STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING ______ B. WING ______	C 10/27/2022

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

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 10/25/22 through 10/27/22. Event ID #L50G11. The following intakes were investigated: NC00192275, NC00193222 and NC00193068. 2 of the 12 allegations were substantiated resulting in a deficiency.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to: 1a) assist a dependent resident (Resident #2) with eating when a Nurse Aide (#1) was observed asking the resident if she wanted to eat instead of attempting to offer the food on the meal tray and instead offered a small amount of a nutritional supplement then placed the supplement on the bedside table and did not return to the resident; 1b) provide incontinence care to a dependent resident (Resident #2); and 2) provide an alternate meal choice during the lunch meal for a resident (Resident #4) who was observed without a lunch tray for 2 of 2 residents reviewed for assistance with Activities of Daily Living (ADLs) care. Findings included. 1. Resident #2 was admitted to the facility on 03/07/22 with diagnoses to include heart failure, diabetes, dementia, and malnutrition. She was	F 677	Premier Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Premier Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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admitted on hospice services.

A care plan dated 03/08/22 revealed Resident #2 required total assistance with ADL's. The goal of care included that ADL care would be completed with staff support as appropriate to maintain or achieve the highest practical level of functioning. Interventions included to provide total assistance with eating, bathing, dressing, transfers, and incontinence care.

The care guide for Resident #2 dated 03/08/22 revealed in part to assist with eating and provide incontinence care frequently and as needed.

The Minimum Data Set (MDS) admission assessment dated 03/17/22 revealed Resident #2 had severely impaired cognition. She had no rejection of care. She required total dependent care with ADL's and was incontinent of bowel and bladder. She received a pureed diet.

1a) An observation of Resident #2 was conducted on 10/25/22 at 2:20 PM. She was lying in bed and appeared to be in no distress. The lunch meal tray was on the bedside table with the lid covering the food. Nurse Aide #1 entered the room at that time and asked Resident #2 if she was ready to eat lunch. The nurse aide immediately stated I will get your milkshake and did not try to feed Resident #2 the lunch meal that was provided and only asked if she wanted to eat. The nurse aide left the room and came back within minutes with a nutritional supplement. Resident #2 drank one swallow then the nurse aide placed the nutritional supplement on the bedside table. Resident #2 remained in no distress lying in bed with her eyes closed.

F 677

and/or any other administrative or legal proceeding.

On 10/25/22, the Director of Nursing obtained alternative meal tray for resident #4.

On 10/25/22, another nurse aide provided and assisted resident #2 with meal. Resident ate 0% and drank 237ml.

On 10/25/22, the nurse aide #2 provided incontinent care to resident #2

On 10/25/22, the Director of Nursing immediately in-serviced NA #1 regarding Meal Delivery with emphasis on (1) It is the responsibility of the nurse and the nursing assistant to document meal and/or liquid intake timely and accurately into the electronic record to include meals or liquids brought in by family from outside vendors (2) If a resident request an alternative meal, the staff must immediately notify the dietary department and obtain requested alternative for the resident. If the alternative cannot be obtained timely the DON and/or Administrator must be notified (3) assisting residents who require feeding assistance with meals.

On 10/25/22, the Director of Nursing initiated an audit of meal intake documentation for 10/25/22 for all residents to include resident #2 and #4. This audit is to ensure a meal tray and/or alternate meal tray was provided to each resident per preference, staff assisted

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F 677	Continued From page 2 An interview was conducted on 10/25/22 at 2:25 PM with Nurse Aide #1. He stated Resident #2 received Hospice care and could voice her needs. He stated she required assistance with eating and received nutritional shakes for breakfast and lunch. He stated Resident #2's appetite varied, she ate well some days and other days would not eat as much but if she did not eat much of her meal, she would usually drink most of the nutritional supplement. Continuous observations of Resident #2 conducted on 10/25/22 from 2:30 PM - 3:30 PM revealed the nutritional supplement remained on the bedside table and had not been touched. At 3:30 PM Resident #2 was asked by the surveyor if she was thirsty, she stated yes. Another nurse aide was asked to provide the nutritional supplement to Resident #2, and she complied. A follow up interview was conducted with Nurse aide #1 on 10/25/22 at 4:00 PM. He stated he did not go back to offer any more of the nutritional supplement to Resident #2 after he initially offered it to her because he had been assisting with another resident and just forgot to go back to check on her. An interview was conducted on 10/26/22 at 2:15 PM with Nurse # 1. She stated she typically worked the 300 hall and routinely provided care to Resident #2. She stated Resident #2 did not eat well, but she would take small bites of her food, and her family was able to get her to eat more and brought in food from home. She stated Resident #2 received a pureed diet and always required assistance with eating but only eats small bites and then will not want to eat any more. She stated the Hospice aide also comes in 2-3	F 677	resident with meals when indicated and staff documented meal intake in the electronic record. The Administrative Nurse and Dietary Manager will address all concerns identified during the audit to include but not limited to providing the resident meal tray/alternate meal tray when indicated, assist resident with meal as needed, notification of physician when resident refusing meals with documentation of meal intake in the electronic record and/or education of staff. The audit will be completed by 11/21/2022. On 10/25/22, the Social Worker initiated questionnaires with all alert and oriented residents regarding Meal Delivery. Questionnaires included (1) Is your meal tray delivered in a timely manner (2) Are you aware that if you do not like what is served there is an alternate? (3) Have you ordered the alternated in the past? (4) Do you get the alternate when you order it? (5) Do staff assist you with tray set up or meals when needed? The Social Worker and hall nurses will address all concerns identified during the audit. Questionnaires will be completed by 11/21/2022. On 10/25/2022 the Director of Nursing and administrative nurses initiated an audit of incontinent care for all residents who are incontinent to ensure residents were provided incontinent care appropriately and timely. All areas of concern were immediately addressed by the Director of Nursing and Administrative Nurses to include providing incontinent	

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F 677 Continued From page 3

days a week and assisted Resident #2 with eating. She stated the nurse aides were supposed to sit down with her to feed her and indicated she was not aware of Nurse Aide #1 not sitting down to assist Resident #2 with eating.

A follow up interview was conducted on 10/26/22 at 3:00 PM with Nurse Aide #1. He stated he did not try to feed Resident #2 her lunch meal he only asked her if she wanted to eat lunch and stated Resident #2 replied no, she didn't want to eat so he gave her the nutritional supplement instead. He stated after she took a few sips of the supplement he placed it on the bedside table and left the room and didn't return to offer her any more of the supplement because he got distracted. Nurse Aide #1 stated he had 16 residents on his assignment, and he got busy and did not get back to Resident #2.

An interview was conducted on 10/26/22 at 5:30 PM with the Director of Nursing. He stated Resident #2 required total assistance with eating and Nurse Aide #1 should have opened the meal tray and attempted to feed Resident #2 and should have provided more assistance with the nutritional supplement to promote adequate nutrition.

1b) Resident #2 was observed for incontinence care on 10/25/22 at 2:30 PM with Nurse Aide #1. Resident #2's brief was soaked with a moderate amount of urine and stool. The skin on her buttocks and perineum was intact with redness noted on the left perineal area.

An interview was conducted on 10/25/22 at 2:30 PM with Nurse Aide #1. He stated Resident #2 required incontinence care then stated he had not

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care as indicated and education of staff. Audit will be completed by 11/21/2022.

On 10/25/2022, the Social Worker completed resident questionnaires with all alert and oriented residents regarding toileting assistance/incontinent care. This audit is to ensure staff are assisting resident with toileting needs and/or incontinent care timely. The Director of Nursing will address all concerns identified during the audit to include but not limited to providing toileting assistance/incontinent care when indicated and re-training of staff. The questionnaires will be completed by 11/21/2022.

On 10/25/22, the Director of Nursing and Administrative Nurses initiated an in-service with all nurses and nursing assistants regarding Meal/Liquid Intake Documentation with emphasis on (1) It is the responsibility of the nurse and the nursing assistant to document meal and/or liquid intake timely and accurately into the electronic record to include meals or liquids brought in by family from outside vendors (2) If a resident request an alternative meal, the staff must immediately notify the dietary department and obtain requested alternative for the resident. If the alternative cannot be obtained timely the DON and/or Administrator must be notified (3) staff are responsible to assist residents with meal when indicated to include but not limited to providing feeding assistance and tray set up.

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F 677	Continued From page 4 performed incontinence care to Resident #2 at any time since his shift began. He stated he worked 7:00 AM - 3:00 PM and his assignment was busy, and he usually provided incontinence care every two hours, but he had not had time to provide incontinence care to Resident #2 during his shift. He stated the brief Resident #2 was wearing at the time was placed on her by the night shift. An interview was conducted on 10/26/22 at 2:15 PM with Nurse # 1. She stated the nurse aides were to provide incontinence care to residents at least every two hours. She stated she was not aware that Resident #2 went most of the day on 10/25/22 without receiving incontinence care. A follow up interview was conducted on 10/26/22 at 3:00 PM with Nurse Aide #1. He stated he had 16 residents on his assignment, and he got busy and did not get to Resident #2 to provide incontinence care until the time of the incontinence care observation. He stated he didn't notify other nurse aides, or the nurse that he was behind on his assignment or needed assistance because other staff had their own workload and would not have time to assist him. He stated he did not notify the Director of Nursing that he needed help to manage his assignment. An interview was conducted on 10/26/22 at 5:30 PM with the Director of Nursing. He stated incontinence care should be provided every two hours or more frequently if needed and Nurse Aide #1 failed to do that on 10/25/22. He stated Nurse Aide #1 should have asked other staff for assistance if needed or he should have come to him.	F 677	On 10/25/2022 the Director of Nursing and Administrative Nurses initiated an in-service with all nurses and nursing assistants regarding Incontinent Care with emphasis on providing incontinent care timely and/or assisting residents with toileting when indicated. In-services will be completed by 11/21/2022. After 11/21/2022, any nurse or nursing assistant who has not worked or received the in-service will complete the in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation. The Social Worker will complete 10 resident questionnaires with alert and oriented residents regarding Meal Delivery weekly x 4 weeks then monthly x 1 month. Questionnaires included (1) Is your meal tray delivered in a timely manner (2) Are you aware that if you do not like what is served there is an alternate? (3) Have you ordered the alternated in the past? (4) Do you get the alternate when you order it? (5) Do staff assist you with tray set up or meals when needed? The Social Worker will address all concerns identified during the interviews. The DON will review the questionnaires weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. 10 Resident Care Audits Meal Assistance will be completed by the Staff Facilitator weekly x 4 weeks then monthly x 1 month utilizing the. This audit is to ensure staff	

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2) Resident # 4 was admitted to the facility on 05/13/22 with diagnoses to include unstageable sacral pressure ulcer, and malaise.

The Minimum Data Set (MDS) admission assessment dated 05/19/22 revealed Resident #4 was cognitively intact. She exhibited no behaviors and no rejection of care. She required extensive two-person assistance with activities of daily living (ADL's) and supervision with set up help with eating.

A care plan dated 05/23/22 revealed Resident #4 required assistance with ADL's. The goal of care was that ADLs would be completed with staff support to maintain the highest level of functioning. Interventions included in part to provide supervision with minimal set up with eating.

An interview was conducted on 10/25/22 at 2:20 PM with Resident #4. She was observed lying in bed and was alert to person, place, and time. She was observed without a lunch meal tray, and she stated she requested the alternate meal choice prior to lunch being served but when the meal tray came out, she was given a tray that did not have the requested alternate meal items. She stated she notified the nurse aide (#6) who was not her assigned nurse aide that it was not the meal tray she ordered, and the nurse aide told her she would notify the kitchen. Resident #4 stated she still had not received the alternate meal.

An interview was conducted on 10/25/22 at 2:25 PM with Nurse Aide #1 who was the assigned nurse aide for Resident #4. He stated he was not aware Resident #4 had not received her lunch

F 677 (Plan of Correction, continued)

provided assistance with meals when indicated to include but not limited to feeding assistance and/or tray set up. The DON will review and initial the Resident Care Audits Meal Assistance weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.
10 Incontinent Care Audits will be completed by the Staff Facilitator weekly x 4 weeks then monthly x 1 month utilizing the Incontinent Care Audit Tool. This audit is to ensure residents are provided incontinent care timely and/or staff assist residents with toileting when indicated. The DON will review and initial the Incontinent Care Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.

The DON will forward the results of the Resident Questionnaires, Resident Care Audits and Incontinent Care Audits to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Resident Questionnaires, Resident Care Audits and Incontinent Care Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 677	Continued From page 6 and he would notify the kitchen. A follow up interview conducted on 10/25/22 at 3:45 PM with Resident #4 revealed she still had not received her lunch meal. An interview was conducted on 10/25/22 at 3:45 PM with Nurse Aide #1. He stated he got busy with another resident and had not gone to the kitchen to get Resident #4 her lunch meal. An interview was conducted on 10/25/22 at 3:50 PM with the Director of Nursing (DON). He was made aware by the surveyor that Resident #4 never received her lunch meal. He stated he would go to the kitchen and take care of the concern. During a follow up observation conducted at 4:00 PM on 10/25/22 Resident #4 was observed being delivered her lunch tray. An interview was conducted on 10/26/22 at 12:30 PM with Nurse Aide #6 who delivered the initial lunch tray to Resident #4 on 10/25/22. She stated Resident #4 told her it was not the meal she ordered when she delivered the lunch tray and stated she notified the kitchen at that time. An interview was conducted on 10/26/22 at 4:30 PM with the Dietary Manager. She stated she was not aware until the DON came to the kitchen and informed her that Resident #4 never received her alternate lunch meal. She stated when it was realized they immediately made the alternate of ham and cheese sandwich with macaroni salad and gave it to the DON to be delivered to the resident.	F 677		

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F 677	Continued From page 7 An interview was conducted on 10/26/22 at 5:30 PM with the Director of Nursing. He stated Nurse Aide #1 should have followed through immediately with assisting Resident #4 in getting her lunch meal once he was made aware and unfortunately that did not occur.	F 677		