STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	04/13/2011

MAY 11 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	DISCLAIMER: Submission of this response and Plan of Correction is not to be construed as an admission against interest by the facility, the Administrator or any employee, agent or other individuals who draft or may be discussed the response and Plan of Correction. In addition, preparation and submission of these Plans of correction does not constitute an admission or agreement of any kind by the facility of any conclusions set for the in this allegation. The submission of this time frame should in no way be considered or construed as agreement with the allegations of noncompliance or admissions by the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda B. Parnell, LNHA	Administrator	4-28-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assure that staff follow standard precautions to wear gloves while administering an injection for 1 of 3 residents observed receiving injections during med pass (Resident #11). The findings included: The Facility Policy titled Administering Medications under subtitled Policy Interpretation and Implementation in part stated: "11. Established facility infection control procedures must be followed during administration of medication (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.)" On 4/13/11 at 08:00 AM, nurse #1 was observed given an IM injection to resident #11 without using gloves during med pass. The nurse was observed obtaining the syringe from the med cart for the 300 hall, uncapping the syringe, withdrawing the medication from the vial and discarding the syringe needle cap into the med cart trash box. The nurse then walked holding the syringe with her bare hands across from the med cart to the resident's room. The nurse informed the resident about the procedure, wiped the resident upper left arm with an alcohol wipe and injects the medication into his arm. The nurse upon given the injection wiped the injection site area again with the alcohol wipe and discarded the syringe in the discard box of the med cart. The nurse then washed and disinfected her hands.	F 441	F441 For resident affected the injection site was visually monitored for s/s of adverse reaction. None was noted. Nurse # 1 was counseled regarding proper infection conrol/standard precaution measures to be taken when administering injections. Resident # 11's chart was reviewed for QA purposes. No issues noted. Date completed: 4/14/11 For all other residents that may be affected by same deficient practice, the following steps have been taken: Directed inservicing was provided to all nurses on proper infe3ction control/standard precaution measures to be taken when administering injections and their responsibilities. Date completed: 4/22/11 Random Medication Administration audits will be performed on each unit weekly x's 3 weeks then monthly x 3 months and forwarded to QA for further recommendations. Date completed May 6, 2011 Director of Nursing is responsible.	5/6/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 2 During interview at 9:30 AM on 4/13/11 with Nurse #1, the nurse stated she was nervous and have forgotten to use gloves prior to given the injection to the resident. The Nurse stated that it was a requirement of the facility that staff wear gloves when giving injections. During interview with the Director of Nursing (DON) and with the Facility Administrator at 12:15 AM on 4/13/11, both the administrator and the DON stated that staff is required to wear gloves when giving injections. During interview with the Administrator at 1:58 PM on 4/13/11, revealed the facility conducted in-services in a regular basis that included Infection control, hand washing and interventions to prevent spread of infections. Multiple interviews with licensed staff reflected that the staff was knowledgeable about infection control facility policies and standard precautions to prevent spread of infections. During interview with the Infection Control Nurse at 4:00 PM on 4/13/11, stated that her expectations were that all staff should follow standard precautions and wear gloves when giving injections to prevent spread of infections. The Infection Control Nurse stated that an in-service had been conducted with all direct care staff on 3/17/11 that had addressed infection control measures.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation at approximately noon the following interior finish for rooms was non-compliant, specific findings include plywood treatment on wall in activity room had not been treated to maintain flame spread rating for sprinklered buildings.	K 015	DISCLAIMER: Submission of this response and Plan of Correction is not to be construed as an admission against interest by the facility, the Administrator or any employee, agent or other individuals who draft or may be discussed the response and Plan of Correction. In addition, preparation and submission of these Plans of correction does not constitute an admission or agreement of any kind by the facility of any conclusions set for the in this allegation. The submission of this time frame should in no way be considered or construed as agreement with the allegations of noncompliance or admissions by the facility. K015 The paneled wall in the Activity room will be treated with flame spread rated paint. All other areas that may be affected by the same deficient practice have been identified for QA purposes. Areas will be treated as per manufacturer recommendations on an ongoing basis. Administrator will inspect wall in Activity Room to ensure that it has been painted with flame spread rated paint. Audit will be performed on annual basis to ensure compliance with Life Safety regulations and that it meets manufacturer recommendations for reapplication as necessary. Maintenance will be responsible.	7-3-11

RECEIVED
JUN 03 2011
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynda B. Parnell, LNHA	Administrator	5-31-11

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DRS