47 populated onto the le and she had not observed te an AIMS assessment or le recommendation for an ted 5/25/2024 from the				
	6/12/2024 at 10:04 ar Resident #47 receiving the nursing staff should assessment every through why an AIMS assessment completed since 11/6 had not reviewed Respective assessment due to expect in May 2024. The DO recently learned how assessments to autostated she had not protraining on the process AIMS assessments direcertification survey training.	In an analysis of an analysis of auto-populating the week she planned the				
F 760 SS=K	CFR(s): 483.45(f)(2)  The facility must ensu §483.45(f)(2) Resider medication errors.  This REQUIREMENT by:  Based on record revi	re that its- nts are free of any significant is not met as evidenced ew and interviews with Itant Pharmacist, Pharmacy	F 76	The facility failed to prevent significant medication errors for 9 of 10 residents		
	rosident, stall, colled	itani i naimaoisi, i naimaoy		medication entries for a for residents		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345185	B. WING _			07/02/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
DDEMIED	LIVING AND DEHAD (	PENTED		106 CAMERON STREET			
PREMIER	LIVING AND REHAB (	ENIER		LAKE WACCAMAW, NC 28450	ı		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From pa	ge 231	, F 7	760			
F 760	Quality Assurance & Wound Clinic Physi prevent significant residents reviewed #51, Resident #46, Resident #32, Resident #8). Resident #8). Resident #8). Resident #8). Resident #8). Resident #8) of 2 tablets of 2 mg administered carvet treat heart failure, he pain) for 25 of the desperienced an eleberath requiring Emevaluation on 3/14/2. Resident #51 was regabapentin (prescriftom 5/8/24 through complaints of const of 0 to 10 with the 1 possible), numbnes She was transferred where she was treat gabapentin and return Resident #46 was regabapentin (prescriftom 5/10/24 through increased pain, trouirritability, nausea, a her normal routine of Resident #419 was	Specialist, Physician, and cian, the facility failed to medication errors for 9 of 10 (Resident #269, Resident Resident #419, Resident #39, dent #10, Resident #50, and dent #269 was administered 6 of (antipsychotic medication) instead of the ordered dosage at bedtime and was not dilol (a medication used to high blood pressure and chest ordered doses. Resident #269 wated pulse and shortness of hergency Department (ED) 24.  Not administered 21 doses of bed for nerve pain) 800 mg in 5/13/24 resulting in ant pain up to a 10 (on a scale 0 being the worst pain is in her legs, and spasms. It is in her legs, and spasms. It is in her legs, and spasms. It is in her legs in with	F 7	reviewed (Resident #269, Resident #46, Resident #39, Resident #32, Resident #39, Resident #50, and Res	ent #10, ent #8).  The facility have the potential to dideficient  The facility have the potential the facility from the he MDS RN an agency DON to be involved in the facility from the her facility from the her facility from the facility fr		
	Daptomycin (antibio	c) and 7 doses of IV otic) for treatment of his cral (triangular bone at the		Resident #269 received 6 20 mg instead of the orde			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345185	B. WING _			07	/02/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	LIVING AND DELIAD CE	NTED		10	06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NIER		L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	base of the spine) pressure ulcer. The resident was hospitalized on 4/5/24 and the 4/26/24 discharge summary indicated they suspected Resident #419's sepsis likely centered around his large stage 4 pressure ulcer with likely chronic osteomyelitis (bone infection).  In addition, the facility: administered 14 doses of Amoxicillin (antibiotic) to Resident #39 instead of the ordered Amoxicillin-Clavulanate; did not administer 34 doses of Resident #32's ordered mirtazapine (antidepressant medication); did not administer 23 doses of Resident #10's ordered tetrabenazine prescribed for the treatment of tardive dyskinesia (involuntary movements such as tongue thrusting, rapid eye blinking, repetitive chewing, that can occur with long term  tablets of 2 mg at bedtime. This resident also did not receive 25 doses of carvedilol, causing the resident to experience an elevated pulse and shortness of breath, requiring an E evaluation on 3/14/24.  Resident #51 missed a total of 21 of gabapentin 800 mg from 5/8/24 in the stage of gabapentin 800 mg from 5/8/24 in the stage of the discharge of the discharge of the spine also did not receive 25 doses of carvedilol, causing the resident to experience an elevated pulse and shortness of breath, requiring an E evaluation on 3/14/24.  Resident #51 missed a total of 21 of gabapentin 800 mg from 5/8/24 in the stage of gabapentin 800 mg from 5/10/24 the stage of gabapentin 800 mg from		carvedilol, causing the resident to	nt			
					shortness of breath, requiring an ED evaluation on 3/14/24.		
					Resident #51 missed a total of 21 dose of gabapentin 800 mg from 5/8/24 throi 5/13/24, resulting in constant pain at a level 10 out of 10, numbness in her leg and leg spasms.	ugh	
					gabapentin 800 mg from 5/10/24 throug 5/17/24, resulting in increased pain, trouble sleeping, anxiety, irritability, nausea, and unable to complete her da		
	doses not administer administer 12 doses of Oxycodone/Acetamin medication), 3 doses medication), 1 dose of	ed as ordered; and did not of Resident #8's nophen (opioid pain of Ozempic (anti-diabetic of Glipizide (anti-diabetic	nd did not  Resident #419 did not receive 6 doses of IV Rocephin and 7 doses of IV daptomycin for treatment of his stage 4 sacral pressure ulcer.				
	(anticoagulant).  Immediate Jeopardy	Amoxicillin-Clavulanate.  diate Jeopardy began on: 3/14/24 for ent #269 when haloperidol and carvedilol not administered as ordered and the ent required ED evaluation due to shortness  Amoxicillin-Clavulanate.  Resident #32 missed 34 doses of Mirtazapine.		Amoxicillin instead of the ordered Amoxicillin-Clavulanate.			
	were not administere resident required ED						
	of breath and an elevated pulse; 5/9/24 for Resident #51 when gabapentin not being administered as ordered resulted in a 10 out of 10 pain scale; 5/12/14 for Resident #46 when				Resident #10 missed 23 doses of tetrabenazine prescribed for the treatm of tardive dyskinesia.	ent	
	resulted in increased	administered as ordered I pain and difficulty sleeping, esident #419 when the			Resident #50 received 8 doses of the prescribed blood pressure medication without following the parameters ordered	ed	

PRINTED: 08/12/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_	<del></del>	Ι,	С
		345185	B. WING				02/2024
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	LIVING AND REHAB CE	INTED		10	06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	ENTER		L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page		F	760	L. H. was idea		
	the nurse was unable	ed (came out of her vein) and			by the provider.		
		e to restart the TV to ed antibiotic. Immediate			Resident #8 missed 12 doses of		
		ed on 6/15/24 when the			oxycodone/acetaminophen, 3 doses of		
		an acceptable plan of			Ozempic, 1 dose of glipizide and 1 dos		
	Immediate Jeopardy				of rivaroxaban.		
		lance at a lower scope and					
	severity of "E" (no ha	rm with the potential for			The DON or Designee will review all		
		arm that is not immediate			Medication Administration Records		
	• · • /	education is completed and			(MARs) for all residents to ensure there	<b>3</b>	
		out in place are effective.			are no missing doses by 8/5/2024. All		
		, #8, and #9 were cited at			missing doses will be reported to the	to.	
	scope and severity "E	Ξ.			provider and documentation will follow ensure compliance by 8/5/2024.	ιο	
	Findings included:				ensure compliance by 6/3/2024.		
					The DON or Designee will also review	all	
	1. Review of Resider	nt #269's hospital discharge			residents receiving blood pressure		
	summary dated 3/7/2	24 indicated the resident was			medications by 8/5/2024 to ensure they	/	
	_ ·	l 2 tablets of 2 milligrams			include parameters to follow, as well as	3	
	, -,	nood and carvedilol 12.5 mg			alert the nurses/med aides to obtain a		
	twice per day.				blood pressure prior to administering th	ie	
	D i d t #000	-l:			medication to ensure compliance by		
		idmitted on 3/7/24 with			8/5/2024.		
	_	uded congestive heart on and toxic encephalopathy			The DON or Designee will educate all		
		der caused by exposure to			nurses and medication aides by 8/5/20	24	
	toxic substances).				on the steps to follow when a medication		
	,				is not in stock, as well as proper		
	Resident #269's adm	ission physician orders			documentation that describes all the st	eps	
		cluded haloperidol 20 mg at			that were taken to ensure the resident		
		mood. The order was entered into receives their medications as ordered.					
	the computer by the previous Director of Nursing				After 8/5/2024 newly hired nursing staf		
	(DON).				will be educated by the DON or Design	ee	
	Resident #269's admission physician orders				during their new hire employee orientation.		
		not include carvedilol 12.5			Olicitation.		
	mg as indicated in his				The DON or Designee will also educate	e all	
	summary.	opilai dioonargo			nurses by 8/5/2024 on the importance		
					following orders in regard to blood		

Facility ID: 923415

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING		0.7	C / <b>02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP COD	•	102/2024	
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB	CENTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From page	age 234	F 7	60			
	·	nt #269's medical record		pressure parameters to ensu	re the		
	revealed the admis	ssion assessment was		resident receives or does not			
		se #9 on 3/7/24 at 3:22 PM.		medication related to the para			
				by the provider. After 8/5/202	4 newly hired		
	Review of Resider	nt #269's March 2024		nursing staff will be educated	by the DON		
		stration Record (MAR)		or Designee during their new	hire		
		lol 20 mg was scheduled to be		employee orientation.			
		00 PM. The MAR was blank on		D : : 7/07/0004 # DO			
		eduled 8:00 PM dose. The MAR		Beginning 7/27/2024, the DO Designee will audit medicatio			
		cation was electronically signed n 3/8/24, 3/9/24, 3/10/24,		administrations 5 times per w			
		and 3/13/24. The MAR further		weeks to ensure all medication			
		dent #269 did not receive		as ordered. Any missed admi	•		
		twice daily from admission on		will result in re-education with			
		morning of 3/14/24 as		appropriate staff members ar			
	_	spital discharge summary. This		disciplinary action will be take			
	resulted in 14 miss	sed doses of the medication		necessary.			
		3/7/24 through the morning of					
	3/14/24.			Beginning 7/27/2024, the DO			
				Designee will interview 3 resi	•		
		dmission Minimum Data Set		week x 12 weeks to ensure h	•		
	'	/24 indicated resident was		being managed effectively. A	-		
	medication.	and received antipsychotic		administrations will result in r			
	medication.			with the appropriate staff mer employee disciplinary action			
	Review of Resider	nt #269's March 2024 MAR		if necessary. Any pain that a			
		s were to be obtained every		expresses that is not being m			
	_	day shift (7:00 AM to 3:00 PM)		effectively will be reported to	-		
		recorded: Blood pressure		'			
	162/90 (elevated),	pulse 113 (elevated),		Beginning 7/27/2024, the LN	HA or		
	respirations 20 and	d temperature 97.0 degrees		Designee will audit the nursin			
	Fahrenheit.			completed by the DON or De			
				weekly x 12 weeks to ensure	•		
		nt #269's electronic health		for the facility. If it is identified			
		nursing progress note written		nursing audits are not comple			
	•	3/14/24 at 12:10 PM which		compliance with the Plan of (			
		complained of shortness of		(POC) it will result in re-educa			
		he did not feel right. Resident were: blood pressure 136/90,		appropriate staff members ar			
	#∠∪y s vilai siyns \	were. Dioou pressule 130/90.	1	disciplinary action will be take	511 (I	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07//	02/2024	
	ROVIDER OR SUPPLIER	ENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 077	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 760	Continued From pag pulse 113 (elevated) 97.5 and oxygen satioxygen. Resident #2 hospital. On 3/14/24 went out of the facilit department.  An interview was cor #9 on 6/13/24 at 2:00 was no longer emplostated she was assig 3/14/24 when he req emergency room for Resident #269 was r #9 further stated Res not feeling well, static wrong, his pulse was breath and reported Nurse #9 stated after the hospital, she revisaw the dose of halo #9 stated she did not haloperidol on her sh given on night shift. saw a dose of 20 mg to be given, she wou was a higher dose th #9 stated she would than normal with the	e 235 In respirations 22, temperature curation of 98% on 3 liters of 269 requested to go to the 4 at 12:25 PM Resident #269 by to the emergency  Inducted via phone with Nurse Depth Nurse #9 stated she byed at the facility. Nurse #9 stated to be sent to the evaluation. Nurse #9 stated not doing well that day. Nurse sident #269 complained of the did not feel good all over. In she sent Resident #269 to ewed his medications and peridol was 20 mg. Nurse to administer Resident #269 infit as it was ordered to be Nurse #9 indicated if she of haloperidol on the MAR lid not have given it since it in an normally ordered. Nurse clarify a dose that was higher	F 760	DEFICIENCY)	vill be y Home d the ed in the le QAPI and ssary to stained. under the and the ed		
	shortness of breath. tests were obtained required. Vital signs emergency departments 138/88, respirations	with a chief complaint of Chest x ray and laboratory with no further treatment upon discharge from the ent were blood pressure 18 and oxygen saturation 94 ge medication list indicated					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		, , ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345185	B. WING			C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1 07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 760	bedtime and carveding There was no indicated significant medication carvedilol.  Review of the electric Resident #269 revealed an order damy give 1 tablet at bloom was entered by the place discontinued on 3/14/24 with a "9" indicating of Resident #269 revealed there was a 3/14/24 at 8:00 PM.  Review of Resident revealed an order damy give 2 tablets at Review of Resident revealed an order damy give 2 tablets at Review of Resident record revealed an i #4 on 3/15/2024 at 3 Resident #269's ord transcribed in the coprogress note indicate incorrect dose of 3/11, 3/12, and 3/13.	to receive in part the dol 2 tablets of 2 mg at lol 12.5 mg twice per day. Iton in the ED report of the n errors with haloperidol or onic health record for aled the resident returned to 4 at 6:44 PM.  #269's physician orders ated 3/14/24 for haloperidol 2 edtime for mood. The order orevious DON and was 5/24.  #2024 MAR for Resident teridol 2 mg give 1 tablet at at 8:00 PM was documented to see nurses notes. Review tursing progress notes no corresponding note on  #269's physician orders ated 3/15/24 for haloperidol 2 bedtime for mood.  #269's electronic health noident note written by Nurse 8:58 PM. The note indicated er for haloperidol was mputer incorrectly. The ted Resident #269 received haloperidol on 3/8, 3/9, 3/10,	F 76				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 760	with no return call red worked at the facility.  The order for carvedi 3/14/24 ED discharge into Resident #269's resident returned to to the March 2024 MAI #269 did not receive daily on the evening morning of 3/20/24 at discharge summary. doses of the medicat A nursing progress in AM written by Nurse discharged home.  An interview was comphone on 6/27/24 at assigned to Resident PM to 7:00 AM and a 20 mg on 3/8/24 at 9 she administered the documented on the March and the Mar	s left on 6/11/24 and 6/12/24 ceived. Nurse #4 no longer filed 12.5 mg indicated in the e summary was not entered physician orders when the he facility.  R revealed that Resident carvedilol 12.5 mg twice of 3/14/24 through the s indicated in the ED This resulted in 12 missed	F 76			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345185	B. WING		07/02/2024	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 760	Continued From paç	ge 238	F 760			
	on 6/13/24 at 9:30 Ashe was assigned to 3/12/24 and 3/13/24 administered the ord Resident #269 at 9:1 and 3/13/24. Unit May question the dose of dose prior to adminion An interview was coon 6/13/24 at 8:15 As indicated normally, to orders in the computor orders with the Physiadmitted. Unit Manasure who was support the hospital, that she it must be someone Manager #2 confirm Resident #269 on 3/10/24 stated in the dose or hold the of 20 mg ordered be ordered.  An interview was coprevious Director of 1:20 PM. The previous Director of 1:20 PM. The previous order for haloperido she did not know who was supported to the orders into the con 3/7/24 when he was coprevious Director of 1:20 PM. The previous order for haloperido she did not know who was supported to the orders into the con 3/7/24 when he was coprevious Director of 1:20 PM. The previous order for haloperido she did not know who was supported to the orders into the con 3/7/24 when he was coprevious Director of 1:20 PM. The previous order for haloperido she did not know who was supported to the control of 1:20 PM. The previous Director of 1:20 PM. The previou	Inducted with Unit Manager #1  I.M. Unit Manager #1 stated I.M. Unit Manager #1 stated I.M. Unit Manager #1 stated I.M. Unit Manager stated she Idered doses of haloperidol to I.M. Unit Manager stated she did not I obtain a clarification of the Istering it.  Inducted with Unit Manager #2 I.M. Unit Manag				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING_			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 106 CAMERON STREET LAKE WACCAMAW, NC 28450	ODE	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT	
F 760	have an explanation of error. The previous Drecall if she sent the opharmacy. The previous Drecalled Resident #26 room but did not know previous DON stated facility shortly after the hospital.  An interview was con Pharmacy Quality Ass 6/12/24 at 11:50 AM. Specialist indicated the tablets of haloperidol Resident #269. The indicated the pharmathospital discharge sure Resident #269. The stated normally the ple discharge summary at entered and would carror to report discrepant Assurance Specialist the pharmacy record not receive a discharge the pharmacy pharmacist called the informed by the previous (DON) to send all Reseas they were entered Precautions indicated extreme caution with arrhythmia. The Quastated there was no computer for the halo	carvedilol and she did not for why other than human DON indicated she did not discharge summary to the ous DON stated she 69 went to the emergency why or the outcome. The she left the position at the eresident was sent to the ducted via phone with the surance Specialist on The Quality Assurance he pharmacy dispensed 30 if 20 mg on 3/7/24 for Quality Assurance Specialist cy did not receive the mmary dated 3/7/24 for Quality Assurance Specialist harmacist compared the and the orders that were still the facility for clarification incies. The Quality indicated documentation in indicated the pharmacy did ge summary for Resident record indicated the facility on 3/7/24 and was ous Director of Nursing sident # 269's medications into the computer. It to use haloperidol with residents with cardiac lity Assurance Specialist losage warning in the	F 7	60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 7/ <b>02/2024</b>
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Consultant Pharmaci The Consultant Phar 20 mg was a high do prescribed in an acut psychiatric diagnosis Pharmacist indicated had the potential for harm and receiving to for a sustained period effects. The Consult adverse effects could to sedation, somnole drooling and severe Consultant Pharmaci error was a significan Consultant Pharmaci carvedilol could resu exacerbation of atrial rate) and congestive Consultant Pharmaci systemic problem wit in the facility for som this with the current I March. The Consult pharmacy was support discharge orders to rentered into the com  An interview was cor Physician on 6/11/24 stated she was new on 6/7/24. The Phys a physician she had 20 milligrams of halo indicated the recomm prescribe was 2.5 mi	ist on 6/12/24 at 9:15 AM. Imacist indicated haloperidol Ise which was usually only Ite setting with a major Is. The Consultant If the high dose of haloperidol Is adverse effects including In medication at that dose Is include but were not limited Is include the haloperidol In medication error. The Is is treported the omission of It in harm due to potential for If fibrillation (irregular heart Inheart failure. The Is it indicated there was a It medication administration Is it indicated the based to receive a copy of the Is it indicated the ones of the reconcile that with what was Inputer by the facility. Inducted via phone with the Is at 1:00 PM. The Physician It the facility having started Is included the ones of the received a dose of the ones of the physician Intended dose that she would Illigrams to 5 milligrams as a	F 76	50		
	indicated the recomn prescribe was 2.5 mi one-time dose for an The Physician furthe	nended dose that she would				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 760	effects such as sedar and respiratory difficute omission of carve medication list from a discharge on 3/20/24 the potential for serior changes in blood preof breath and worser failure.  An interview was conditional discharge of Nursing (Interpretational discharge) and interview was conditional discharge of the error Resident #269's order made by the previous did not recall how she error. The DON state transcribed correctly to be faxed to the phase of the error administrator on 6/12 Administrator stated medications would be administered correctly unaware of the error transcription of Resident #51 was diagnosis which inclusing arthritis, pressure ulcous disorder that cause and interview was conditional disorder that cause and inclusions which inclusions which inclusions which inclusions which inclusions with the cause of the carror transcription of the error transcription of Resident #51 was diagnosis which inclusions which inclusions which inclusions with the cause of the carror transcription of the error	cion, increased tiredness, alty. The Physician reported edilol from Resident #269's admission on 3/7/24 through a was concerning and had us adverse effects including ssure, heart rate, shortness sing of congestive heart  adducted with the current DON) on 6/12/24 at 2:15 PM. The incorrect dose of ared to Resident #269 was a merror. The DON stated she for with the transcription of area and stated the error was a DON. The DON stated she are was made aware of the dishe expected orders to be and the discharge summary farmacy by the floor nurse.  Adducted with the was transcribed and y. She stated she was that occurred with the lent #269's medications.  Admitted on 10/19/23 with added in part: chronic pain ack pain, rheumatoid ers, and spastic paraplegia ers progressive weakness, ain and muscle spasms of	F 76		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION
F 760	revealed an 11/21/23 milligrams (mg) 4 times Review of Resident # Data Set (MDS) date was cognitively intact. The MDS assessment scheduled and as net pain interview was not repain interview and repair interview was not repain interview was not re	#51's physician orders forder for gabapentin 800 res per day for nerve pain. #51's quarterly Minimum rd 4/4/24 indicated resident rt and exhibited no behaviors. In the was coded as received reded pain medication. The rot assessed.  Ration Administration Record rident #51's gabapentin was rinistered at 9:00 AM, 12:00 right and specified the revealed the following revealed the following revealed the following revealed the following revealed the service #8 red the corresponding revealed the rival of gabapentin rmacy. Red indicated Nurse #8 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no reg note. Red indicated Nurse #9 red there was no	F 76	0	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	345185	B. WING		07/02/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110112024
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
documented a "9" corresponding nu  Following readmis pain assessment Nurse #9. The particular Resident #51 had pain rating of 10 a sleep and day to opain.  A nursing progress indicated Resident too much pain.  An interview was at 5:12 PM with N was assigned to F5/10/24. Nurse #Resident #51. Nu increased pain why gabapentin. Nurse the MAR indicated available. If a mestated she would Unit Manager #1. recall when, but shanager #1 that I not available. Nu frustrated about my gabapentin as ord.  A nursing progress 5/10/24 at 3:24 Al reported her legs the nurse informe.	on PM indicated Nurse #8 and there was no raing note.  Sision to the facility on 5/8/24, a dated 5/9/24 was completed by an assessment indicated a pain almost constantly with a and the pain made it hard to day activities were limited due to as note by Nurse #9 on 5/9/24 at #51 refused a shower due to conducted via phone on 6/13/24 lurse #8. Nurse #8 stated she Resident #51 on 5/8/24 and 8 stated she was familiar with rese #8 stated Resident #51 had nen she did not receive her see #8 stated "9" documented on the medication was not dication was not available, she wait a few days and then notify Nurse #8 stated she did not he knew she notified Unit Resident #51's gabapentin was rese #8 stated Resident # 51 was ot receiving the medication	F 76		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLETED	
		345185	B. WING		C 07/02/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0710212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 760	notes revealed the for #51's gabapentin: 5/10/24  - The MAR for 9:00 A documented a "9" and corresponding nursir.  - The MAR for 12:00 documented a "9" and corresponding nursir.  - The MAR for 5:00 F documented a "9" and corresponding nursir.  - The MAR for 9:00 F documented a "9" and corresponding nursir.  - The MAR for 9:00 F documented a "9" and administration record the facility was await 800 mg from the phate was a signed to Resident from 7:00 AM to 7:00 Resident # 51's gabate 5/9/24 and 5/10/24 for 9:00 AM, 12:00 PM are vealed she documented and she do	edication administration allowing related to Resident allowing related to Resident allowing related to Resident allowing related Nurse #9 and there was no ag note. and indicated Nurse #9 and there was no ag note. and indicated Nurse #9 and there was no ag note. and indicated Nurse #13 and the corresponding	F 76		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		345185	B. WING			l	0
NAME OF DE	ROVIDER OR SUPPLIER	343103	B. Willo	_	STREET ADDRESS, CITY, STATE, ZIP CODE	071	02/2024
NAME OF F	NOVIDER ON SUFFLIER				106 CAMERON STREET		
PREMIER LIVING AND REHAB CENTER				LAKE WACCAMAW, NC 28450			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	245	F	76	0		
	The MAR and the me notes revealed the fol #51's gabapentin: 5/11/24  - The MAR for 9:00 A #1 documented a "9" corresponding nursing. The MAR for 12:00 P documented a "9" and progress note on 5/11 gabapentin 800 mg with pharmacy and the nurnext shift to follow up. The MAR for 9:00 P documented a "9" and corresponding nursing. The MAR for 9:00 P documented a "9" and corresponding nursing. An in-person interview Manager #1 on 6/13/2 Manager #1 revealed Resident #51 on 5/11 PM and she documer gabapentin was not a doses at 9:00 AM and #1 stated she did not	dication administration lowing related to Resident  M indicated Unit Manager and there was no g note.  PM indicated Unit Manager and there was no g note.  M indicated Nurse #14 d the corresponding 1/24 at 4:15 PM indicated ras pending from the rse pass on information to  M indicated Nurse #2 d there was no g note.  w was conducted with Unit 24 at 8:00 AM. Unit she was assigned to 1/24 from 7:00 AM to 3:00					
		to interview Nurse #14 via left on 6/13/24 and 6/14/24 eived.					
	at 3:48 AM indicated	en by Nurse #2 on 5/12/2024 Resident #51 complained of nd requested to be sent to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, , ,	E SURVEY IPLETED
		345185	B. WING _		0.	C 7/ <b>02/2024</b>
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450		1102/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	oriented and stated the gabapentin withdraw medication as ordered. An Emergency Depa 5/12/24 at 6:11 AM in evaluated for a chief had been out of her gays and now she was cramps. The ED Surpresented to the ED reported she had not thought she was in gin the ED, at 4:43 AM was administered gardischarge instruction. 800 mg 4 times per coprimary care physicial prescription medication. Resident #51 was dison 5/12/24 at 6:11 AM. An interview was con #2 on 6/14/24 at 2:24 was an agency nurse from 7:00 PM to 7:00 assigned to Resident Nurse #2 recalled se hospital on 5/12/24 d not having her prescription during the shift as	esident #51 was alert and hat symptoms were due to al from not receiving her d.  rtment (ED) Summary dated adicated Resident #51 was complaint that the facility gabapentin for a couple of as experiencing full body mmary stated Resident #51 on 5/12/24 at 4:22 AM and had her gabapentin and abapentin withdrawal. While 1 on 5/12/24 Resident #51 bapentin 800 mg. The swere to restart gabapentin lay, to follow up with her an and to not stop taking on for pain suddenly. Scharged back to the facility M.  Inducted via phone with Nurse at the facility and worked	F 7	760		
	receive her prescribe	al for evaluation and to d medication gabapentin for d she notified the provider of to the hospital.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1	7170212024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	A progress note writted at 10:09 AM indicated from the hospital at all Manager #1 was made Resident #51 had not and was sent to the eleobtain it.  The MAR for 5/12/24 inaccurately documer 12:00 PM, and 5:00 Figabapentin which ind the hospital. (Reside on 5/12/24 at approxi #14's progress note] adose of gabapentin which independent with messages with no return call reduction and requested to the word and requested to the facility having received emergency room. Refacility having received emergency room staff gabapentin at the facility supposed to get it or a room physician sent and gabapentin 800mg for the emergency room gabapentin 800mg for the emergency room gabapentin 800mg for the emergency room gabapentin 800mg for the emergency gabapent	en by Nurse #14 on 5/12/24 d Resident #51 returned pproximately 8:00 AM. Unit le aware on 5/11/24 that received her gabapentin mergency room last night to  revealed Nurse #14 nted a "6" for the 9:00 AM, PM doses of Resident #51's icated the resident was in nt #51 returned from the ED mately 8:00 AM [per Nurse and the next scheduled has due at 9:00 AM).  to interview Nurse #14 via seleft on 6/13/24 and 6/14/24 heived.  The property of the seident was all to go to the emergency called for transfer to the seident #51 returned to the d gabapentin at the resident #51 returned to the d gabapentin at the seident #51 told the f that until she received her fility, she would continue to room every time she was at least daily. Emergency	F 7	760		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1 0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 760	indicated Resident #8 spasms and reported gabapentin prescriptificality and was havir Medication Administrindicated Resident #8 gabapentin 800 mg or Resident #51 was dison 5/12/24 at 9:41 Pl continue with gabapet The MAR and the menotes revealed the for #51's gabapentin: 5/13/24  The MAR for 9:00 A documented a "9" an administration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration record the facility was await 800 mg from the phanadministration the phanadministra	ed 5/12/24 at 8:50 PM 51 presented with muscle I she was unable to get her on refilled at the nursing ng breakthrough pain. The ation Record for the ED 51 was administered on 5/12/24 at 9:12 PM. scharged back to the facility W with instructions to entin 800 mg 4 times per day.  edication administration fillowing related to Resident  AM indicated Nurse #15 Id the corresponding I note at 10:05 AM indicated ing delivery of gabapentin rmacy. PM indicated Nurse #15 Id the corresponding I note at 1:41 PM indicated ing delivery of gabapentin rmacy. PM indicated Nurse # 15 Id there was no ig note. PM indicated Nurse # 15 Id there was no ig note. PM indicated Nurse # 11 Id the corresponding I note at 10:52 PM indicated ing delivery of gabapentin rmacy I dicated a supply of 120 sent to the facility for	F 76	50	

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		' '	E CONSTRUCTION	COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	NTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 760	A 6/7/24 nursing progression of the hospital as of 6 for interview.  An interview was condon 6/13/24 at 8:00 And she was in the role of weeks. Unit Manager and out of gabapenting room evaluations due medication. Unit Manor how she became a errors of Resident #5 medication gabapent.  An interview by phone Consultant Pharmaci. The Consultant Phar	gress note indicated insferred to the hospital due ion. Resident #51 remained i/19/24 and was unavailable ducted with Unit Manager #1 M. Unit Manager #1 stated if Unit Manager for 3-4 rr #1 recalled Resident #51 and required emergency is to not receiving the ager #1 did not recall when aware of the medication 1 not receiving the ordered in.  The was conducted with the st on 6/12/24 at 9:14 AM. macist stated she discussed taining medications for ch when the current Director me into the position at the ant Pharmacist indicated not as ordered could cause rawal symptoms, and thythm problem causing and was a significant consultant Pharmacist symptoms may start within	F 760		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/00/0004
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	L		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 760	being available but be position, she had not The DON stated a sy facility to track medication refills.  An interview was con Administrator on 6/14 Administrator stated a would be administered physician. The Admin did not have a comprewhat to do when they was not available for An interview via phore Physician on 6/18/24 indicated the dose of 4 times per day was a and it was not recommendating the medication withdrawal and sever increased pain was a receiving the schedul and it could start with indicated omission of a medication error an serious adverse outcome adverse outcome of not receive the medication gabap physician. She stated the facility to obtain the administered as one of the medication of the same content of the medication of the stated the facility to obtain the administered as one of the medication of the same content of the medication of the stated the facility to obtain the administered as one of the medication of the same content of the	eing new to the DON investigated the problem. Investigated the problem. Investigated the problem. Investigated the problem. In the action refills to prevent further a errors due to not obtaining aducted with the 1/24 at 4:10 PM. The she expected medications do as ordered by the interest of the expected medications and the expected medication administration.  The ewas conducted with the expected with the expected medication administration.  The ewas conducted with the expected to abruptly stop due to the potential for the expected in 12 hours. The Physician stated definite concern due to not expected in 12 hours. The Physician expected in 12 hours. The Physician expected in 12 hours. The Physician expected in 12 hours are to the hospital increased pain was the fing the scheduled doses of the expected in the expected by the expected in the responsibility of the medications so they could	F 760		
	diagnosis which inclu				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345185	B. WING		07/02/2024	
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			,	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 01/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 760	revealed a 12/6/23 of milligrams (mg) 2 tind Resident #46's quart (MDS) assessment resident was cognitive Resident #46 receive pain medication, paid conducted, and resident was conducted, and resident was a Controll #46 revealed the last gabapentin delivered Nurse #7 on 5/10/24 count to 0 pills remaid (MAR) indicated gat administered at 9:00 specified the docum see the nursing note medication administ following related to 6 medication:  5/10/24  - The MAR for 9:00 documented a "9" and corresponding nursis 5/11/24  - The MAR for 9:00 documented a Ten MAR for 9:00 documen	#46's physician orders order for gabapentin 800 mes per day for nerve pain.  terly Minimum Data Set dated 3/12/24 indicated vely intact with no behaviors. ed scheduled and as needed in interview should be dent had no pain in the deet Drug Record for Resident at dose from the supply of don 4/8/24 was signed out by at 8:00 AM bringing the ining.  cation Administration Record papentin 800 mg was to be 0 AM and 9:00 PM and entation of a "9" indicated to es. This MAR and the ration notes revealed the Resident #46's pain	F 760			
	- The MAR for 9:00 documented a "9" and corresponding nursi					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING			С	
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	L	12	1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	note at 9:09 AM indic delivery of gabapentii - The MAR for 9:00 P documented a "9" and corresponding nursin-recorded at 9:37 PM. 5/13/24 - The MAR for 9:00 A documented a "9". The material of the material o	M indicated Nurse #6 he corresponding nursing ated awaiting pharmacy n. M indicated Nurse #3 d there was no g note. A pain level of 9 was  M indicated Nurse #6 he corresponding nursing ated awaiting pharmacy n. M indicated Nurse #17 pain level of 8 was recorded responding nursing note at he medication on order from  M indicated Nurse #7 d there was no g note. M indicated Nurse #17 d there was no g note. M indicated Nurse #7 d there was no g note. M indicated Nurse #7 d there was no g note. M indicated Nurse #7 d there was no g note. M indicated Nurse #17 d there was no g note. M indicated Nurse #17 d there was no g note. M indicated Nurse #17 d there was no g note. M indicated Nurse #17 d there was no g note. M indicated Unit Manager The corresponding nursing ated waiting for delivery of	F	760			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	· · ·	0110212024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 760	documented a "9". To note on 5/17/24 at 12 medication delivery for 5/17/24 at 10:09 AM medication delivery or pharmacy.  The MAR for 9:00 For documented a "9". A for medication delivery or pharmacy.  The MAR for 9:00 For documented a "9" are corresponding nursing recorded at 9:04 PM.  An interview was core 6/13/24 at 1:45 PM. assigned to Residen and 5/12/24 from 7:00 stated she documented and 5/12/24 at 9:00 for gabapentin and in not administered due Nurse #3 stated Resunable to sleep when medication gabapen.  An interview was core 6/13/24 at 12:30 PM an agency nurse that several months. Nurse that several months is not available on the form the schedule 5:00 PM doses on 5/46 stated she did not doses of gabapentin.  An interview was core.	The corresponding nursing 2:40 AM indicated awaiting from pharmacy.  AM indicated Nurse #5 An administration note dated indicated awaiting of gabapentin from  PM indicated Nurse #2 and there was no no note. A pain level of 7 was a stated she was at #46 on 5/10/24, 5/11/24,	F 76	60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		0	C 7/02/2024
	OVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		770272027
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	Resident #46 from 7 5/13/24, 5/14/24, and gabapentin was not cart for the ordered of stated she did not not provider that the menurse #17 revealed for pain and Resider pain, irritability and a medication.  An interview was con 6/13/24 at 11:30 AM an agency nurse at the Nurse #7 was assign 5/14/24 and 5/15/24 Nurse #7 stated she ordered dose of gab 5/15/24 at 9:00 AM of Nurse #7 stated Reshad increased pain wordered gabapentin.  An interview was con 6/13/24 at 8:15 A she was assigned to from 7:00 AM to 3:00 stated gabapentin we #46 on 5/16/24 at 9:00 AM. assigned to Residen AM to 7:00 PM shift.	7 stated she was assigned to :00 PM to 7:00 AM shift on d 5/15/24. Nurse #17 stated available on the medication doses at 9:00 PM. Nurse #17 orify the pharmacy or the dication was not available. gabapentin was prescribed at #46 exhibited increased anxiety from not receiving the multiple moducted with Nurse #7 on . Nurse #7 revealed she was the facility since March. The did not administer the apentin on 5/14/24 and due to it not being available. Sident # 46 was upset and when she did not receive the	F 76	60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG	(X3	(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	<b>!</b>	07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	the medication and opain. Nurse #5 state order, so she did not a construction of the pain. Nurse #5 state order, so she did not a construction of the pain. An interview was assignt 5/17/24 from 7:00 Pt stated she did not accompany of the pain of	bbserved Resident #46 in ad she the medication was on attempt to obtain it.  Inducted via phone with Nurse 5 PM. Nurse #2 stated she ned to Resident #46 on M to 7:00 AM. Nurse #2 Iminister the ordered PM on 5/17/24 due to it being Image W Nurse #11, nurse assigned 16/16/24 7:00 PM to 7:00 AM. On 6/11/24 and 6/12/24 with	F 7			
	Review of a 5/27/24 by the Consultant Ph medication error was	medication came in.  Medication Record Review narmacist indicated a didentified in Resident #46's pord. The note indicated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 760	Continued From pag	ge 256	F 76	60	
	, • .	ked out of stock for 13 doses harmacist indicated to review			
	Pharmacist on 6/12/ when the current Dir started, the Consulta held a meeting with concern with signific the omission of orde Consultant Pharmac gabapentin as order pain, withdrawal syn heart rhythm probler	nducted with the Consultant 24 at 9:14 AM. In March rector of Nursing (DON) ant Pharmacist stated she the DON to discuss her ant medication errors due to red medications. The cist indicated the omission of ed could cause increased aptoms, and tachycardia (am causing elevated heart difficant medication error.			
	Nursing (DON) on 6 stated she did not keep gabapentin was not and the omission of a significant medical she met with the Coshe started in Marcherrors due to the om DON stated she thou with the fax machine pharmacy was not requests. The DON provided new fax made be problems and sheep shee	nducted with the Director of /12/24 at 2:00 PM. The DON now why the medication available for Resident #46 a prescribed medication was tion error. The DON stated insultant Pharmacist when a and discussed medication ission of medications. The ught there was a problem as in the facility and that the ecciving orders and refill stated the pharmacy achines but there continued to be did not know why.  If with the DON on 6/12/24 at the nurses on the medication is reorder medications within only being depleted so that is were not omitted due to the DON stated she was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	01702/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTI	ON
F 760	Continued From pag	e 257	F 76	60		
	gabapentin 800 mg t through 5/17/24, that	did not receive ordered wice per day from 5/10/24 t this was a significant she had not investigated				
	Administrator on 6/14 Administrator stated be administered as of	4/24 at 4:10 PM. The she expected medications to ordered by the physician and edication was a medication				
	error. The Administr	ator stated nursing staff did to do when a medication				
	Physician on 6/18/24 indicated the dose of twice per day, was a it was not recomment the medication. The pain was a definite of the scheduled gabap Physician indicated the medication gabapensignificant medicatio for adverse outcome the facility's responsi	nducted via phone with the lat 1:20 PM. The Physician of gabapentin ordered, 800 mg high dose of medication and aded to abruptly stop taking Physician stated increased oncern due to not receiving bentin as ordered. The che omission of the ordered tin for Resident #46 was a merror and had the potential. The Physician stated it was ibility to obtain the ninister them as ordered.				
	4. Resident #419 wa recently on 08/07/23	s admitted to the facility most				
	pressure ulcer, Type hemiplegia and hem (cerebral infarction)	in part, a sacral stage 4 2 Diabetes Mellitus, iparesis following a stroke affecting his dominant right rt failure, and altered mental				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING _	B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER	NTER		106 0	EET ADDRESS, CITY, STATE, ZIP CODE CAMERON STREET (E WACCAMAW, NC 28450	, ,,,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE CO		
F 760	02/09/24 revealed Reimpaired cognition. B extremities on one side one stage 4 pressure injury that were not phad received pressure	MDS assessment date sident #419 had severely oth upper and lower de were impaired. He had ulcer and one deep tissue resent on admission. He e ulcer care.	F	760				
	from the community Nound Care physicial intravenous (IV) antib 02/23/24 for Resident grams intravenous da Daptomycin 500 Milling daily x 4 weeks, 3) Plong catheter that is invein, often in the arm body, used when IV tong period), and 4) find additional doses at Power 18 documenter 02/23/24 at 2:15 AM to the facility from the to the hospital to have	a #419: 1) Rocephin 2 aily x 4 weeks, 2) grams (mg) intravenous CC line insertion (a type of inserted through a peripheral into a larger vein in the reatment is required over a rest dose at the hospital then remier Living nursing home.  In a progress note dated that Resident #419 returned Thospital. He had been sent the a PICC line placed and						
	#8 documented the Phospital called and st place the PICC line a been placed in his lef administration. The f 500 mg and Rocephia at the hospital.  The March 2024 Med Records (MAR's) reve	of antibiotic therapy. Nurse ICC line nurse at the ated she was unable to and a (peripheral) IV had t forearm for medication irst infusion of Daptomycin a 2 grams was administered lication Administration ealed the following orders: one) 2 grams intravenously						

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		345185	B. WING				02/2024
	ROVIDER OR SUPPLIER	INTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		×=
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	date 2/25/24; and 2) solution reconstituted time a day for treatments at the date of the antibiotic dates: 03/16/24, 03/1 03/22/24, and 03/23/3 the antibiotic Daptom 03/15/24, 03/16/24, 03/15/24, and 03/23/3 A progress note writte 3/15/24 at 3:38 pm do IV had infiltrated (can fluid into the surround able to give the 1:00 Daptomycin 500 mg. unsuccessful attempt A progress note writte at 12:28 am document to place an IV in Resi was unsuccessful.  Progress notes writte 03/16/24 at 11:24 am Resident #419 did no medications because A progress note writte 03/17/24 at 4:36 pm dacquired and the antibute of the medication and the m	Daptomycin intravenous I 500 mg intravenous I 500 mg intravenously one ent of infection for 4 weeks, and stop date 03/24/24. Aled the resident did not Rocephin on the following 7/24, 03/20/24, 03/21/24, 24; and he did not receive bycin on these dates: 03/17/24, 03/20/24 03/21/24, 24.  The by Agency Nurse #2 on occumented Resident #419's are out of the vein and leaked ding tissue) and she was not pm dose of antibiotic. She made two as to restart the IV.  The by Nurse #13 on 03/16/24 anted she attempted one time ident #419's left forearm and out receive his antibiotic. The did not have an IV.  The by Agency Nurse #2 on documented an IV site was	F	760			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIED FOR THE APPROPRIED CORRESPONDED TO THE APPROPRIED CORRESPONDS OF THE APPROPRIED CORRESP	D BE COMPLETION	
F 760	antibiotics were not of a check mark that wo medications had been A progress note writt 03/20/24 at 6:49 pm #419's IV had not be beginning of the shift the IV 3 times and the restart the IV 2 times unsuccessful. The sadministered. She of charge nurse had been an agency.  On 03/21/24 the MAI meaning other/see phaide #5 for both the land the Daptomycin antibiotics were not of a check mark that wo medications had been A progress note writt 03/22/24 at 3:51 pm start an IV for Reside unsuccessful.  A progress note writt documented Resider antibiotics because he had an interview conduction the hospital due to the hospital due to the land interview conductions and the facility constitutions are not of the hospital due to the hospital due to the hospital due to the land interview conductions are not of the facility constitutions.	documented on the MAR with buld have indicated the in administered.  en by Agency Nurse #3 on documented Resident en working since the it. She attempted to restart e charge nurse tried to it, but all 5 attempts were cheduled antibiotics were not ould not remember who the en but thought she was from  R was marked "9" (a code rogress notes) by Medication Rocephin 8:00 am dose on 1:00 pm dose. The documented on the MAR with buld have indicated the in administered.  en by Agency Nurse #2 on documented she had tried to ent #419, but the attempt was en by Nurse #13 on 03/23/24 at #419 did not receive his he had no IV access.	F 76			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 017022024		
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F 760	and put the resident infection. She stated been notified or the sent out to the hosp established to enable medications. She san intervention so to been given the antion of the latest o	ctiveness of the medications t at risk for worsening of his ed the provider should have resident should have been obtal to get IV access ble the facility to administer the stated there should have been that the resident could have biotic medications.  The Wound Care Nurse on PM she stated the Nurse as aware the IV was out. She supposed to come to the he IV. She stated although nursing note, she was a ware Resident #419 had no red for Resident #419 on  The Agency Director of 16/12/24 at 1:05 PM she employed at the facility on mented if she had been a facility nurses could not and if unsuccessful she would ovider, obtained an order for a d have sent the resident out to ablished within 24 hours of the ttempt to re-establish IV	F 760				
	at 1:50 PM she star resident was getting if she had tried to re She could not reme	Agency Nurse #2 on 6/12/24 ted she was not sure why the g antibiotics and was not sure estart his IV access or not. Ember if she had notified the edications could not be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 760	In an interview with NPM she stated while stopped working and but could not. She could not start his IV). Anoth tried and could not go passed on in report to unsuccessful attempt not notify the provide access. She noted the also tried to start the not know the names thought they were also cared for Resident #403/20/24.  In an interview with Leat 8:13 AM she stated that the resident had document a progress remember the date so In an interview with Note 10 am she stated #419 on 03/16/24, 03 recalled when she as site, she could not fin understand why he could not have IV acceptable.	lurse #3 on 6/12/24 at 1:55 she was working the IV site she tried to restart the IV commented that Resident ck" (meaning it was difficult er agency nurse on duty et the IV started. She to the next nurse the sto restart the IV. She did that the resident had no IV e nursing supervisor on duty IV and could not. She did of the other two nurses but so from an agency. She at 19 on 03/19/24 and  Unit Manager #2 on 6/13/24 d she had notified the NP no IV access but did not a note. She could not	F 760		

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		345185	B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		01102/2024	
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F 760	contact the NP on OPM. She had been March 2024. An ad 06/13/24 at 3:07 PM attempts were maddifferent surveyors of survey week with no Multiple unsuccess 06/12/14 at 1:50 PM physician employed An additional attem 3:00 PM with no resmade to contact the surveyors on the terweek with no response	offul attempts were made to 26/12/14 at 1:48 PM and 3:36 employed at the facility in Iditional attempt was made on M with no response. Other e to contact the NP by on the team throughout the coresponse.  If attempts were made on M and 3:33 PM to contact the Id at the facility in March 2024. pt was made on 06/13/24 at sponse. Other attempts were exphysician by different am throughout the surveynse.	F 76	60			
	03/22/23 of Resider revealed the wound (Centimeters) long of The wound progress large amount of ser liquid mixed with bloodebrided with a min There was no odor. measured 6.6 cm loodeep. The skin surmoist, warm and resigns of infection.  In an interview with on 6/14/24 at 12:23 notified that the resided the hospit Resident #419 to resident wounders.	and Clinic assessment dated in the 419's Stage 4 sacral ulcer in measured 6.4 cm in x 3.8 cm wide x 0.8 cm deep. It is was deteriorating with a so-sanguineous (a thin watery bod) drainage. The wound was simal amount of bleeding.  After debridement the wound ong x 3.9 cm wide x 0.9 cm rounding the wound was iddened but did not exhibit.  The Wound Clinic physician in PM he stated he was not ident did not have IV access. It is dordered a PICC line to be stall on 02/23/24 and for exceive his first dose of estated the resident had					

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(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	reached a plateau in had increased draina ordered antibiotics rebiofilm on a wound the resident had a poor plongevity because hele commented that the doubted the misses have affected the over A progress note writte 04/05/24 at 12:45 pm #419 had been sent to possible aspiration. Clinic that he had been sent to possible aspiration. Clinic that he had been sent to possible aspiration. Clinic that he had been sent to possible aspiration. So with: 1. altered mental aspiration pneumonic heart failure, 4. dysphelectrolyte abnormalifulcer of the sacra regencephalopathy/acut nephrolithiasis and din hypertension, 10. seit Diabetes Mellitus, and The hospital physicia patient remained obter of his hospital stay are patient likely had an example of the patient's sepsis lillarge Stage 4 decubit likely has chronic sacresident was dischargers.	treatment and the wound ge. He explained he often lated to resident bacteria at had stalled. He stated the prognosis overall with limited had so many comorbidities, the resident was very ill, and ad doses of antibiotics would evall length of his longevity.  The by Agency Nurse #2 on a documented that Resident to the hospital due to the hospital due to the hospital due to the had notified the Wound	F7	760			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		07/02/2024
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	Continued From parthe Administrator was Jeopardy on 6/12/2 The facility provided Plan: Identify those recipinare likely to suffer, as a result of the noncomplete facility failed to errors (Resident #2 #51, and Resident #2 #51, and Resident #2 for the facility failed to discharge orders what to the facility on 03/100 Resident #269 was 03/07/2024. On 03/100 Chief complaint of some requested to go to the Resident #269 did where the Resident #269 return discharge orders what incorrectly. Resider facility with orders for at bedtime and carwas determined that	ge 265 vas notified of Immediate 4 at 5:34 PM. d the following IJ Removal ents who have suffered, or a serious adverse outcome as ompliance: prevent significant medication 69, Resident #419, Resident	F 76	DEFICIENCY)		
	#269 received 6 do: to a transcription er failed to transcribe to admission on 03/07 03/14/2024. The fact doses of carvedilol failure of transcription	rough 03/13/2024. Resident ses of haloperidol 20mg due for on admission. The facility the carvedilol 12.5 mg upon /2024 and readmission on cility failed to administer 26 12.5 mg as ordered due to the on. Resident #269 continued nedication through discharge				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345185	B. WING			1	C / <b>02/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450			02/2024
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F 760	from the facility on 03  The facility failed to a gabapentin 800 mg 4 dates of 05/08/2024 ff51). Resident #51 c 05/09/2024 Resident to too much pain. On complained of legs fe Resident #51 complain which Resident #51 returneresident was treated gabapentin at the hos 05/12/2024 Resident and anxiety due to no requested to go to the gabapentin in the ER administer a total of 2 between 05/08/2024 #51.  The facility further fai order of gabapentin (had a routine order fot times a day. Resident receiving this medica and made it hard to scomplained of irritabin nausea. Resident #40 not been able to get activities and perform in her legs. Resident gabapentin between Resident #46 had a putring the time the fagabapentin.	dminister a routine order of times a day between the to 05/13/2024 (Resident omplained of pain. On #51 refused a shower due 05/10/2024 Resident #51 refused of pain and spasming 1 requested to go to the ER. d from the ER where the for acute pain and received spital. In the evening on #51 complained of agitation of receiving gabapentin and ER. Resident #51 received to 21 doses of gabapentin and 05/13/2024 to Resident #46 or gabapentin 800 mg 2 t #46 complained of not tion which caused more pain	F7	760			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG			LETED
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F 760	Ceftriaxone 2 mg introperson (IV) for 7 days between through 03/23/2024 (determined that the all an infected Stage 4 sometimed that the all an infected Stage 4 sometimed that the all and infected sometimed that the all resident shade adverse and/or serior the deficient practice, also identified that all and readmitted to the result of transcription medication orders. And Nursing identified that and unstageable woutherapy and periphers high risk for missed in On 06/13/2024 Unit Nan audit for the past some and readmissions to orders the resident worders were transcribe electronic medical readmissions there we errors. The 5 identified corrected post audit of physician was made at transcription errors and corrections.  On 06/13/2024 the Adversaria serior and corrections.	avenous (IV) for 6 days and yoin 500 mg intravenous en the days of 03/15/2024 Resident #419). It was ntibiotics were ordered for acral wound. However, it ever receive the IV and experienced low grade sting tachycardia.  If ector of Nursing identified en the potential to experience as outcomes as a result of a The Director of Nursing residents who are admitted facility are at high risk as a errors and missed additionally, the Director of all residents with stageable ands requiring antibiotic all or intravenous lines are at medication administration.  Managers (UM) completed and of all admissions determine what medication as admitted with and if the ed correctly into the cords system. The audit admissions and transcription errors were on 06/13/2024. The aware of the identified	F7	760			

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F 760	o community of the property of		F 76	60		
	administration errors to 05/17/2024. It was pharmacy had made medication in a time determined that nurs comprehensive under they identify that a nadministration.	er investigate the gabapentin is that occurred 05/08/2024 - is determined that the ean error and not shipped the ely manner. It was further sing staff do not have a erstanding of what to do when nedication is not available for				
	for the past 90 days if any residents were if so if the IV medical was determined by through this audit the for residents were not prescribed and/or or deficit practice by not timely manner. There deficient practice of The new primary castarted on 06/07/202 identified IV medical.	JMs also completed an audit of all residents to determine e ordered IV medications and ations were administered. It the Director of Nursing at either the IV medications of readily available when redering through an ordering of ordering IV medication in a refore, resulting in a facility administering IV medications. The provider for the facility who 24 was made aware of the tion administration errors on mpletion of the audit.				
	process or system for adverse outcome from and when the action on 04/01/2024, the introduced the procest out out out out out out out out out ou	Director of Nursing ess of triple admission check r of Nursing identified that the				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 760	the triple admission of 06/12/2024 the proce resident admission to Nursing will assign a admission. The assign the hospital discharge resident. The assigned highlight the discharge continued and/or chan Nurse will then enter order tab in the electroder tab in the electroder tab in the electroder tab in the facility and is physically within the first 24 hou admission to the facility will initiate a second a performed on the residence in the Director of Nursin task. The Director of Nursin task. The Director of I of the 2 Nurses assign admission check is now ho put in the orders Nurse is to create a corders, questionable completed or found with the follow up on the to ensure all actions in correctly.	Ms and newly introduced heck to all Nurses. As of ss is as follows; Upon the facility the Director of Floor Nurse to the ned Floor Nurse will review orders for the given of Floor Nurse will then e orders that need to be need. The assigned Floor this information under the onic medical records tent has been admitted to sically in the facility.  Aurs of the resident's sity, the Director of Nursing admission check to be dent. This process includes admitting orders, so, etc. The second erformed by 2 Nurses who grassigns to complete the Nursing will ensure that one ned to complete the second of the original Floor Nurse. The next step for the Floor hecklist of any missed orders, and/or items not within the initial admission is to be completed by no this day and given to the owill keep record of the he Director of Nursing will checklist the next morning	F 7	760			

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F 760	they understand the rimplemented to preverence. This education are full-time, part-time staff.  On 06/12/2024 the Dithat a daily medication by the UMs to ensure obtained from the phaprevent further medically medication refill comprehension and keeping to the time of the Director of Nursing daily medication refill comprehension and keeping to the time of ti	dmission check to ensure new process that has been ent future transcription in is to include all nurses who e, as needed, and agency director of Nursing ensured in refill log will be maintained that medications are earmacy in a timely manner to eation administration delays. In a director of Nursing will ensure their knowledge.  The Director of Nursing will ensure the facility is refer transcription and eation. This education is to dinurses who are full-time, and agency staff. No nurse eafter 06/12/2024 until the eated on the triple admission to edaily medication refill log receive this education from the did attended to the triple admission to ensure the facility is refer transcription and eation. This education from the eated on the triple admission to ensure the facility is receive this education from the did attended to the triple admission to ensure the education from the ensure the education from the ensure the education in the ensure the emergency of a medication is not in the ensure that the emergency of a medication is not in the ensure that the ensurement of the ensu	F	760			

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		345185	B. WING		C <b>07/02/2024</b>	
	ROVIDER OR SUPPLIER  LIVING AND REHAB C	ENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0110212024	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 760	include all nurses we needed, and agency educate all nurses we needed, and agency orders to ensure accadinistration of IV barriers with IV medwill notify the Direct Effective 06/14/2024 ensure that no nurse the nurse has receiv comprehensive und physician orders to and administration of the nurse has received and administration of the nurse has an effective system are transcribed correction administered their of the nurse of the nur	er. This education is to ho are full-time, part-time, as y staff.  4 the Director of Nursing will who are full-time, part-time, as y staff on following physician curate transcription and medications. If there are lication administration nurses or of Nursing immediately.  4 the Director of Nursing will e will work in the facility until wed education and has a erstanding of following ensure accurate transcription	F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING				02/2024	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
				1	106 CAMERON STREET			
PREMIER	LIVING AND REHAB (	CENTER		L	_AKE WACCAMAW, NC 28450			
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE		
F 760	F 760 Continued From page 272		F	760				
	emergency medica	tions system and following						
		ensure administration of IV						
		ng staff explained that the						
		e would clarify the orders from						
		nary from the hospital, enter						
	_	ectronic medical record.						
	Within 24 hours, the	e second check was to be						
	done to include rev	iewing diagnoses,						
	medications, diet, la	abs, etc. by 2 nurses ensuring						
	1 of the 2 nurses w	as not the original nurse who						
	put the orders in. T	he nursing staff explained that						
	once all the orders	were in and checked and sent						
		hey were to create a checklist						
	-	rs within 24 hours and give to						
	the Director of Nurs	<del>-</del>						
		sing staff was conducted to						
	•	tood how to enter orders in the						
		nd receive confirmation that						
		as processed. Additionally, the						
		ned the process of utilizing the						
		taff were to utilize the						
		m to ensure medications were						
	_	n the pharmacy once ordered.						
		dication was not delivered						
		as ordered, the Unit Manager						
		h the pharmacy the next day.						
		confirmed understanding of						
	· ·	rocess. An audit was						
		3/2024 by the Unit Managers s of all admissions and						
	•	termine what medication						
		was admitted with and if the						
		ribed correctly into the						
		records system. The audit						
	showed that out of							
		were 5 identified transcription						
		fied transcription errors were						
		t on 06/13/2024. The						
		e aware of the identified						
	r.,, 5.5.611 1140 11144		1		T. Control of the Con		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C <b>07/02/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
					106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 760	F 760 Continued From page 273		F	760			
	transcription errors ar	nd informed of the					
		Managers also completed					
		90 days of all residents to					
	_	lents were ordered IV					
		e IV medications were					
		s for the IV administration					
		with concerns identified					
	and corrected. The physician was made aware of the identified errors and informed of the corrections. The removal date of 06/15/24 was						
	validated.	10 val acto 01 00/10/21 was					
		arge summary dated d the following physician avulanate 875 mg-125 mg					
		oral every 12 hours for 7					
	05/02/24 with a diagn	mitted to the facility on nosis of a urinary tract					
	infection (UTI).						
	Review of the order a	audit details revealed Nurse					
	#7 had entered the a	dmission orders from the					
	hospital discharge su	mmary into the computer					
	system on 05/02/24 a	at 4:31 PM for Resident #39.					
	In an interview with A						
		she stated she did not					
	_	ne admission orders for					
		oted she worked for an					
		was the only facility that did					
		orders with the provider for					
		ering them into the computer					
	_	derstanding that someone					
	else faxed the discha						
		was given the discharge					
	orders to enter into the computer. She said she did not remember putting the orders in because						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIF 106 CAMERON STREET LAKE WACCAMAW, NC 28450		0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 760	F 760 Continued From page 274 she had to manage the hall she was working on,		F 7	760		
	pass medications and who might be on a ca	d cover medication aides rt. In addition to all that, she urses also had to enter 3 to 4				
	#39 had intact cogniti urinary catheter. He genitourinary surgery	m Data Set (MDS) /08/24 revealed Resident on. He had an indwelling had undergone recent (refers to the urinary organs ired skilled nursing care.				
	Record) for May 2024 administered Amoxici mouth every 12 hours 05/04/24, 05/05/24, 0	The facility MAR (Medication Administration Record) for May 2024 revealed Resident #39 was administered Amoxicillin 875 mg-give 1 tablet by mouth every 12 hours for UTI on 05/03/24, 05/04/24, 05/05/24, 05/06/24, 05/07/24, 05/08/24, 05/09/24, and 05/10/24 for a total of 14 doses.				
	6/12/24 at 9:50 AM sl between Amoxicillin a was that the addition Amoxicillin work bette were affected. She w provider to be notified	ne Consultant Pharmacist on the stated the difference and Amoxicillin-Clavulanate of Clavulanate helped the far and more types of bacteria would have expected the storeport the medication of additional treatment was				
	on 06/12/24 at 4:40 F followed up on the ph and had not notified t antibiotic had been at to determine if further	the Director of Nursing (DON) M she stated she had not armacy recommendation the provider that the wrong dministered to Resident #39 treatment was necessary.				
	In an additional interview with the DON on					<b> </b>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	3770272024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	06/13/24 at 9:00 AM was responsible for fa orders to the pharma a medication error that orders were not doubt after they were put in reported she had not board with the new "had instituted for revision in an interview with P 09/13/24 at 9:15 AM had only received the through the computer received a copy of the summary. If the phar summary for a new a orders were checked into the computer systifferences the facility clarification. The phar orders put into the sy known there was a di was a big disconnect the error was caught pharmacist review.  In an interview with P 12:21 PM she stated Medication Regimen 05/02/24 when he was She received the order into the computer systhospital discharge summary to would have alerted the difference between the order of the computer of the difference between the order of the computer systhospital discharge summary to would have alerted the difference between the order of	she stated the hall nurse axing the hospital discharge by. She concluded this was at was not caught, and these ale checked by another nurse to the computer system. She been able to get staff on Homework' check list she ewing new orders.  Tharmacy Tech #1 on she stated the pharmacy of corders for Resident #39 or system and had not the hospital discharge macy received a discharge against the orders entered atem and if there were any of would be notified for a surmacy only reviewed the stem and would not have screpancy. She stated this with this facility and noted on the next scheduled  Tharmacist #1 on 06/13/24 at she had completed the Review for Resident #39 on as admitted to the facility. Bees that had been entered atem. She did not have a mmary to compare the explained if she had a compare the orders, she	F 7			

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		07/02/2024
	ROVIDER OR SUPPLIER	ENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET  AKE WACCAMAW, NC 28450	1 0110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 760	In an interview with the at 8:34 AM she state from the hospital care admitted to the facility particle. The provider to review into the computer system from the provider to review into the computer system from the provider to review into the computer system from the provider to review into the computer system from the provider to review into the computer system from the provider to the provider system and the provider system into the computer system and the provider system into the computer system and the provider system and the provider system and the provider system in the provider system	she did not receive discharge facility very often.  Unit Manager #2 on 06/13/24 and the discharge summary me with the resident when ty. She explained that the he admission orders into the me the discharge summary. It olicy for the floor nurse to call we the orders. All orders put stem went directly to the potal discharge summary was harmacy by the floor nurse. It of the floor nurse is the facility of the floor nurse. It of the floor nurse is the facility of the floor nurse is the floor system. She responsibility of the floor or orders for the last 4 to 5 the floor the floor the floor orders for the last 4 to 5 the floor orders for the last 4 to 5 the floor orders for the last 4 to 5 the floor orders.  The DON on 06/14/24 at 4:30 the floor nurses to the summaries to the	F 760	,	
	any differences between discharge summary the computer. She a notified of any medic recommendations to In an interview with 106/19/24 at 9:30 AM notified that Resider	ne physician when alerted to veen the orders on the and the orders entered into also expected provider to be cation errors and pharmacy be addressed.  The facility physician on she stated she had not been at #39 was given the wrong dishe had just started at the			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPL  ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPL  A. BUILDING (X3) DATE : COMPL		LETED			
		345185	B. WING			02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 077	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	occurred. However, Resident #39 yester any symptoms of a life feel any further interstated she would exthere was a pharmar medication error so when it occurred.  6. Resident #32 was 05/09/24 with diagnod depression.  Review of the hospit 05/09/24 for Resider Mirtazapine 15 millig major depression. C 75 mg oral tablets extablets (225 mgs) by depression.  A care plan dated 06 #32 received antider Interventions include as ordered by the photograph of the Minimum Data assessment dated 0 #32 was cognitively and no rejection of cantidepressant medic (MAR) dated May 20 documentation that I (mgs) at bedtime for ordered or administer and support of the Medical Company of the Medical Compan	d was not his doctor when this she reported she had seen day and he was not having JTI at this time. She did not vention was required. She pect to be notified whenever by recommendation or a sthat it could be addressed admitted to the facility on bees including major.  The facility on the sees including major and discharge orders dated in #32 revealed to continue grams (mgs) at bedtime for continue Venlafaxine (Effexor) at mouth every morning for the facility of the sees including major.  The facility on the sees including major and discharge orders dated in the sees including major.  The facility on the sees including major and the sees including major.  The facility on the sees including major and the sees including major.  The facility on the sees including major and the sees including major.  The facility on the sees including major and the sees including major.  The facility on the sees including major and the sees including major.  The facility on the seed in the sees including major.  The facility on the sees including major.  The facility of the sees including major.  The fac	F 76			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 760	(MAR) dated May 2 received the antide 225 mgs beginning medication was adr though 05/31/24.  Review of the Medi (MAR) dated June 2 documentation that (mgs) at bedtime fo ordered or administ 06/01/24 through 06 reviewed. This resultance was desired to the Medi (MAR) dated June 2 received the antide 225 mgs daily at 8:04.  A psychiatry evalual Psychiatrist dated 06 Resident #32 was edepression. Reside and anxiety. No aggreported, no delusic falls, no complaints somnolence. He was	cation Administration Record 024 revealed Resident #32 pressant medication Effexor 05/10/24 at 8:00 AM. This ministered daily from 05/10/24  cation Administration Record 2024 revealed no Mirtazapine 15 milligrams r major depression was ered to Resident #32 from 6/12/24 the date the MAR was lted in 12 missed doses.  cation Administration Record 2024 revealed Resident #32 pressant medication Effexor	F 76	,	
	psychotropic medic of care included to for sleep which may at maximum dosage Abilify (atypical anti adjunct for depress	, adjustment to the facility, and ation management. The plan trial Melatonin (supplement) help with mood. Effexor was but will consider adding psychotic) in the future as an ion. No medication signs or ported. Will continue to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>7/02/2024</b>	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	770272024	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Resident #32 was alert and oriented easily engaged in recently admitted concerns with his history of depression antidepressant meinitially stated her however he later resince he had been depression medicate to engage in activities room because other people and hime. He indicated room and in bed, hout of bed more of different today as when he first came was glad he was heatfif to take care of continually encour and participate in the stated he receix know exactly what indicated he did remedication.  During an interview Nurse #7 stated sl Resident #32 and needs. She report person, place, and confusion. She stated but did not we care but did	w on 06/10/24 at 1:30 PM observed lying in bed. He was to person, place, and time. He conversation and stated he to the facility and had no care. He indicated he had a ion and had been on edications in the past. He had not been seen by Psychiatry ecalled talking with a "doctor" in in the facility about his ation. He stated he did not like ties in the facility or go out of he didn't like to be around he had been that way for a long he was content staying in his but he would try to start getting ften. He reported he felt no far as his mood compared to be to this facility. He stated he here and was happy that he had of him. He reported that staff traged him to get out of bed daily activities, but he didn't want to. Inved medications, but he did not at medications he was on but be deeper an antidepressant.  W on 06/12/24 at 04:15 PM he was routinely assigned to was familiar with his care ed he was alert and oriented to deten the was alert and oriented to deten the was cooperative with ant to get out of the bed. She at #32 had no behaviors and he	F	760			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345185	B. WING _				C <b>02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		106 CAMER	ORESS, CITY, STATE, ZIP CODE ON STREET CCAMAW, NC 28450	1 011	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	reported he had not e	e 280 king his medications. She expressed any concerns to sion except for the fact of	F	760				
	been like that since h She indicated he rece for depression but wa Mirtazapine 15 mgs d	t of bed each day but he had is admission to the facility. Eived Effexor 225 mgs daily as not aware of an order for laily. She reported there had as mood or behaviors since						
	Manager #2 stated ships Resident #32 was ord bedtime. She stated the assigned nurse was rethe admission orders summary but acknown nurse that entered Resorders into the electroday of his admission. recently implemented of this year for the Uncheck and the Director complete a 2nd check transcribed accurately process had no 1st all the Nurse Practitioner medications when she but the Nurse Practitioner medications when she but the Nurse Practitions when she stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the stated the Mirtaz overlooked and she was Practitioner reviewed medication orders but the stated the st	responsible for transcribing from the hospital discharge ledged that she was the esident #32's admission onic medical record on the She reported they had a system in March or Apriloit Manager to do the 1st or of Nursing (DON) to to ensure the orders were y. Before that time the ad 2nd check. She stated if would also review the did the initial evaluation, oner did not sign the order medications were reviewed. Appine 15 mgs was just was responsible for the error. It is not sure if the Nurse Resident #32's admission to the Nurse Practitioner had						
	Resident #32 had a h	repancies to her. She stated istory of depression, and had complaints of being						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345185	B. WING		C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET LAKE WACCAMAW, NC 28450	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 760	at that time. She star condition since his a followed by the Psyce evaluated him last we buring an interview of Consultant Pharmac Mirtazapine was typi used for depression mgs per day. She staincrease according to stated due to Reside low dose of Mirtazapings which was the right would be no potential receiving 15 mgs of During an interview of Psychiatrist stated simitially on 05/22/24. A history of depressionshe was not aware of Mirtazapine 15 mgs but she would most is medication if he had reported Mirtazapine starting dose with a mgs per day. It was decline in appetite and However Resident #was high, and it would would would woold wo	ordered Psychiatry services and he had no change in dmission. She stated he was hiatrist and the Psychiatrist eek.  on 06/13/24 at 11:59 AM the ist stated the starting dose of cally 7.5 to 15mg but when the dose goes up to 30 to 40 ated there had been no dose to the hospital notes. She ent #32 being prescribed a sine and receiving Effexor 225 maximum daily dose there all outcome of harm from not Mirtazapine.  on 06/13/24 at 12:35 PM the ne evaluated Resident #32 She stated Resident #32 She stated Resident #32 had on and anxiety. She reported of an admission order for at bedtime for Resident #32, ikely have discontinued the been receiving it. She anaximum daily dose of 45 also used off label to treat a red induce weight gain. 32's BMI (body mass index) ld not have been prescribed	F 760	,	
	have discontinued it receiving the maximi Effexor and Mirtazap agents and due to po not initially prescribe	ent. She reported she would due to Resident #32 um dose of Effexor and bine both having serotonin blypharmacy, she typically did both. She reported she #32 again last week on			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	anticonvulsant medicidepression) 25 mgs there would be no si for harm from not reaming daily since his a reported she had evoccasions since his recently last week an stated Resident #32. She indicated she with plan of care and was Mirtazapine 15 mgs.  During an interview of Director of Nursing (aware Resident #32 at bedtime when he process was that the time of admission entering medication would enter orders, implemented a new DON in March 2024. 1st and 2nd check be ensure the medicatic accurately. She state clarified by the physical clarified by the hospiadmission. She indicident was a controlled to the discrepation of the discrepation of the discrepation discrepation discrepation discrepation in the reliable to the discrepation discrepation discrepation discrepation and the sum of the discrepation discrepation discrepation discrepation discrepation and the reliable to the sum of the discrepation discrepation discrepation discrepation discrepation discrepation discrepation and the reliable to the sum of the discrepation discrepa	a trial of Topamax (an cation prescribed off label for twice a day. She stated gnificant outcome or potential ceiving the Mirtazapine 15 admission to the facility. She aluated Resident #32 on two admission in May, most and his mood was stable. She remained at his baseline. as satisfied with the current a not planning to add to the treatment plan.  on 06/14/24 at 4:00 PM the DON) stated she was not had an order for Mirtazapine was admitted. She stated the a residents assigned nurse at an was responsible for orders, or the Unit Managers	F 7	60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345185	B. WING _			07/0	2/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450	DDE	••••	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 760	Check for accuracy at Multiple attempts wer contact the Nurse Pra Director during the tir admitted. They were facility, and there was 03/09/22 with diagnos subacute dyskinesia movements that can uncontrollable moven psychotropic medicat disorder.  A care plan dated 03/revealed an alteration related to Tardive Dysincluded to administed 4 physician's order datablets. Give 2 tamorning for Tardive D. The Minimum Data Sassessment dated 03/#10 had moderately in exhibited no behavior He received psychotromaking for Tardive D. The most recent Abnoscale (AIMS) assess revealed Resident #1 which indicated mild services of the Medical Review	the time of his admission.  The made during the survey to actitioner and the Medical me Resident #32 was no longer employed by the same response.  The made during the survey to actitioner and the Medical me Resident #32 was no longer employed by the same response.  The made during drug induced by induced (involuntary muscle range from slight tremors to ments of the body induced by ions), and schizoaffective  The made during drug induced (involuntary muscle range from slight tremors to ments of the body induced by ions), and schizoaffective  The made during the survey to active involved in the ment dated 03/06/24 for Resident mazine 25 milligrams (mg) iblets by mouth in the byskinesia.  The made during the survey to active involved in the maxime doublet involved in the maxime doublet involved in the maxime doublet involved in the maxime during involved in the maximum during involved involved in the maximum during involve	F 7	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l l	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345185	B. WING			C 07/02/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	•	07/02/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 760	Continued From page	e 284	F 7	760				
	received Tetrabenazi the physician's order	ne 25 mgs daily according to						
	(MAR) dated April 20	ation Administration Record 24 revealed Resident #10 ne 25 mgs daily according to						
	written by the Psychi signs or symptoms or	ion note dated 04/10/24 atrist revealed in part; no f Tardive Dyskinesia such as ng, or leg movements, only						
	(MAR) dated May 20 Tetrabenazine 25 mg by mouth daily sched 9:00 AM had a chart medication was not a	ation Administration Record 24 for Resident #10 revealed oral tablets. Give 2 tablets luled for administration at code of "9" indicating the administered and to see the es on the following dates and						
	05/09/24 at 9:00 AM 05/10/24 at 9:00 AM 05/11/24 at 9:00 AM 05/12/24 at 9:00 AM 05/13/24 at 9:00 AM 05/15/24 at 9:00 AM 05/17/24 at 9:00 AM 05/18/24 at 9:00 AM 05/20/24 at 9:00 AM 05/24/24 at 9:00 AM 05/25/24 at 9:00 AM 05/26/24 at 9:00 AM 05/27/24 at 9:00 AM 05/27/24 at 9:00 AM 05/28/24 at 9:00 AM 05/28/24 at 9:00 AM 05/30/31 at 9:00 AM 05/30/31 at 9:00 AM							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 760	Continued From pag	e 285	F 76	О	
	05/09/24 through 05/revealed no docume. Tetrabenazine 25 mg administered according Review of the Medica (MAR) dated June 20 revealed Tetrabenazitablets by mouth dail administration at 9:00 indicating the medica and to see the nursing following dates:	g tablets were not ing to the physician's order. ation Administration Record 024 for Resident #10 ine 25 mg oral tablets. Give 2			
	06/03/24 06/05/24 06/07/24 06/08/24 06/10/24 06/11/24 06/12/24				
	06/03/24 through 06/ revealed no docume. Tetrabenazine 25 mg administered accordi A Psychiatric evaluat written by the Psychi signs or symptoms o	<u> </u>			
	06/11/24 at 12:30 PN	ervation was conducted on I with Resident #10. He was in the side of his bed. He was			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345185	B. WING _			C 07/02/2024		
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		7110212024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 760	alert, and oriented to He was not aware of received daily. Mild b noted with no other s Dyskinesia observed  During an interview w 3:00 PM she stated F the Tetrabenazine 25 were waiting on Phar She reported that she yesterday on 06/12/2 medication and they waiting for the prior a returned from the fact the medication. She sreported to her they waithorization form the been notified today if the facility. She state to Resident #10, he waithorization with activambulated around the She reported she had symptoms of Tardive tremors which was his been no change in his	person, place, and month. what medications he ilateral hand tremors were ymptoms of Tardive  vith Nurse #7 on 06/12/24 at Resident #10 had been out of mgs for a while, and they macy to refill the medication. e called the pharmacy 4 to ask about the informed her they were uthorization form to be ility before they could refill stated the Pharmacy vould send over another rough fax, but she had not the fax was received here at d she was routinely assigned vas independent with limited vities of daily living (ADL) and e facility daily with a cane. d not observed any Dyskinesia except for mild s baseline and there had	F 7	,				
	Pharmacy Technician for Tetrabenazine 25 originally filled and set The Pharmacy dispersion 30-day supply. She sanother 60 tablets/30 She stated they had the medication since needed to get prior at	m#1 stated the initial order mgs for Resident #10 was ent to the facility on 03/06/24. Insed 60 tablets which was a stated they dispensed -day supply on 04/06/24. Into the dispensed anymore of 04/06/24 because they uthorization to continue to fill stated a prior authorization						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			1	0 <b>2/2024</b>	
	ROVIDER OR SUPPLIER	NTER		106 CAMER	DDRESS, CITY, STATE, ZIP CODE RON STREET ACCAMAW, NC 28450	1 017	02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page		F7	760				
	was due to be refilled last correspondence regarding the medical another prior authorization to the Pharmacy. She medication authorization authorization authorization or change that was covered by reported the turnarou long it took the physic complete the form and Pharmacy. She state record they had not reauthorization from the not sent the medicatifacility's responsibility sent back to the Pharmaciprescribed Tetrabena She reported he had to treat Tardive Dyski Tetrabenazine. She sepharmacy records the authorization form be sent the medication from the consultant Pharmaciprescribed Tetrabena. She reported he had to treat Tardive Dyski Tetrabenazine. She sepharmacy records the authorization form be	e the medication to a drug the residents insurance. She and time depended on how cian and the facility to d get it back to the d according to the Pharmacy eccived the prior e facility and therefore had on. She reported it was the to ensure the forms were						
	medication. She state in the medical record reported that she add medical record review She indicated she fol Nursing (DON) today facility to complete he	ed the only symptoms noted were mild tremors. She dressed this issue on the vishe completed 05/26/24. Howed up with the Director of when she came to the er monthly review and it was orization form had not been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345185	B. WING _			C <b>7/02/2024</b>
	ROVIDER OR SUPPLIER	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	typically she expect medication irregular facility within 30 days no significant outcomissed doses of Tecause him to continuindicated mild trem. During an interview Director of Nursing Practitioner and Practitioner and Practitioner and Practitioner and Practitioner and Practitioner and was not aware a prior authorization authorization form and returned to the received in the facility when the form was reported Resident the number of dose miscommunication provided. She reposed that once the was given to the Practitioner to review Physician or Nurse DON whether the refill or changed to stated this did not gave the medication Manager #2 who we form to the Physici faxing the signed for the signed for the provided faxing the signed faxing the signed for the provided faxing the signed faxing the signed faxing the signed faxing the signed faxing the provided faxing the signed faxing the s	armacy. She indicated sted to see follow up on arities that she reported to the sys. She stated there would be ome from not receiving the etrabenazine, it would only nue having symptoms but sors were baseline for him.  You on 06/13/24 at 3:30 PM the (DON) stated the Nurse sysician who prescribed the enclonger working for the she was not aware Resident the Tetrabenazine until today the Pharmacy was waiting on in form. She indicated the should have been completed enclosed at the facility. She was not aware of the received at the facility. She was not aware of the should not have missed estate to the and education would be sorted the process should have form was faxed to the facility it hysician or the Nurse ew and sign. Then the encet are received medication. She occur. She stated she typically in authorization forms to Unit was responsible for giving the an or Nurse Practitioner then form to the Pharmacy. She did the forms were getting faxed	F	760		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	<u> </u>	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 289	F 76	60		
1-700	Multiple Attempts we investigation to conta and Nurse Practitionaresponse.  During a phone internament of the Psychiatrist's Resident #10 on 06/0 Tetrabenazine was pourse Practitioner who facility. She stated sho 06/07/24 that Reside for Tardive Dyskinesi had not received the beginning of May 200 reported to her in the symptoms of Tardive thrust, and leg move ther evaluation on 02/07/24 tremors and no other Dyskinesia. She typic Tetrabenazine, and if from the insurance of the medication. She #10 not having ongoing Dyskinesia and only no significant outcommedication and state cause withdrawal syr She indicated there in condition.  8. Resident #50 was 10/06/23. Diagnoses	re made during the act the previous Physician er and there was no view on 06/18/24 at 10:06 stated she last evaluated 07/24. She stated the rescribed by the facility no no longer worked at the ne noted in her evaluation on the 10 was on Tetrabenazine a, but she was not aware he medication since the 24. She stated staff had past that Resident #10 had Dyskinesia such as tongue ments but indicated during 014/24, 04/10/24, and most she only observed mild resymptoms of Tardive cally did not prescribe an edded prior authorization company due to the high cost are stated due to Resident ang symptoms of Tardive mild tremors there would be the from not receiving the did the medication did not mptoms after it was stopped. The admitted to the facility on a sincluded, in part, coronary				
		plood pressure, chronic congestive heart failure.				
	The Minimum Data S	et (MDS) quarterly				

AND DUAN OF CORRECTION INDESTRUCTION NUMBERS		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 760	#50 was cognitively in A review of a physicia 10/06/23 revealed give medication to treat or milligrams twice daily heart rate less than 6 pressure (SBP) less administer with meals A review of Resident administration record administer the Carve revealed the following 100/59 mm/Hg and the 159 bpm at 9:00 AM and Manager #1 05/15/24 the blood perion 100/68 mm/Hg at 9:00 Nurse #9 05/26/24 the blood perion 100/63 mm/Hg at 5:30 Unit Manager #1 05/27/24 the blood perion 100/69 mm/Hg at 5:30 Unit Manager #1 A review of Resident administration record administer the Carve revealed the following 106/04/24 the blood perion 106/04/24 the blood peri	2/20/24 revealed Resident intact.  an's order written on we one tablet of Carvedilol (a pronary artery disease) 12.5 or and to hold medication for a 60 bpm or systolic blood than 110 mg/Hg and s.  #50's medication I (MAR) for May 2024 to dilol 12.5 milligrams g:  ressure recording was the heart rate recording was and was signed off by Unit  ressure recording was signed off by the same and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was and was signed off by the same are recording was are recording wa	F 76		
	administer the Carve revealed the following 06/04/24 the blood p	dilol 12.5 milligrams g: ressure recording was 0 AM and was signed off by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 07/02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 760	108/69 mm/Hg at 9:0 MA #3 06/08/24 the blood pmm/Hg at 9:00 AM a signed off by Unit Ma 06/10/24 the blood pmm/Hg at 9:00 AM a An interview was cor Consultant on 06/11/The Pharmacist Con parameters given in was that the blood pineld according to the reading was outside the resident would be hypotension (low blook (decreased heart rate given.  An interview was cor on 06/14/24 at 1:17 finitials on the medical May and June were meant she gave the she signed off in the checkmark, then she held it according to the Unit Manager stated parameters of the phresident's blood president's blood president's blood presidentials on the medical June were hers and successful the same control of the medical of the medica	ressure recording was 00 AM and was signed off by ressure recording was 96/60 nd at 5:30 PM and was	F 76		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3	B) DATE SURVEY COMPLETED
		345185	B. WING _			C <b>07/02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		07/02/202-4
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	and there was a checked she should have held have held an interview was comphone on 06/18/24 and whenever there was initials on the MAR it administered. She so checkmark were on the she administered the she administered the having (DON) on 06 DON revealed the number of the vital signs were of the order stated to have medication should be giving the medication heart rate was low comphone the should have should be giving the medication heart rate was low complex to the order stated to have should be giving the medication heart rate was low complex to the should have should be given the should be given	ckmark, then she gave it and dit due to the parameters.  Inducted with Nurse #9 via to 5:30 PM. She reported a checkmark and nursing meant that it was tated if her initials and the MAR on 05/15/24, then a medication.  Inducted with the Director of 6/14/24 at 5:00 PM. The	F 7	60		
	8/19/23 with diagnos	ndmitted to the facility on es which included chronic e 2 Diabetes Mellitus, and				
		rly Minimum Data Set (MDS) /24/24 indicated she was				
	2/28/24 indicated: - Oxycodone/Acetan tablet by mouth two t	ninophen 5/325 mg - 1 tablet				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		3110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	Continued From pag	e 293	F 76	60		
	Resident #8's physic an order for routine p	cian's orders did not include pain monitoring.				
	revealed the residen	from 2/28/24 through 6/12/24 t received nophen 5/325 mg as ordered				
	A Nurse Practitioner note (NP) dated 4/16/24 at 8:00 am indicated Resident #8 had concerns about her pain medication refills. The note further indicated the NP explained and showed to the primary nurse an order from pharmacy indicating the medication was dispensed.					
	-	e to interview NP via phone n 7/1/24 at 3:45 pm with no				
	Oxycodone/Acetami scheduled to be adm 8:00 pm. This MAR	revealed the following 8's				
		inistration Record (MAR) entation of a "9" indicated to s.				
	documented a "9" ar corresponding nursir 4/18/24 - The MAR for 8:00 a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 760	note at 9:06 am indic the arrival of Oxycod mg from the pharmar - The MAR for 8:00 p documented a "9" an note at 9:36 pm indic the arrival of Oxycod mg from the pharmar 4/19/24 - The MARfor 8:00 at documented a "9" an note at 12:53 pm indic of the facility with her lunch. - The MAR for 8:00 p documented a "9" an note at 8:42 pm indic the arrival of Oxycod mg from the pharmar 4/20/24 - The MAR for 8:00 at (MA #5) documented corresponding nursin 4/21/24 - The MAR for 8:00 at documented a "9" an corresponding nursin 4/22/24 - The MAR for 8:00 at documented a "9" an note at 9:34 am indic the arrival of Oxycod mg from the pharmar - The MAR for 8:00 p documented a "9" an note at 9:34 am indic the arrival of Oxycod mg from the pharmar - The MAR for 8:00 p documented a "9" an note at 8:53 pm indic order. 4/23/24	atted the facility was awaiting one/Acetaminophen 10/325 cy.  Immindicated Nurse #9 do the corresponding record atted the facility was awaiting one/Acetaminophen 10/325 cy.  Immindicated Nurse #9 do the corresponding record atted the corresponding record atted Resident #8 was out to husband and friend for the indicated Nurse #8 do the corresponding record atted the facility was awaiting one/Acetaminophen 10/325 cy.  Immindicated Medication Aide to a "9" and there was no ag note.  Immindicated MA #5 do there was no ag note.  Immindicated Nurse #6 do the corresponding record atted the facility was awaiting one/Acetaminophen 10/325 cy.	F 76		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING		1	C / <b>02/2024</b>	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 01	102/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDS OF THE APPREDED TO	JLD BE	(X5) COMPLETION DATE	
F 760	documented a "9" an note at 9:46 am indic on hand and had bee - The MAR for 8:00 p documented a "9" an note at 8:38 pm indic order from the pharm 4/24/24 - The MAR for 8:00 a documented a "9" an corresponding nursin During a phone interwith Nurse #8, she in have her scheduled 8 mg available on 4/19 indicated in her nursi awaiting delivery fron stated Resident #8 di of pain.  During an interview w 12:00 pm, she explair medication was not a cart. She indicated the ordered. She further voice any complaints  Attempts were made phone with messages return call received. at the facility.  Attempts were made phone with messages return call received.  Attempts were made phone with messages return call received.	d the corresponding record ated the medication was not in ordered. In indicated Nurse #8 did the corresponding record ated the medication was on acy.  In indicated Nurse #9 did there was no indicated Nurse #9 did there was no indicated Resident #8 did not indicated Resident #8 was in the pharmacy. She further indicated Resident #8's valiable on the medication indicated Resident #8's valiable on the medication indicated Resident #8 did not indicated Res	F 760				

AND DLAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C 07/02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CI	ENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	related to Resident # Oxycodone/Acetamic   6/2/24 - The MAR for 8:00 a   (MA #3) documented   administration record   the medication was a   ordered.  During a phone inter   at 12:21 pm she indi   available in the narce   cart on 6/2/24 and sl   waiting for the medic   the pharmacy. Reside   complaints of pain.  Resident #8 was inter   am, she indicated sh   she spoke to the DO   pain medication. Sh   previous NP on 4/16   her pain medication.   NP explained the me   by the pharmacy.	and the medication revealed the following tess	F 7	60		
	there was a problem being available. She	edication. She further stated with the medications not indicated she expected the the pain medications as cian.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0770212024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE COMPLETION
F 760	Continued From pag	ge 297	F 76	50	
	on 6/28/24 at 4:10 p pain medication to be the physician.  b. A physician's order 9/22/23 indicated Order (mg) - inject 1 mg suskin) one time a day for type 2 Diabetes  The April 2024 Medi (MAR) indicated Rescheduled to be admirriday. This MAR a	Mellitus.  cation Administration Record sident #8's Ozempic was ninistered at 8:00 am every nd the medication revealed the following			
	documented a "9" at administration record the medication had by 4/19/24  - The MAR for 8:00 documented a "9" at administration record indicate why the medicate why the medicate with message return call received at the facility.  The May 2024 MAR	am indicated Nurse #9 nd the corresponding d note at 7:53 am did not dication was not given. e to interview Nurse #9 via es left on 6/28/24 with no Nurse #9 no longer worked and the medication revealed the following			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	01102/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 760	documented a "9" a administration recor the medication was  An interview with Nurevealed she ordered and was told it woult that night. She furth information in report but was unsure if the night nurse.  e. A physician's ordered and was told it woult was unsure if the night nurse.  e. A physician's ordered a "9" a corresponding administration notes documented a "9" a corresponding administration with messages left or received.  e. A physician's ordered a "9" a corresponding administration notes and with messages left or received.  e. A physician's ordered a "9" and mouth two times and Mellitus.  The May 2024 MAR administration notes and mouth two times and Mellitus.	am indicated Nurse #7 Ind the corresponding Id note at 9:17 am indicated Inse #7 on 6/12/24 at 2:50 pm Id the Ozempic on 5/17/24 Id be delivered to the facility Inser revealed she passed this Is to the on-coming night nurse Is injection was given by the Insert of Resident #8 dated Ivaroxaban (anticoagulant)15 In the evening for atrial In and the medication Is revealed on 5/30/24 MA#5 Ind there was no Inistration record note. In the interview MA #5 by phone In 6/28/24 with no return call In the resident #8 dated In the interview MA #5 by phone In 6/28/24 with no return call In the resident #8 dated In the interview MA #5 by phone In 6/28/24 with no return call In the resident #8 dated In the interview MA #5 by phone In 6/28/24 with no return call In the resident #8 dated In the interview MA #5 by phone In 6/28/24 with no return call In the resident #8 dated In the interview MA #5 by phone In 6/28/24 with no return call In the interview MA #5 by phone In the interview MA #5 by	F 76			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 55.125.	_		(	c
		345185	B. WING		<del></del>	07/	02/2024
	ROVIDER OR SUPPLIER  LIVING AND REHAB CE	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761 SS=E	In an interview with the on 6/12/24 at 11:00 a problem with the med She further stated she administer all medical physician.  A phone interview with 6/17/24 at 11:21 am in medications was not adverse effects. She anticoagulant medical would possibly be have stated missing pain of the having increased pair Label/Store Drugs and CFR(s): 483.45(g)(h)(s) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessory instructions, and the examplicable.  §483.45(h) Storage of §483.45(h)(1) In accordance professional principle appropriate accessory instructions, and the examplicable.	ng the arrival of Glipizide 10 y.  The Director of Nursing (DON) m, she stated there was a lications not being available. The expected the nurses to stions as ordered by the stated missing diabetic optimal but had no serious further stated missing tions adverse outcome ving a stroke. She also nedication would possibly be and displayed by the stated missing tions adverse outcome ving a stroke. She also nedication would possibly be and displayed by the stated missing tions adverse outcome ving a stroke. She also nedication would possibly be and displayed by the stated missing tions adverse outcome ving a stroke. She also nedication would possibly be and displayed by the strong and biologicals and cautionary expiration date when the state and lity must store all drugs and compartments under proper and permit only authorized		760			7/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345185	B. WING			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	LIVING AND REHAB CE	ENTER			06 CAMERON STREET		
				L	AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distribinguantity stored is min be readily detected. This REQUIREMENT by:  Based on observation facility failed to: discavaccine and a bottle laxative medication) South station medication rooms restore an unopened be refrigerator per manual 400-hall medication of dispose of 4 bottles of an in use inhaler with date or expiration dacart. The facility failed ointment with an open failed to discard an esolution on the 300 Hwas for 3 of 3 medication storage.  Findings included:  1a. Observation of the room was conducted Unit Manager #1 in a expired medications  14 doses of COVID-	affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can  T is not met as evidenced  on and staff interviews, the ard 10 doses of COVID-19 of senna syrup (a liquid that were expired in the ation room for 1 of 2 viewed. The facility failed to bottle of eye drops in the ufacturer's instructions on the cart. The facility failed to bot expired eye drops and had in no resident name, opened the on the 200 Hall medication ed to label a tube of eye ened and expiration date and expired bottle of atropine hall medication cart. This ation carts observed for  the South station medication in on 6/11/24 at 2:30 PM with attendance. The following were observed:	F	761	The facility failed to discard 10 doses COVID-19 vaccine and a bottle of sensity syrup that were expired in the South Station medication room for 1 of 2 medication rooms reviewed.  The facility failed to store an unopened bottle of eye drops in the refrigerator promanufacturer's instructions on the 400-Hall medication cart.  The facility failed to dispose of 4 bottle expired eye drops and had an in-use inhaler with no resident name, opened date, or expiration date labeled on the 200-Hall medication cart.  The facility failed to label a tube of eye ointment with an opened and expiration date and failed to discard an expired bottle of atropine solution on the 300-hmedication cart. This was for 3 of 3 medication carts observed for medicatistorage.  All residents residing in the facility have been identified as having the potential	na er s of lall on	
	with a printed expirate box.	tion date of 6/2/24 on the			be affected by the alleged deficient practice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			С		
		345185	B. WING _			07/02/2024		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	LIVING AND REHAB C	ENTED		106	CAMERON STREET			
PREMIER	LIVING AND REHAB CI	ENTER		LA	KE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	An interview was cor on 6/11/24 at 2:30 Pl medication carts wer medications on the of the pharmacist check carts each time on him 1b. Observation of to on 6/11/24 at 3:00 Pl attendance revealed Resident #421's uno .005% eye drops wit refrigerate until open	nna syrup with a printed 24/24 on the label.  Inducted with Unit Manager #1 M revealed the nurses on the re to check for expired carts. Unit Manager #1 stated ked one of the medication er monthly visit.  The 400-hall medication cart M with Unit Manager #1 in :  I pened bottle of latanoprost h a label which indicated led. The unopened bottle	F 7	761	The Director of Nursing (DON) or Designee will review all medication car to ensure all expired medications are disposed of appropriately, all opened e drops are labeled and store appropriate all inhalers are labeled appropriately, a will ensure all unopened eye drops are stored per the manufacturers instructio by 8/5/2024.  The DON or Designee will educate all nurses and medication aides by 8/5/20 on the appropriate storage of medicatio to include unopened eye drops, as well appropriate labeling of all opened medications. After 8/5/2024 newly hired staff will be educated by the DON or	ye ely, nd ns 24 ons, l as		
	was noted in the top drawer of the medication cart not refrigerated.  An interview was conducted on 6/11/24 at 3:30 PM with Nurse #7. Nurse #7 indicated the Unit Managers asked the nurses to check the medication carts for expired medications and eye drops that required refrigeration, but she did not know who was responsible for making sure it was done.  1c. Observation of the 200-hall medication cart on 6/11/24 at 3:30 PM with Medication Aide (MA) #3 in attendance revealed:  Resident #14's opened bottle of Vyzulta 0.024% ophthalmic solution with a date opened of 4/22/24. According to the manufacturer's expiration information, it was good for 8 weeks after opening, or 6/10/24.				Designee during their new hire employ orientation.  The DON or Designee will audit all medication carts 3 times per week x 12 weeks to ensure all expired medication are disposed of appropriately, all medications are stored appropriately, all opened medications are labeled. An expired medications found, and/or labe missing will result in re-education and additional training for the appropriate nursing staff.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hom Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA	s and y ls		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		01702/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From pa solution 2-0.5% with The manufacturer in discard 4 weeks aft was 5/22/24.  Resident #24's latar solution with a hand an expiration dimanufacturer's instruecks, or 28 days at Resident #30's latar solution with a hand and an expiration dimanufacturer's instruecks or 28 days at An in-use Ventolin imedication cart with There was no label expiration date.  1d. Observation of on 6/11/24 at 3:45 Frevealed:	ge 302 In a date opened of 4/24/24. Instructions indicated to er opening. or 28 days, which Inoprost 0.005% ophthalmic dwritten date opened of 5/3/24 ate of 5/31/24. The ructions indicated to discard 4 after opening. Inoprost 0.005% ophthalmic dwritten date opened of 5/2/24 ate of 6/2/24. The ructions indicated to discard 4 after opening. Inhaler was found on the In no resident name or dose. In with a date opened or an Ithe 300-hall medication cart	F 76	DEFICIENCY)	dits and necessary to s sustained. n of nece under the 2024 and the pecified		
	Resident #169's ciloxan ophthalmic ointment 0.3% with no date opened and no expiration date on the label.  Resident #20's atropine solution 1% use 1 drop under the tongue every 3 hours as needed. The bottle had a handwritten date opened of 5/9/24 and an expiration date of 6/9/24.  An interview was conducted on 6/11/24 at 3:47 PM with MA # 3. MA # 3 indicated she was new to working on the medication cart, so she was not sure, but she thought the Unit Managers checked						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345185	B. WING			07/	02/2024
	DER OR SUPPLIER	NTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE  06 CAMERON STREET  .AKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the  An Nur stat exp the their che med laber of the laber	rsing (DON) on 6/1 ted her expectation bired medications of medication rooms re was a breakdow ecking the medicati dications and check eled and dated. sident Records - Id R(s): 483.20(f)(5), Raility may not re ident-identifiable to The facility may re ident-identifiable to ordance with a con ees not to use or of eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con ees not to use or of eep to the extent the do so. Raility may re ident-identifiable to ordance with a con ees not to use or of eep to the extent the do so. Raility may re ident-identifiable to ordance with a con eep to the extent the do so. Raility may re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the do so. Raility may not re ident-identifiable to ordance with a con eep to the extent the ordance with a con eep to the extent the do so.	ducted with the Director of 1/24 at 4:05 PM. The DON in was that there would be no on the medication carts or in an interest the process for on carts for expired exing that medications were dentifiable Information 483.70(i)(1)-(5) interest information that is in the public. It is an agent only in intract under which the agent disclose the information in facility itself is permitted exercises and practices, the facility it records on each resident ented; each at the public interest in the public is permitted.		842			7/27/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING	B WING		C	
NAME OF PE	ROVIDER OR SUPPLIER	3-3103	5	_	STREET ADDRESS, CITY, STATE, ZIP CODE	071	02/2024
WAWL OF TH	TOVIDER OR GOLT EIER				106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			LAKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 842	Continued From page	e 304	F	842	2		
	(i) To the individual, o						
		permitted by applicable law;					
	(ii) Required by Law;						
	(iii) For treatment, pay	•					
	operations, as permit with 45 CFR 164.506	ted by and in compliance					
		, activities, reporting of abuse,					
		violence, health oversight					
	activities, judicial and	administrative proceedings,					
		ooses, organ donation					
		urposes, or to coroners,					
		uneral directors, and to avert alth or safety as permitted					
		with 45 CFR 164.512.					
		ility must safeguard medical ainst loss, destruction, or					
	§483.70(i)(4) Medical for-	records must be retained					
		required by State law; or					
		e date of discharge when					
	there is no requireme						
		ars after a resident reaches					
	legal age under State	e law.					
		dical record must contain- on to identify the resident;					
	. ,	sident's assessments;					
		ve plan of care and services					
	provided;						
	(iv) The results of any and resident review e	/ preadmission screening					
	determinations condu						
	(v) Physician's, nurse	•					
	professional's progres						
	(vi) Laboratory, radiol	ogy and other diagnostic					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	11102/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	This REQUIREMENT by: Based on record review of the facility failed to act Medication Administration of medication (Resident # reviewed for medication of the facility for the facility failed to act Medication Administration of medication of the facility failed to act Medication (Resident # reviewed for medication of the failed fai	equired under §483.50.  is not met as evidenced  ew, and staff, Pharmacy sultant Pharmacist interviews curately document on the ation Record (MAR) the lications for 2 of 10  10 and Resident #8) ons.	F 842	The facility failed to accurately docum on the Medication Administration Reco (MAR) the administration of medication for 2 of 10 residents (Resident #10 and Resident #8) reviewed for medications.  All residents residing in the facility has been identified as having the potential be affected by the alleged deficient practice.  The Director of Nursing (DON) or Designee will review the MAR for the residents involved by 8/5/2024, to ensimedication administration is being documented appropriately.	ord ons ond sid ss. ve I to	
	Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time.  05/14/24 at 9:00 AM 05/16/24 at 9:00 AM 05/19/24 at 9:00 AM 05/21/24 at 9:00 AM 05/22/24 at 9:00 AM 05/22/24 at 9:00 AM 05/29/24 at 9:00 AM 05/29/24 at 9:00 AM 05/29/24 at 9:00 AM Review of the Medication Administration Record (MAR) dated June 2024 for Resident #10 revealed Tetrabenazine 25 mg oral tablets. Give 2 tablets by mouth daily at 9:00 AM was signed off as administered on the following dates and time.			The DON or Designee will educate all nurses and medication aides by 8/5/2 on the importance of documenting medications as they are being administered, to ensure all medication are given as ordered by the provider. 8/5/2024 newly hired nursing staff will educated by the DON or Designee dutheir new hire employee orientation.  Beginning 7/27/2024, the DON or Designee will audit a MAR 5 times peweek for 12 weeks to ensure all medication administrations are being documented accurately. Any medicati administrated that is not documented result in re-education and additional training for the appropriate nursing states.	o24  ns After be rring  r	

OF DEFICIENCIES CORRECTION	L IDENTIFICATION NUMBER:			COMF	(X3) DATE SURVEY COMPLETED	
	345185	B. WING			C / <b>02/2024</b>	
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			106 CAMERON STREET	•		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
06/02/24 at 9:00 AM 06/04/24 at 9:00 AM 06/06/24 at 9:00 AM 06/09/24 at 9:00 AM 06/09/24 at 9:00 AM 06/09/24 at 9:00 AM During a phone interpharmacy Technician for Tetrabenazine 25 originally filled and so The Pharmacy dispersonanther 60 tablets/30 She stated they had the medication since needed to get prior at the medication after 05/0 medication would not facility for administration and they been available administration after 05/06/24 due to waiting form. She indicated thave been available administration after 05/06/24 forms and interview of the pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated thave been available administration after 05/06/24 forms and interview of the pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 forms and interview of the pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 due to waiting on pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 due to waiting on pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 due to waiting on pharmacy records Tebern dispensed from 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 due to waiting form. She indicated that they been available administration after 05/06/24 due to waiting form.	view on 06/13/24 at 2:00 PM in #1 stated the initial order ings for Resident #10 was ent to the facility on 03/06/24. Insed 60 tablets which was a stated they dispensed 0-day supply on 04/06/24. Insed 60-day supply on 04/06/24. Insed 60-day supply on 04/06/24. Insed 60-day supply on 04/06/24. Insed they dispensed anymore of 04/06/24 because they uthorization to continue to fill stated they did not refill the 106/24 and indicated the 106/24 and indicated the 106/24 and indicated the 106/24 at 2:15 PM the 106/13/24 at 2:15 PM the 106/13/24 at 2:15 PM the 106/13/24 at 3:00 PM 106/12/24 at 3:00	F 842	Beginning 7/27/2024, the audit reviewed by the LNHA or DON results of the audits will be reviewed by the LNHA or DON results of the audits will be reviewed. The facility will review the audit make recommendations as neassure ongoing compliance is The facility will utilize this plant correction to ensure complian mandated regulation by 8/6/20 audits will continue for the specific points.	N, and the viewed in the ad API)  The QAPI dits and ecessary to a sustained. In of ce under the 024 and the ecified		
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag 06/02/24 at 9:00 AM 06/04/24 at 9:00 AM 06/06/24 at 9:00 AM 06/09/24 at 9:00 AM During a phone inter Pharmacy Technician for Tetrabenazine 25 originally filled and so The Pharmacy dispee 30-day supply. She another 60 tablets/30 She stated they had the medication since needed to get prior a the medication. She medication would no facility for administra  During an interview of Consultant Pharmacy pharmacy records Te been dispensed from 05/06/24 due to waiti form. She indicated to have been available administration after 05  During an interview of Nurse #7 stated Res the Tetrabenazine 25 were waiting on phar She reported that she yesterday on 06/12/2 medication and they waiting for the prior a returned from the face	A 345185  ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 306 06/02/24 at 9:00 AM 06/04/24 at 9:00 AM 06/06/24 at 9:00 AM	A BUILDING B. WING	ROVIDER OR SUPPLIER  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 306  06/02/24 at 9:00 AM  06/04/24 at 9:00 AM  06/09/24 at 9:00 AM  06/09/24 at 9:00 AM  06/09/24 at 9:00 AM  06/09/24 at 9:00 AM  During a phone interview on 06/13/24 at 2:00 PM Pharmacy Technician #1 stated the initial order for Tetrabenazine 25 mgs for Resident #1 0 was originally filled and sent to the facility on 03/06/24. The Pharmacy dispensed 60 tablets which was a 30-day supply. She stated they dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they had not dispensed another 60 tablets/30-day supply on 04/06/24. She stated they did not refill the medication would not have been available in the facility for administration after 05/06/24 and indicated the medication would not have been available in the facility for administration after 05/06/24 at 3.00 PM Nurse #7 stated Resident #10 had been out of the Tetrabenazine 25 mgs for a while, and they were waiting on pharmacy to refill the medication. She reported that she called the pharmacy yeasted you of 05/12/24 to ask about the medication and they informed her they were wa	A BUILDING  345185  B. WING  STREET ADDRESS, CITY, STATE, 2IP CODE  106 CAMERON STREET  LIVING AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MIST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 306  COntinued From page 306  CO06/02/24 at 9:00 AM  06/09/24 at 9:00 AM  06/09/24 at 9:00 AM  O6/09/24 at 9:00 AM  During a phone interview on 06/13/24 at 2:00 PM Pharmacy Technician #1 stated the initial order for Tetrabenazine 25 mgs for Resident #10 was originally filled and sent to the facility on 03/06/24.  She stated they had not dispensed anymore of the medication since 04/06/24 because they needed to get prior authorization to continue to fill the medication would not have been available in the facility for administration after 05/06/24 at 2:15 PM the Consultant Pharmacist stated according to the pharmacy records Tetrabenazine 25 mgs for all while will be reviewed by the LNHA or DON, and the audits will be reviewed by the LNHA or DON, and the medication would not have been available in the facility of administration after 05/06/24.  During an interview on 06/13/24 at 2:15 PM the Consultant Pharmacist stated according to the pharmacy records Tetrabenazine 25 mgs for all while and the sufficiency of the medication would not have been available in the facility for administration after 05/06/24 at 2:15 PM the Consultant Pharmacist stated according to the pharmacy records Tetrabenazine 25 mgs for a while, and they were waiting on a prior authorization form. She indicated the medication would not have been available in the facility for administration after 05/06/24 at 0 ask about the medication and they informed her they were waiting on pharmacy to refill the medication. She reported that she called the pharmacy yesterday on 06/12/24 to ask about the medication and they informed her they were waiting on pharmacy to refill the medication.	

AND DIAN OF COPPECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER		S 1	STREET ADDRESS, CITY, STATE, ZIP CODE  06 CAMERON STREET  .AKE WACCAMAW, NC 28450	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	the MAR that the Tetradministered to Residente medication was in done in error.  During an interview of Manager #2 stated slisigned off on the MAI Tetrabenazine 25 mg 05/16/24, 05/22/24, 03 and 06/09/24 when the facility. She indicated During an interview of Nurse #6 stated if she she administered Tet Resident #10 on 05/2 was not in the facility. An attempt was made 06/13/24 at 04:01 PM the MAR that she administered Tet Resident #10 medication was not in response.  During an interview of Manager #1 stated if that the Tetrabenazin to Resident #10 on 0 was not in the facility. During a phone interview of Manager #1 stated if that the Tetrabenazin to Resident #10 on 0 was not in the facility. During a phone interview and the Tetrabenazin Resident #10 on 05/1 was not in the facility.	rabenazine 25 mgs was dent #10 on 06/06/24 when of in the facility then it was on 06/13/24 at 3:25 PM Unit the didn't know why she R that she administered as to Resident #10 on 15/29/24, 06/01/24, 06/02/24, the medication was not in the	F 842			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 842	Director of Nursing (I aware that Resident Tetrabenazine availa 2024. She reported t signed off on the MA administered if they of the facility.  During an interview of Administrator stated were accurately docu administration on the education would be publication. Type pain.  Resident #8 was a 8/19/23 with diagnos atrial fibrillation, Type pain.  Resident #8's quarte Assessment dated 5 cognitively intact.  Review of the physic revealed the followin 8/19/23: Rivaroxaba in the evening for atr 8/19/23: Glipizide 10 times a day for type 2/28/24: Oxycodone 1 tablet by mouth on 2/28/24: Oxycodone/Acetamin Oxycodone/Acetamin	DON) stated she was not #10 did not have ble during May and June he nurses should not have R that the medication was didn't have the medication in on 06/14/24 at 3:30 PM the she expected that the nurses umenting medication residents MAR. She stated provided.  Indidited to the facility on es which included chronic es 2 Diabetes Mellitus, and and rly Minimum Data Set (MDS) (724/24 indicated she was ian orders for Resident #8 g: n 15 mg - 1 tablet by mouth ial fibrillation on mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 5/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Acetaminophen 10/325 mg - 1 tablet by mouth two 2 Diabetes Mellitus (Ace	F 84			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
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F 842	administration notes in administration docum #8's Oxycodone/Acet 4/6/24 at 8:00 pm 4/7/24 at 8:00 pm 4/7/24 at 8:00 pm During an interview with 12:00 pm, she explain in electronic medical unassigned since more further stated she had and go into another significated she gave the #8 but forgot to docum was given. The narcoindicated her signature In an interview with U at 1:00 pm, she state gave this medication count sheet reviewed 8:00 pm for the medic Oxycodone/Acetamin scheduled to be administration.	revealed no medication entation related to Resident aminophen:  with Nurse #19 on 6/28/24 at ned Resident #8 was listed record (EMR) as ving to her new room. She do to click out of one screen creen to document ation for Resident #8. She elemedication for Resident ment in EMR the medication of the count sheet reviewed re at 8:00 am.  mit Manager #1 on 6/28/24 do she could not recall if she on at 8:00 pm. The narcotic indicated her signature at cation.  dication Administration ted Resident #8's ophen 5/325 mg was nistered at 2:00 pm. This tion administration do to Resident #8's	F 842		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		O7/02	2/2024
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	07/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 842	During a phone inter 6/28/24 at 12:00 pm, was listed in electror unassigned since more further stated she had and go into another signedication administre indicated she gave the 48 but forgot to document was given. The narror indicated her signature. The May 2024 Mer Record (MAR) indicated her signature. The May 2024 Mer Record (MAR) indicated her signature. The May 2024 Mer Record (MAR) indicated her signature. The May 2024 Mer Record (MAR) indicated her signature. The June 2024 Mer Record (MAR) indicated her signature. The June 2024 Mer Record (MAR) indicated her signature. The June 2024 Mer Record (MAR) indicated her medicated her medicated her signature. The April 2024 Mer Record (MAR) indicated her signature. The April 2024 Mer Record (MAR) indicated her signature. The April 2024 Mer Record (MAR) indicated her signature. The April 2024 Mer Record (MAR) indicated her signature. The April 2024 Mer Record (MAR) indicated her signature.	view with Nurse #19 on she explained Resident #8 ic medical record (EMR) as oving to her new room. She do to click out of one screen is screen to document ation for Resident #8. She he medication for Resident ment in EMR the medication iotic count sheet reviewed re at 2:00 pm.  dication Administration atted Resident #8's mophen 5/325 mg was atinistered at 2:00 pm. This ation administration administration at the Resident #8's mophen:  dication Administration in the Resident #8's mophen 5/325 mg was atinistered at 2:00 pm. This ation administration at the Resident #8's mophen 5/325 mg was atinistered at 2:00 pm. This ation administration notes on administration in administration red to Resident #8's mophen:	F 84	2		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	343103	D: Willo			07/	02/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET		
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F 842	medication administra medication document #8's Rivaroxaban:  4/7/24at 6:00 pm 4/16/24 at 6:00 pm 4/19/24 at 6:00 pm 4/20/24 at 6:00 pm 4/21/24 at 6:00 pm 4/24/24 at 6:00 pm 4/29/24 at 6:00 pm During an interview w 12:00 pm, she explair in electronic medical unassigned since mo further stated she had and go into another s medication administra indicated she gave th #8 but forgot to docur was given.  In an interview with U at 1:00 pm, she stated gave this medication f. The May 2024 Med Record (MAR) indicated Rivaroxaban 15 mg wadministered at 6:00 medication administrations.	ation notes revealed no ration related to Resident  with Nurse #19 on 6/28/24 at ned Resident #8 was listed record (EMR) as ving to her new room. She do to click out of one screen creen to document ration for Resident #8. She re medication for Resident ment in EMR the medication  mit Manager #1 on 6/28/24 do she could not recall if she on 4/21/24 at 6:00 pm.  ication Administration red Resident #8's	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024
	ROVIDER OR SUPPLIER	:NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0110212024
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F 842	at 1:00 pm, she state gave this medication g. The June 2024 Me Record (MAR) indicated Rivaroxaban 15 mg vadministered at 6:00 medication administred medication documenths's Rivaroxaban: 6/2/24 at 6:00 pm 6/9/24 at 6:00 pm During a phone intervat 12:31 pm, she stated given. She further standminister this specific Unit Manager #1, the did not give this med In a phone interview 6/28/24 at 1:00 pm, seedication aides work carts, but she could remedication on 6/9/24 During a phone intervat 12:48 pm, she indicated an NA at the facility. Was performing the juand had given the medication on 6/9/24 and 6:00 pm	Unit Manager #1 on 6/28/24 and she did not recall if she on 6/9/24 at 6:00 pm.  Redication Administration atted Resident #8's as scheduled to be pm. This MAR and the ation notes revealed no attaiton related to Resident  Aview with MA #3 on 6/28/24 atted the Rivaroxaban was not atted she was unable to fic medication. She informed a nurse covering her, that she ication.  With Unit Manager #1 on she stated she did cover the rking on the medication not recall if she gave this	F 84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION	
F 842	Record (MAR) indication may was schedule am and 6:00 pm. This administration notes documentation related 4/7/24 at 8:00 am 4/7/24 at 6:00 pm 4/16/24 at 6:00 pm 4/19/24 at 6:00 pm 4/20/24 at 6:00 pm 4/21/24 at 6:00 pm 4/24/24 at 6:00 pm 4/29/24 at 6:00 pm 5/20/24 at 6:00 pm 5/20/	edication Administration ated Resident #8's Glipizide d to be administered at 8:00 s MAR and the medication revealed no medication at to Resident #8's Glipizide:  With Nurse #19 on 6/28/24 at med Resident #8 was listed record (EMR) as oving to her new room. She d to click out of one screen screen to document ation for Resident #8. She me medications for Resident ment in EMR the	F 84	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING				0
NAME OF D	ROVIDER OR SUPPLIER	343103	B: Wiito		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	02/2024
NAIVIE OF PI	ROVIDER OR SUPPLIER						
PREMIER	LIVING AND REHAB CE	NTER	106 CAMERON STREET				
					LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page 5/11/24 at 6:00 pm  j. The June 2024 Med Record (MAR) indicat 10 mg was scheduled am and 6:00 pm. This administration notes radministration docum #8's Glipizide: 6/2/24 at 6:00 pm 6/9/24 at 6:00 pm During a phone intervat 12:31 pm, she state administered this med 12:48 pm, she indican NA at the facility. was performing the joand had given the meif she had documente computer.  k. The June 2024 Med Record (MAR) indicat was scheduled to be a every Friday and specimedication administration.	dication Administration ed Resident #8's Glipizide to be administered at 8:00 s MAR and the medication revealed no medication entation related to Resident riew with MA #3 on 6/28/24 ed she does not recall if she	F 8		DEFICIENCY)	ATE	DATE
	In an interview with th on 6/12/24 at 11:00 ar problem in the facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C 07/02/2024	
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	<u>1 077</u>	02/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	the nurses accountable documentation.  During a phone intervon 6/28/24 at 4:10 pn pain medication to be	e 315  ted she was trying to hold ble for accurate medication  view with the Administrator n, she stated she expected administered as ordered by	F	842			
F 849 SS=D	do either of the follow (i) Arrange for the prothrough an agreement Medicare-certified ho (ii) Not arrange for the services at the facility a Medicare-certified ho resident in transferrin arrange for the provision when a resident requivalent to the transferring the LTC facility through a paragraph (o)(1)(i) of the LTC facility must requirements: (i) Ensure that the hoprofessional standard to individuals providing to the timeliness of the lii) Have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the timeliness of the liii have a written agriculture of the professional standard to the liii have a written agriculture of the professional standard to the liii have a written agriculture of the professional standard to the liii have a written agriculture of the professional standard to the liii have a written agriculture of the professional standard to the liii have a written agriculture of the liii have a written agriculture of the professional standard to the liii have a written agriculture of the liiii have a written agriculture of the liiii have a written agriculture of the liiii have a writ	services. sterm care (LTC) facility may ving: ovision of hospice services at with one or more spices. se provision of hospice of through an agreement with hospice and assist the g to a facility that will sion of hospice services sests a transfer.  sice care is furnished in an agreement as specified in this section with a hospice, meet the following spice services meet as and principles that apply ag services in the facility, and se services. The ement with the hospice	F	849			7/27/24
	the hospice and an a the LTC facility before	uthorized representative of uthorized representative of e hospice care is furnished to itten agreement must set out					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245405	B. WING				0
		345185	D. WING			07/	02/2024
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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· ····································	EIVING AND REHAD GE				LAKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	1		-		DETICIENCE!		
F 849	Continued From page	e 316	F	849	9		
	at least the following:						
	(A) The services the h	nospice will provide.					
		ponsibilities for determining					
		ce plan of care as specified					
	in §418.112 (d) of this	s chapter.					
		LTC facility will continue to					
	provide based on eac	ch resident's plan of care.					
		process, including how the					
	communication will be	e documented between the					
	LTC facility and the he	ospice provider, to ensure					
	that the needs of the	resident are addressed and					
	met 24 hours per day						
	(E) A provision that th	ne LTC facility immediately					
	notifies the hospice a	bout the following:					
	(1) A significant chang	ge in the resident's physical,					
	mental, social, or emo	otional status.					
	(2) Clinical complicati	ons 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 dea	ath.					
		that the hospice assumes					
		rmining the appropriate					
	course of hospice car	•					
	determination to char	nge the level of services					
	provided.						
		at it is the LTC facility's					
		sh 24-hour room and board					
		nt's personal care and					
	_	dination with the hospice					
		nsure that the level of care					
		tely based on the individual					
	resident's needs.						
		he hospice's responsibilities,					
	•	ed to, providing medical					
		ement of the patient; nursing;					
	counseling (including	· ·					
	bereavement); social	work; providing medical					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		345185	B. WING			07/	02/2024
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	LIVING AND DEHAD CE	NTED	106 CAMERON STREET		106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NIEK			LAKE WACCAMAW, NC 28450		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
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	1				DET IOIEIO I)		
F 849	Continued From page	e 317	F	849	9		
	supplies, durable med	dical equipment, and drugs					
	necessary for the pall	liation of pain and symptoms					
	associated with the te	erminal illness and related					
	conditions; and all oth	ner hospice services that are					
	necessary for the care	e of the resident's terminal					
	illness and related co	nditions.					
	(I) A provision that w	hen the LTC facility					
	personnel are respon	sible for the administration					
		es, including those therapies					
		te by the hospice and					
		oice plan of care, the LTC					
		administer the therapies					
		tate law and as specified by					
	the LTC facility.						
		g that the LTC facility must					
	report all alleged viola	ations involving					
	_	t, or verbal, mental, sexual,					
		ncluding injuries of unknown					
		priation of patient property					
	by hospice personnel						
		ately when the LTC facility					
	becomes aware of the						
		he responsibilities of the					
	hospice and the LTC	•					
	bereavement services	s to LTC facility staff.					
	0400 70/ \/0\ = :::	TO ( '''')					
		TC facility arranging for the					
	provision of hospice of						
		gnate a member of the					
	•	ary team who is responsible					
	for working with hosp						
		e resident provided by the					
	LTC facility staff and I						
		member must have a					
	_	unction within their State					
		and have the ability to					
		r have access to someone					
	that has the skills and	I capabilities to assess the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		0.	C 7/ <b>02/2024</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 0	110212024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 849	responsible for the form (i) Collaborating with and coordinating LTC the hospice care plar residents receiving the (ii) Communicating wand other healthcare provision of care for the conditions, and other of care for the patien (iii) Ensuring that the with the hospice mediattending physician, participating in the pras needed to coordin medical care provide (iv) Obtaining the foll hospice:  (A) The most recent to each patient.  (B) Hospice election (C) Physician certific the terminal illness si (D) Names and cont personnel involved in patient.  (E) Instructions on head to the patient.  (E) Instructions on head to the patient.  (C) Hospice medicate each patient.  (G) Hospice physician any) orders specific to (v) Ensuring that the orientation in the polifacility, including patient.	disciplinary team member is allowing: In hospice representatives C facility staff participation in aning process for those nese services. In hospice representatives providers participating in the the terminal illness, related a conditions, to ensure quality and family. In LTC facility communicates dical director, the patient's and other practitioners rovision of care to the patient that the hospice care with the diby other physicians. In owing information from the condition and recertification of pecific to each patient, act information for hospice in hospice care of each ow to access the hospice's em. In and attending physician (if	F 84	19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		C 07/02/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		702/2021
				106 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER		LAKE WACCAMAW, NC 28450		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 849		C residents.  TC facility providing hospice	F 8	49		
	care under a written a each resident's writte the most recent hosp description of the sen facility to attain or ma practicable physical, well-being, as require This REQUIREMENT by:  Based on record revihospice staff interview maintain communicat services provided by record complete with documentation, hospivist notes in the facili record and failed to ohospice services for hospice (Resident #4 Findings included:  Resident #48 was ad 05/03/24 with diagnosheart failure, dementi  Review of Resident #4 impairment. Resident #4 impairment. Resident revealed Resident revealed no evidence order for hospice services whi	agreement must ensure that in plan of care includes both lice plan of care and a vices furnished by the LTC intain the resident's highest mental, and psychosocial at §483.24.  I is not met as evidenced liew, staff interviews, and we the facility failed to ion and coordination of hospice in the medical hospice admission lice plan of care, and hospice ty's electronic medical btain physician orders for a for 1 resident reviewed for 8).  mitted to the facility on sees that included congestive a, seizures, and edema.  48's Admission Minimum ssment dated 05/09/24 8 had moderate cognitive 1.448 was coded as receiving lie a resident.		The facility failed to maintain communication and coordination services provided by hospice medical record complete with admission documentation, hose care, and hospice visit notes if facility's electronic medical recording failed to obtain physician order hospice services for 1 of 1 resort reviewed for hospice (Resider All residents residing in the factories and the process of the factories of	in the hospice spice plan of in the cord and rs for ident it #48).  cility have cotential to icient  ector of vill review all iving to ensure for hospice the hospice sentation.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BOILD	_			С
		345185	B. WING				/02/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024
					06 CAMERON STREET		
PREMIER	LIVING AND REHAB CE	NTER			AKE WACCAMAW, NC 28450		
	OUR MAR DV OT	TELEVIT OF DEFINITION			<u> </u>		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	Continued From page	F	849				
	statement, hospice n	ursing visit record forms,			Resident #48's medical record to ensu	re	
	and no election of ho				there is communication and coordination	on	
		record found for Resident			of services provided by hospice in the		
		otes written by facility			medical record complete with hospice		
	nurses regarding hos	pice visits, but no hospice			admission documentation, hospice pla	n of	
	notes were present ir	resident's medical record.			care, and hospice visit notes in the		
					facility's electronic medical record (EM	R)	
	An interview was con	ducted on 06/13/24 at 9:35			and obtain physician orders for hospice		
	AM with the Director of Nursing (DON). She				services by 8/5/2024 if it is not already		
		er expectation that Hospice			ordered or submitted in the EMR.		
		nicated more fully to facility					
		ce failed to provide them			The LNHA, DON, or Designee will		
	with Resident #48's complete hospice record				educate the Medical Records Clerk and		
		e admission documentation,			Admissions Coordinator by 8/5/2024 or	n	
		hospice visit notes, and			the importance of uploading hospice	- 11	
	· ·	physician order. The DON			notes in a timely manner and ensuring		
	said it was her expec				hospice documentation for the resident	. 15	
		paper communication spice and her nursing staff,			received to the facility upon admission and continuously once admitted to the		
	I -	ne DON then said she was			facility while receiving hospice services	2	
		e for not following up with			After 8/5/2024 newly hired staff will be	<b>,.</b>	
		ld have, and for the facility			educated by the DON or Designee dur	ina	
		ocess in place to obtain and			their new hire employee orientation.	9	
		ice medical records timely					
	into their electronic m	_			The DON or Designee will educate the		
					nurse managers on the requirement to		
	An interview was con	ducted on interview with			enter a physicians order for hospice		
	Medical Records on (	06/13/24 at 10:10 AM.			services for all involved residents by		
	Medical Records con	firmed Resident #48 was			8/5/2024. After 8/5/2024 newly hired st	aff	
	under Hospice care s	since 05/03/24. Medical			will be educated by the DON or Design	iee	
		nad not received: a resident			during their new hire employee		
		ive care plan, hospice			orientation.		
	admission document						
		hospice services. She			The LNHA, DON, or Designee will aud		
		ments should have been			hospice residents charts 3 times per w		
	provided by the Hosp	pice and were not.			x 12 weeks to ensure the medical reco		
	A i t	dusts disc 00/40/04 1/40/04			includes all up-to-date hospice notes.	-	
		ducted on 06/13/24 at 10:24			missing documents that are not upload		
	AM with Hospice Nur	se #12. She stated			will result in re-education and additional	41	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345185	B. WING _				C <b>02/2024</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450		1 017	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 849	Resident #48 was vis she kept all her docur electronic-pad and will provide copies of the but gave a verbal rep member. She said she day before and did no verbally reported off to not know what happer information once the She said the resident her and the facility's roughly revealed that not had been provided to electronic medical receptation that Resi Hospice medical receptation that Resident was her expectation that facility all the Hospice which was not being important to her and the know what Hospice pwhat their nursing stat Hospice and facility swell and following the had not happened in An interview was con AM with the Administration expectation that Residence medical receptation.	ited by her weekly. She said mentation on her hen she left, she did not notes to the nursing staff ort to a nursing staff he had visited the facility the ot know the nurse she of the horizon. Hospice Nurse #12 did ned to her verbal report facility nurse left her shift. Was being well cared for by nursing staff. Hospice Nurse all Hospice documentation the facility to scan into their cord. She said it was her dent #48's complete ords be available to facility.  #/24 at 10:20 AM with the oner (NP) revealed that it hat Hospice provide to the endocumentation timely, done. The NP stated it was the attending physician to hysicians were ordering and ff were doing, so that taff were communicating asame plan of care, which this case.  ducted on 06/13/24 at 10:50 rator. She said it was her dent #48's complete ords be available to facility		349	training for the appropriate staff member reviewed by the Licensed Nursing Hom Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QAC Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained. The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this corrective action.	ne the PI to d. the he	7/27/24
F 880 SS=F			F 8	380			7/27/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		C 07/02/2024	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450	1 0110212024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 880	Continued From pa	ge 322	F 880			
	infection prevention designed to provide comfortable environ development and tradiseases and infection program.  The facility must est and control program a minimum, the following services und communicable staff, volunteers, vis providing services und arrangement based conducted accordinaccepted national staff, services und communicable staff, volunteers, vis providing services und communicable staff, volunteers, vis providing services und conducted accordinaccepted national staff, services und conducted accordinates accepted national staff, services und conducted national staff, services und conducted accordinates accepted national staff, services und conducted national staff, s	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ons.  a prevention and control ablish an infection prevention in (IPCP) that must include, at awing elements:  tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals inder a contractual upon the facility assessment g to §483.70(e) and following tandards;  en standards, policies, and				
	but are not limited to (i) A system of surve possible communical infections before the persons in the facilit (ii) When and to who communicable disea- reported; (iii) Standard and tra- to be followed to pre-	eillance designed to identify able diseases or ey can spread to other ey; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345185	B. WING _		C 07/02/2024		
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		770272027	
(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 APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 880	involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstances must prohibit employ disease or infected secontact with resident contact will transmit to (vi)The hand hygiene by staff involved in disease of infected secontact will transmit to (vi)The hand hygiene by staff involved in disease or infected secontact will transmit to (vi)The hand hygiene by staff involved in disease of involved in disease staff involved in dise	ation of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the sunder which the facility ees with a communicable kin lesions from direct or their food, if direct the disease; and a procedures to be followed rect resident contact.  The for recording incidents acility's IPCP and the ten by the facility.  The store, process, and is to prevent the spread of	F 8	<u> </u>			
	policy for enhanced thygiene during woun (Resident #66) whose The facility also failed surveillance plan for infections in the facility development and tracking diseases and infections.	parrier precautions and hand d care for 1 of 3 residents e wound care was observed. d to implement an infection monitoring and tracking ty to help prevent the nsmission of communicable ons. This deficient practice affect 70 of 70 residents in		hand hygiene during wound ca residents (Resident #66) whose care was observed.  The facility failed to implement infection surveillance plan for n and tracking infections in the fathelp prevent the development a transmission of communicable	are for 1 of 3 e wound an nonitoring acility to and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345185	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CO	•	07/02/2024	
TO UNE OF TH	NOVIDEN ON CONTENEN			106 CAMERON STREET	.02		
PREMIER	LIVING AND REHAB	CENTER		LAKE WACCAMAW, NC 28450			
	I		LAKE WACCAMAW, NC 282				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From page	age 324	F 88	30			
	the facility.		100	and infections.			
	the facility.			and infections.			
		icility Enhanced Barrier documented enhanced barrier		All residents residing in the factor been identified as having the be affected by the alleged depractice.	e potential to		
		s) are used as an infection		'			
	prevention and cor	ntrol intervention to reduce the		The Director of Nursing (DO	,		
		ıg resistant organisms		Designee, will implement an			
	, ,	ents. EBPs employ targeted		infection control meeting on	-		
		se during high contact resident		basis, as well as assign task			
		n contact precautions do not Gloves and gown are applied		appropriate staff members to aspects of infection preventi			
		the high contact resident care		are being monitored by 8/5/2			
		ed to before entering the room).		are some mornered by 6/6/2	1021.		
		contact resident care activities		The DON or Designee will e	ducate all		
		of gown and gloves for EBPs		staff by 8/5/2024 on the imp			
	include wound car	e (any skin opening requiring a		infection prevention and con	trol in all		
	dressing). EBPs a	re indicated for residents with		aspects of the long-term car	е		
		welling medical devices		environment. After 8/5/2024	-		
		O colonization. Signs are		staff will be educated by the			
		r or wall outside the resident		Designee during their new h	ire employee		
		e type of precautions and PPE		orientation.			
	available outside t	ve Equipment) required. PPE is		The DON or Designee will e	ducata tha		
	avaliable outside ti	ne room.		wound care nurse and appro			
	Review of the facil	ity Handwashing/Hand Hygiene		nursing staff by 8/5/2024 on	•		
		I the facility considered hand		appropriate PPE and hand h	-		
	' '	y means to prevent the spread		technique while providing re			
		ciated infections. Hand		wound care, to ensure the ri			
	hygiene is indicate	d: immediately before touching		transmission is minimized. A	After 8/5/2024		
	a resident, before	performing an aseptic task		newly hired staff will be educ	cated by the	<b> </b>	
		indwelling device or handling		DON or Designee during the	eir new hire	<b> </b>	
		al device, after contact with		employee orientation.			
		or contaminated surfaces, after				<b> </b>	
	_	t, after touching the resident 's		Beginning 7/27/2024, the DO		<b> </b>	
		re moving from work on a		Designee will attend an infe			
		a clean body site on the same		meeting weekly and maintai		<b> </b>	
	i resident and imme	diately after glove removal.	1	from each meeting including	jout not	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
3		345185	B. WING			C 07/02/2024		
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	02/2024	
MANUE OF THOUBER OR OUT FIELD								
PREMIER	LIVING AND REHAB CE	NTER		106 CAMERON STREET				
				LAKE WACCAMAW, NC 28450				
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 880	Continued From page	÷ 325	F 8	880				
					limited to topics discussed, education being provided, and staff members in attendance.			
	The use of gloves does not replace hand washing/hand hygiene.  On 06/14/24 at 10:00 am an observation of the Enhanced Barrier Precautions sign posted on Resident #66's door instructed staff to clean hands before entering and after leaving the room and to wear gloves and a gown for high contact resident care activities including wound care or any skin opening requiring a dressing. A supply of gowns and gloves were located in a bin in the hallway next to the resident's room.  An observation of wound care was made on 06/14/24 at 10:12 AM. Present were the Treatment Nurse and the Wound Care Specialist physician. The physician and the nurse donned gloves and gowns prior to entering the room. The physician partially removed the dressing and measured the Stage 4 coccyx pressure ulcer. Both the physician and the nurse removed their gloves and gowns and discarded them in an acceptable receptacle. In the hallway the physician and the nurse used alcohol based hand rub (ABHR). The physician directed the nurse to change the treatment to a new debriding ointment and a border dressing daily. The Treatment Nurse obtained the new ointment from the treatment cart and entered the room without donning a gown. She donned gloves and removed the old dressing and discarded it in an appropriate receptacle. The nurse discarded her gloves and donned new gloves before applying the new treatment. She did not wash her hands or use ABHR after she discarded her gloves or before moving to a clean body site on the same				Beginning 7/27/2024, the DON or Designee will audit hand hygiene and I donning/doffing 3 times per week x 12 weeks to ensure staff are maintaining compliance with EBP regulations. Any lack of competency in the areas of infection prevention and control, to incl but is not limited to, PPE donning/doffi and hand hygiene, will result in re-education and additional training for appropriate staff members.  Beginning 7/27/2024, the audits will be reviewed by the Licensed Nursing Hon Administrator (LNHA) or DON, and the results of the audits will be reviewed in monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for 3 months. The QA Committee will review the audits and make recommendations as necessary assure ongoing compliance is sustained The facility will utilize this plan of correction to ensure compliance under mandated regulation by 8/6/2024 and the audits will continue for the specified timeframe as described in this correction action.	ude ng the the the the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345185	B. WING		07/02/2024		
NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 06 CAMERON STREET AKE WACCAMAW, NC 28450	01702/2024		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (PROSE APPRODE)	JLD BE COMPLETION		
F 880	stated she changed the old dressing and and she thought that she did not think she she changed her glo had forgotten to weathe room to complete stated she should had an interview with the o6/14/24 at 1:30 PM Nurse should have we care and performed removing the old dredressing.  In an interview with the Nursing on 6/14/24 at expected staff to we treating residents on precautions and perfindicated.  2. The facility's "Infe Program" policy date Preventionist (IP) was surveillance of health tracking outbreaks a transmission precaution. She was documentation of trainfections, infection in 2023 through May 2 binder with monthly	her gloves between removing applying the new dressing that was adequate. She stated that to wash her hands if eves. She acknowledged she ar a gown prior to reentering the the dressing change and the average put one on.  The Infection Preventionist on the stated the Treatment the worn a gown during wound hand hygiene between the essing and applying the new the Agency Director of that 4:30 PM she stated she are the appropriate PPE when the enhanced barrier form hand hygiene when the country of the desired prevention and Control and the enhanced barrier form hand hygiene when the enhanced b	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIEICATION NILIMPED:		PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024	
	NAME OF PROVIDER OR SUPPLIER  PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  106 CAMERON STREET  LAKE WACCAMAW, NC 28450	1 01/02/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		RECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B		BE COMPLETION	
F 880		24. vith the Director of Nursing	F 88	80		
F 940	hegan her position as not responsible for in An interview with the 4:00 pm revealed shis since 2/02/24 and was Infection and Epidem The Administrator stamonitoring or tracking facility. She indicate was trying to get infe Administrator further	Administrator on 6/14/24 at e had been the Administrator as Statewide Program for niology (SPICE) certified. At the IP had not been go the infections within the doshe was helping the IP who ction control in order. The stated the facility should go and tracking infections.	F 94		7/27/24	
SS=F	S483.95 Training Read A facility must develor an effective training pexisting staff; individual contractual arrange consistent with their must determine the anecessary based on specified at § 483.70 include but are not limplied to ensure the same and the facility failed to ensure the same and the easurance Performa	quirements  pp, implement, and maintain program for all new and hals providing services under ment; and volunteers, expected roles. A facility mount and types of training a facility assessment as  (e). Training topics must		The facility failed to ensure all staff received training on dementia care, infection control policies and procedur and the elements of the Quality Assurance Performance Improvement (QAPI) program.	res	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345185	B. WING _		0	7/02/2024	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB C	CENTER		LAKE WACCAMAW, NC 28450			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 940	Continued From pa	ge 328	F 94	40			
	all residents.	_					
				All residents residing in the	facility have		
	Findings included:			been identified as having the be affected by the alleged d	e potential to		
	A review of the 202	3 and 2024 annual education		practice.			
	records from April 2	2023 to May 2024 provided by					
	the facility revealed	no documented evidence that		The Licensed Nursing Home	e		
		ction control training on		Administrator (LNHA), Direct			
	· ·	ures and QAPI training were		(DON), Staff Development (			
	conducted for the st	taff.		Registered Nurse (RN), or I			
				review the education that ha			
		#5's personnel file was		provided to all staff from Jar	•		
		aled a date of hire of		until current by 8/5/2024 to			
		as no documentation of ction control and QAPI training		ongoing education is being Licensed Nursing Home Ad	•		
	in the personnel file	_		(LNHA) and DON have dete			
	in the personnerine			there has been a trending p			
	A phone interview v	vas conducted on 7/1/2024 at		failure for the facility not have			
		ation Aide #5. During the		Staff Development Coordinate			
	•	on Aide #5 stated she was not		Registered Nurse (RN) for a			
	able to recall having	g QAPI training since April		one year when investigating			
	2023 and thought s	he had received some training		issue. However, the LNHA	nas hired a		
	on infection control	and dementia care in the last		full-time Staff Development	Coordinator		
	year but was unable	e to recall for certain.		RN to ensure compliance.			
	b. Nurse Aide (NA)	#2's personnel file was		The LNHA, DON, or Design	ee will		
	reviewed and revea	lled a date of hire of		educate the Staff Developm	ent		
		as documentation NA# 2 had		Coordinator RN by 8/5/2024			
		care training on 12/5/2023,		importance of ongoing educ			
		ocumentation NA #2 had		staff employed at the facility			
		ontrol training on policies and		educate on assisting in the			
	procedures and QA	PI training.		completion of an annual edu			
	A			calendar that will be availab			
		vas conducted on 6/18/2024 at		as of 8/5/2024. After 8/5/202	•		
	•	. She stated she felt like		staff will be educated by the			
		had been overlooked with the		Designee during their new horientation.	iire empioyee		
	_	dministrative team. She eceived training on dementia		onemation.			
		ning since changing roles as		The LNHA, DON, or Design	ee will		
	ouro unu wati i liali	mig onice enalighing releads	1		OO WIII	1	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345185	B. WING		C 07/02/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				106 CAMERON STREET			
PREMIER	LIVING AND REHAB CE	ENTER		LAKE WACCAMAW, NC 28450			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETION DATE	
F 940	Continued From pag	e 329	F 940	0			
	the activities director	in 2024. She only recalled		educate the Staff Development			
	attending an in-servi	ce about not wearing gloves		Coordinator RN by 8/5/2024 on the	е		
	_	fection control training since		importance of ongoing education			
	April 2023.			staff to ensure all staff receive train	•		
				dementia care, infection control pe			
		6:14 pm in a phone interview		and procedures, and the elements	s of the		
	with Nurse #8 who had worked at the facility the last two years, she stated she did not know what			Quality Assurance Performance			
				Improvement (QAPI) program. Aft 8/5/2024 newly hired staff will be			
	QAPI was. She said she had not received training while at the facility on QAPI or dementia care and			by the DON or Designee during the			
	_	ection control training on		hire employee orientation.	CII TICVV		
	policies and procedu			mile employee enemation.			
				Beginning 7/27/2024, the LNHA, I	OON, or		
	d. On 6/19/2024 at 8	:31 am in a phone interview		Designee will audit 12 employee	,		
	with Medication Aide	#3, she stated she had		education records monthly for 12	months		
	worked at the facility	since 8/2023. When asked if		to ensure ongoing education is be	ing		
	she had received QA	API training,, Medication Aide		completed for all staff. Any month			
		t know what QAPI was.		identified that education was not			
		rther stated she had not		completed will result in re-educati			
		ntrol training and did not		additional training for the appropri			
		entia care training since		member. If there are any newly hi			
	8/2023.			to begin working at the facility the	y WIII		
	e On 6/1/2024 at 7-6	56 am in a phone interview		also be audited.			
		Set (MDS) Nurse #4, she		Beginning 7/27/2024, the audits w	ill he		
		en no infection control and		reviewed by the Licensed Nursing			
		April 2023 and she was		Administrator (LNHA) or DON, an			
	_	ving dementia care training.		results of the audits will be review			
		S S		monthly Quality Assurance and			
	On 6/14/2024 at 4:11	pm in a phone interview		Performance Improvement (QAPI	)		
		Coordinator, she stated the		Meeting monthly for 3 months. Th			
	_	any evidence that infection		Committee will review the audits a			
		QAPI training was provided to		make recommendations as neces	•		
		ility. She explained when the		assure ongoing compliance is sus	tained.		
		opment Coordinator (SDC)		The facility will utilize this plan of			
		office was cleaned and no		correction to ensure compliance u			
		ened to all the training		mandated regulation by 8/6/2024			
	documentation of all	the staff at the facility.		audits will continue for the specific			
				timeframe as described in this cor	rective	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345185	B. WING _			C <b>07/02/2024</b>	
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER LIVING AND REHAB CENTER				100	6 CAMERON STREET		
PREMIER	LIVING AND REHAD CE	NIER		LAKE WACCAMAW, NC 28450			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ION SHOULD BE HE APPROPRIATE	
F 940	Continued From page	÷ 330	F 9	940			
F 940	In a phone interview of (DON) on 6/19/24 at was no Staff Develop the facility when she was no Staff Develop the facility when she was no Staff Develop the facility when she was the development of the stated since there was responsible for document of the stated since there was responsible for document of the conducted by different members, and stated not recorded any training control and QAPI training control and QAPI training the control and QAPI training the months ago, the sassigned to the new hired in April 2024. Swas unable to manage due to learning the roworking on the back If the facility. She reveates in the facility currently did not coordinator and the responsibility to the DON Administrator explaining of dementia of control and document ultimately to the DON Administrator explaining turnover in the DON presponsibility of scheen	with the Director of Nursing 10:22 am, she stated there ment Coordinator (SDC) at was hired in March 2024. she was unable to locate gladementia care, infection licies and procedures and taff since April 2023. She is no SDC, she was menting the staff's training the administrative staff since March 2024 she had ming hours and could not on dementia care, infection on the staff of th		140	action.		