DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

received 12/3/12 accepted AH

"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345217	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 11/8/2012

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide the required liability and appeal notice for one of three sampled residents (resident #1). Findings include:

Resident #1 was admitted on 2/18/1997. MDS dated 10/11/2012 noted that resident was severely impaired for cognition.

In an interview with the Accounts Receivable Office Manager on 11/08/2012 at 10:20 AM, the office manager stated that Resident #1 ' s Medicare benefits expired on May 19, 2012. The office manager could not produce the letter that was sent to the responsible party (RP) of the resident.

In an interview on 11/8/2012 at 10:45 AM, the facility administrator stated that the person, who was responsible for the letters at the time Resident #1 ' s letter would have been sent, was no longer employed in the facility. The office manager and administrator then stated that they could not find the letter that was sent to Resident #1 ' s RP.

The facility was not able to provide documentation that Resident #1 ' s responsible party (RP) received an approved Notice of Medicare non-coverage letter that notified the resident that Medicare services were ending, and the right to appeal this notice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	11/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, and record review the facility failed to ensure bathing choices were honored for 1 of 15 residents (resident #21). The findings include: Resident #21 was admitted on 3/27/2012 and readmitted on 11/1/2012 with the cumulative diagnosis of encephalopathy, disorder of metabolism, osteoarthritis, abnormality of gait, symbolic dysfunction, sialolithiases, end stage renal disease, hypertension, depression, anxiety, malaise and fatigue, difficulty in walking, muscle weakness, congested heart failure, esophageal reflux, hypothyroidism, arthritis and degenerative joint disease. Review of the Minimum Data Set (MDS) dated 4/3/2012 revealed resident #21 was cognitively intact and was an extensive assist of one person for activities of daily living including personal hygiene. The MDS revealed resident #21 indicated it was important to choose between a bed bath or shower for daily preferences. Review of MDS dated 10/4/2012 revealed resident #21 remained cognitively intact and needed extensive	F 242	Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Cont.	11/30/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy K. Pless	Administrator	11/21/2012

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
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F 242	Continued From page 1 assist of one for personal hygiene and remained to require physical help in part of bathing activity of one person. Review of the Care Plan (CP) dated 10/4/2012 for resident #21 revealed a focus area of requires assistance with potential to restore maximum function of self sufficiency for bathing/hygiene related to weakness, decreased balance and endurance with the diagnosis of end stage renal disease, encephalopathy due to metabolic disease with interventions for staff to break task into segments, give the resident steps one at a time to avoid overwhelming the resident, encourage the resident to participate in self care as ability permits, focus on all areas of activities of daily living that require assistance from staff. On 10/6/2012 at 9:57 am an interview with resident #21 revealed that she would like to take a shower 5 days a week. Resident #21 stated that she had received a shower only 2 days a week and that she had talked with the Director of Nursing (DON) about her concern. Resident #21 indicated the DON told her she could only receive a shower 2 days a week not 5 days like resident #21 had requested. Resident stated " I would feel much better if I could get a shower 5 days a week. " Review of the resident concern log dated 6/25/2012 revealed resident #21 had reported to a social worker that " my showers are 3 times a week and now they want me to shower 2 times per week. " The form indicated resident #21 outcome expectations were to have showers 3 times per week not 2 times per week. The form indicated the social worker informed the DON	F 242	F 242 483.15(b) Self Determination-Right to Make Choices DON met with resident #21 to discuss residents' choice for shower days and will receive a shower 3 X's per week as resident requested. 100% audit was done with all interviewable resident's, to include resident #21, to ensure all choices are being honored by Administrative Staff completed on 11/23/2012 using a QI tool. All Resident Concerns for the past 3 months were reviewed to ensure all choices were honored by Facility Consultant completed on 11/27/2012. Cont.	11/30/2012

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F 242	Continued From page 2 and the Administrator about resident #21 concerns of her shower schedule. The form revealed the DON on 6/25/2012 documented, " met with resident with the administrator and informed her that showers are given two days a week and can be adjusted to the day she would like to get a shower. The resident continued to request to get a shower when she wants. The resident was informed that daily assistance with bath (bed) will occur. Resident insisted on at least 3 showers a week. " The form indicated on 6/26/2012 at 6:30 pm resident #21 informed the charge nurse and assigned aide that she would like her showers on Wednesday and Friday on the 3 pm to 11 pm shift. The form indicated the shower sheet for resident #21 was changed for resident #21 to receive only 2 showers a week. On 11/6/2012 at 3:54 pm an interview with the DON revealed she had spoken with resident #21 about shower concerns. The DON indicated per the facility protocol showers are only given 2 times per week and then full head to toe bed baths. The DON indicated she could not guarantee 3 showers a week to the residents our facility policy is for 2 days a week. The DON was asked by this surveyor what her expectation was from the staff if a resident had requested another shower more than their allotted 2 showers per week. The DON responded with if the staff could accommodate with time management they will try to accommodate, the staff could do bed baths, but our policy is 2 showers a week. The DON stated " I could not guarantee 3 showers or more a week for all residents per our guidelines and I would like to provide consistent care throughout the facility.	F 242	100% of staff will be in-serviced on Residents Rights conducted by the facility Social Worker(s) completed on 11/30/2012. Ombudsman will be contacted to schedule a date on when she can present an in-service on Residents Rights to staff. All alert and oriented residents will be interviewed using a QI tool by Administrative Staff and follow up on Residents concerns will be done by the Facility Social Workers in the area(s) of choices, weekly X4, then monthly X3. The Executive QI committee will meet and review audits to identify and address concerns and/or trends and to determine the frequency and the need for continued monitoring weekly X4, then monthly X3.	11/30/2012

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F 242	Continued From page 3 Throughout the survey time several staff members revealed that all residents received 2 showers per week. Most staff members did reveal if a resident had asked for additional showers they would try to accommodate the resident request. Review of the facility bathing protocol dated 4/2007 revealed that bathing of residents will be done according to the facility ' s schedule. Resident will be given 2 full baths per week (according to health status) and a partial or complete bath on other days, depending on the status of the resident. This will not be documented because it is a part of daily care. On 11-6-2012 at 4:12 pm and interview with resident #21 revealed that she agreed to the 2 showers per week and picked her days due to she was told that was all she was aloud to have per the DON. Resident #21 stated, " I was only ok with it because that is all I could get per the DON. " Resident #21 indicated she wanted a shower 5 days per week if she could have her choice.	F 242		

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible

The above isolated deficiencies pose no actual harm to the residents

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F 156	Continued From Page 1

for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to provide the required liability and appeal notice for one of three sampled residents (resident #1). Findings include:

Resident #1 was admitted on 2/18/1997. MDS dated 10/11/2012 noted that resident was severely impaired for cognition.

In an interview with the Accounts Receivable Office Manager on 11/08/2012 at 10:20 AM, the office manager stated that Resident #1 ' s Medicare benefits expired on May 19, 2012. The office manager could not produce the letter that was sent to the responsible party (RP) of the resident.

In an interview on 11/8/2012 at 10:45 AM, the facility administrator stated that the person, who was responsible for the letters at the time Resident #1 ' s letter would have been sent, was no longer employed in the facility. The office manager and administrator then stated that they could not find the letter that was sent to Resident #1 ' s RP.

The facility was not able to provide documentation that Resident #1 ' s responsible party (RP) received an approved Notice of Medicare non-coverage letter that notified the resident that Medicare services were ending, and the right to appeal this notice.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217/	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ DEC 27 2012	12/05/2012

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

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type II-protected construction, one story, with a complete automatic sprinkler system. Facility are using NCSBC special locking system. The deficiencies determined during the survey are as follows:	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:30 pm onward, the following items were noncompliant, specific findings include: cross corridor doors on 100 and 200 did not close for smoke tight seal on activation of fire alarm test.	K 027	The Maintenance Director removed the hardware from the top of the door that was not necessary for closure, and made adjustments to ensure that the door closes for a smoke tight seal on activation of fire alarm test. The Maintenance Director will monitor all cross corridor doors during each fire alarm test and make repairs/ adjustments as needed. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	12/11/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy K. Rhyne — TITLE: Administrator — (X6) DATE: 12/18/2012

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K 027	Continued From page 1 42 CFR 483.70(a)	K 027		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:30 pm onward, the following items were noncompliant, specific findings include: 1. dry storage room door requires two motion of hand to exit out of room. 2. gate in courtyard coming out of special care unit was pad locked(pad lock was removed at time of survey). 42 CFR 483.70(a)	K 038	The Maintenance Director replaced the lock on the door to the dry storage room with a non-thumb button on 12/05/2012. The pad lock on the gate in the courtyard outside of the SPARK Unit was removed at time of the survey on 12/05/2012, and will not be replaced. The Maintenance Director or Maintenance Assistant will monitor the non-thumb button lock on the dry storage room monthly and make any corrections/repairs as necessary. The Maintenance Director or Administrator will monitor the gate in the courtyard outside of the SPARK Unit during each fire drill and on an on-going basis to ensure that the gate opens easily to allow egress from the facility. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	12/11/2012

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	345217	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	12/05/2012

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K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:30 pm onward, the following items were noncompliant, specific findings include: on activation of fire alarm test chime on 800 not did not work(audible). 42 CFR 483.70(a)	K 056	On 12/05/2012, Charles Taylor Electric Company representative came to the facility and replaced the audio unit on 800, ensuring that the chime will work on activation of the fire alarm system. The Maintenance Director will monitor all stations for compliance of audible chimes during each fire alarm test, and make corrections if warranted. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed.	12/11/2012

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

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