	-	ID HUMAN SERVICES				FORM	MAPPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	PLETED
		345217	B. WING				C 22/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225 SS=D	ALLEGATIONS/INDI		F	225			10/10/17
	483.12(a) The facility (3) Not employ or oth who-	must- erwise engage individuals					
	(i) Have been found g	guilty of abuse, neglect, opriation of property, or urt of law;					
	or her professional lic						
	licensing authorities a actions by a court of l	e nurse aide registry or any knowledge it has of aw against an employee, unfitness for service as a icility staff.					
		egations of abuse, neglect, atment, the facility must:					
	abuse, neglect, explo including injuries of u misappropriation of re reported immediately after the allegation is cause the allegation i						
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

**Electronically Signed** 

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.

10/16/2017

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/31/201 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		SURVEY PLETED
		345217	B. WING				22/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHAB	ILITATION CENTER			225 WHITE STREET		
				•	JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	Continued From page	e 1	F	225			
		e the allegation do not involve		220			
		sult in serious bodily injury, to					
		he facility and to other					
		the State Survey Agency and					
		ces where state law provides					
	, ,	g-term care facilities) in					
		te law through established					
	procedures.						
	(2) Have evidence th thoroughly investigat	at all alleged violations are ed.					
	(3) Prevent further po exploitation, or mistre	otential abuse, neglect,					
	investigation is in pro						
		s of all investigations to the					
	administrator or his o	or ner designated					
		ling to the State Survey					
		king days of the incident, and					
		n is verified appropriate					
	corrective action mus						
		T is not met as evidenced					
	by: Based on record rev	view and staff interview, the			Premier Nursing and Rehabilitation		
		ediately report an allegation of			Center acknowledges receipt of the		
	-	istrator, failed to file a 24			Statement of Deficiencies and propo	ses	
		a 5 working day report to the			this Plan of Correction to the extent		
	Health Care Personn	nel Investigations for one (1)			this summary of findings is factually		
	of one (1) sampled r	esident . (Resident # 31)			correct and in order to maintain		
	The findings include:				compliance with applicable rules and provisions of quality of care of reside The Plan of Correction is submitted a	nts.	
	Resident # 31 was a	dmitted to the facility on			written allegation of compliance. Pre-		
		noses of chronic kidney			Nursing and Rehabilitation Center's		
	disease, hypokalemia	a, heart failure, major			response to this Statement of Deficie	ncies	
	depression and Alzhe				does not denote agreement with the		
	resident's Minimum [	Data Set (MDS) dated			Statement of Deficiencies nor does it		

Facility ID: 923022

If continuation sheet Page 2 of 36

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		345217	B. WING		09	/22/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, 2		
				225 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETIO DATE
F 225	Continued From page	- 2	F 22	5		
	1 0	e resident's cognition was	1 22	constitute an admissior	that any	
	moderately impaired.			deficiency is accurate.	•	
				Nursing and Rehabilita		
	Review of the nurse's	s note dated 9/14/2017		reserves the right to ref		
	documented "Resider	nt # 31 came to Social		deficiencies through Inf		
		orm her that nursing staff		Resolution, formal appe		
	-	a dog. Resident # 31stated		and/or any other admin	istrative or legal	
		all night in her day clothes.		proceeding.		
		that staff would not assist I just walk by and laugh.		F225		
	-	ed that resident was in bed		1225		
		not left up all night. Staff		The allegation of negle	ect for resident #31	
		nat resident has been upset		related to staff treating		
		mood since the weekend."		by being left up all nigh was reported to the Adu	t in day clothes	
	During an interview o	n 9/20/2017 at 10:00 AM,		Director of Nursing (DC		
	the Social Worker sta	ited Resident # 31 on		the Nursing Consultant	. A 24 hour report	
		her about the staff treating		for the allegation of neg		
		ig left up all night in her day		completed and faxed to		
	clothes. The Social W			Personnel Investigation	-	
		ation on her own but she did n to the Administrator or the		Administrator. The Adr	-	
		She further indicated that she		investigating the allega 9/20/17. The SW was o		
	-	leged allegation was a report		suspended pending inv	•	
		ted next time a resident		policy on 9/20/17 relate		
		ed neglect or abuse she will		report an allegation of r		
	report immediately to	the Administrator.		#31. The SW is no lon	ger employed by	
				the facility as of 9/26/17		
		on 9/20/2017 at 10:10 AM,		a thorough investigation		
		I she was doing fine at the		concluded the investigation		
		indicated she did not recall to her by being left up all		and determined the alle for resident #31 was ur		
		n 9/14/2017. Observation of		5 day report was comp		
		the resident lying in bed and		Administrator and faxed	-	
	was dressed appropri			Care Personnel Investi		
		-		On 9/22/17, all alert an		
	-	vith Director of Nursing		residents to include res		
		at 4:30 PM, she stated she		interviewed by the seco		
	was not made aware	by the Social Worker of the		to ensure there were no	o allegations to	

Facility ID: 923022

If continuation sheet Page 3 of 36

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		3 NO. 0938-039 DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G		COMPLETED	
		245247	B. WING _			C	
	ROVIDER OR SUPPLIER	345217	B. WING_	STREET ADDRESS, CITY,		09/22/2017	
	NOVIDER OR SUIT EIER			225 WHITE STREET	STATE, ZII GODE		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC	28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 225	allegation of neglect of 9/14/2017. DON addo made aware of the re- 10:00 AM by the Nurs Social Worker's note. expectation was for the reported immediately of the allegation of ne DON reported she co 9/20/2017 in reference report of neglect. She not neglected by the During an interview w 9/20/2017, at 3:50 PM made aware by the S of neglect by Resider further indicated his e to report to him imme abuse or neglect. He	of Resident # 31 on ed the first time she was eport was on 9/20/2017 at se consultant who read the . She indicated her he Social Worker to have to her and the Administrator eglect by Resident # 31. The ompleted the investigation on ce to the resident's alleged e concluded the resident was staff at the facility. with the Administrator, on M, he stated he was not Social Worker of an allegation ht # 31 on 9/14/2017. He expectation was for the staff ediately of any allegation of added he will then file a 24 d a 5 working day report to	F 2	include neglect the to the Administrative report and a 5 we Health Care Person not been filed. The findings from the 100% of all resid 31 progress note identify any alleg by the Facility Co to ensure that all were reported to Director of Nursin report and 5 wor Health Care Person were filed. There allegations to inco the progress note reported to the A 100% in-service Resident Abuse/ Facility Consulta facility staff, to in managers (Admi	lents to include resident # es were reviewed to gations to include neglect onsultant on 9/21/17 and l identified allegations the Administrator and/or ng and a 24 hour initial king day report to the sonnel Investigations e were no other clude neglect identified in es that had not been		
				Payroll, reception director, Activity worker), mainten staff, housekeep licensed nurses, dietary staff, Ger assistant and act included, reportin include neglect in Administrator or Administrator an the responsible p	asions Coordinator, nists, maintenance Director, second social nance assistant, therapy ing staff, laundry staff, nursing assistants, ri Care aides, Activity tivity aides. The in-service ng all allegations to mmediately to the Director of Nursing, the d Director of Nursing are people for investigating all a resident's cognitive		

Facility ID: 923022

If continuation sheet Page 4 of 36

	MENT OF HEALTH AN S FOR MEDICARE & I				PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345217	B. WING		09/22/2017
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
PREMIER	NURSING AND REHABI	LITATION CENTER		25 WHITE STREET IACKSONVILLE, NC 28546	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 225	Continued From page	- 4	F 225	status does not determine if allegation should be reported. All newly hired therapy staff, housekeeping staff, lar staff, licensed nurses, nursing assist dietary staff, Geri Care aides, depar managers, and activity staff will rece the resident abuse/neglect policy in service during orientation by the stat facilitator. The Director of Nursing or the Unit Facilitator will review all resident pro notes to include resident # 31, 5 time week for 4 weeks, weekly for 4 week then monthly for 1 month to identify allegations to include neglect and er that all identified allegations were immediately reported to the Adminis and/or Director of Nursing and a 24 initial report and 5 working day repor the Health Care Personnel Investiga were filed utilizing a Progress Note Review QI Audit Tool. The Social Wo will interview all alert and oriented residents to include resident # 31 we 8 weeks then monthly x 1 month to identified any resident that verbalize allegation to include neglect and ens the allegation had been reported immediately to the Administrator and Director of Nursing and a 24 hour in report and 5 working day report to th Health Care Personnel Investigation filed. The Social Worker will immedia notify the Administrator of any allega identified during the audits that had been reported. The Administrator will immediately initiate the protocol for a neglect, or misappropriation of resid	undry tant, tment sive ff gress es per ks any nsure trator hour rt to trator hour rt to ations orker eekly x d an sure d/or itial he were ately ations not II abuse,

Event ID: L0PV11

Facility ID: 923022

If continuation sheet Page 5 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345217	B. WING		C 09/22/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	•
PREMIER	NURSING AND REHABI	LITATION CENTER		225 WHITE STREET JACKSONVILLE, NC 28546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMPLETION DATE DATE DATE
F 225	Continued From page	ə 5	F2	225 property as appropriate the 24 hour report and report to the Health Car Investigation, conductir investigation, and provi action with the staff me report the allegation. Th will review and initial the Review QI Audit tools a interview tools for comp ensure all areas of com addressed weekly for 8 monthly for 1 month. The Administrator will fo of the Progress Note Re and the Resident Interview Executive QI Committe months. The Executive meet and review the Pr Review Audit Tools and Interview Tools and add concerns and/or trends changes as needed, to frequency of monitoring months.	5 day working re Personnel ag a thorough de disciplinary mber who failed to ne Administrator e Progress Note nd the resident oletion and to cerns were weeks and then orward the results eview Audit Tools iew Tools to the e monthly x 3 Ql committee will ogress Note the Resident dress any issues, and to make include continued
F 323 SS=J	HAZARDS/SUPERVI (d) Accidents.		F 3	323	10/11/17
	The facility must ensu (1) The resident envir from accident hazard	ronment remains as free			
		eives adequate supervision es to prevent accidents.			
	(n) - Bed Rails. The f	facility must attempt to use			

Event ID: L0PV11

Facility ID: 923022

If continuation sheet Page 6 of 36

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/31/2017 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	COM	E SURVEY PLETED
		345217	B. WING				C / <b>22/2017</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABI	I ITATION CENTER			225 WHITE STREET		
					JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 323	appropriate alternativ bed rail. If a bed or s must ensure correct i maintenance of bed r to the following eleme (1) Assess the reside from bed rails prior to (2) Review the risks a the resident or reside informed consent prior (3) Ensure that the be appropriate for the re This REQUIREMENT by:	es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents. In for risk of entrapment installation. And benefits of bed rails with int representative and obtain or to installation. ed's dimensions are sident's size and weight. T is not met as evidenced iews, observations, staff	F	323	F 323-Accidents and Incidents		
	smoked and utilized of assess 6 of 6 sample #182, #59, #85, #212 smoking to prevent a not harmed during the incident and she remain Immediate jeopardy b Resident #122 went of connected to back of cigarette and lighter if assessed for safe sm on the dangers of sm since her admission to	ampled residents (#122) who boxygen therapy, and failed to d residents (#16, #125, ) on the smokers list for safe ccidents. Resident #122 was e potentially hazardous ained at the facility. began on 07/05/17 when butside with her oxygen tank her wheelchair with a n hand and had not been oking or educated by staff oking while using oxygen o the facility. was removed on 09/22/17 at cility provided and			<ul> <li>On 7/5/17 resident # 122 was observed with a cigarette and oxygen on by the facilitator and staff facilitator assistant. The cigarette was not lit and was removed by the staff facilitator, and the resident was brought back into the facility on 7/5/17 by the staff facilitator at 4:08 pr On 7/5/17 the staff facilitator educated resident # 122 on smoking while wear oxygen. The staff facilitator notified the administrator and assigned hall nurse 7/5/17 at 4:20 pm.</li> <li>On 7/5/17 the assigned hall nurse matches physician and residents representation (RR) aware at 4:40 pm. Upon notification to the RR, they stated, "we sometimes give her cigarettes to keep in her room On 7/5/17 the assigned hall nurse and nursing assistant searched the resider room and was unable to find any cigar</li> </ul>	staff byed n. ing on de ative tion 5 " the nt	

Facility ID: 923022

If continuation sheet Page 7 of 36

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SI	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLE	ETED
		345217	B. WING		C	
	ROVIDER OR SUPPLIER	545217		STREET ADDRESS, CITY, STATE, ZI		2/2017
	ROVIDER OR SUFFLIER			225 WHITE STREET	FCODE	
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	- 7	E 00	20		
1 525			F 32			
	compliance. The facil	ity remains out of r scope and severity of D		paraphernalia. The assignation of the paraphernalia paraphernalia.		
	-	al harm with potential for		not able to find any cigar	•	
		arm that is not immediate		paraphernalia.		
		e education and ensure		On 7/5/17 the assigned	hall nurse	
		out into place are effective		educated the RR on the		
		to prevent accidents.		The RR verbalized under	rstanding.	
		·		On 7/6/17 the social wor	•	
	Examples #2, #3, #4,	, #5, #6, and #7 are cited at		resident #122 on danger	s of smoking with	
	no actual harm with p	ootential for more than		oxygen on and the smok	king policy.	
		not immediate jeopardy at		On 9/21/17 the facility u		
	the scope and severi	ty of (E).		of the Registered Nurse		
				clinical consultant initiate		
	The findings included	1:		investigation to ascertain		
	Bovious of the facility'	a "Smaking Daliay" datad an		resident attempting to sr	• •	
		s "Smoking Policy" dated on "It is the responsibility of		Upon the conclusion of t was determined the cau	-	
		ehabilitation Center to		failure to assess the resi		
		nment for all Residents.		smoke with oxygen, failu		
		ehabilitation Center is a		facility smoking policy re		
	-	us, this includes electronic		smoke-free and failure to		
	-	an individual who smokes		determination in residen	t #122 desire to	
	and you are alert and			smoke. The facility also		
	evaluated by staff and	d deemed safe to smoke off		communicate with famili	es on bringing in	
		quired that the resident must		the smoking parapherna		
		of the facility each time they		The social worker intervi		
	-	e. All smoking paraphernalia		and oriented residents, t		
		nursing staff. Absolutely no		residents #122, #16, #12		
		e kept in the resident's room		and #212, on 9/21/17 to		
		not permitted to assist with comply with this policy will		resident that smokes to		
	result in discharge fro			oxygen use, utilizing the interview tool: 1. Do you	-	
		on no raonty.		do you wish to stop smo	-	
	1. Resident #122 wa	is admitted to the facility on		wish to stop smoking, do		
		ted into the facility on		an intervention to stop s		
		e diagnoses including		you been educated on th	-	
		nic obstructive pulmonary		policy? 5. Do you unders		
		estive heart failure, dyspnea,		smoking with Oxygen is		
	cognitive communica	tion deficit and anxiety. The		could cause and explosi		

Facility ID: 923022

If continuation sheet Page 8 of 36

		MEDICAID SERVICES	חיד וו MI וו דיסע)	LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED
						С
		345217	B. WING		0	9/22/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
				225 WHITE STREET		
PREIMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 2854	16	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 323	Continued From page	e 8	F 32	3		
		a Set assessment dated	1 02	know where the desi	unated smoking area	
	· ·	at Resident #122 had no		is located? 7. Do you		
	short or long term me			smoking is not allowe		
		needed supervision for		areas? Six (6) reside		
	-	and locomotion on and off		as smokers who do r		
		t was coded as using a		intervention to stop s	•	
		and coded no for receiving		that identifies as no l	-	
		arterly Minimum Data Set		identified residents th		
		ated 08/01/17 indicated that o short or long term memory		paraphernalia were s	e assigned resident's	
	problems and was co				e Admissions Director	
		physician's orders date on		and will be only provi		
		at the resident was receiving		upon request to ensu		
	2 liters of oxygen con	•		The six residents tha smokers, residents #	t were identified as	
	Resident #122 was lis	sted on the "smokers list"		#85 and #212, and tw		
	that was provided by			are on oxygen, to inc were educated on the	lude resident #122,	
	Resident #122's curre	ent care plan was initiated on		usage and smoking of		
	11/11/16, was review	ed and the resident was not		social worker.		
	care planned for smo	king.		The 6 residents, residents		
				#182, #59, #85 and #		
		ssessed for smoking upon		were provided a smo		
		y on her cognitive status of nation from MDS and		safe smoking on 9/20 of Nursing (DON) an		
		get to the smoking area		Set (MDS) nurse by		
		this information, the resident		clinical assessment of		
		okers list per Director of		ability, staff interview		
	Nursing interview on			gathered from the me		
				determine that the re		
		lent report dated on 07/05/17		smoke independently		
		wed. The report revealed		and must be supervis		
		o be smoking outside in		The results of the sm		
		ring O2 (Oxygen). Two staff tte away from resident.		for safe smoking dete were five residents in		
		k into building. The dangers		Safe/independent sm		
		aring O2 was explained to		#16, #125, #182, #59		
	-	nt stated she understood,			a supervised smoker	
	but also states she or	nly wanted one cigarette.		due to physical limita		

Facility ID: 923022

If continuation sheet Page 9 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345217	B. WING		C 09/22/2017		
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
					25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
F 323	Continued From page	<b>5</b> Q	F 3	23			
1 020			F J.	23	and one regident identified as no longe	ro	
		nd MD made aware. No			and one resident identified as no longe smoker, resident #122. All residents	a	
		Action taken: Cigarette taken ent warned of dangers of			identified as smokers were placed on t	ho	
		as told resident was outside			appropriate smoking list (safe verse	lie	
		I went to door and resident			unsafe smokers) by the Director of		
	•	ther staff members were			Nursing on 9/21/17 to prevent accident	'e	
		dent brought back into			Each of the six residents that were		
		ned of the dangers of			identified as smokers, residents #16,		
	•	[Name of physician] was			#125, #182, #59, #85 and #212, care		
		onsible party)." The incident			plans were updated on 9/21/17 by the		
	report was completed				MDS nurse to reflect the current smoki	na	
					status.		
	Nurse's notes dated (	07/05/17 at 4:20 PM for			100% review of physician orders, for th	e	
		reviewed. The notes (written			six residents identified who smoke,		
		d "Resident observed to be			residents #16, #125, #182, #59, #85 ar	nd	
		arking lot while wearing O2.			#212, was completed on 9/21/17 by the		
		ook cigarette away from			Corporate Nurse Consultant to identify		
	resident. Resident br	rought back in building. The			any resident with an order for oxygen u	ise.	
	dangers of smoking v	vhile wearing O2 explained			No resident that has been identified as	а	
	to resident. Resident	stated she understood, but			smoker required oxygen based upon		
	also states she only w	wanted one cigarette.			physician order review and observation		
	Resident #122 emerg	gency contact person and			9/21/17 by the corporate nurse consult	ant.	
	Medical Doctor (MD)				100% of progress notes and incident		
		worker's (SW) notes dated			reports from 7/1/17 to 9/21/17 were		
		PM revealed a cognitive			reviewed, to include residents #122, #1		
		ducted on Resident #122			#125, #182, #59, #85 and #212, by the		
	•	hile using oxygen. The note			Corporate Consultant by 9/21/17 to		
		was informed by staff that			identify any other residents who were		
		d when outside smoking.			smoking with oxygen. There were no		
	Resident scored a 15	-			other residents identified as smoking w	יונח	
	-	ng Resident #122 was			oxygen.	_	
		W educated resident on the			A Red tag indicating oxygen usage was	5	
	dangers of smoking v				placed on the mobility device for easy		
		company's smoking policy			identification and safety by the		
		g a lighter in her top bedside			maintenance director on 9/21/17 for all		
		so stated she keeps her			twenty residents identified with physicia	311	
	-	n. Resident did not have			orders for oxygen use.		
	•	side dresser or room at the			As of 9/21/17 the designated resident		
	•	e lighter. SW informed			smoking area was relocated outside, ir	ı	

Facility ID: 923022

If continuation sheet Page 10 of 36

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · · ·	LETED
			A. BOILDING			С
		345217	B. WING			22/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				225 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIC DATE
F 323	Continued From page	e 10	F 32	23		
	· · · · · · · · · · · · · · · · ·	ette paraphernalia must be		the covered pavilion in the	ne courtvard at	
		cart and not to be kept in		the 100 hall exit by the A	-	
	resident's rooms. SV	V gave resident's lighter to		Smoking aprons, fire ext		
		ted nurse of company's		smoking blankets and fir		
		ig unaware of policy and new		containers, to include red		
		informed resident as to		placed in the smoking ar		
	where her items woul	t she would need to sign in		the maintenance director measures. Red signage		
		ig. SW informed nurse to be		Oxygen beyond this poir		
		joing out smoking with		placed in the designated		
	oxygen and maybe re	emove resident's oxygen		9/21/17 by the maintena	nce director.	
	once going out to sme	oke."		A bright colored sign was	-	
	The SW was not available for interview during the			front entry door and the		
	The SW was not available for interview during the investigation.			smoking area for family i visitors to NOT provide r smoking paraphernalia b	esidents with	
	On 09/20/17 at 9:55 A	AM, Resident #122 was		maintenance director on	-	
		nt #122 stated she has not		The facility's smoking po		
	been out to smoke in	over a month due to health		on 9/20/17 by the Admin		
		nt further stated that she		A Resident Council Mee		
		with her oxygen turned on.		9/20/17 by the council pr		
		moking materials are kept in		discuss the update of the		
		se on the hall. During the nt #122 she was observed		There were Twenty-five attended the resident co		
	receiving oxygen via			the activity room.		
				All six residents identifie	d as smokers,	
	Observation on 09/20	)/17 at 9:55 AM revealed an		residents #16, #125, #18	-	
	oxygen sign posted o			#212, were educated on		
		was an oxygen sign posted		smoking policy on 9/21/2	2017 by the social	
		door frame to the resident's		worker.	doriontad	
	room.			All twenty seven alert an residents to include resid		
	On 09/20/17 at 2:50 F	PM, Nurse #1 was interview.		#125, #182, #59, #85 an		
		ed to Resident #122 on		educated on the smoking		
		11:00 PM shift). Nurse #1		oxygen safety and signe		
		e the resident cigarettes and		smoking policy, on 9/21/		
	-	Nurse #1 said that on		worker. Notification of the		
		evelopment Coordinator		smoking policy was sent		
	(SDC) reported to her	r that the resident was		Stated Postal Service or	1 9/21/2017 to all	

Facility ID: 923022

If continuation sheet Page 11 of 36

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345217	B. WING		c	9/22/2017
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	NURSING AND REHABI			225 WHITE STREET		
	NURSING AND REHADI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	e 11	F 32	3		
		ygen was turned on. The		resident representatives, to	o include	
		hat she did not witness the		resident representatives of		
		eing lit. She stated that the		#122, #16, #125, #182, #5		
	resident was outside	at the end of the building		#212 by the Activities Direct	ctor.	
	and not in the design	ated smoking area when the		100% in service was initiat		
	incident occurred.			Corporate Nurse Consulta		
				for all staff to include, Adm		
		PM, Staff Development		Account Receivable (AR),		
-		t (SDCA) was interviewed. t she was in her office on		QI nurse, Treatment nurse Facilitator, Staff Facilitator		
		ff Development Coordinator		Admissions Coordinator, P		
		w the resident out their office		receptionists, maintenance	•	
		jen tank attached on back of		maintenance assistant, the		
		cigarette in her hand. The		housekeeping, laundry, lice		
	SDCA further stated t	that the SDC told her to go		to include Nurses #1 and #		
		d be there shortly. The		assistants, to include NA #	1 and MA #1,	
		and took the unlighted		dietary staff, Geri Care aid	-	
		ident and took her back in		Director, Activity assistant		
	-	C followed shortly and assist		aide on what to do if they w		
		ack into the building. The		resident smoking on oxyge		
		not remember if the oxygen other the nasal cannula was		service will be included in agency personnel training		
		ent's face. She further		after that by the Staff Facil		
		ted the incident to the 300		in-service included that the		
	hall nurse (Nurse #1)			is to immediately remove t		
	, , ,			from potential harm, secur		
		PM, Nursing Assistant (NA)		safety and notify the nurse		
		NA #1 was assigned to		resident is observed smok		
		/20/17. NA #1 stated that		oxygen. The nurse will ass		
		he resident go out and		resident and notify the phy		
	smoke.			residents representative of		
	0n 00/20/17 at 2:12 1	<sup>D</sup> M, Med Aide #1 (MA) was		and complete the incident document in the medical re	•	
		stated that she saw the		nurse will also notify the Ad		
		ng area about a month ago,		Director of Nursing. Any re		
		smoking. She further stated		as smoking while on oxyge		
		een the resident attempt to		follow the facility reviewed		
	smoke with her oxyge	-		will be issued a 30-day not		
	, , , , , , , , , , , , , , , , , , , ,			placed on one to one supe		

Facility ID: 923022

If continuation sheet Page 12 of 36

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (	CONSTRUCTION		IO. 0938-03 E SURVEY	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· ,			COMPLETED		
						С		
		345217	B. WING		0	9/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			·		
PREMIER	NURSING AND REHABI	LITATION CENTER		22	5 WHITE STREET			
				JA	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 323	Continued From page	e 12	F 32	23				
		PM, Resident #122 was			discharge. All in servicing was comple	eted		
		t #122 stated that she thinks			by 09/22/17.			
	her cigarette was not	lit on 07/05/17. She further			A 100% in service was initiated to the	all		
		would have cut off her O2			licensed nurses, to include Nurses #1			
	before she went outs	ide to smoke.			#2, on 9/21/17 by the Director of Nurs	•		
	0 00/00/17 10 10				and was completed by 9/22/17. The in	ſ		
		PM, Resident #122's Medical			service included the following:	: -1 4		
	. ,	rviewed. The MD assigned ted that the facility did call			Nurses Responsibility of Assuring res			
		incident (07/05/17) and he			safety to prevent smoking with oxyger When a newly admitted resident that	1		
	-	ident was smoking with O2,			smokes is on oxygen or a current resi	ident		
		The MD further stated that it			that smokes receives a new order for	aont		
	was over two months	ago, and he did not			oxygen, the nurse must immediately r	notify		
	remember.				the MD and obtain an order to remove	-		
					oxygen while smoking. The Nurse is			
	On 09/20/17 at 5:05 I				responsible for assuring that resident			
	emergency contact re				smoking paraphernalia is securely loc			
		nt #122 emergency contact			in the medication cart. The nurse mus			
		that she remembers the			assure that all oxygen equipment (nat	sal		
		ying the resident got in /ith the O2 turned on. She			cannula and e-tank) is removed per physician order before giving a reside	nt		
		e did not remember the			smoking paraphernalia. The nurse mu			
		e cigarette was lit. She			assure that the oxygen is reapplied w			
		e assumed that the cigarette			the resident finishes smoking.			
	was lit.				100% in service was initiated by the			
					Director of Nursing on 9/20/17 for all	staff,		
	On 09/21/17 at 9:06 /	AM, Telephone interview with			administrator, Account Receivable (A	R),		
		nt Coordinator (SDC). The			DON, ADON, QI nurse, Treatment nu			
		was in her office conducting			Staff Facilitator, Staff Facilitator assis	tant,		
	orientation class on 0				Admissions Coordinator, Payroll,			
		her office window at the			receptionists, maintenance director,			
	-	(not in the designated cigarette and lighter in her			maintenance assistant, therapy staff, housekeeping, laundry, licensed nurs	96		
	hand with the oxygen				to include Nurses #1 and #2, nursing	03,		
		C said she immediately told			assistant, to include NA #1 and MA #	1.		
		and get the cigarette and			dietary staff, Geri Care aides, Activity			
		ent. She further stated that			Director, Activity assistant and activity			
	-	e to get the resident and told			aide on revised Smoking Policy dated			
		hall (Nurse #1) to write up			9/20/2017. All in servicing was comple			

Facility ID: 923022

If continuation sheet Page 13 of 36

		MEDICAID SERVICES					<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· /	E SURVEY PLETED
			A. BUILDIN	IG			
		245247	B. WING				С
		345217				09	/22/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET		
		-		JA	ACKSONVILLE, NC 28546		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIO DATE
F 323	Continued From page	e 13	F 3	23			
	the incident that the r	esident was outside with			by 09/22/17.		
	cigarette, lighter and	O2 attached to wheelchair.			On 9/21/17 the vice president of		
		she told Nurse #1 to check			operations educated the new interim		
	the resident's room for	or cigarettes and lighters.			administrator and Director of Nursing of	on	
		ot tell Nurse #1 that the			the requirement of root cause analysis		
	resident was smoking	g the cigarette. She further			and implementation of the plan of		
	stated that the reside	nt can ambulate and since			correction to protect all residents.		
	she had been back to	o facility from hospital			On 9/21/17 the admissions process wa	as	
	(6/6/17), she had not	seen the resident go out to			updated to include the revised smokin	g	
	smoke. She stated the	hat the resident came back			policy by the Administrator. All newly		
	-	oxygen. The SDC said she			admitted residents regardless of smok	-	
		if the nasal cannula was in			status will be educated on and sign the		
		nd she did not know if the			acknowledgment of the revised smoking	ng	
		She was just alarmed when			policy by the admissions coordinator.		
		n cigarette and lighter in her			After November 19, 2017 no newly		
		ink attached to wheelchair.			identified smokers will be allowed to		
		the cigarette was not lit. The			smoke on the premises. Any newly		
		at before the resident's last			identified smoking residents to include		
		n 05/29/17 she was able to			admission, on or before November 19	,	
	ampulate with a walk	er to go outside and smoke.			2017, smoking assessment will be		
	On 09/21/17 at 9:40				completed by the licensed nurse and		
		N stated that there was no			reviewed by the Director of nursing to identify if the resident is a safe or unsa	ofo	
		on to the resident prior to			smoker and placed on the appropriate		
		moking precautions while on			smoking list by the Director of Nursing		
		ther stated that the facility			The assigned hall nurse will review the		
	was considered a sm				orders to ensure the resident does not		
		idmitted and smoked were			have orders for oxygen. If the resident		
		heir cognition being intact			an order for oxygen, the nurse will not		
	and being able to get				the medical doctor to obtain an order t	•	
	independently.				remove the oxygen while the resident		
					smoking. The Minimum Data Set nurse		
	On 09/21/17 at 3:30 I	PM, the Nurse #1 was			will develop or update the care plan w		
		rse #1 stated that she			the smoking safety interventions.		
	followed up with Resi	ident #122's emergency			Residents identified as supervised		
		e who stated she sometimes			smokers will be assessed upon		
		122 cigarettes and lighters.			identification as a smoker and quarter	у	
	-	- 0			after that by the MDS nurse to ensure	-	
		de on 09/22/17 at 11:00 AM	1	- 1	change to the smoking status. Any		

Facility ID: 923022

If continuation sheet Page 14 of 36

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE	CONSTRUCTION		D. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		COMPLETED	
						С	
		345217	B. WING		09/	/22/2017	
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 323	Continued From page	e 14	F 32	23			
		ner room sitting up in her			resident that is identified as an		
		en sign posted on back of			unsupervised/safe smoker will be		
		ygen sign posted on the right			assessed upon identification as a smo	ker	
	side of door frame to				and monthly after that that by the MDS		
		e made of Resident #122			nurse to ensure no change to the smo	king	
	smoking during the fo	our-day survey period.			status.		
	0 00/00/47 14 44				The Director of Nursing and/or Social		
		PM, the Director of Nurses			Worker will audit the completion of	,	
		ed. DON stated that it is her staff and residents that			residents smoking assessment for any change in status, to include residents		
		lity's policy on smoking. The			#122, #16, #125, #182, #59, #85 and		
		Resident #122 would be			#212, signature for newly admitted		
	assessed and care p				residents receipt of the smoking policy	,	
	expected all incident	reports to be thoroughly			and smoking care plans for identified		
	-	pleted accurately. The DON			smoking residents weekly x 8 weeks th		
	further stated that in				monthly x 1 month to assure accuracy		
		es as being smoke free			and appropriateness to meet the safet	-	
		rere smoking at the end of DON stated that all residents			needs of residents utilizing a Smoking Audit Tool. The License Nurse, Admiss		
		ad to be cognitively intact			Coordinator and/or the MDS nurse will		
		ated smoke area without			immediately retrained during the audit		
	assistance from staff				any identified areas of concern by the		
					Director of Nursing.		
	On 09/22/17 at 5:25 l	PM, the Administrator was			The Director of Nursing will review the		
		ministrator stated that the			incident report form to ensure a proper		
	•	e facility's smoking policy on			investigation, the follow-up to include a		
		nis expectation that staff and			appropriate intervention initiated, for a		
	residents follow the s				incidents to include smoking with oxyg documentation contained within the	jen,	
		e smoking be completed. rator was not employed at			medical record and revised or updated	4	
		time of the 07/05/17 incident			care plan, to include residents #122, #		
	with Resident #122.				#125, #182, #59, #85 and #212, three		
					times per week for 4 weeks, then weel		
		d Director of Nursing were			for 4 weeks, and then monthly for 1 me	onth	
		ediate jeopardy on 09/21/17			utilizing an Accident Hazards/Supervis	sion	
	at 11:00 AM.	••••••••••••••••••••••••••••••••••••••			Audit tool. The Quality Improvement		
		AM, the facility provided an			nurse, the assigned licensed nurse or		
	acceptable allegation	of compliance.			MDS nurse will be immediately retrain		
		·			during the audit for any identified area		

Event ID: L0PV11

Facility ID: 923022

If continuation sheet Page 15 of 36

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(Y3) DAT	E SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	PLETED
						С
		345217	B. WING		09	/22/2017
IAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
				225 WHITE STREET		
REMIER	NURSING AND REHABI			JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	e 15	F 32	23		
	Plan of correcting the		1 02	concern by the Director	of Nursing	
		122 was observed with a		The Administrator will re	-	
		on by the staff facilitator and		the Smoking QI Audit To		
		nt. The cigarette was not lit		Accident Hazards/Super		
	-	the staff facilitator, and the		weekly x 8 weeks then n	-	
		back into the facility on		for completion and to en		
	7/5/17 by staff facilita	tor at 4:08 pm.		concern were addressed		
	On 7/5/17 the staff fa	allitator advanted the		On 9/21/17, the administ		
		while wearing oxygen. The		president of operations, clinical director will begin		
	-	the administrator and		of the completed Accider	-	
	nurse on 7/5/17 4:20			Hazards/Supervision Au		
		•		Smoking QI Audit Tools f		
		ed hall nurse made the		systems for a safe enviro	onment to include	
		nts representative (RR)		a safe environment and	•	
		oon notification to the RR,		the smoking policy and s		
	-	etimes give her cigarettes to		resident safety, to includ		
	keep in her room."			#16, #125, #182, #59, #8 remains in place and are		
	On 7/5/17 the assigned	ed hall nurse and the		properly. The review will		
	•	rched the resident room and		indicated by initiating the	-	
		y cigarette paraphernalia.		four weeks to ensure ad		
		hed the room again and		supervision and oversigh		
	was not able to find a	ny cigarette paraphernalia.		clinical director and vice		
				operations weekly until t		
		ed hall nurse educated the		assurance team review of		
		ns. The RR verbalized		determines the facility ha		
	understanding.			substantial compliance a oversight is no longer inc		
	On 7/6/17 the social v	vorker re-educated the		The Director of Nursing of		
		of smoking with oxygen on		will present the finding of		
	and the smoking polic			Hazards/Supervision Au		
				Smoking QI Audit Tool at	t the monthly	
		under the direction of the		Quality Improvement Co		
	Registered Nurse (RM			The Quality Improvemen		
		thorough investigation to		review the results of the		
		or the resident attempting to		3 months, identify trends	s, and utilize the	
	smoke with oxygen.			five why root cause anal	and a second second second	

Event ID: L0PV11

Facility ID: 923022

If continuation sheet Page 16 of 36

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	OMPLETED	
						С	
		345217	B. WING			09/22/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE			•	
PREMIER	NURSING AND REHAB	ILITATION CENTER		225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From pag	e 16	F 32	23			
		of the investigation, it was		The Director of Nursing	or Administrator		
		all failure to assess the		will present the findings			
	resident desire to sm	oke with oxygen, failure to		hazard/supervision audi			
		oking policy related to being		Smoking QI Audit Tool to			
	smoke-free and failu			Assessment and Assura			
		dent #122 desire to smoke.		Committee quarterly me			
	-	d to communicate with		quarter. The quarterly C			
	to residents.	the smoking paraphernalia		will review the quality im	•		
	to residents.			recommendation and fa the recommendations. T			
	The procedure for im	plementing the acceptable		committee will perform a			
		the specific deficiency cited.		cause analysis as neede			
				additional recommendat			
	100 % of alert and or	riented residents and		oversight. The administr			
	residents with oxyge	n use were interviewed on		responsible for ensuring			
	9/21/17 to identify an	y residents that smoke by		Committee concerns, ar	nd		
		o resident was identified		recommendations are a	0		
		e of 13 as a smoker through		further training or other			
	interviews from staff	and families.		sustained to maintain re			
	Thoro are 27 plort ar	nd oriented residents and 20		compliance in the area of Accidents Hazards/Supe			
	residents with oxyge			The administrator and D			
				will be responsible for th			
	The social worker int	erviewed the 27 alert and		of the revised smoking p			
	oriented resident res	idents on 9/21/17 utilizing the		assessment of the resid	•		
		ol: 1. Do you smoke? 2. If		and systematic changed	l for the		
	yes do you wish to st	top smoking? 3. If you wish		prevention of incidents a	and accident.		
	to stop smoking, do			Corporate oversight will	• •		
		moking? 4. Have you been		the corporate clinical dir			
		lity smoking policy? 5. Do		president of operation's			
		smoking with Oxygen is		administrator and Direct	-		
	-	a cause and explosion? 6. Do		implements and monitor correction.	s the plan of		
	-	designated smoking area is nderstand that smoking is					
		of these areas? Six (6)					
		fied as smokers who do not					
		on to stop smoking and one					
		no longer a smoker. The					
		moking paraphernalia will be					

Facility ID: 923022

If continuation sheet Page 17 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345217	B. WING				C 22/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	secured in the medica resident's hall and on upon request to ensu All six residents ident educated on the follow on 9/21/2017 by the s following: The six residents that and twenty residents educated on the haza smoking on 9/21/2017 The 6 residents were assessment on 9/20/7 (DON) and the Minim by resident observation the residents' ability, information gathered determine that the resi independently or unsu- supervised. The results of the Sm determined that there identified as Safe/indor resident identified as physical limitation and no longer a smoker. A Resident Council M 9/20/17 by the counci update of the Smokin Twenty-five residents council meeting in the Each of the six reside	ation cart on the assigned ly provided to the residents re safety. ified as smokers were wing revised smoking policy social worker to include the are identified as smokers that are on oxygen were ards of oxygen usage and 7 by the social worker. provided a smoking 17 by the Director of Nursing um Data Set (MDS) nurse on, clinical assessment of staff interviews and from the medical record to sident is safe to smoke afe smoker and must be toking evaluations were five residents ependent smokers, one a supervised smoker due to d one resident identified as leeting was called on il president to discuss the g policy. There were that attended the resident	F	323			

Facility ID: 923022

If continuation sheet Page 18 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345217	B. WING				22/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	the MDS nurse to refl status. 100% review of physi resident identified wh 9/21/17 by the Corpor identify any resident wh No resident that has b requires oxygen base review and observatio corporate nurse cons 100% of progress not were reviewed by the 9/21/17 to identify any smoking with oxygen residents identified as 100% of incident repor were reviewed by the 9/21/17 to identify any smoking with oxygen residents identified as 0n 9/21/17 the identify any smoking with oxygen residents identified as 0n 9/21/17 the identify any smoking with oxygen residents identified as 0n 9/21/17 the admiss to include the revised administrator. The ne smoking status will be acknowledgment of the the admissions coord The resident smoking under a covered pation smoking blanket, Nati Association (NFPA) a extinguisher and NFF placed within this area	ect the current smoking cian orders, for the six o smoke, was completed on rate Nurse Consultant to with an order for oxygen use. been identified as a smoker ed upon physician order on on 9/21/17 by the ultant. There were no other s smoking with oxygen. There were no other s smoking with oxygen. Sions process was updated smoking policy by the w admissions regardless of e educated on and sign the here revised smoking policy by inator.	F	323				

Facility ID: 923022

If continuation sheet Page 19 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/31/2017 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345217	B. WING				C / <b>22/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	and locked in the nurs only be accessible with member. A bright colored sign of entry door and the ne- area for family member provide residents with the maintenance direct Any resident that asso the admitting nurse with assessment completer reviewed by the Direct hall nurse will review resident does not hav resident does not hav resident had an order medical doctor to obta oxygen while the reside Minimum data nurse of care plan with the sm Residents identified a be evaluated upon ad that by the MDS nurses smoking status. Any r an unsupervised/safe upon admission and r needed to ensure no status. Notification of the char was sent via the Unite 9/21/2017 to all resider residents that scored educated on the smol safety on 9/21/2017 to	he resident will be housed se medication cares and will th the aid of the staff was placed on the front why designated smoking ers and visitors to NOT a smoking paraphernalia by ctor on 9/21/17. essed upon admission from ill have the smoking ed by the licensed nurse and ctor of nursing. The assigned the orders to ensure re orders for oxygen. If the the nurse must notify the ain an order to remove the dent is smoking. The will develop or update the oking safety interventions. Is supervised smokers will missions and quarterly after e to ensure no change to the resident that is identified as smoker will be assessed reassessed monthly or as changes to the smoking of Stated Postal Service on ent representatives. All a 13 to 15 on the BIMS was king policy and oxygen by the social worker.	F	323			
		by the social worker. 13 to 15 of their minimum					

Facility ID: 923022

If continuation sheet Page 20 of 36

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/31/2017 MAPPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/22/2017		
		345217	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	<ul> <li>9/21/17. The remain not alert and oriented their BIMS will have to notification letter sent Service to their respect Representatives (RR office.</li> <li>The designated resid outside, in the covered the 100 hall exit. Sm extinguishers, smokin smoking containers, for provided as safety me to state "NO Oxygen been placed in the de 9/21/17 by the mainter paraphernalia has be resident's possession placed in a secured be Coordinator on 9/21/17</li> <li>A Red tag indicating of on the mobility device safety by the mainter all twenty residents we 100% in service was Nurse Consultant on administrator, Accour ADON, QI nurse, Tre Facilitator, Staff Facil Coordinator, Payroll, director, maintenance housekeeping, laund assistant, dietary staff Director, Activity assi</li> </ul>	the smoking policy on ing 146 residents that are l and scored 12 or below on he smoking policy and t via United States Postal active Resident ) on 9/21/17 by the business ent smoking area is located ed pavilion in the courtyard at oking aprons, fire ng blankets and fire proof to include red trashcans, are easures. Red signage was beyond this point" have esignated smoking area on enance director. All smoking en removed from the six n with their permission and bocation by the Admission 17. boxygen usage will be placed e for easy identification and nance director by 9/21/17 for <i>r</i> ith oxygen use. initiated by the Corporate 9/20//17 for all staff, nt Receivable (AR), DON,	F	323				

If continuation sheet Page 21 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345217	B. WING				C 22/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	oxygen. This in service orientation, agency per annually after that. The the staff member is to resident from potential safety and notify the re- the resident and notify residents representation complete the incident medical record. The re- Administrator and Dim- resident identified as and failure to follow the policy will be issued as placed on one to one Any employee that has will be removed from in-service education he servicing will be completed by 9 has not received the if from the schedule und has been provide. The following: Nurses Responsibility to prevent smoking we When a newly admitted on oxygen or a current receives a new order immediately notify the remove the oxygen we responsible for assuri- paraphernalia is secu- medication cart. The to	e will be included in ersonnel training and his in-service included that immediately remove the al harm, secure the resident nurse. The nurse will assess y the physician and ive of the occurrence and report and document in the nurse will also notify the ector of Nursing. Any smoking while on oxygen he facility reviewed smoking a 30-day notification and supervision until discharge. As not received the in service the schedule until the has been provide. All in oleted by 09/22/17. Is initiated to the licensed the Director of Nursing and 0/22/17. Any employee that n service will be removed til the in-service education e in service included the of Assuring resident safety ith oxygen ed resident that smokes is not resident tha	F	323			

Facility ID: 923022

If continuation sheet Page 22 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345217	B. WING			0	C 9/22/2017
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 323	removed per physicia resident smoking para assure that the oxyge resident finishes smol 100% in service was for all staff, administra (AR), DON, ADON, Q Staff Facilitator, Staff Admissions Coordina maintenance director, therapy staff, houseke nurses, nursing assis aides, Activity Directo activity aide on revise 9/20/2017. Any emploi the in service will be r until the in-service ed All in servicing will be Premier Nursing and smoking policy was re On 9/21/17 the vice p educated the new inte Director of Nursing or cause analysis and in correction to protect a The administrator, Dir worker will audit the r assessment, smoking monthly to assure acc be appropriate to meen needs of residents. The Director of Nursir	n order before giving a aphernalia. The nurse must in is reapplied when the king. initiated by the on 9/20/17 ator, Account Receivable an urse, Treatment nurses, Facilitator assistant, tor, Payroll, receptionists, maintenance assistant, eeping, laundry, licensed tant, dietary staff, Geri Care or, Activity assistant and d Smoking Policy dated byee that has not received removed from the schedule ucation has been provide. completed by 09/22/17. Rehabilitation Center evised on 9/20/17. resident of operations erim administrator and in the requirement of root inplementation of the plan of all residents. rector of Nursing or social esidents smoking policy and care plans curacy and they continue to et the safety meet the safety ill review the incident report	F	323	3		

If continuation sheet Page 23 of 36

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345217	B. WING		09/22/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CO	•
PREMIER	NURSING AND REHABI	LITATION CENTER		25 WHITE STREET ACKSONVILLE, NC 28546	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 323	Continued From page	e 23	F 323		
	initiated, for all incide oxygen, documentati medical record and re On 9/21/17, the admi operations, and corpo begin a weekly review Hazards/Supervision systems for a safe er	In appropriate intervention Ints to included smoking with on contained within the evised or updated care plan. Inistrator, vice president of orate clinical director will w of the completed Accident Audit tool to ensure the invironment to include a safe lementation of the smoking			
	policy and supervisio in place and are func- will be complete, as i audit tool, for four we supervision and over director and vice presuntil the quality assur committee determine	n for resident safety remains tioning properly. The review ndicated by initiating the eks to ensure adequate sight of the corporate clinical sident of operations weekly			
	set nurse (MDS) will Accident Hazards/Su monthly Quality Impro Meeting. The Quality MDS nurse will review monthly X 6 months,	Improvement Committee or w the results of the audits identify trends, and utilize se analysis and make			
	present the findings of hazard/supervision a Assessment and Ass quarterly meeting to quarterly QAA Comm	nent and or MDS nurse will of accident udit tool to the Quality urance (QAA) Committee equal six months. The nittee will review the quality nendation and facilities			

Facility ID: 923022

If continuation sheet Page 24 of 36

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING				C 22/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 323	follow-up to the recom QAA committee will p analysis as needed, r recommendation, and administrator will be r QAA Committee cond are addressed throug interventions are sust compliance in the are Hazards/Supervision. The title of the persor implementing the acc The administrator and responsible for the im smoking policy, asses smoke and systematic prevention of incident oversight will be provid director and vice pres- ensure the administra- implements and moni The credible allegatio at 4:55 PM when inter- nursing staff, adminis staff confirmed they h training on the facility remove all oxygen tar- into the new designat storage system for sn available smoking equ aprons, cigarette butt fire blankets. Intervie 1st and 2nd shifts on revealed residents we interviews revealed res-	amendations. The quarterly erform additional root cause make an additional l provide oversight. The esponsible for ensuring the erns, and recommendations h further training or other ained to maintain regulatory a of Free of Accidents a responsible for eptable plan of correction. d Director of Nursing will be plementation of the revised asment of the resident who c changed for the s and accident. Corporate ded by the corporate clinical ident of operations to tor and Director of Nursing tors the plan of correction. n was verified on 09/22/17 rviews with residents, trative staff and non-nursing ad received in-service s revised smoking policy to hks and tubing prior to going ed smoking area, the new hoking materials, the uipment including smoking cans, fire extinguisher and ws were conducted on the 09/22/17. Observations ere smoking safely, and	F	323				

Facility ID: 923022

If continuation sheet Page 25 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING			C 09/22/2017		
NAME OF PF	ROVIDER OR SUPPLIER		1	ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER	NURSING AND REHABII				225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page	25	F	323	3			
	06/17/16 with multiple diabetes mellitus, con hypertension, chronic disease, asthma, peri cognitive communicat MDS assessment dat that Resident #16 had memory problems and needed extensive ass daily living. The resid wheelchair.	a obstructive pulmonary ipheral vascular disease and tion deficit. The Annual ted on 08/14/17 indicated d no short or long term d was cognitively intact and sistance with activities of tent was coded as using a						
	upon admission base status of being intact and Resident #16 cou independently. With t was added to the smo Nursing interview on S							
	Resident #16 was not until 09/20/17 per DO	t assessed for safe smoking N and record review.						
	reviewed on 09/19/17							
	Resident #16 was list was provided by the f	ed on the "smokers list" that acility.						
	-							

If continuation sheet Page 26 of 36

<b>CENTERS FOR MEDICARE &amp; M</b>	D HUMAN SERVICES					APPROVED . 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	345217	B. WING				_ 22/2017	
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER NURSING AND REHABILI	ITATION CENTER			25 WHITE STREET ACKSONVILLE, NC 28546			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
<ul> <li>09/20/17 at 9:20 AM to smoking area safely sr</li> <li>Review of Resident #1 dated on 09/20/17 revea a safe smoker and may now and care plan was</li> <li>On 09/20/17 at 9:55 AI interviewed. Resident cigarettes and lighter in signed himself out and would sign him out.</li> <li>On 09/22/17 at 10:30 A interviewed. Nurse #2 goes out to smoke indefurther stated that ciga Resident #16 were kep</li> <li>On 09/22/17 at 10:40 A NA #1 stated that the r independently in the defunction of the smoke follow the facilities that the resident were the parking lot. The Dr on the smokers list hard</li> </ul>	<ul> <li>e of the Resident #16 on</li> <li>p:53 AM in the designated moking.</li> <li>6 smoking evaluation ealed that the resident was y smoke independently supdated.</li> <li>M, Resident #16 was #16 stated that he kept his in his room and sometimes</li> <li>d sometimes the nurse</li> <li>AM, Nurse #2 was stated that the resident ependently. Nurse #2 rettes and lighters for ot on the medication carts.</li> <li>AM, NA #1 was interviewed. esignated smoking area.</li> <li>M, the Director of Nurses d. DON stated that it is her aff and residents that ty's policy on smoking. The sident #16 would be inned, and that she eports to be thoroughly leted accurately. The DON is past the facility</li> </ul>	F	323				

Facility ID: 923022

If continuation sheet Page 27 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345217	B. WING			C 09/22/2017			
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE				
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 323	residents on the curre educated on the revis and if the residents w observed and assess 09/20/17. On 09/22/17 at 5:25 F interviewed. The Adm facility has revised the 09/20/17 and it was h residents follow the si assessments for safe 3. Resident #125 was 12/05/12 with multiple personal history of tra chronic kidney diseas anxiety disorder, type obstructive pulmonary weakness. The 5 day 06/27/17 indicated hat memory problems and needed supervision for The Resident was coor Resident #125 was as upon admission base status of being intact and Resident #125 coor independently. With the was added to the smo Nursing interview on the Resident #125's revision 06/27/17 was reviewed care planned for smol	DON further stated that all ent smokers list were ed facility policy on smoking ere still smoking they were ed for safe smoking on PM, the Administrator was ninistrator stated that the e facility's smoking policy on is expectation that staff and moking policy and smoking be completed. a admitted to the facility on e diagnoses including unsient ischemic attack, se stage 3, hypertension, 2 diabetes mellitus, chronic y disease and muscle y MDS assessment dated on id no short or long term d was cognitively intact and or activities of daily living. ded as using a wheelchair. ssessed (MDS) for smoking d only on her cognitive per information from MDS ould get to the smoking area this information, the resident okers list per Director of 9/21/17 at.9:40 AM. and and the resident was not king.	F	323					

Facility ID: 923022

If continuation sheet Page 28 of 36

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/31/2017 // APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING				C <b>22/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHABII	ITATION CENTER			225 WHITE STREET		
				•	JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	28	F	323	3		
	On 09/20/17 at 9:15 A interviewed. Residen not been out to smoke Resident #125 stated cigarettes and lighter stated that she has has smoking area. Reside was not going to say y cigarettes. On 09/20/17 at 10:30 NA #1 said she had n out to smoke in the la No observations were smoking during the fo Review of Resident # dated on 09/20/17 rev a safe smoker and ma now and care plan wa On 09/22/17 at 3:30 F interviewed. Nurse #2 the resident go out to was storing Resident on the medication car that she was not awa storing cigarettes and On 09/22/17 at 4:14 F (DON) was interviewe expectation that the s smoke follow the facil DON further stated Re assessed and care pla	AM, Resident #125 was t #125 stated that she had e for two months. that she kept her own in her room. Resident #125 ad a hard time getting to the ent #125 further said she where she keeps her AM, NA#1 was interviewed. ot observed the resident go st couple of months. e made of Resident #125 ur-day survey period. 125 smoking evaluation vealed that the resident was ay smoke independently as updated. PM, Nurse #2 was 2 said she had not observed smoke in a few months and #125 cigarettes and lighter t. Nurse #2 further stated re that Resident #125 was a lighter in her room. PM, the Director of Nurses ed. DON stated that it is her taff and residents that ity's policy on smoking. The esident #125 would be anned, and that she					
		eports to be thoroughly pleted accurately. The DON					

Facility ID: 923022

If continuation sheet Page 29 of 36

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	): 10/31/2017 APPROVED ). 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
	345217	B. WING			09/2	22/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PREMIER NURSING AND REHABILI	TATION CENTER		225 WHITE STREET JACKSONVILLE, NC 2	8546		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>the parking lot. The DC on the smokers list had and get to the designat assistance from staff. I residents on the curren educated on the revise and if the residents were observed and assessed 09/20/17.</li> <li>On 09/22/17 at 5:25 PM interviewed. The Admi facility has revised the 09/20/17 and it was his residents follow the sm assessments for safe s</li> <li>4. Resident #182 was 04/21/15 with multiple of vascular dementia, maj bipolar disorder, alcoho diabetes mellitus. The dated on 07/11/17 indic had no short or long ter was cognitively intact a assistance with activitie Resident #182 was assistance per the set of the se</li></ul>	e past the facility s as being smoke free re smoking at the end of ON stated that all residents d to be cognitively intact ted smoke area without DON further stated that all nt smokers list were d facility policy on smoking re still smoking they were d for safe smoking on M, the Administrator was inistrator stated that the facility's smoking policy on s expectation that staff and noking be completed. admitted to the facility on diagnoses including jor depressive disorder, ol abuse and type 2 Annual MDS assessment cated that Resident #182 rm memory problems and and needed extensive es of daily living. The s using a wheelchair. sessed (MDS) for smoking only on her cognitive er information from MDS uld get to the smoking area his information, the resident kers list per Director of	F 32	3			

Facility ID: 923022

If continuation sheet Page 30 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345217	B. WING			C 09/22/2017		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	07/11/17 was reviewed care planned for smoo Resident #182 was list that was provided by On 09/20/17 at 9:35 A interviewed. Resident longer smokes. The been out to smoke for stated that the nurse cigarettes and lighter from the nurse to go of On 09/20/17 at 11:00 NA #1 stated that she resident go out to smo Review of Resident # dated on 09/20/17 rev a safe smoker and ma now and care plan wa On 09/22/17 at 11:05 interviewed. Nurse # seen the resident go time until 09/20/17 wh smoking. On 09/22/17 at 4:14 F (DON) was interviewed expectation that the s smoke follow the facill DON further stated R assessed and care pl expected all incident	<ul> <li>and the resident was not king.</li> <li>asted on the "smokers list" the facility.</li> <li>AM, Resident #182 was at #182 stated that she no resident states she has not r 6 or 7 months. She further on the hall kept her and she got permission but to smoke.</li> <li>AM, NA #1 was interviewed.</li> <li>a has never seen the oke.</li> <li>AM, Nurse #2 was 2 stated that she has not out and smoke in a long nen she assessed for safe</li> <li>PM, the Director of Nurses ed. DON stated that it is her staff and residents that lity's policy on smoking. The esident #182 would be anned, and that she reports to be thoroughly</li> </ul>	F	323				
	expected all incident	reports to be thoroughly pleted accurately. The DON						

Facility ID: 923022

If continuation sheet Page 31 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			PLETED
		345217	B. WING				C 22/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
PREMIER	NURSING AND REHABI	LITATION CENTER					
					JACKSONVILLE, NC 28546 PROVIDER'S PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 31	F	323			
		es as being smoke free					
		ere smoking at the end of					
		DON stated that all residents ad to be cognitively intact					
	and get to the design	ated smoke area without					
	assistance from staff. residents on the curre	DON further stated that all					
		sed facility policy on smoking					
		ere still smoking they were					
	observed and assess 09/20/17.	ed for safe smoking on					
		PM, the Administrator was					
		ninistrator stated that the					
	-	e facility's smoking policy on his expectation that staff and					
	residents follow the si	moking policy and					
		s smoking be completed. s admitted to the facility on					
		osis of cerebral infarction,					
	myocardial infarction,	chronic obstruction					
	pulmonary disease, a resident's Minimum D	nd hypertension. The					
		e resident's cognition was					
		pairment with her upper					
	extremity.						
	Review of Resident #	85 care plan dated					
		e resident was not care					
	planned for smoking.						
	Review of the facility's Resident # 85 was ide	s smoking list revealed entified as a smoker.					
	Review of Resident #	85's medical records					
		through 9/21/2017 revealed					
	there was no smoking	g assessment completed.					
		n 9/20/2017 at 3:00 PM, who was assigned to the					

Facility ID: 923022

If continuation sheet Page 32 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATE	
		345217	B. WING	-			C 22/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
PREMIER	NURSING AND REHABI	LITATION CENTER					
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	•	JACKSONVILLE, NC 28546 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 323	the day. She also indindependent smoker at the resident outside the During the observation 9/21/2017 at 11:00 All observed smoking cig and was being supervation. The resident was weat During the interview windicated the Nurses at the cigarettes in the mixer providing the cig. During an interview windicated the Nurses at the cigarettes in the mixer providing the cig. During an interview windicated the Nurses at the cigarettes in the mixer providing the cig. During an interview windicated the Nurses at the cigarettes in the mixer providing the cig. During an interview windicated the Nurses at the cigarettes in the mixer providing the cig. During an interview with assessment. She add staff was to complete after the resident was further added if the resident the resident was further added if the residents who were inclusion. During an interview with a second and if they with the they were they wer	t Resident # 85 had a with the resident throughout licated the resident was an and her sitter usually takes he facility to smoke. In of the resident on M, the resident was yarette outside the facility vised by her private sitter. Aring a smoking apron. with the private sitter she at the facility were keeping hedication cart and they yarettes to the resident. With Director of Nursing at 10:30 AM, she reported t b# 85 was identified as a not complete the smoking led her expectation of the the smoking assessment i identified as a smoker. She	F	323			
		y disease, chest pain and					

Facility ID: 923022

If continuation sheet Page 33 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING				C 22/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 323	anemia. The resident dated 8/28/2017 indic was intact and had no extremity. Review of the care pla Resident # 59 was no Review of the facility's Resident # 85 was ide Review of Resident # 4/13/2017 through 9/2 no smoking assessme During the interview of Nurse Aide (NA) # 1 v resident reported that outside the facility to signing herself out. During the observatio 9/21/2017 at 11:00 Al observed smoking cig The resident was inde cigarette. During an interview w (DON) on 9/20/2017 at that the staff did not co assessment for Resid was identified as a sin expectation of the sta smoking assessment as a smoker. She ado safe smoker then they the staff members.	<ul> <li>'s Minimum Data Set (MDS) sated the resident's cognition of impairment with her upper</li> <li>an dated 8/30/2017 revealed of care planned for smoking.</li> <li>as smoking list revealed entified as a smoker.</li> <li>59's medical records 21/2017 revealed there was ent completed.</li> <li>on 9/20/2017 at 3:15 PM, who was assigned to the the resident regularly went smoke independently after</li> <li>an of the resident on M, the resident was garette outside the facility.</li> <li>appendently smoking the</li> <li>with Director of Nursing at 10:30 AM, she reported complete the smoking lent # 59 even though she</li> </ul>	F	323				

Facility ID: 923022

If continuation sheet Page 34 of 36

	-	ID HUMAN SERVICES				FORM	M APPROVED	
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED	
		345217	B. WING			C 09/22/2017		
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
PREMIER	NURSING AND REHABI	LITATION CENTER			225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	<ul> <li>9/20/2017, at 3:50 PM residents who were id assessed and if they windependently they will when they went outsid</li> <li>7. Resident # 212 was</li> </ul>	A, he stated he expected the dentified as smokers to be were not safe to smoke ere to be supervised by staff de to smoke a cigarette.	F	323	3			
	hypotension, hypokal resident's Minimum D 8/28/2017 indicated th	emia and osteoarthritis. The						
	Review of the care pla Resident # 212 was n smoking.	an dated 8/28/2017 revealed not care planned for						
	-	s smoking list revealed dentified as a smoker.						
		212's medical records 0/2017 revealed there was ent completed.						
	Nurse Aide (NA) # 1 v resident reported that	on 9/20/2017 at 3:20 PM, who was assigned to the the resident went outside ke after signing out herself.						
	During an interview w	ith Director of Nursing						

If continuation sheet Page 35 of 36

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 10/31/2017 APPROVED . 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED C		
		345217	B. WING		_		, 22/2017	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
PREMIER	NURSING AND REHABI	LITATION CENTER		225 WHITE STREET JACKSONVILLE, NC 28	8546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 323	that the staff did not of assessment for Resid was identified as a sin expectation of the sta smoking assessment resident as a smoker, was not a safe smoker supervised by the sta During an interview w 9/20/2017, at 3:50 PM residents who were id assessed and if they independently they w	at 10:30 AM, she reported complete the smoking lent # 212 even though she noker. She added her iff was to complete the when they identified a . She added if the resident er then they were to be	F 32	23				

Facility ID: 923022

If continuation sheet Page 36 of 36