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 _____	C 01/19/2019

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E 000	Initial Comments An unannounced Recertification/Complaint Investigation survey was conducted on 11/14/19 through 11/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3O7X11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 1/14/19 through 1/19/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J. Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/11/18 and was removed on 01/19/19. An extended survey was conducted. No deficiencies were cited as a result of the complaint investigation. NC00145820. Event ID #3O7X11. Multiple attempts were made to post the SOD on 02/04/19, but technical problems with accessing the survey (which was locked) prevented this from occurring.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		2/15/19

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

Electronically Signed | 02/14/2019

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F 580	Continued From page 1	F 580		

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to notify the physician and the Responsible Party (RP) when a pressure ulcer was discovered for 1 of 2 Residents (Resident #36) whose pressure ulcers were reviewed. Findings included: Resident #36 was admitted to the facility on 10/12/10 with diagnoses of diabetes, hypertension, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 11/06/18 revealed Resident #36 was cognitively intact and did not reject care. Resident #36 required the extensive assistance of one person for bed mobility and hygiene. Resident #36 was frequently incontinent of bladder and always incontinent of bowel. Resident #36 was at risk for, but did not have, a pressure ulcer and had a pressure reducing device on the bed. Review of the Pressure Injury Assessment dated 01/07/19 and signed by the Occupational Therapist (OT), revealed Resident #36 had a Stage 3 gluteal crease pressure ulcer that was acquired in the facility on 01/01/19. The wound was 1.4 cm (centimeters) in length and 0.7 cm in width with a depth of 0.7 cm. There was 99% granulation tissue (new connective tissue with tiny blood vessels) with no slough (dead tissue) or eschar (dry, black, hard necrotic tissue). The physician and Resident #36's Responsible Party	F 580	The physician for Resident #36 was notified of a new area found on the resident on 1/07/19. The Resident Representative (RP) for Resident #36 was notifed of a new area found on the resident on 01/07/19. All other residents who have Pressure Ulcer's have been reviewed to ensure proper notification has been made. Systemic changes made to ensure proper notification of new skin issues are as follows: Nurses were inserviced on 2/8/19 on regulatory requirement to notify RP and MD of all changes in condition. Reviewed Interact guidance adopted from AMDA Clinical Practice Guidelines regarding Acute Changes in Long Term Care with nurses to educate on which condition changes require immediate notification and which are non-immediate. Interact guidelines placed at nurses stations for ease of access. Emphasis placed on expectation that ALL changes will be identified, documented, and notification will be made.	

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F 580	Continued From page 3 (RP) were notified of the pressure ulcer on 01/07/19 by the OT. In an interview on 01/16/19 at 10:50 AM the OT stated she was in the facility on 12/31/18 and 01/01/19. She indicated she had not been informed that Resident #36 had a pressure ulcer on either of those days. The OT stated she found out about the pressure ulcer on 01/04/19 in the morning meeting when the Director of Nursing (DON) told her that Resident #36 had a Stage 3 pressure ulcer. In a follow-up interview on 01/16/19 at 4:35 PM the OT stated she went to evaluate Resident #36's pressure ulcer on 01/04/19 and was told by Nurse #3 that the DON had already evaluated the wound. The OT went to speak with the DON and when she got back to Resident #36's room, Nurse #3 had placed a dressing over the pressure ulcer. She indicated she did not notify the physician or Resident #36's RP of the wound until 01/07/19 when she realized that no one had made the notifications. In an interview on 01/17/19 at 9:28 AM the DON stated she did not really remember what date she found out about Resident #36's pressure ulcer but thought that it was sometime in December 2018. She indicated Nurse #3 had informed her of the pressure ulcer. When informed that the documentation listed the acquired date as 01/01/19 she indicated that sounded about right. The DON indicated she had not notified the physician or Resident #36's RP of the pressure ulcer. In a telephone interview on 01/17/19 at 1:23 PM Nurse #8 stated when she performed Resident	F 580	New orders will be reviewed on daily basis (M-F) by MDS Coordinator or designee to be brought to morning meeting to make WCC aware of new treatments initiated. Nurses were inserviced to initiate incident reports for any new open areas. This form has a page for notification, therefore they are prompted to complete the notification. All weekly skin observations are audited daily to ensure notification of any new areas has been made to RP and MD. New incident reports are audited by WCC daily (M-F) and checked to ensure notification was made to RP and MD. Nurses who failed to make notifications will be individually educated and/or counseled. Audit results will be forwarded to the QAA Committee for review and further recommendations as necessary. Director of Nursing/QA Coordinator or Designee will be responsible.	

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F 580	Continued From page 4	F 580		

#36's skin assessment on 01/01/19 she was unsure if the area in the gluteal cleft was open or not. She indicated that unless she knew it was open she would not have notified the physician or Resident #36's RP.

In an interview on 01/17/19 at 5:15 PM Nurse #2 stated she messaged the DON using the secure computer messaging system on either 12/29/18 or 12/30/18 regarding a new open area in Resident #36's gluteal crease. She indicated that at that time the open area appeared to be the size of the eye of a needle. Nurse #2 stated she did not document the open area or notify Resident #36's physician or RP of the wound.

In an interview on 01/18/19 at 10:27 AM Nurse #3 indicated Resident #36's pressure ulcer was hard to see because the gluteal cleft had to be pulled apart to see the area. She stated she did not find the area initially, but she had seen it and it was a small open area with no slough or drainage. She indicated that on 01/04/19 the DON and the OT had gone to look at Resident #36's pressure ulcer. She indicated the DON told her to put Calcium alginate (used to absorb drainage) on the wound and to cover the wound with an absorptive dressing.

In a follow-up interview on 01/18/19 at 11:40 AM Nurse #3 stated she applied the dressing to Resident #36's pressure ulcer that the DON recommended but did not place the order on the TAR or document that the treatment had been done. She indicated that she had not notified Resident #36's physician about the pressure ulcer and did not notify Resident #36's RP. Nurse #3 indicated that if she had been the nurse who found the wound she would have notified the

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F 580	Continued From page 5 physician and Resident #36's RP. In an interview on 01/19/19 at 10:18 AM the DON stated that the process when a pressure ulcer was discovered was to document the ulcer, report to her, notify the physician of the wound and request orders for treatment, and to notify the RP. The DON stated that the nurse who initially discovered the pressure ulcer should have notified the physician and Resident #36's RP. The DON stated that she may have recommended a treatment to Nurse #3 but she expected the nurse to call the physician to confirm that the recommended treatment was acceptable and that would have been a second chance at notification. In a telephone interview on 01/19/19 at 5:25 PM Resident #36's physician stated he expected to be notified of any new pressure ulcers. He verified that he was not aware of Resident #36's pressure ulcer until 01/07/19 when it was reported by the OT. He indicated he would expect a call so he could have the opportunity to decide on a treatment or to direct the facility to use the Standing Orders that were available.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to code information correctly for 3 of 22 sampled residents (Resident #4, #30, and #58) whose minimum data set (MDS)	F 641	Corrections made for resident(s): The Minimum Data Sets (MDS) that were inadvertently not coded to reflect weight	2/15/19

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F 641	Continued From page 6 assessments were reviewed. Findings included: 1. Resident #30 was admitted to the facility on 05/10/16. The resident's documented diagnoses included diabetes, hypertension, and hyperlipidemia. The resident's Weight Summary documented he weighed 196 pounds on 06/06/18, 177.5 pounds on 11/14/18, and 165.5 pounds on 12/19/18. (The resident experienced a 12 pound or 6.8% weight loss in one month between 11/14/18 and 12/19/18. The resident also experienced at 30.5 pound or 15.6% weight loss in six months between 06/06/18 and 12/19/18). The resident's 12/28/18 quarterly minimum data set (MDS) assessment documented he was 71 inches tall, weighed 165 pounds, and his weight was stable with no significant weight loss or gain over the past month or past six months. During an interview with the MDS Nurse on 01/18/19 at 10:14 AM she stated the facility's Dietary Manager (DM) and Registered Dietitian (RD) worked together to code all the information in the Swallowing/Nutritional Status section of the MDS assessments. She commented the DM and RD actually entered the data in the computer themselves so she only had to verify that their section of the MDS was completed. During an interview with the DM on 01/18/19 at 10:51 AM she stated she did help code the information requested in the Swallowing/Nutritional Status section of the MDS assessments. She reviewed facility weight worksheets which documented Resident #30 experienced a 6.8% weight loss in one month and	F 641	loss for Resident #30, Hospice for Resident #58 and Antipsychotic medication for Resident #4, were modified to reflect the services being received by these residents. This human error did not affect the in-place services that were already actually being provided for our residents. Modification of quarterly assessments were made and submitted for residents # 4 and #58 on 1/18/19. Modification of quarterly assessments were made and submitted for residents #30 on 2/11/19. Measures for other residents with the potential to be affected: Most recent MDS assessment for all residents who receive Hospice services were audited to ensure proper coding. Most recent MDS assessment for all residents who receive antipsychotic medications were audited to ensure proper coding. Most recent MDS assessment for all residents who experienced a loss of 5% or greater in one month and/or a weight loss of 10% or greater in 6 months were audited to ensure they were coded for significant weight loss. Measures put in place and Systemic Changes: Care plan coordinator and interdisciplinary team inserviced on importance of	

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F 641	Continued From page 7	F 641		

had already experienced a 16.4% weight loss between a weight of 198 pounds on 08/22/18 and a weight of 165.5 pounds on 12/19/18. After review of the worksheets, she reported when residents experienced a weight loss of 5% or greater in one month and/or a weight loss of 10% or greater in six months they should be coded for experiencing significant weight loss on their MDS assessments. The DM was unable to explain why she did not code Resident #30 for significant weight loss on his 12/28/18 quarterly MDS. She commented she thought it was human error or an oversight on her part.

During an interview with the Director of Nursing (DON) on 01/18/19 at 2:19 PM she stated it was her expectation that all MDS data be coded correctly. She remarked accurate MDS data was important for determining resident care needs and for reimbursement of the care provided.

2. Resident #58 was admitted to the facility on 06/01/18. The resident's documented diagnoses included cerebrovascular accident (CVA), vascular dementia, hypertension, and diabetes.

Record review revealed in the electronic medical record there was a 06/07/18 physician order for Resident #58 to receive hospice services.

The resident's 12/05/18 quarterly minimum data set (MDS) documented the resident's cognition was severely impaired, and he was receiving no special treatments or services including hospice.

During an interview with the MDS Nurse on 01/18/19 at 10:14 AM she stated in the census section of Resident #58's electronic medical record it documented the resident had been

accuracy of MDS coding by Nursing Home Administrator on 2/12/19.

Environmental changes implemented to ensure less interruptions and fewer distractions during care planning process.

How facility will monitor performance so solutions are sustained:

5% of all MDS□s completed will be audited weekly x's 4 weeks, then 5% monthly x's 2 months to ensure sections O0100.K, N0450.A, K0300 are coded accurately by Interdisciplinary Team (IDT) members.

Audits will be forwarded to QAPI committee monthly for review and further recommendations as necessary.

Director of Nursing/QA Coordinator is responsible.

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 _____	C 01/19/2019

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F 641	Continued From page 8	F 641		

receiving hospice services since 06/01/18. She reported the provision of hospice services was supposed to be documented in the Special Treatments, Procedures, and Programs section of quarterly and full MDS assessments. After reviewing Resident #58's 12/05/18 MDS, she commented the resident should have been coded as receiving hospice services. According to the MDS Nurse, the mistake was human error or an oversight on her part.

During an interview with the Director of Nursing (DON) on 01/18/19 at 2:19 PM she stated it was her expectation that all MDS data be coded correctly. She remarked accurate MDS data was important for determining resident care needs and for reimbursement of the care provided.

3. Resident #4 was admitted to the facility on 07/06/12 with diagnoses that included, in part, Diabetes Mellitus, chronic kidney disease, bipolar disorder, major depression and psychosis.

Review of the October 2018 Medication Administration Record revealed that Resident #4 was receiving the antipsychotic medication Seroquel 50 milligrams at bedtime daily for a diagnosis of psychosis.

Section N, Line N0410A of the quarterly Minimum Data Set Assessment (MDS) dated 10/05/18 documented Resident #4 received an antipsychotic on seven days during the assessment period. On the same MDS assessment, Line N0450 was answered, "no", the resident did not receive antipsychotic medication routinely.

During an interview conducted with the MDS Nurse on 01/15/19 at 4:45 PM she said Line item

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F 641	Continued From page 9 N0450 on the MDS assessment dated 10/05/18 for Resident #4 was coded in error and should have been marked "yes" that the resident did receive seven days of antipsychotic medication during the assessment period. She commented that she would create an assessment modification to correct the error. In an interview conducted with the Director of Nursing on 01/15/19 at 5:10 PM she stated that she expected the information in an MDS assessment to be accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		2/15/19

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F 656	Continued From page 10 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a plan of care related to pain for 1 of 1 residents reviewed for pain and failed to implement care plan interventions to prevent unsupervised facility exits for 1 of 1 residents reviewed for accidents (Resident #6). The findings included: 1. Resident #6 was admitted to the facility on 05/24/18 with diagnoses that included, in part, dementia, leg pain, joint pain and chronic pain syndrome, delirium, anxiety, adjustment disorder with mixed anxiety and depressed mood, and insomnia. a. Review of the last comprehensive five day Minimum Data Set Assessment (MDS) dated 06/06/18 for Resident #6 documented in the Care Area Assessment section (CAA, #19) that pain	F 656	Corrections made for resident: 1. Care plan for Resident #6 was updated on 1/19/19 and implemented by Social Worker and DON to include placement of additional SCB on rollator because she has successfully removed the SCB from her body in the past and is dependent on rollator for ambulation. 2. Care Plan for resident #6 was updated to reflect planning for triggered area of pain on 1/17/19. 3. Implementation of plan of care was ensured on 12/18/18 by the following actions: Order was entered into electronic medical record (EMR) to ensure function is	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

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PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 656	Continued From page 11 triggered as a focus area and was checked indicating that a care plan would be developed. Review of the plan of care dated 12/04/18 for Resident #6 revealed that the facility did not develop a care plan related to pain for Resident #6. Review of the January 2019 physician orders revealed that Resident #6 was ordered Meloxicam 15 Milligrams (mg) daily for pain, Tramadol 50 mg every eight hours as needed for pain, Tylenol 325 mg (2 tablets) every four hours as needed for pain, and Diclofenac Sodium Gel 1% (2) grams transdermal every six hours as needed for joint pain. Review of the January 2019 Medication Administration Record (MAR) revealed that Resident #6 received Meloxicam 15 mg daily as scheduled, fifteen doses of Tramadol 50 mg between January 1, 2019 and January 17, 2019 and one dose of Tylenol 650 mg during the same time period. In an interview conducted with the MDS Nurse on 01/17/19 at 12:15 PM she stated that there was no care plan developed for Resident #6 related to pain. She said that when she reviewed the last comprehensive care plan that was done it was indicated in CAA section that a care plan for pain would be developed. She commented that the nurse who had completed the assessment was no longer employed at the facility. She said that a care plan should have been developed as indicated in the CAA section of the MDS assessment and that she would create one to correct the error. In an interview conducted with the Director of	F 656	validated each night shift by nurse. Task was entered into EMR to ensure placement is validated each shift by CNA. Measures for other residents with the potential to be affected: Care plans for all residents who triggered for pain were audited to ensure care plan for pain was developed. All other residents at risk of wandering were reviewed to ensure care plans were updated and implemented. System Changes: Care plan coordinator and interdisciplinary team inserviced on importance of accuracy and follow through. Environmental changes implemented to ensure less interruptions and fewer distractions during care planning process. How facility will monitor performance so solutions are sustained: Admission Assessment Audit performed weekly by Minimum Data Set (MDS) Coordinator to ensure all newly admitted residents have been assessed for wandering within 24 hours of admission. Audit performed weekly by Minimum Data Set (MDS) Coordinator to ensure all comprehensive care plans due in previous week have addressed each Care Area Assessment as indicated. SCB Audit completed by Social Worker for	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 12 Nursing on 01/17/19 at 12:30 PM she stated that she expected the MDS assessments to be accurate and for all triggered CAA areas checked to be included in the plan of care have a care plan developed. b. Review of the 30 day MDS assessment for Resident #6 dated 06/27/18 revealed she had severely impaired cognition and was only able to answer questions on the mini mental assessment with cueing from staff. She used a wheelchair for ambulation. She required supervision for locomotion on the unit and was independent for locomotion off the unit. Review of Resident #6's care plan revealed that on 08/13/18, after the resident exited the facility unsupervised on 08/11/18, the Social Worker updated the care plan to include a goal for the resident to remain safe and not leave the facility unattended through the next review date. New care plan interventions initiated on 8/13/18 included: Check the function of the wanderguard each night (nursing), Check placement of the wanderguard each shift (nursing), and Wanderguard in place to ankle (nurse aides). Review of Resident #6's medical record revealed no documentation from 8/13/18 to 12/18/18 that nursing staff implemented the care plan interventions to checking the function of the resident's Wanderguard each night and to check the placement of the Wanderguard each shift as specified on the resident's care plan. A nursing progress note date 12/18/18, written by Nurse #3, revealed Resident #6's Wanderguard alarm did not sound when she attempted to exit or reenter the facility's front door and it was	F 656	100% of residents assessed to be at risk for elopement weekly for 3 months to include: Order entered into EMR to ensure function is validated each night shift by nurse. Task is entered into EMR to ensure placement is validated each shift by CNA. Care plan reviewed for inclusion of wandering issues. Wandering list up-to-date. Pictures available to staff of all wandering/elopement risk residents. Possessions checked for any objects that could potentially be utilized to remove the SCB. Audits will be forwarded to QAPI committee monthly for review and further recommendations as necessary. Social Services Director is responsible.	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

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F 656	Continued From page 13 discovered that she was not wearing a Wanderguard bracelet. In an interview conducted with Nurse #3 on 1/18/19 at 10:25 AM she stated that she was able to intercept Resident #6 on 12/18/18 as she attempted to exit the facility's front door unsupervised. She said she saw the resident as she opened the door before she crossed the threshold. Nurse #3 stated she did not hear the door alarm go off when the resident exited the door or when she re-entered the building. She said she found that Resident #6 was not wearing a wanderguard bracelet. On 01/17/19 at 5:42 PM an interview was conducted with Nurse #2, who cared for Resident #6. Nurse #2 confirmed there was no indication on the Medication Administration Record, Treatment Administration Record or in Point of Care indicating that staff had checked the placement of the resident's Wanderguard each shift and the function each night as specified on the resident's care plan. In an interview conducted with the Director of Nursing on 01/17/19 at 6:35 PM she stated that she expected interventions documented on the plan of care to be communicated to and implemented by staff.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		2/14/19

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F 686	Continued From page 14 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff, and physician interviews the facility failed to assess and document a pressure ulcer when discovered and performed a treatment to a pressure ulcer without physician orders for 1 of 2 residents (Resident #36) whose pressure ulcers were reviewed. Findings included: Review of the Facility Protocol For Wound Care Standing Orders (SO) revised 01/13 revealed the treatment for a Stage 1 pressure ulcer was to apply skin prep every day. The SO for a Stage 2 pressure ulcer was to clean with Normal Saline (NS), apply skin prep to the peri-wound (the area around the wound) and then place hydrogel and a foam dressing to the wound three times each week and as needed. The SO for a Stage 3 pressure ulcer was to clean the area with NS and then apply skin prep to the peri-wound. NS moistened gauze with hydrogel was to be applied to the pressure ulcer and then a dry dressing was to be placed over the moistened gauze and hydrogel. The treatment was to be done twice each day. Resident #36 was admitted to the facility on 10/12/10 with diagnoses of diabetes, hypertension, and osteoarthritis.	F 686	Res #36 was assessed and treatment orders initiated per MD order on 1/7/19. All other residents with pressure areas were reviewed to ensure assessments were completed and treatment orders initiated. Nurses were inserviced on 2/8/19 on regulatory requirement to notify RP and MD of all changes in condition. Reviewed Interact guidance adopted from AMDA Clinical Practice Guidelines regarding Acute Changes in Long Term Care with nurses to educate on which condition changes require immediate notification and which are non-immediate. Interact guidelines placed at nurses stations for ease of access. Emphasis placed on expectation that ALL changes will be identified, documented, and notification will be made. New orders will be printed on daily basis (M-F) by MDS Coordinator or designee to	

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F 686	Continued From page 15 Review of the quarterly Minimum Data Set (MDS) dated 11/06/18 revealed Resident #36 was cognitively intact and did not reject care. Resident #36 required the extensive assistance of one person for bed mobility and hygiene. Resident #36 was frequently incontinent of bladder and always incontinent of bowel. Resident #36 was at risk for, but did not have, a pressure ulcer and had a pressure reducing device on the bed. Review of the Care Plan updated 11/06/18 revealed Resident #36 was at risk for skin breakdown related to decreased bed mobility and incontinence of bowel and bladder. Interventions included to assess the skin for red areas, to turn and reposition Resident #36 on each Nursing Assistant (NA) round and as needed, and to perform a weekly body audit. Review of the December 2018 Treatment Administration Record (TAR) revealed no orders for pressure ulcer treatments for Resident #36. Review of the Skin Observation Tool dated 01/01/19 and signed by Nurse #8, revealed Resident #36 had excoriations to the buttocks but did not mention a pressure ulcer. Review of the Pressure Injury Assessment dated 01/07/19 and signed by the Occupational Therapist (OT), revealed Resident #36 had a Stage 3 gluteal crease pressure ulcer that was acquired in the facility on 01/01/19. The wound was 1.4 cm (centimeters) in length and 0.7 cm in width with a depth of 0.7 cm. There was 99% granulation tissue (new connective tissue with tiny blood vessels) with no slough (dead tissue) or	F 686	be brought to morning meeting to make WCC aware of new treatments initiated. Nurses were inserviced to initiate incident reports for any new open areas. This form has a page for notification, therefore they are prompted to complete the notification. All weekly skin observations are audited daily to ensure notification of any new areas has been made to RP and MD. New incident reports are audited by WCC daily (M-F) and checked to ensure notification was made to RP and MD. Nurses who failed to make notifications will be individually educated and/or counseled. Audits will be forwarded to the QAPI Committee for review and further recommendations as necessary. Director of Nursing/QA Coordinator is responsible.	

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F 686	Continued From page 16	F 686		

eschar (dry, black, hard necrotic tissue). The physician and Resident #36's Responsible Party (RP) were notified of the pressure ulcer on 01/07/19.

Review of the Order Recap Report revealed an order dated 01/07/19 for OT to treat the pressure ulcer with 48 sessions in 60 days for pain at the gluteal crease pressure injury site. OT was to evaluate and treat as indicated. There was also an order dated 01/07/19 to cleanse the gluteal crease site one time a day with NS or wound cleanser; mix collagen powder with NS; apply to wound bed site; apply CA+ (calcium) alginate; prepare the skin with a skin barrier; and to apply an absorptive dressing. OT was to perform the dressing change Monday through Friday and Nursing was to perform the dressing change on Saturday and Sunday.

Review of the Skin Observation Tool dated 01/08/19 and signed by Nurse #7, revealed Resident #36 had excoriations to the buttocks but did not mention a pressure ulcer.

Review of the January 2019 TAR revealed the initial treatment for Resident #36's pressure ulcer was documented as completed on 01/08/19.

Review of the Pressure Injury Assessment dated 01/16/19 and signed by the OT, revealed Resident #36 had a gluteal cleft pressure ulcer acquired in the facility on 01/01/19. The wound was now 0.7 cm in length and 0.3 cm in width with a depth of 0.3 cm. There was 99% granulation tissue with no slough or eschar. The pressure ulcer was improving and was approximately one half the size that was documented on the first assessment.

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F 686	Continued From page 17	F 686		

In an observation on 01/15/19 at 4:20 PM Resident #36 was lying on her back in the bed. The pressure reducing mattress was in place and functioning.

In an observation on 01/16/19 at 9:10 AM Resident #36 was lying in the bed slightly on her right side. The pressure reducing mattress was in place and functioning.

In an interview on 01/16/19 at 10:50 AM the OT stated she was in the facility on 12/31/18 and 01/01/19. She indicated she had not been informed that Resident #36 had a pressure ulcer on either of those days. The OT stated she found out about the pressure ulcer on 01/04/19 in the morning meeting when the Director of Nursing (DON) told her that Resident #36 had a Stage 3 pressure ulcer.

In an observation and interview on 01/16/19 at 11:00 AM Resident #36 was lying on an air mattress in bed. She was rolled to her left side in preparation for the pressure ulcer treatment. The dressing was removed and no drainage or odor was noted. A small open area with minimal depth was seen in Resident #36's gluteal cleft when the OT separated the buttocks. The wound bed was red with no slough or necrotic tissue. There was a ring of white scar tissue surrounding the wound. The edges of the wound were well defined. There was no tunneling or undermining seen. Resident #36's peri-wound was normal for Resident #36's skin tone and there was no sign of infection. Resident #36 stated she was able to reposition herself in bed and preferred to remain in bed rather than get up. She stated she was able to use the call light to call for assistance with

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

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F 686	Continued From page 18	F 686		

incontinent care when needed.

In a follow-up interview on 01/16/19 at 4:35 PM the OT stated she went to evaluate Resident #36's pressure ulcer on 01/04/19 and was told by Nurse #3 that the DON had already evaluated the wound. The OT went to speak with the DON and when she got back to Resident #36's room, Nurse #3 had placed a dressing over the pressure ulcer. She indicated there was no order in place for a dressing on 01/04/19. The OT stated she did not remove the dressing to evaluate the pressure ulcer or write a treatment order because she did not feel the dressing should be removed at that time. The OT stated she evaluated and wrote orders for a treatment for Resident #36's pressure ulcer on 01/07/19.

In a telephone interview on 01/17/19 at 5:06 AM Nurse #7 indicated that when she performed Resident #36's skin assessment on 01/08/19, there was a thick layer of cream on the buttocks. She indicated there were excoriations to the buttocks but she was unable to see the gluteal cleft because of the cream. She indicated that at the time she performed the skin assessment she was not aware that Resident #36 had a pressure ulcer in the gluteal cleft.

In an interview on 01/17/19 at 9:28 AM the DON stated she did not really remember what date she found out about Resident #36's pressure ulcer but thought that it was sometime in December 2018. She indicated Nurse #3 had informed her of the pressure ulcer. When informed that the documentation listed the acquired date as 01/01/19 she indicated that sounded about right. The DON indicated she had not notified the physician or Resident #36's RP of the pressure

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F 686	Continued From page 19	F 686		

ulcer.

In a telephone interview on 01/17/19 at 1:23 PM Nurse #8 stated on 12/25/18 she noted a deep red color to Resident #36's buttocks. She indicated she was unsure if the area was open or not. Nurse #8 stated that on 01/01/19 the area was still red. She indicated she had not notified the physician or Resident #36's RP.

In an interview on 01/17/19 at 5:10 PM Resident #36 stated she did not remember exactly when the area on her bottom opened or who the staff member was, but she indicated that someone wiped her with a somewhat dry cloth and she felt the area on her bottom open up. She indicated the area was an old pressure ulcer site.

In an interview on 01/17/19 at 5:15 PM Nurse #2 stated she messaged the DON using the secure computer messaging system on either 12/29/18 or 12/30/18 regarding a new open area in Resident #36's gluteal crease. She indicated that at that time the open area appeared to be the size of the eye of a needle. Nurse #2 stated she did not document the open area or notify Resident #36's physician or RP of the wound.

In an interview on 01/18/19 at 10:27 AM Nurse #3 indicated Resident #36's pressure ulcer was hard to visualize because the gluteal cleft had to be pulled apart to see the area. She stated she did not find the area, but she had seen it and it was a small open area with no slough or drainage. She indicated that on 01/04/19 the DON and the OT had gone to look at Resident #36's wound. She indicated the DON told her to put Calcium alginate (used to absorb drainage) on the wound and to cover the wound with an absorptive

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F 686	Continued From page 20	F 686		

dressing.

In a follow-up interview on 01/18/19 at 11:40 AM Nurse #3 stated she applied the dressing to Resident #36's pressure ulcer that the DON recommended but did not place the order on the TAR or document that the treatment had been done. She indicated she did not follow the Standing Orders (SOs) for wound care that the facility had in place. Nurse #3 indicated that she had not notified Resident #36's physician about the pressure ulcer prior to or after performing the wound treatment.

In an interview on 01/19/19 at 10:18 AM the DON stated that the process when a pressure ulcer was discovered was to document the ulcer, report it to her, notify the physician of the wound and receive orders, and to notify the RP. She indicated that Nurse #3 should not have performed a treatment to Resident #36's pressure ulcer without an order from the physician. The DON indicated that if a treatment was done, she expected the order to be placed on the TAR and signed off as completed. The DON stated that she may have recommended a treatment to Nurse #3 but she expected the nurse to call the physician to confirm that the recommended treatment was acceptable.

In a telephone interview on 01/19/19 at 5:25 PM Resident #36's physician stated it was unacceptable, poor patient care to have treated the pressure ulcer without orders. He indicated he would expect to be given the opportunity to decide on a treatment or to direct the facility to use the Standing Orders that were available. The physician indicated that wounds needed to be documented when discovered so healing could

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F 686	Continued From page 21 be monitored.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, Physician interview, and record review the facility failed to provide supervision to prevent a cognitively impaired resident who displayed wandering and exit seeking behaviors from exiting the facility unsupervised for 1 of 1 residents (Resident #6) reviewed for accidents. Resident #6 was found unsupervised outside of the facility by facility staff on two separate occasions (08/11/18 and 11/17/18) and returned inside with no injuries. Additionally, the facility failed to monitor Resident #6's Wanderguard each shift for placement and each night for function and on 12/18/18 when she was attempting to make another unsupervised exit from the facility staff discovered she was not wearing her Wanderguard. Immediate Jeopardy began on 08/11/18 when Resident #6 was found outside of the facility without supervision by Nursing Assistant (NA) #1 at the end of the street approximately 325 feet away from the facility. Resident #6 exited the facility unsupervised again on 11/17/18 through the front door, crossed the sidewalk and walked	F 689	Corrective action for involved resident: On 8/11/18, wandering assessment was completed and a SCB was applied. On 8/12/18, staff brought in some red nail polish to satisfy resident□s request and provide an activity that was meaningful for the resident. On 8/13/18, care plan was updated and implemented by Activities Director to include the opportunities for her to go shopping and on other outings of her choice to satisfy her desire to be independent. On 8/13/18, mental health services visited with resident and recommended psychotherapy 1-4 times per month as well as adding an anti-depressant to her medication regimen. All staff (including nursing, therapy, social services, activities, housekeeping/environmental services, dietary, maintenance and administrative departments) were inserviced on CODE	1/19/19

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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 689	Continued From page 22 on to the paved driveway before staff (who were alerted by the door alarm) reached her. Immediate Jeopardy was removed on 01/19/19 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #6 was admitted to the facility on 05/24/18 with diagnoses that included dementia, delirium, anxiety, adjustment disorder with mixed anxiety and depressed mood, insomnia and chronic pain syndrome. Review of Resident #6's plan of care from the resident's admission to the facility on 5/24/18 until 08/13/18 revealed there was no care plan for wandering or exit seeking behaviors. Review of the admission assessment completed on 06/06/18 revealed behaviors were not triggered in the Care Area Assessment (CAA) section and there was no documentation that behaviors would be carried forward to the care planning phase. Review of Resident #6's nursing progress notes revealed staff documented that Resident #6 displayed the following behaviors in June 2018: Review of a note written, by Nurse #5 on 06/06/18 at 2:41 PM, revealed Resident #6 complained of not wanting to stay at the facility and wanting to stay with family.	F 689	PINK/Missing Resident emergency procedure by 8/23/18. Initiated Admission assessment schedule on 9/11/18 to ensure no assessments were omitted from admission process. □Dealing with behaviors / Verbal de-escalation□ inservice was scheduled and provided to staff by mental health hospital staff on 11/29/18. □Effective Communication with Residents□ inservice was provided to staff on 12/11/18. Staff re-inserviced on CODE PINK with special emphasis on recognizing resident□s exit seeking behaviors. Completed 11/20/18. Nursing Home Administrator contacted wandering resident/access control system company on 11/19/18 with concerns. New upgrades to wandering resident/access control system to increase transmitter signal reception installed on 11/30/18. On 11/19/18, mental health services visited with resident. Replaced SCB 12/19/18. Order was entered into EMR to ensure function is validated each night shift by nurse. 12/19/18 Task was entered into EMR to ensure placement is validated each shift by CNA. 12/19/18 Wandering list updated. 12/19/18 Ensured picture was available to staff of all wandering/elopement risk residents. 12/19/18 IDT discussed alternate placement in skilled facility with locked dementia unit. 12/19/18	

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 _____	C 01/19/2019

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 689	Continued From page 23 Review of a note written, by Nurse #5 on 06/08/18 at 4:39 PM, specified Resident #6 was restless and agitated, complained she was supposed to go home, and wanted money and directions out. Review of a note written, by Nurse #6 on 06/18/18 at 2:05 AM, revealed she came out of her room asking to call a cab so she could get help. Review of a note written, by Nurse #5 on 06/28/18 at 2:45 PM, revealed she repeatedly complained of wanting to go home at the shift start. Review of the 30 day Minimum Data Set Assessment (MDS) dated 06/27/18 revealed that Resident #6 had severely impaired cognition. She used a wheelchair for ambulation. She required supervision only for locomotion in her room and was independent for locomotion off the unit. She did not display any behaviors and was not resistant to care. The assessment further revealed Resident #6 did not have wandering behaviors during the assessment period. Review of Resident #6's medical record revealed a Wander Risk Assessment was not completed by staff until after the resident's first unsupervised exit from the facility which occurred on 08/11/18. Review of the progress note written by Nurse #1 on 08/11/18 at 3:42 PM documented Resident #6 was found at the stop sign at the end of the street beside the church by an aide (Nurse Aide #1) who was returning from her break. (The stop sign is approximately 325 feet from the facility. The street is a residential 2 lane paved road with	F 689	Ombudsman contacted via email for assistance in finding alternate placement on 1/2/19. Representative from skilled facility with locked unit came to facility to assess resident for appropriateness of admission 1/9/19. Care plan for Resident #6 was updated on 1/19/19 and implemented by Social Worker and DON to include placement of additional SCB on rollator because she has successfully removed the SCB from her body in the past and is dependent on rollator for ambulation. Nail clippers were removed from resident□s possession by Social Worker on 1/19/19. For all other residents at risk: Facility wide audit completed to ensure all residents have been assessed for wandering within past quarter and that any residents at risk have been evaluated for the necessity of an SCB on 1/18/19. Facility wide audit conducted of wandering resident/access control system for all residents wearing bracelets as well as the door mag lock panels on 1/18/19. SCB Audit completed on 1/18/19 including: Order entered into EMR to ensure function is validated each night shift by nurse. Task is entered into EMR to ensure placement is validated each shift by CNA.	

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 _____	C 01/19/2019

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 689	Continued From page 24 uneven shoulders on both sides.) During an interview conducted with Nurse Aide (NA) #1 on 1/18/19 at 11:10 AM she stated she went out for lunch between 12:30 PM and 1:00 PM on 08/11/18. When she was driving back to the facility she noticed one of the facility residents alone, with her rolling walker at the stop sign at the end of the street. She stated she immediately put the car in park, got out and talked to Resident #6 and convinced her to get back into her car with her. NA #1 stated she called the facility and told them she found Resident #6 down the road at the stop sign, but before she could inform them Resident #6 was in her car and safe they hung up. By the time she got back to the facility with Resident #6 staff were outside looking for her. NA #1 stated she asked Resident #6 where she was going and she told her she wanted some red nail polish. She stated she was able to convince Resident #6 to go back into the building by promising her that she would personally bring her some red nail polish. NA #1 stated the weather wasn't rainy or cold and she remembered Resident #6 had on pants, shoes and a shirt and was appropriately dressed for the day. On 01/17/19 at 1:30 PM an observation was made of the street where Resident #6 was found by Nurse Aide (NA) #1 on 08/11/18. This observation revealed the street was a residential 2 lane paved road with uneven shoulders on both sides. Where the resident was found was 350 feet away from the facility (walked off by the survey team). The temperature outside the facility on 08/11/18 at 11:50 AM was 88.7 degrees Fahrenheit according to the National Weather	F 689	Care plan reviewed for inclusion of wandering issues. Wandering list up-to-date. Pictures available to staff of all wandering/elopement risk residents. Audit performed by Registered Nurse on 1/19/19 to ensure no objects that could be utilized to remove SCB are readily accessible to residents wearing these bracelets. System Changes: Staff inservices started on 1/19/19 to re-educate nurses on using function checking device. Anyone who has not received this inservice will not be allowed to clock in until they have signed that they received inservice. Staff inservices started on 1/19/19 to re-educate CNAs on the importance of accurate documentation in EMR. Anyone who has not received this inservice will not be allowed to clock in until they have signed that they received inservice. Staff inservices to be scheduled for mental health services to educate regarding behaviors that signal a potential for an attempted elopement as well as behavior interventions and management. Weekly task was added to each resident who wears a SCB□s EMR to check possessions for any objects that could potentially be utilized to remove the SCB. How facility will monitor performance so solutions are sustained:	

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 _____	C 01/19/2019

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 689	Continued From page 25 Service-Raleigh. Review of the facility incident report dated 08/11/18 at 2:45 PM written by the Director of Nursing recorded the following interview with Resident #6: "I have been asking over and over all week to go to the store to get some nail polish, scissors and earrings and they haven't let me go yet. I was trying to go to the store to get my stuff. I normally can go to the store and do the things I want to on my own." Resident #6 was crying. Description of the immediate action taken: She was assessed and a Wanderguard bracelet was placed on her right ankle. No injuries were noted. Review of an elopement incident note written by Nurse #1 on 08/11/18 at 3:42 PM and attached to the incident report revealed that a wandering assessment was completed and the resident was determined to be not safe to leave the facility on her own. A Wanderguard was placed on the resident to alert staff if the resident tried to go outside so that staff could assist her. Activities was going to check with the resident on planned trips to the store to see if she wanted to go as she had exited the facility to go to the store. The mental health group also assessed the resident on 08/11/18 and wrote new orders for Zoloft 25 milligrams (mg) daily, a medication used for anxiety and depression because the resident had been noticed with episodes of crying. The resident's care plan was updated for elopement. In an interview conducted with the Director of Nursing (DON) on 01/17/19 at 6:35 PM she stated a Wander Risk Assessment was not completed when the Resident #6 was admitted to the facility. The DON commented that staff had not recognized the exit seeking behaviors	F 689	Facility wide audit conducted weekly of wandering resident/access control system for all residents wearing bracelets as well as the door mag lock panels by environmental services. SCB Audit completed by Social Worker for 100% of residents assessed to be at risk for elopement weekly for 3 months to include: Order entered into EMR to ensure function is validated each night shift by nurse. Task is entered into EMR to ensure placement is validated each shift by CNA. Care plan reviewed for inclusion of wandering issues. Wandering list up-to-date. Pictures available to staff of all wandering/elopement risk residents. Possessions checked for any objects that could potentially be utilized to remove the SCB. Director of Nursing is responsible.	

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 _____	C 01/19/2019

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 689	Continued From page 26	F 689		

displayed by the resident before her unsupervised exit from the facility on 08/11/18 and staff did not consider her to be an elopement risk. The DON stated Resident #6 was not wearing a Wanderguard prior to 08/11/18 which allowed her to exit the front door of the facility unsupervised and undetected on 08/11/18.

Review of the facility incident report dated 11/17/18 at 7:35 AM written by the Director of Nursing documented the following incident description: "Resident #6 had an attempted elopement around 7:00 AM but was redirected by staff and brought to the 400 hall day room. At approximately 7:30 AM the alarms were going off, by the time staff got to resident she was in the parking lot." The resident description was documented as: "Resident stating she was leaving because staff was "doping her sister up." Talking about her roommate." The immediate action taken as documented on the incident report: "Resident assisted back in the building x1 and brought back to the 400 hall day room for breakfast."

Review of the nurse progress note written on 11/17/18 at 10:22 AM by Nurse #2 specified she intercepted Resident #6 trying to elope out the front door at 7:00 AM on 11/17/18 when she was reporting for work. She put the resident in the 400 hall day room and went to take report from the third shift nurse. At 7:35 AM the alarm sounded but by the time staff could reach the resident she had crossed the threshold and got into the parking lot. She notified the physician and the family. At that time the granddaughter told her that the resident had stated the weekend before that she was going to run away.

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 _____	C 01/19/2019

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 689	Continued From page 27	F 689		

An observation on 01/18/19 at 1:45 PM of where staff located Resident #6 on 11/17/18 revealed the resident in the facility's front parking lot approximately 20 feet from the facility's front entrance (walked off by survey team). Observations of both the sidewalk and parking lot revealed they were evenly paved.

The temperature outside the facility on 11/17/18 at 7:40 AM was 36.5 degrees Fahrenheit according to the National Weather Service-Raleigh.

In an interview conducted with Nurse #2 on 01/17/19 at 5:42 PM she described Resident #6's unsupervised exit that occurred on 11/17/18. She stated she heard the alarm go off at the front door and she went immediately to the door but Resident #6 had made it across the sidewalk and into the paved driveway in front of the facility before she could get to her. She stated there was no traffic in the drive way because most employees reporting for work had already parked and were in the facility. She said the weather wasn't cold and it was not raining that morning and she could not remember what the resident was wearing. She stated earlier during the morning of 11/17/18 at 7:00 AM Resident #6 made an attempt to elope from the facility and she put the resident in the day room. Nurse #2 explained she did not assign anyone to watch Resident #6 in the day room because when she went into the chart room and she thought if the resident tried to exit the facility's front door again she would be able to see her through a window in the chart room. Nurse #6 stated she did not see Resident #6 go past the window in the chart room and the resident successfully exited the facility's front door unsupervised at 7:35 AM.

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 _____	C 01/19/2019

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 689	Continued From page 28	F 689		

Review of the elopement incident follow up note written by the Social Worker on 11/19/18 (no time recorded) revealed she documented she had been made aware Resident #6 attempted to exit the building because her sister was being doped up. The note stated Resident #6 was having increased confusion and delusions. The mental health team was contacted and assessed the resident that morning.

A nursing progress note date 12/18/18, written by Nurse #3, revealed Resident #6's Wanderguard alarm did not sound when she attempted to exit or reenter the facility's front door and it was discovered that she was not wearing a Wanderguard bracelet.

During an interview conducted with Nurse #3 on 1/18/19 at 10:25 AM she stated that she was able to intercept Resident #6 on 12/18/18 as she attempted to exit the facility's front door unsupervised. She said she saw the resident as she opened the door before she crossed the threshold. Nurse #3 stated she did not hear the door alarm go off when the resident exited the door or when she re-entered the building. She said she found that Resident #6 was not wearing a Wanderguard bracelet.

Review of Resident #6's care plan revealed that on 08/13/18, after the resident exited the facility unsupervised on 08/11/18, the Social Worker updated the care plan to include a goal for the resident to remain safe and not leave the facility unattended through the next review date. New care plan interventions initiated on 8/13/18 included: Check the function of the Wanderguard each night (nursing), Check placement of the

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 _____	C 01/19/2019

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 689	Continued From page 29	F 689		

Wanderguard each shift (nursing), and Wanderguard in place to ankle (nurse aides).

Review of Resident #6's medical record revealed no documentation from 8/13/18 to 12/18/18 that nursing staff implemented the care plan interventions to checking the function of the resident's Wanderguard each night and to check the placement of the Wanderguard each shift as specified on the resident's care plan.

On 01/17/19 at 5:42 PM an interview was conducted with Nurse #2, who cared for Resident #6. Nurse #2 confirmed there was no indication on the Medication Administration Record, Treatment Administration Record or in Point of Care indicating that staff had checked the placement of the resident's Wanderguard each shift and the function each night as specified on the resident's care plan.

During an interview conducted with the Director of Nursing on 01/17/19 at 6:35 PM she stated that she expected interventions documented on the plan of care to be communicated to and implemented by staff.

On 01/19/19 at 9:52 AM Physician #1 was interviewed by phone. She stated she was made aware that Resident #6 had been outside the building on multiple occasions. She reported she was told the resident went out the doors with other visitors and was found unharmed and without injury. She commented she was assured by the facility that they had put interventions in place to protect the residents. She also remarked that the Medical Director had been informed and involved in dealing with elopements. Physician #1 stated she felt

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 _____	C 01/19/2019

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 689	Continued From page 30	F 689		

Resident #6 was safe in the building because there had been no reports of trouble in the last month. She reported she was involved with the facility in developing policies about how to deal with newly admitted residents who present with wandering tendencies or later began exhibiting exit seeking behaviors.

On 01/19/19 at 5:25 PM the Medical Director was interviewed by phone. He stated he was aware the facility had issues with residents leaving the building unsupervised. He did not remember if they specifically spoke about Resident #6. He stated he felt Resident #6 was safe because there was not a lot of traffic where the facility was located. He stated he felt Resident #6 would have the problem of trying to leave a facility wherever she was placed.

The facility Administrator and Director of Nursing were notified of Immediate Jeopardy on 01/18/19 at 3:55 PM.

On 01/19/19 at 12:54 PM the facility provided the following credible allegation of immediate jeopardy removal:

The plan to correct specific deficiency and facts that led to the alleged deficient practice:

Summary of events:

Resident #6, an 86 year old female, was admitted from home where she lived with daughter to Premier Living and Rehab Center (PLRC) on 5/24/18 with diagnoses of decreased mobility, dementia, and chronic pain syndrome. Resident was alert, verbal with clear speech, and used wheel chair for locomotion, propelling herself.

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 _____	C 01/19/2019

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 689	Continued From page 31	F 689		

On 5/27/18, she was assessed by physical therapy to have high fatigue and difficulty walking and was able to ambulate 8 feet with minimal assist using a front wheel walker. She was discharged from physical therapy on 7/10/18 having met the goal of being able to ambulate 300 feet with stand by assistance and occasional verbal cues.

Summary of events that led to alleged deficient practice:

On 8/11/18, resident left facility and was approximately 200 yards from front door when spotted by a Certified Nursing Assistant (CNA) and brought back in through front doors. Resident was assessed by Registered Nurse (RN) to be alert and oriented to person, place, time and situation. She had no injuries. When describing what occurred, she was tearful and she stated she had been doing things on her own all her life and she was just going to the store to get some things she needed.

On 11/17/18, resident demonstrated some confusion and was trying to leave through the front doors. Licensed Practical Nurse (LPN) redirected her and helped her to the Day Room for breakfast. About 30 minutes later, the alarm sounded and she had crossed over the threshold of the front door and stepped approximately 4 feet past front doors (per camera footage review). When resident was describing what had occurred, she told the nurse that she was leaving because they were "doping up her sister" (referring to her roommate).

On 12/18/18, Resident #6 was observed exiting

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 _____	C 01/19/2019

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 689	Continued From page 32	F 689		

front door of facility by RN who was leaving out of side exit after completion of her shift. RN initiated Code Pink and resident was easily redirected back into building. Resident was visualized throughout entire incident and no injuries were incurred. The resident was found to be missing her secure care bracelet (SCB).

Root Cause Analysis (RCA) discovered 2 system failures:

No wandering assessment had been completed despite resident having verbalized a desire to go home on one occasion as well as requesting to call a cab in order to get help related to pain in her knees (after topical pain medication had been applied). Therefore, there was no trigger for a wandering/elopement care plan.

The Care Plan was developed on 8/13/18 to include applying SCB, checking function and placement; however, there was no communication with the staff to check placement or function of SCB.
Corrective action for involved resident:

For 8/11/18 event:

On 8/11/18, wandering assessment was completed and a SCB was applied.

On 8/12/18, staff brought in some red nail polish to satisfy resident's request and provide an activity that was meaningful for the resident.

On 8/13/18, care plan was updated and implemented by Activities Director to include the opportunities for her to go shopping and on other outings of her choice to satisfy her desire to be

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 _____	C 01/19/2019

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 689	Continued From page 33	F 689		

independent.

On 8/13/18, mental health services visited with resident and recommended psychotherapy 1-4 times per month as well as adding an anti-depressant to her medication regimen.

All staff (including nursing, therapy, social services, activities, housekeeping/environmental services, dietary, maintenance and administrative departments) were in-serviced on CODE PINK/Missing Resident emergency procedure by 8/23/18.

Initiated Admission assessment schedule on 9/11/18 to ensure no assessments were omitted from admission process.

For 11/17/18 event:

'Dealing with behaviors / Verbal de-escalation' in-service was scheduled and provided to staff by mental health hospital staff on 11/29/18.

'Effective Communication with Residents' in-service was provided to staff on 12/11/18.

Staff re-in-serviced on CODE PINK with special emphasis on recognizing resident's exit seeking behaviors.

Nursing Home Administrator contacted wandering resident/access control system company on 11/19/18 with concerns.

New upgrades to wandering resident/access control system to increase transmitter signal reception installed on 11/30/18.

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 _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 689	Continued From page 34 On 11/19/18, mental health services visited with resident. For 12/18/18 event: Replaced SCB 12/19/18. Order was entered into electronic medical record (EMR) to ensure function is validated each night shift by nurse. Task was entered into EMR to ensure placement is validated each shift by CNA. Wandering list updated. Ensured picture was available to staff of all wandering/elopement risk residents. IDT discussed alternate placement in skilled facility with locked dementia unit. Ombudsman contacted via email for assistance in finding alternate placement on 1/2/19. Representative from skilled facility with locked unit came to facility to assess resident for appropriateness of admission 1/9/19. Measures put in place to ensure deficient practice does not occur: Facility wide audit completed to ensure all residents have been assessed for wandering within past quarter and that any residents at risk have been evaluated for the necessity of an SCB on 1/18/19. SCB Audit completed on 1/18/19 including:	F 689		

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 35 Order entered into EMR to ensure function is validated each night shift by nurse. Task is entered into EMR to ensure placement is validated each shift by CNA. Care plan reviewed for inclusion of wandering issues. Wandering list up-to-date. Pictures available to staff of all wandering/elopement risk residents. Staff in-services started on 1/19/19 to re-educate nurses on using function checking device. Anyone who has not received this in-service will not be allowed to clock in until they have signed that they received in-service. Staff in-services started on 1/19/19 to re-educate CNAs on the importance of accurate documentation in EMR. Anyone who has not received this in-service will not be allowed to clock in until they have signed that they received in-service. Staff in-services to be scheduled for mental health services to educate regarding behaviors that signal a potential for an attempted elopement as well as behavior interventions and management. Care plan for Resident #6 was updated on 1/19/19 and implemented by Social Worker and DON to include placement of additional SCB on rollator because she has successfully removed the SCB from her body in the past and is	F 689		

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 689	Continued From page 36	F 689		

dependent on rollator for ambulation.

Audit performed by Registered Nurse on 1/19/19 to ensure no objects that could be utilized to remove SCB are readily accessible to residents wearing these bracelets.

Nail clippers were removed from resident's possession by Social Worker on 1/19/19.

Weekly task was added to each resident who wears a SCB's EMR to check possessions for any objects that could potentially be utilized to remove the SCB.

How facility will monitor performance so solutions are sustained:

SCB Audit completed by Social Worker for 100% of residents assessed to be at risk for elopement weekly for 3 months to include:

Order entered into EMR to ensure function is validated each night shift by nurse.

Task is entered into EMR to ensure placement is validated each shift by CNA.

Care plan reviewed for inclusion of wandering issues.

Wandering list up-to-date.

Pictures available to staff of all wandering/elopement risk residents.

Possessions checked for any objects that could potentially be utilized to remove the SCB.

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 689	Continued From page 37 Admission Assessment Audit performed weekly by Minimum Data Set (MDS) to ensure all newly admitted residents have been assessed for wandering within 24 hours of admission. All audits will be forwarded to Quality Assurance Performance Improvement Committee for further recommendations. Date of Compliance for Credible Allegation of Compliance: 1/19/19 Person Responsible for implementing Credible Allegation of Compliance: Director of Nursing The credible allegation of Immediate Jeopardy removal was validated on 01/19/19 at 3:38 PM. A sample of staff that included nurses, nurse aides, and non-clinical employees were interviewed regarding in-servicing related to the deficient practice. All interviewed staff members stated they had been in-serviced regarding elopement and the facility procedure for checking alarmed or locked doors. A review of all documents developed to correct the deficient practice was completed. All facility policies and procedures that were revised to address the deficient practice were reviewed. A review of audit forms that were developed to ensure that in-services presented to all staff were understood and allowed an opportunity for staff to interact with dialogue were also reviewed. All doors that were alarmed were checked and verified to be working properly.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		2/15/19

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 _____	C 01/19/2019

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PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 692	Continued From page 38 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide protein supplementation as recommended by the Registered Dietitian (RD) for wound healing and depleted protein stores for 1 of 4 sampled residents (Resident #75) reviewed for nutrition. Findings included: Record review revealed Resident #75 was admitted to the facility on 10/23/17. The resident's documented diagnoses included absence of left great toe, osteomyelitis, and diabetes. 11/15/18 lab results documented Resident #75's albumin was low at 2.7 grams per deciliter (g/dL) with normal limits being 3.5 - 5.2 g/dL. The	F 692	Corrective Action for affected resident(s): Orders were written for resident #75 for a protein supplement to enhance wound healing on 1/19/19. All other residents having potential to be affected: All residents□ records for those residents with wounds were reviewed/audited for Registered Dietician (RD) recommendations to ensure they had been followed. Changes in the system:	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER LIVING AND REHAB CENTER	106 CAMERON STREET LAKE WACCAMAW, NC 28450

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F 692	Continued From page 39 resident's total protein was within normal limits at 6 g/dL with the normal range being 6 - 8.7 g/dL. Review of weekly wound assessments revealed Resident #75 was readmitted to the facility, after hospitalization, on 12/03/18 with wounds that included a left great toe amputation site, a left second toe diabetic ulcer, right plantar fifth metatarsal bone resection (callus removal), and a left lateral foot deep tissue injury (DTI) between the fifth toe and heel. In a 12/11/18 Admission Summary the Dietary Manager (DM) documented, "Readmit with (diagnosis) of osteomyelitis. Resident is alert/oriented times 3. Feeds self in room and generally consumes 76-100% of most meals served. Resident with wound on (right) lateral foot. Will have RD to (re-evaluate) and make (needed recommendations)...." Resident #75's 12/24/18 quarterly minimum data set (MDS) documented his cognition was moderately impaired, he exhibited no behaviors including resistance of care, he was independent in eating requiring set-up assistance only, he was 71 inches tall and weighed 240 pounds, he experienced significant weight loss, and he had one DTI/one diabetic foot ulcer/one surgical wound. In a 01/07/19 Nutrition/Dietary note the Registered Dietitian (RD) documented, "(Resident #75) continues with a surgical wound to his (left) foot, an open area to his (right) shin, and an area to his (right) 5th toe for which he remains on a (multivitamin) and vitamin C daily. (Resident #75) continues to tolerate a regular diet without difficulty, eating well at 75-100% of meals	F 692	- All recommendations from RD will be entered as orders by RD. - RD will exit with DON after visits to ensure all residents reviewed are discussed and orders correctly added to the electronic medical record (EMR). Monitoring: -All progress notes over previous 24 hours are reviewed by DON daily (M-F) using the 24 hour summary report. -New orders will be reviewed on daily basis (M-F) by MDS Coordinator or designee to be brought to morning meeting to crosscheck dietary orders against recommendations. -Any recommendations without orders written will be corrected immediately and noted in morning meeting minutes. Audit results will be forwarded to the QAPI Committee for review and further recommendations as necessary.	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 40	F 692		

served. As of 01/02/19 his weight was at 238 lbs (pounds) which reflects a loss of 21 (pounds) x 6 (months) (down 8.1% x 180 days)....As of 11/15/18 his albumin was moderately depleted at 2.7 (g/dL), so will initiate 30 (milliliters) _____ (name of protein supplement) daily to help replete his visceral protein stores and to promote wound healing...."

Further review of Resident #75's medical record revealed no order was written to initiate the protein supplement recommended in the RD's 01/07/19 note.

01/16/19 lab results documented Resident #75's albumin was low at 3.1 g/dl with normal being 3.5 - 5.2 g/dL. His total protein was also low at 5.8 g/dL with normal being 6 - 8.7 g/dL.

During an interview with the MDS Nurse on 01/18/19 at 10:14 AM she stated the Director of Nursing (DON) received nutrition recommendations and made sure they were implemented timely through a physician order.

During an interview with the DM on 01/18/19 at 10:51 AM she stated she could make nutrition recommendations including those for protein supplementation. She reported she usually considered protein supplementation when residents experienced weight loss, had healing wounds, and/or had low albumin levels. She commented she provided her recommendations to the MDS Nurse who wrote an order for them. According to the DM, after submitting nutrition recommendations the MDS Nurse usually produced an order for them within 24 hours.

During an interview with the DON on 01/18/19 at

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 41 12:18 PM she stated the DM and RD worked together to make nutrition recommendations. However, she reported she had not received any nutrition recommendations for December 2018, and so far she had received no recommendations for Resident #75 in January 2019. She explained the physician gave permission for nurses in the facility to write orders for nutrition recommendations without having to run them through him because of the level of expertise exhibited by the DM and RD. According to the DON, she considered nutrition as one of various important components in the wound healing process. She commented the facility utilized protein supplements to promote wound healing if there were labs to document depleted protein stores. During a telephone interview with the RD on 01/18/19 at 2:19 PM she stated she was unsure why recommendations for Resident #75's protein supplementation were not implemented. She reported the resident was currently only eating 50% of most meals, and his lab work documented depleted protein supplies so it was important to cover all bases to help promote wound healing. She commented Resident #75 had a history of saying he was willing to try nutritional supplements, but then later refusing them about 50% of the time. However, she stated the facility needed to give the resident the opportunity to try and replenish his protein supplies and promote his wound healing. The RD reported by not receiving the protein supplement she recommended Resident #75 missed about 15 grams of extra protein a day.	F 692		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		2/15/19

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 _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 42	F 732		

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 43 Based on record review and staff interviews the facility failed to update the staff posting with the actual hours worked by the Nursing Assistants (NA) on night shift for 2 of 4 daily nurse staffing forms reviewed. Findings included: Review of the Assignment Sheet dated 01/12/19 revealed there were three NAs working that night. Review of the Daily Nursing Staff Posting revealed that on night shift on 01/12/19 four NAs worked 30 hours. The posting had not been updated to reflect that there were only 3 NAs and the actual hours worked should have been 22.5 and not 30. Review of the Assignment Sheet dated 01/13/19 revealed there were three NAs working that night. Review of the Daily Nursing Staff Posting revealed that on night shift on 01/13/19 four NAs worked 30 hours. The posting had not been updated to reflect that there were only 3 NAs and the actual hours worked should have been 22.5 and not 30. In an interview on 01/15/19 at 5:06 PM the Director of Nursing (DON) verified that on 01/12/19 and 01/13/19 there were only three NAs that worked on night shift because one aide had been unable to come to work. She also verified that the posting for 01/12/19 and 01/13/19 had not been updated and that it should have been. She indicated that Nurse #7 should have updated the posting on 01/12/19 and that Nurse #8 should have updated the posting on 01/13/19. In a telephone interview on 01/17/19 at 4:21 AM Nurse #7 stated the nurses did not update the	F 732	The actual hours worked for the night shift on 1/12/19 and 1/13/19 were reviewed for accuracy and found to have not been updated at the end of night shifts on these two dates as per policy. Nursing staff were inserviced on 02/08/19 on updating the Nurse Staffing Hours at the end of each shift to accurately reflect hours worked by direct care staff. The Nurse Staffing sheet has been re-designed and automated for the nursing staff to be able to update it easily and more accurately. The Human Resources/Administrative Assistant will audit the sheets daily to ensure that the hours being posted match the hours worked from the timeclock. Audit results will be forwarded to the Quality Assurance Committee for review and further recommendations and/or changes as necessary. Nursing, Central Supply/Scheduler and HR/Administrative Assistant are responsible.	

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 44 posting sheet except to correct the census as needed. She indicated she was never informed that she should also correct the staffing numbers or hours if there was a change. Nurse #7 verified that there were only three aides that worked on night shift on 01/12/19. In a telephone interview on 01/17/19 at 1:23 PM Nurse #8 verified that only three aides worked on night shift on 01/13/19. She indicated she did not update the posting because she had never been told it was part of her responsibilities. In a follow-up interview on 01/19/19 at 10:18 AM the DON stated she expected the Daily Nursing Staff Posting to be updated every shift as necessary.	F 732		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		2/15/19

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 _____	C 01/19/2019

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 842	Continued From page 45 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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	345185	A. BUILDING _____ B. WING _____	C 01/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 46 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 1 of 22 Residents (Resident #36) whose medical records were reviewed. Findings included: Resident #36 was admitted to the facility on 10/12/10 with diagnoses of diabetes, hypertension, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 11/06/18 revealed Resident #36 was cognitively intact and did not reject care. Resident #36 required the extensive assistance of one person for bed mobility and hygiene. Resident #36 was frequently incontinent of bladder and always incontinent of bowel. Resident #36 was at risk for, but did not have, a pressure ulcer and had a pressure reducing device on the bed. Review of Resident #36's Nursing Notes on 12/29/18 and 12/30/18 revealed no mention of a pressure ulcer that was initially discovered on one of those days. Review of the Skin Observation Tools did not show that any skin assessment sheets were documented for 12/29/18 or 12/30/18 when Resident #36's pressure ulcer was discovered.	F 842	Corrective Action: Pressure injury assessment was documented in medical record for Res #36 and treatment orders written per MD order on 1/7/19. All other residents with pressure areas were reviewed to ensure assessments were documented and treatment orders written. Nurses were inserviced on complete and accurate documentation. They were instructed to report all new or changed conditions of residents to MD and RP as well as to document all their interventions and the resident□s response to interventions. All changes in condition should be noted on an SBAR and any new pressure injuries should have an incident report filed. Interact change in condition guide was reviewed with nurses and several examples were discussed as a group. New orders will be reviewed on daily basis (M-F) by MDS Coordinator or designee to be brought to morning meeting to review for possible new changes in condition and review for appropriate documentation.	

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F 842	Continued From page 47 Review of the Pressure Injury Assessments did not show that any pressure injury assessments were done on 12/29/18 or 12/30/18 when Resident #36's pressure ulcer was discovered. Review of the January 2019 Treatment Administration Record (TAR) revealed no order for treatment to the pressure ulcer until 01/07/19 even though a treatment was completed on 01/04/19. Review of the Skin Observation Tool dated 01/01/19 revealed no mention of Resident #36's pressure ulcer that was discovered in December 2018. Review of the Skin Observation Tool dated 01/08/19 revealed no mention of Resident #36's pressure ulcer that was discovered in December 2018. In an interview on 01/16/19 at 4:35 PM the Occupational Therapist (OT) stated that on 01/04/19 during the morning meeting, the Director of Nursing (DON) had informed her of Resident #36's pressure ulcer. She indicated she went to evaluate the wound and Nurse #3 had already put a dressing over the wound. She stated there was no order for the wound treatment. The OT stated that she did not evaluate the pressure ulcer until 01/07/19. In a telephone interview on 01/17/19 at 5:06 AM Nurse #7, who performed Resident #36's Skin Assessment on 01/08/19, stated she did not see Resident #36's gluteal cleft because it was covered in a thick cream. Nurse #7 indicated that she should have removed the cream so she	F 842	All progress notes over previous 24 hours are reviewed for complete documentation by DON or designee daily (M-F) using the 24 hour summary report. All weekly skin observations are audited daily to ensure they have been completed; any new areas notated on skin observations are forwarded to Occupational Therapist/Wound Care Coordinator (OT/WCC) to ensure areas have been assessed and documented appropriately and treatment orders written. Weekly audits will be performed comparing daily huddle sheets to 24 Hour Summary Report to ensure every change in condition is documented in the medical record. Nurses who failed to assess or document changes in condition, including skin integrity changes, will be individually educated and/or counseled. Audits will be forwarded to the QAPI Committee for review and further recommendations as necessary. OT/WCC and Director of Nursing are responsible.	

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F 842	Continued From page 48	F 842		

could have seen the area more clearly. She indicated she found out later that the resident had a pressure ulcer.

In a telephone interview on 01/17/19 at 1:23 PM Nurse #8, who performed Resident #36's Skin Assessment on 01/01/19, stated she was unsure if the area had been open or not. She indicated she had heard later that a pressure ulcer had been found.

In an interview on 01/17/19 at 5:15 PM Nurse #2 stated she had notified the DON via the secure messaging system in the computer on either 12/29/18 or 12/30/18 that Resident #36 had a pressure ulcer. She stated she did not fill out a Skin Observation Tool or do a Pressure Injury Assessment but thought she had written a note. Nurse #2 checked her nursing notes and verified there was no note regarding Resident #36's pressure ulcer.

In an interview on 01/18/19 at 10:27 AM Nurse #3 stated she had applied a dressing to Resident #36's pressure ulcer on 01/04/19 but did not put the order on the TAR or sign that she had done the treatment. Nurse #3 stated that she should have transcribed the order to the TAR and signed that it was done.

In an interview on 01/18/19 at 10:27 AM the DON stated that when a pressure wound was found the nurse needed to fill out a Pressure Injury Assessment. She indicated a treatment should not be performed without putting it on the TAR and signing that it had been completed.

In a follow-up interview on 01/19/19 at 10:18 AM the DON stated that documentation should be

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F 842	Continued From page 49 accurate and complete. She indicated that if a treatment was done and not transcribed onto the TAR and signed off, the documentation would be considered to be incomplete and inaccurate.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interviews and record reviews the facility's Quality Assessment and Assurance (QAA) Committee failed to develop an action plan to prevent unsupervised exits from the facility by cognitively impaired sampled residents. Resident #6 exited the facility while unsupervised on two separate occasions which occurred in August 2018 and in November 2018. The QAA committee also failed to maintain implemented procedures and monitor the interventions that were implemented following a recertification survey in January 2018 and subsequently recited in January 2019 on the current recertification and complaint survey. This was for two recited deficiencies in the areas of development of resident Care Plans (F656) and having complete and accurate documentation (F842). The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA Program. Findings included: This tag is cross referenced to:	F 867	The facility Quality Assessment and Assurance Committee (QAA) met on 1/31/19 with all members present, including the Administrator, Director of Nursing/QA Coordinator, Occupational Therapist, Social Worker, Dietary Director, Plant Maintenance Director, MDS Coordinator, RN Support Staff, CNA/Medication Aide Support Staff, Pharmacist, Medical Director and Owner. All current Performance Improvement Plans (PIP) in progress were discussed and recorded in the minutes. Members provided ongoing audits to the Director of Nursing/QA Coordinator. 1/31/19. The committee determined in December 2018 at the Quarterly QAA meeting that the QAA committee would be meeting on a monthly basis until further notice. The current Medical Director has	2/15/19

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F 867	Continued From page 50 1. F689: Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, staff interviews, Physician interview, and record review the facility failed to provide supervision to prevent a cognitively impaired resident who displayed wandering and exit seeking behaviors from exiting the facility unsupervised for 1 of 1 residents (Resident #6) reviewed for accidents. Resident #6 was found unsupervised outside of the facility by facility staff on two separate occasions (08/11/18 and 11/17/18) and returned inside with no injuries. Additionally, the facility failed to monitor Resident #6's Wanderguard each shift for placement and each night for function and on 12/18/18 when she was attempting to make another unsupervised exit from the facility staff discovered she was not wearing her Wanderguard. During an interview with the Director of Nursing (DON)/QA Coordinator on 01/17/19 at 6:35 PM she stated during the facility's quarterly Quality Assurance (QA) committee meeting in June 2018, she mentioned to the committee that the facility's Wander Risk Assessment was not being completed by staff when a resident was admitted. She said in September 2018 she developed a checklist of admission assessments for staff to sign off when residents were admitted to the facility. In December 2018 a QA meeting was held, but many items were being considered in that meeting and a QA plan regarding resident elopements was not discussed. She said that she was planning to present the issue of resident elopements to the QA committee at the January 2019 meeting. She stated that the facility's Medical Director attended the June 2018 QA	F 867	resigned, effective February 28, 2019 and an Interim Medical Director will begin on March 1, 2019. 1/31/19 On 2/8/19, Department Heads were inserviced on how to properly fill out a PIP. Each were instructed how to identify and look at their current systems and ensure that there is a check and balance mechanism to review and determine patterns and/or trends that would indicate system issues or failures in their respective departments. They were instructed to report findings/concerns in the morning stand-up meetings and we would collectively decide if a PIP is necessary and begin that process. They were instructed that corrective action must be taken immediately when an actual or potential risk exists for a negative event or patterns/trends are identified. The Department Heads were given a PIP template to go by when issues or system failures are identified. They were instructed that once a PIP has been started and they begin to work out the 4-Point Action Plan that they are to present their progress to the Administrator and Director of Nursing no later than 72 hours (3 working days)so that we can ensure that all affected residents and/or system issues have been addressed and identify if there is anything that may need to be reviewed additionally. Audits and frequency will be determined at that time. Once approved, the plan will be implemented. They will present the plan and audits at the monthly QAA meeting for further recommendations as	

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F 867	Continued From page 51 meeting. He was invited to the December QA meeting but did not attend. In a telephone interview with the Medical Director on 01/19/19 at 5:25 PM he stated that he attended most quarterly QA committee meetings held by the facility. He commented he was aware the facility was having issues with elopement but did not remember discussing elopement in general as an area of concern during a QA meeting. 2. F656: Development of Care Plans. Based on staff interviews and record review the facility failed to develop a plan of care related to pain for 1 of 1 residents reviewed for pain and failed to implement care plan interventions to prevent unsupervised facility exits for 1 of 1 residents reviewed for accidents (Resident #6). Review of the facility's survey history revealed F656 was cited during the facility's 01/12/18 annual recertification/complaint investigation survey for not developing Care Plans. The facility was re-cited during the current 01/19/19 annual recertification/complaint investigation survey for the same issue of not developing Care Plans. In an interview on 01/19/19 at 10:18 AM the Director of Nursing (DON)/QA Coordinator stated she was unsure why the facility had not corrected the issue of the development of Care Plans because the facility had completed a plan of correction and audits since they were cited for the deficient practice in 2018. She indicated the QA program may have failed for the development of Care Plans because the person who was responsible for developing the Care Area Assessment Summary (CAA), and who no longer	F 867	necessary. The Administrator and/or Director of Nursing/QA Coordinator or designee will keep a copy of the PIP in a notebook for all newly identified PIPs and monitor progress to ensure they are implemented/completed and effective. Administrator is responsible.	

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F 867	Continued From page 52	F 867		

worked at the facility, did not actively pursue the Plan of Correction (POC) that was developed

3. F842: Complete and Accurate Documentation. Based on record review and staff interviews the facility failed to maintain complete and accurately documented medical records for 1 of 22 Residents (Resident #36) whose medical records were reviewed.

Review of the facility's survey history revealed F842 was cited during the facility's 01/12/18 annual recertification/complaint investigation survey for incomplete documentation in a resident's medical record. The facility was re-cited during the current 01/19/19 annual recertification/complaint investigation survey for the same issue of incomplete documentation.

In an interview on 01/19/19 at 10:18 AM the Director of Nursing (DON)/QA Coordinator stated she was unsure why the facility had not corrected the issue of incomplete and inaccurate documentation because the facility had completed a plan of correction and audits since they were cited for the deficient practice in 2018. The DON stated she felt the QA program may have failed for complete and accurate documentation because the nurses may not have been aware that skin issues were considered a change of condition. She indicated that the facility may not have pressed hard enough on the issue of complete and accurate documentation.