DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &	MEDICAID SERVICES
OFFIGEROLOGY MEDIOWING &	MICDIONID OFFICER
TATEMENT OF DECIDIONOIS	LAVA DOOMEDED CHINDLES CO

PRINTED: 11/02/2011 FORM APPROVED

CENTER	S FOR WEDICARE &	VIEDICAID SERVICES	4		OMP	IC. 0330-0331		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE			
		345217	B. WNG		10/	/20/2011		
NAME OF PR	ROVIDER OR SUPPLIER	in the state of th		ET ADDRESS, CITY, STATE, ZIP CODE				
PREMIER	NURSING AND REHABI	LITATION CENTER		WHITE ST ^{OO} / A A WAY CONVILLE, NC 28546				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 272	Premier Nursing and Rehabilitation Center				
	The facility must cond a comprehensive, acc reproducible assessm functional capacity. A facility must make a assessment of a resident assessment by the State. The assidentification and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior particularly physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sum the additional assessmareas triggered by the Data Set (MDS); and	ent of each resident's comprehensive lent's needs, using the nstrument (RAI) specified essment must include at lographic information; atterns; ng; nd structural problems; d health conditions; status;		acknowledges receipt of the Statement of Deficiencies proposes this plan of correct to the extent of findings is factually correct and in or maintain compliance with applicable rules and provious of quality of care of reside The plan of correction is submitted as a written allegation of compliance. Premier's response to the Statement of Deficiencies not denote agreement with Statement of Deficiencies does it constitute an admittat any deficiency is accumulated for the deficiencies on this Statement of Deficien	and ection der to der to sions ents. does th the nor ission irate. the ment formal al any	11/11/2011		

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

Any deficiency statement ending with an asterisk (*) detotes 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

TITLE

program participation.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (X2) MI		LE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
		345217	B. WN	B. WNG			10/20/2011		
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER				22	EET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE ST ACKSONVILLE, NC 28546				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 272	This REQUIREMENT by: Based on record revi	is not met as evidenced ew, resident and staff failed to assess the need one of two residents	F	272	F272 483.20(b)(1) COMPREHE ASSESSMENTS Appointment was made visual examination on 11/10/2011 for resident	for	E		
	Resident #44 was adr 05/09/2011 with cumulincluded Lack of Coordination, and Difficulty In Walki. Review of the resident Data Set (MDS) dated resident had vision im but not regular print in "and did not use correfurther indicated it was the resident to have be magazines to read. Varea on the MDS. Review of the resident 05/19/2011 indicated decreased/impaired all No glasses" as a focus included obtain eye ex	Unspecified Falls, Insomnia ang. I's admission Minimum I 05/92/11 indicated the pairment "sees large print newspapers and books ctive lenses. The MDS is somewhat important for books, newspapers and ision triggered as a care I's initial care plan dated (Visual alteration with bility to read regular print, is problem. Interventions			A 100% review of each resident's MDS and trigg care areas to include vis done by the MDS coordi and completed on 10/28 to ensure that any reside triggered vision as a care had appropriate intervers and appointments scheen necessary. Director of inserviced MDS staff on importance of follow-up areas triggered on the re MDS on 10/28/2011. Re who have been seen by sight visual services provided an appointment wischeduled for the next for visit by visual services.	ion wa inator 3/201: ent wl e area ntions duled : Vursin the on ca esident on- vided : to be s who ill be	1 ho s as ng are at	นในใจอน	
	The resident was obse	rved in her room on			,				

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE : COMPL			
		345217	B. WIN	G	10	/20/2011
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 6 225 WHITE ST JACKSONVILLE, NC 28546	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 272	The resident reports but broke them a lo reported glasses here. The facility Director interviewed on 10/2 indicated it was the Coordinator to asservision problems. The facility MDS co 10/20/2011 at 11:00 or another nurse perfor resident #44. So were assessed in the on the taminated ca Were glasses present the facility was documented or Coordinator reporte staff asked the resident, and that we was documented or coordinator reporte staff asked the resident, and that we was documented or coordinator reporte staff asked the resident, and that we was documented or coordinator reporte staff asked the resident, and that we was documented or coordinator reporte staff asked the resident, and that we was documented or coordinator reporte staff asked the resident, to her known control of the staff asked the resident, to her known control of the staff asked the resident, to her known control of the staff asked the resident, to her known control of the staff asked the resident, to her known control of the staff asked the resident control of the staff asked the staff asked the resident control of the staff asked t	M resident sitting on her bed. ed she used to wear glasses ng time ago. She further	F	The MDS coordinated audits, to include weekly for four weekly for two rensure compliance reports will be give Director of Nursing four weeks and the for two months for follow-up. The executive QI or review the results weekly for four weekly for two reduction indicated areas of trends and will for indicated to deter for and/or frequence continued monitors.	resident #44, reeks and then months to re. Audit ven to the ng weekly for nen monthly or review and committee will s of the audits reeks then months for any of concern or illow-up as rmine the need ency for	11/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ULTIF LDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217		B. WING)/2011	
	ROVIDER OR SUPPLIER	IABILITATION CENTER		22	EET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE ST ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN ⁻	rs	F	000				
		iciencies cited as a result of stigation for 10/17/11-10/20/11.			·			
		•						
		DEDICHED DEDDESENTATIVE'S SIG			TITLE		(X6) DATE	

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.

PRINTED: 12/06/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(x 1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
	İ	7. 6.449	345217	B. WI	NG_	11/17/2011
	PROVIDER OR SUPPLIER	AB	LITATION CENTER		2.2	EET ADDRESS, CITY, STATE ZIP CODE 25 WHITE ST ACKSONVILLE, NC. 28546
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MU	ENT OF DEFICIENCIES OT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 029 SS=E	One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 pro	cor an nir	struction (with % hour approved automatic fire accordance with 8.4.1 hazardous areas. When fire extinguishing system are separated from	К	029	1) The non-occupled resident rooms on the L-wing will be equipped with self-closing devices by Support Services and completed by 12/31/2011. 2) The corridor door to the clean linen room on 300 Hall was adjusted by the maintenance
	other spaces by sm doors. Doors are s	oke elf- ive	s are separated from resisting partitions and losing and non-rated or plates that do not exceed om of the door are			supervisor on 12/01/2011 to ensure that it will close, latch, and seal. All corridor doors (to hazardous areas) will be checked by maintenance supervisor or maintenance assistant to ensure that they close, latch, and seal. Adjustments or replacements will be done as necessary. All corridor doors (to hazardous areas) will be checked weekly by
K 045 . SS≃D	Based on observat at approximately 11 was noted: 1) The non occuple were found to be us the doors were not 2) The Clean Linen hall did notclose, lat 42 CFR 483.70(a) NFPA 101 LIFE SA Illumination of mear discharge, is arrang single lighting fixture		t met as evidenced by: on Thursday 11/17/2011 AM onward the following sident rooms in the L. wing for temporary storage and ipped self-closing devices. m corridor door on 300 and seal. Y CODE STANDARD f egress, including exit so that failure of any ulb) will not leave the area s not refer to emergency vilh section 7.8.) 19.2.8	КО)45	maintenance supervisor or maintenance assistant to ensure closure, latch, and seal, and adjustments or replacements done as necessary. A QI tool will be utilized. QI tools will be reviewed by the Quality Improvement Committee monthly for determination of the need for additional QI monitoring and for follow-up as needed Charles Taylor Electric installed lighting to Illuminate the exit path to the public way from the exit door for the 700 Hall SPARK Unit exit door on 12/14/2011. Maintenance supervisor or maintenance assistant will monitor egress lighting, including Exit discharge on a weekly basis and make repairs as necessary.
A ROBATORY			t met as evidenced by:	IATURE		(X6) DATE

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FORM CMS-2567(02-99) Provious Versions Opsolete

Event ID: SL8021

Facility 10; 923022

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	T OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2), M A. BUI		PLE CONSTRUCTION S 01 - MAIN BUILDING	D1	(X3) DATE ȘI COMPLE	
			.345217	B, WIN	/G_	<u> </u>		11/17	7/2011
	PROVIDER OR SUPPLIER	1/8	LITATION CENTER		22	eet address, city, state, 25 white st ACKSONVILLE, NC 285	46		
(X4) IO PREFIX TAG	(EACH DEFICIENC	YMÜS	NY OF DEFICIENCIES Y BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CÒRRECTIVE CROSS-REFERENCED DEFICI	AOTION SHO TO THE APPR	ULO BE	COMPLETION DATE
K 046	Based on observa at approximately 1 was noted: 1) The exit path to	tion 1:15 the	on Thursday 11/17/2011 AM onward the following		045	(cont.) A QI tool will be u be reviewed by the Qual Committee monthly for need for additional QI m up as needed	ty improven determinatio onitoring and	nent n of the I follow-	
K 052 SS=F	NFPA 101 LIFE SA A fire alarm system installed, tested, at with NFPA 70 Nati 72. The system ha and testing prograt requirements of NI	red in on a sign of the sign o	Y CODE STANDARD uired for life safety is aintained in accordance Electrical Code and NFPA approved maintenance mplying with applicable 70 and 72. 9.6.1.4	Κ¢	052	Charles Taylor Electric of battery for the fire alard 11/18/2011. The maintenance assistant battery backup weekly operable. Should the breplaced. A QI tool will be utilized reviewed by the Quality Committee monthly for need for additional QI follow-up as needed.	control par mance super the super that extery fail, it we then tools will improvement determination	nel on visor or larm on tit is ; will be I be on of the	[1](8](1
K 069 SS∺F	Based on observa at approximately 1 was noted: 1) Upon testing the the Eire Alarm Con- due to loss of power operated. (Fire did 42 CFR 483.70(a) NFPA 101 LIFE SA Cooking facilities a		t met as evidenced by: on Thursday 11/17/2011 AM onward the following alarm on battery backup Panel (FACP) went down d failed to continue to eate on AC power) Y CODE STANDARD otected in accordance NFPA 96	КО	69	1)The deep fat fryer was p hood on 11/18/2011 by th supervisor. The dietary sta keep the deep fat fryer po- hood at all times by the manual supervisor on 11/18/2011.	maintenan aff was Instru sitioned und aintenance	re Icted to er the	11/18/11

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STATEMENT	OF DEFICIENCIES OF CORRECTION		PROVIDER/SUPPLIER/CLIA	(X2) N		PLE CONSTRUCTION O1 - MAIN BUILDIN	00	<u>:</u>	(X3) DATE SU COMPLE	irvey Teo
	•		345217	B, Wil			1		11/17	//2011
PREMIEI (X4) ID PREFIX	numany er	A T 03	SILITATION CENTER VENT OF OFFICIENCIES UST BE PRECEDED BY FULL TOENTIFYING INFORMATION)	ID PREF YAG	22 J/	EET ADDRESS, GITY, STATES WHITE ST ACKSONVILLE, NC 21 PROVIDER'S PL (EACH CORRECTIN CROSS-REFERENCE	354 4H C 7E A 11 TO	F CORRECTION SHOU	ULO BE	, (XS) COMPLETION DATE
K 144 SS=D	Continued From p This STANDARD Based on observat approximately 1 was noted: 1) A deep fat fryer under the hood. 2) The kitchen air was not properly the experiencing a high exhaust hoods op 42 CFR 483.70(a) NFPA 101 LIFE S Generators are infunder load for 30 accordance with Newson the experiencing and the exhaust hoods op 42 CFR 483.70(a) NFPA 101 LIFE S Generators are infunder load for 30 accordance with Newson the experiencing with Newson the experience of the experience of the exhaust high experience of the experience of the exhaust high experience of the exhaust high exhaust high experience of the exhaust high experience of the exhaust high exh		ot met as evidenced by: on Thursday 11/17/2011 AM onward the following s not properly protected aust and supply systems nced. The Kitchen was egating pressure with the ing. TY CODE STANDARD cted weekly and exercised tres per month in		144	The maintenance sugassistant will monitor deep fat fryer 3 x were compliance. A QI tool will be utilize reviewed by the Qual Committee monthly need for additional Committee monthly need for additional Committee month was relected to a second for a second follow-up as needed.	da d	isor or main positioning to ensure Of tools will improve ment determination positoring are y waiver — A tor panel for ed by Charle visor or main nunclator per pairs if necessity (it tools well improve ment determinations)	of the	12/14/11
			bsoleto Event ID; SL8D2		<u>برج</u>	ollity (O: 923022 -	;	H co	ntinuation she	nel Page 3 of 3
CODM CMC	2687(N2-98) Previous Versio	hi d	Inscieto Event ID; SLEDZ	I	£R(mit in arriver.	: :	., 50		-

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ABORAYORY DIRECTORS OR PROVIDER OR SUPPLIER TAIL STREET ADDRESS, CITY, STATE, DIP CODE STANDARD STREET ADDRESS, CITY, STATE, DIP CODE SWITTE ST JACKSONVILLE, NC 28584 FROWDERS PLANDS CRARACTION CONTROL RESIDENCE OF YOUR STANDARD K 025 NFPA 101 LIFE SAFETY CODE STANDARD SSS=F STROKE barriers are constructed to provide at least, a one half hour life resistance rating in a coordance with 8.0. Smoke burriers are protected by fire-rated glazing or by wired glass panets and steel frames. A minimum of two separate compatitions of annows partners are provided on each floor. Dampers are not required in duct penetrations of annows partners in fully ducted healing, ventilating, what air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1 is.3, 19.1.6.4 This STANDARD Is not met as evidenced by: Based on observation on Thursday 111/17/2011 at approximately 11; 16; AM omystath the following was noted: 1) There are holes and/or penetrations in the smoke wall that were not sealed in order to maintain the required-file resistance rating of the wall in the following locations. 1) There are holes and/or penetrations in the smoke wall that were not sealed in order to maintain the required-file resistance rating of the wall in the following locations. 1) Therapy room smoke wall 800 rehab b) Therapy room smoke wall 800 rehab		T OF DEFICIENCIES. OF CORRECTION	(X)) PROVIDERISUPPLIER/CLIA DENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION		. (X3) DATE,S	
PREMIER NURSING AND REPAGLITATION CENTER (X4) ID PREMY (SACH DEFICIENCY MISS SEE PRECEDED BY FULL TAG (SACKSOMILLE, NC 28545) (X4) ID PREMY TAG (SACKSOMILLE) (SACKSOMILLE, NC 28545) (X4) ID PREMY TAG (SACKSOMILLE) (SACKSOMI				345217	B. WIN	G	<u> </u>	+	. 11/1	7/2011
Finding in the sample of the state of the st		‡ •	IA 6	LITATION CENTER		22	S WHITE ST		CODE	,
Smoke barriers are constructed to provide at least, a one half hour hie resistance rating in accordance with 8.3 is 5 moke barriers may terminate at an afritum wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not jequired in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1 [8.3, 19.1.6.4] This STANDARD is not met as evidenced by: Based on observation in Thursday 11/17/2011 at approximately 11/15. AM onward the following was noted: 1) There are holes and/or penetrations in the smoke wall that were not sealed in order to maintain the required/fig resistance rating of the wall in the following (calcions. a) Therapy room stroke wall 800 A smoke wall. 42 CFR 483,70(a)	PREFIX	(EACH DEFICIENCY	'MÜ	IST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE CROSS-REFERENCE)	EACT TO T	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
A PODA Y DIG CONTROL OD A DO MODINA DE PROCENTATIVE D'ADMAY (DE	SS=F	Smoke barriers are least a one half hou accordance with 8.3 terminate at an afric protected by fire-rat panels and steel fra separate compartm floor. Dampers are penetrations of smotheating, ventilating, 19.3.7.3, 19.3.7.5, 1 This STANDARD is Based on observati at approximately 11 was noted: 1) There are holes a smoke wall that wer maintain the require wall in the following a) Therapy room b) Therapy room wall.		nstructed to provide at resistance rating in smoke berriers may wall. Windows are glazing or by wired glass is, A minimum of two are provided on each required in duct barriers in fully ducted a air conditioning systems. In the tas evidenced by: on Thursday 11/17/2011 AM onward the following or penetrations in the ot sealed in order to resistance rating of the ations.	KO	25	Penetrations in the sn in the therapy room 8 therapy room 800A by supervisor on 12/08/2 throughout the facility maintenance supervisors is satisfant and penetra necessary. A QI tool will be utilize reviewed by the Quali	ob Re / matr of 11 or	valls were sealed hab and in the atenance All smoke walls be inspected by maintenance sealed as tools will be provement ermination of the	12/8/11
	ABOBAYORY	NOSCYCHE OD ODOLIGO	die	IDDI ING GEODEOGNIATIVED NON	AYLIDE		C Time			YEN DATE

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Event ID: SL8D21

Facility IO: 923022

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