PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING _			1	C /03/2018
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		STREET ADDRESS 225 WHITE STRE JACKSONVILLI		1 00/	30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580 SS=D	CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involveresults in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter tre a need to discontinue treatment due to adve commence a new for (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and provice physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s).	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial eatening conditions or u; eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or effer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the elso promptly notify the lent representative, if any, or roommate assignment u(e)(6); or ent rights under Federal or ens as specified in paragraph ecord and periodically mailing and email) and resident	F	80			8/15/18
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ε		TITLE		(X6) DATE

08/23/2018 **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.

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		345217	B. WING _				C 03/2018
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID IENCY MUST BE PRECEDED BY FULL PREF OR LSC IDENTIFYING INFORMATION)		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	that is a composite di §483.5) must disclosi its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on record rev staff interviews, the faphysician of Resident Mechanical lift (sit to straps to slip around caused the resident's color. This was evide reviewed for accident The findings included Resident # 37 was addiagnoses of Alzheim cerebrovascular disemuscle weakness, pathe quarterly Minimus 5/23/2018, indicated had been severely in extensive assistance mobility. Resident #3 dependent with the a transfers, dressing ar indicated Resident #3 moving from a seated	osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations. The is not met as evidenced itews, family interview and acility failed to notify the entity failed to notify	F	580	Premier Nursing and Rehabilitation Center Acknowledges receipt of the Statemen Deficiencies and proposes this Plan of Correction to the extent that this summ of findings is factually correct and in or to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Premier Nursing and Rehababilitation Center's response to Statement of Deficiencies does not denote Agreement with the Statement of Deficiencies nor does it constitute an Admission that any deficiency is accura Further, Premier Nursing and Rehabilitation Center reserves the righ Refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal Procedure and/or any other administra or legal proceeding. F580	ary der of this ate.	

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		345217	B. WING _		08	3/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	•		
				225 WHITE STREET			
PREMIER	NURSING AND REH	ABILITATION CENTER		JACKSONVILLE, NC 28546			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE	
F 580	Continued From p	age 2	F 5	80			
	Resident # 37's ca	are plan, dated 3/18/2018,					
	indicated Residen	t # 37 required "assistance for		A 100% review of all residen	ts' progress		
		aging process, short and long		notes will be completed by the	•		
	term memory defic			Improvement (QI) nurses, th			
		ibulatory, weakness, unsteady		supervisor, was initiated on 8			
		nsitions." The interventions		ensure appropriate documer			
		ving: monitor for safety		include when there is an acc			
		ers using mechanical lift (sit to		resident physician and resident			
	stand lift) with aid of 2 persons, report to nurse any decrease in ability to transfer safely and			representative (RR) has bee			
1 -		-		any significant change in res			
	monitor for safety	awareness.		accident, for the last 30 days			
	A review of Reside	ent #37's Care Guide, updated		to 8/1/2018. The resident's p			
		dicated the following: the		and/or RR will be notified of			
	i i	Activity of Daily Living (ADL)		areas of concern and the no	•		
		2 person assist with toileting.		be documented in the reside			
		nical lift (sit to stand lift; vest		medical record by the Qualit	У		
		rson assist. The resident		Improvement (QI) nurses, th	-		
	required non-skid	footwear.		Facilitator and/or RN superv	isor, and will		
				be completed by 8/2/2018 ut	tilizing a		
		e's note, dated 6/23/2018,		resident census.			
		t # 37 exhibited difficulty					
		-to-stand lift per staff interview;		An in-service was initiated for			
		ssisted Resident # 37 onto the		licensed nurses, on 8/1/2018	•		
	toilet when feet sli	pped off mechanical lift.		Facilitator regarding notificat			
				physician and/or RR of any s	-		
		cility 's incident log for Resident		change in resident's condition			
		ncident report had been		when there is an accident ar			
	completed after th	e 6/23/2018 incident.		documentation of notification entered into the resident's m			
	During an intervie	w with Resident #37's		will be completed by 8/2/201			
		(RP) on 7/31/2018 at 2:00 PM,		wiii be completed by 6/2/201	.		
		on 6/23/2018 he came to visit		When there is any significan	t change in		
		found her almost "choked" on		resident's condition, to include			
		t's straps. The RP indicated		is an accident, the license nu			
		ssistant (NA), NA #3, had been		responsible for notifying the			
		Resident #37's room and		physician and/or RR and do			
		her safely down to the		notification in the resident's	•		
		toilet seat. The RP reported he		medical records. The Quality			

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		345217	B. WING _			08/	03/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREMIER	NURSING AND REHAB	II ITATION CENTER		22	25 WHITE STREET		
· ···	NONOINO AND INCHAD	ENAMOR SERVER		J	ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 580	F 580 Continued From page 3 had been concerned about Resident #37's safety while being transferred on a mechanical lift. He		F t	580	Improvement (QI) nurses, the RN		
	further indicated the guidelines as require lift because he had r	ed on a mechanical lift. He staff did not follow the d while using the mechanical oticed on the day of the en transferred by one nurse			supervisor, Unit Facilitator will review 1 of residents progress notes, daily 3 tim a week for 4 weeks then weekly for 4 weeks then monthly for 1 month to ens appropriate documentation for notification	es ure	
	Resident #37 had no	The RP further reported t been wearing shoes or			of the physician and/or RR, for any changes in the resident, to include whe there is an accident, is recorded in the	n	
	nonskid socks per the care guide and the strap around the lower legs had not been applied.				resident medical record utilizing a MD/I Notification QI Audit Tool. The Quality	RR	
	10:00 AM, NA # 1 re				Improvement (QI) nurses, the Staff Facilitator and/or RN supervisor, will		
		n Resident # 37 on cated before lunch, she had resident from the bed to the			immediately notify the MD/RR for any identified areas of concern and docume in the clinical record and provide retrain		
	toilet with the sit-to-s	tand (mechanical lift) by ed Resident #37 started to			with the license nurse. The DON will review and initial the RR/MD notification	-	
	slip from the lift before	re getting on the toilet. NA# mber had arrived for a visit			QI Audit Tool weekly for 8 weeks then monthly for 1 month for completion and		
	and found Resident	#37 had slipped from the #1 stated the RP had started			ensure all areas of concern were addressed and documented in the		
	to assist to keep her unable to stop the re	from falling but had been sident from slipping and the ught at the resident 's neck.			electronic medical records and retrainir provided with the responsible staff member.	ng	
	the bathroom to get	it Resident # 37 on the lift in more help from another staff en in another resident ' s			The Executive QI committee will meet monthly and review the MD/RR		
	room at the end of th				Notification QI Audit Tool to make changes as needed, to include continue	ed	
	room waiting for add	but stood by the resident 's itional assistance to get the			frequency of monitoring for 3 months.		
	to the incident she had Resident # 37 to the	nanical lift. NA #1 stated prior ad been in a panic to get bathroom before the family ' dded the family of Resident			The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring relains	ted	
	#37 had wanted Res	ident # 37 up in the mornings			to the plan of correction.		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
345217	B. WING		C 08/03/2018
IER		STREET ADDRESS, CITY, STATE, ZIP CO 225 WHITE STREET JACKSONVILLE, NC 28546	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
e facility had been short of staff not find anyone to assist her with sident # 37 on the mechanical lift. desident #37 is always "dancing" e standing) while being transferred ical lift, making it a more difficult view with NA #2 on 8/1/2018 at # 2 stated he came down to so room after he finished giving patient. He had been told he Resident # 37 who had been left he mechanical lift. NA #2 he had arrived at Resident # 37's lad noticed the resident ' s face we and the lift ' s straps were by leck. NA # 2 reported he did not Resident # 37 's knees were for or not because everything had last. He further indicated the last. He further indicated the last does the resident ' s family member had last. He further indicated the last does the last of t	d d d d d d d d d f o f d f o f f	80	
	IDENTIFICATION NUMBER: 345217 JER JEHABILITATION CENTER MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) Impage 4 The facility had been short of staff not find anyone to assist her with resident #37 on the mechanical lift resident #37 is always "dancing" to standing) while being transferre sical lift, making it a more difficult review with NA #2 on 8/1/2018 at #2 stated he came down to so room after he finished giving any patient. He had been told he resident #37 who had been left the mechanical lift. NA #2 he had arrived at Resident #37's had noticed the resident 's face lue and the lift's straps were by neck. NA #2 reported he did not resident #37's knees were not or not because everything had ast. He further indicated the was tilted towards the front of her tated after he had assisted the resident 's family member had ast. He further indicated the was tilted towards the front of her tated after he had assisted with getting the mechanical lift. NA #2 added the mechanical lift and had been to room and stated she needed the stated she had entered Resident #37 or stated she had entered Resident #	A. BUILDIN 345217 B. WING MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) The page 4 The facility had been short of staff and find anyone to assist her with resident # 37 on the mechanical lift. Resident #37 is always "dancing" The standing) while being transferred dical lift, making it a more difficult To repair the finished giving In patient. He had been told he The Resident # 37 who had been left the mechanical lift. NA #2 The had arrived at Resident # 37's and noticed the resident 's face flue and the lift 's straps were by the resident # 37 's knees were for or not because everything had flast. He further indicated the flue was tilted towards the front of her tated after he had assisted the flue and the lift. NA #2 added flue mechanical lift. NA #2 added do him with getting Resident # 37 off cated Nurse # 1 assessed after the resident had been foliet. To resident # 31 off cated Nurse # 1 assessed after the resident had been foilet. To resident # 31 off cated Nurse # 1 assessed after the resident had been foilet. To resident # 31 off cated Nurse # 1 assessed after the resident had been foilet.	STREET ADDRESS, CITY, STATE, ZIP C 225 WHITE STREET JACKSONVILLE, NC 28546 MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL SRY OR LSC IDENTIFYING INFORMATION) In page 4 e facility had been short of staff not find anyone to assist her with sident #37 on the mechanical lift. Resident #37 is always "dancing" e standing) while being transferred ical lift, making it a more difficult view with NA #2 on 8/1/2018 at # 2 stated he came down to s room after he finished giving r patient. He had been told he Resident # 37 who had been left the mechanical lift. NA #2 he had arrived at Resident # 37's had noticed the resident 's face use and the lift 's straps were by neck. NA # 2 reported he did not Resident #37's knees were soor or not because everything had ast. He further indicated the was tilted towards the front of her tated after he had assisted with getting the mechanical lift. NA #2 added d him with getting Resident # 37 off cated Nurse # 1 assessed after the resident had been the mechanical lift and had been oilet. view with MA #1 on 8/1/2018 at 10: stated NA # 1 had come out of s room and stated she needed ated she had entered Resident #

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345217	B. WING				/03/2018	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		225 V	EET ADDRESS, CITY, STATE, ZIP CODE WHITE STREET KSONVILLE, NC 28546		33,2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE	
F 580	the platform of the lift been waiting for NA patient had been con added the resident's as she slid down the strap had slipped by During an interview of 11:10 AM, Nurse #1 assigned to care for Nurse #1 stated NA difficulty during the total the bed to the toilet of Nurse #1 stated Resident to slip some resident to slip some reported NA # 1 had assistance. She furth the NA # 1 to have a using the lift. She in persons. Nurse #1 socks or shoes had a sock or shoe	ipped down with her feet off it. MA # 1 indicated she had # 1 to get more help as the instantly slipping. MA #1 face had turned red in color lift. MA # 1 indicated the the resident's neck. with Nurse #1 on 8/1/2018 at stated she had been Resident #37 on 6/23/2018. # 1 reported to her they had ransfer of Resident #37 from using the mechanical lift. ident # 37 had slid off the lift led to use the leg straps and bees which caused the e from the lift. Nurse #1 been using the lift with no her stated she had expected sked for assistance when dicated the lift required 2 stated the use of nonskid always been required to	F	580	DEFICIENCY)			
	but they had not bee stated she had also appropriate for Resid indicated she had as she had been transfe s and stated she did Resident #37. Nurse report the incident to of Nursing (DON) be Resident # 37 's slip an incident or accide looking back at what resident, she should	eet from slipping off the lift in used by NA # 1. Nurse #1 felt the sit to stand lift was not dent # 37. Nurse # 1 ssessed Resident #37 after erred to the toilet by the NA ' d not notice any injury to e # 1 indicated she did not the physician or the Director cause she did not think of o on the mechanical lift as ent. Nurse #1 stated in had happened to the have reported the incident to and completed an incident						

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		345217	B. WING			1	C
NAME OF PR	ROVIDER OR SUPPLIER	343217	B. WING _	STREE	T ADDRESS, CITY, STATE, ZIP CODE	08/	/03/2018
				225 WI	HITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACK	SONVILLE, NC 28546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		3E	(X5) COMPLETION DATE
F 580	had not been made a incident on 6/23/2018 expectation would hat to have notified him of especially if the residucolor during the incidence of	with the Physician on I, the Physician indicated he ware of Resident #37 's B. The physician indicated his we been for the facility staff of the incident emphasizing ent had turned purple blue in ent. With the Staff Development in 8/2/2018 at 11:30 AM, the exported to her, during the blue in end been asked to assist in 6/23/2018, she had seen turned purple blue and the gred on her neck while she anical lift. The SDC bught a supervisor had ent after it happened on the overheard a conversation bund the time it happened. The SDC stated she C at the time of Resident # lift accident. With the DON on 8/2/2018 at exported she had not been incident of 6/23/2018 at exported she had not been incident of 10 silpped off the lift. The expectation of nursing staff have completed an incident ave started an in-service	F	580			
	training on the proper	use of a mechanical lift. her expectation was for the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345217	B. WING				C /03/2018
	ROVIDER OR SUPPLIER NURSING AND REHABI			ST 22	TREET ADDRESS, CITY, STATE, ZIP CODE S WHITE STREET ACKSONVILLE, NC 28546	1 06/	03/2016
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	8/2/2018 at 12:40 PM he had just learned a #37's slip off the mec Administrator stated I been for the staff to h the DON immediately an in-service on the plift. Administrator also	with the Administrator on I, the Administrator reported bout the incident of Resident	F	580			
F 600 SS=J	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's message of the second of the sec	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This aited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is is not met as evidenced fews, observations, family	F	600	F600 Free From Abuse and Neglect CFR(s): 483.12(a)(1) On 6/23/18 on 7-3 shift Nursing Assista (NA) #1 was transferring resident #37 v		8/15/18

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		345217	B. WING			1	00/0040
NAME OF D	DOVIDED OD CUIDDUED	343217	B: Wii(0 _	CT	REET ADDRESS, CITY, STATE, ZIP CODE	08/	03/2018
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
PREMIER	NURSING AND REHA	BILITATION CENTER			5 WHITE STREET		
				JA	ACKSONVILLE, NC 28546		
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F 600	Continued From pa	ae 8	F	300			
	-	d to implement care plan and	' '		the sit to stand lift with one person ass	ict	
		tions indicating use of 2			from the chair to the bathroom. Reside		
	_	while transferring with the use			#37 started to slip while in the sit to sta		
	1 -	t to stand) and failed to ensure			lift. NA #1 retrieved assistance from NA		
		non-skid footwear for 1 of 5			and NA #3 to transfer resident #37 due		
		reviewed for accidents.			slipping while in the sit to stand lift.		
		ed during a transfer from the			Resident #37 was noted purplish blue	n	
		h allowed the lift's straps to			the face during transfer.		
	slip around the resid	dent 's neck which caused the			Nurse #1 assessed resident #37 while	in	
		ırn purplish blue in color.			the bathroom with no injuries noted.		
		assessed at the facility and			A thorough investigation was initiated of		
	found to have no ph	nysical injuries.			8/1/2018 by the Administrator and Dire		
					of Nursing to identify the root cause of		
	L P. C. L	(D : 1 + # 07			failure of prevention of accident related		
	-	y for Resident # 37 began on			resident #37. During the investigation i	[
		e resident slipped while only			was found that the Director of Nursing		
		as transferring her using a staff failed to properly secure			failed to appropriately investigate the	\n	
		nsure she was wearing			incident after reading the documentation of the incident note in the clinical record		
		ne lift's straps slipped around			on 6/25/18 due to failure to flag the	-	
		causing the resident's face to			incident for follow up. The Director of		
		mmediate Jeopardy was			Nursing failed to assure re-assessmen	t of	
	1	8 when the facility provided an			resident #37 for a different method of li		
		allegation of Immediate			transfer to prevent accident since being	g .	
	-	The facility will remain out of			unable to stand on 6/23/18. It was also		
	compliance at a sco	ope and severity of D (not			determined by the Administrator that the	e	
		tential for more than minimal			Nursing assistant failed to follow the		
		mediate Jeopardy) to allow for			resident care guide for 2 person assist		
		g or monitoring to be			related to rushing to get the resident		
	accomplished.				dressed and out of bed before the fam	-	
					came to the room. Per interview with the	ie	
	The findings include	2 0:			nursing assistant on 8/2/18, nursing		
	A rovious of the re-	oufacturor's manual			assistant #1 stated she failed to pull the	3	
	A review of the mar	nufacturer's manual mechanical lift used at the			call bell cord and left the resident in a		
					compromising position in an attempt to		
		2013, included the following ion the mechanical lift and			get assistance faster. The Administrat determined that the Nursing Assistant	וט	
		the base, so that the patient's			failed to adhere to education that was		
	1 -	d on the footrest. The lower			provided regarding emergency lift		

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	NUIDONIO AND DELLA	DU ITATION OFNITED		22	25 WHITE STREET		
PREMIER	NURSING AND REHA	ABILITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 600	F 600 Continued From page 9		F 6	600			
F 600	legs (below the knower-leg on the lift vertical position of resistance just belot tighten the strap and Resident # 37 was diagnoses of Alzhe cerebrovascular dimuscle weakness, The quarterly Minit 5/23/2018, indicate had been severely extensive assistant mobility. Resident dependent with the transfers, dressing indicated Resident moving from a sea position and was of assistance. The M was not steady whand had only been assistance. The M had no trial of a toil been frequently included. Resident # 37's call indicated Resident mobility due to the term memory deficilimitations/non-ambalance during trail	ees) should be parallel to the t. Adjust the horizontal and the pad for comfortable by the kneecaps. Attach and round the lower legs." admitted on 11/12/2014 with simer 's disease, sease, dementia, generalized pain and abnormal posture. mum Data Set (MDS), dated and required and she had required and she had required and toileting. The MDS assistance of 2 staff for and toileting. The MDS assistance of 2 staff for and toileting. The MDS and toileting and she had required the position to a standing and pable to stabilize with staff and to stabilize with sta	F	600	procedures on 4/9/18. Nursing Assistant #1 was removed from the schedule on 8/1/18 by the Director Nursing pending an investigation of resident #37 incident. A 24 hour report was completed and sent to the Health Care Personnel Registry by the Administrator on 8/2/18. Corrective Actions On 8/01/18, interviews were initiated by the Social Workers with all alert and oriented residents with questions in regards to: 1. Has the facility failed to provide care 2. If yes please explain? The resident concern process was followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 10 of all residents to include resident #37 utilizing mechanical lifts was initiated by the Minimum Data Set (MDS) coordinated the resident's current mechanical use was the safest method of transfer. The audit was completed by 8/2/18. The MDS coordinator re-evaluated the resident care plan and care guide, and completed a therapy referral by 8/2/18 any identified areas of safety concerns	y y y y tor, e lift ne	
	stand lift) with aid	ers using mechanical lift (sit to of 2 persons, report to nurse oility to transfer safely and			observed during the audit. On 8/1/18, a questionnaire was initiate with 100% of all nurses and nursing	d	

		L IDENTIFICATION NUMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			D 11/11/0			С	
		345217	B. WING		08	3/03/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	NURSING AND REHAB	II ITATION CENTED		225 WHITE STREET			
PREMIER	NURSING AND REHAD	ILITATION CENTER		JACKSONVILLE, NC 28546			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 600	0 Continued From page 10		F 60	0			
	monitor for safety aw	areness		assistants by the Quality Impro	vement		
				(QI) nurse with questions regar			
	A review of Resident	#37's current Care Guide		Do you feel any resident tr	-		
		cated the following: the		method, to include type of mec			
		ivity of Daily Living (ADL)		needs to be changed?	,		
		person assist with toileting.		2. If yes, what resident and re	eason whv?		
		al lift (sit to stand lift; vest		This questionnaire was comple			
		on assist. The resident		8/2/18. The MDS coordinator re			
	required non-skid for			the resident transfer method, u	pdated the		
	•			resident care plan and care gui	ide, and		
	A review of a nurse's note, dated 6/23/2018 and			completed a therapy referral by	/ 8/2/18 for		
	written by Nurse # 1,	indicated Resident # 37		any identified areas of safety co	oncerns		
	exhibited difficulty sta	anding with a sit-to-stand lift		expressed during the questionr	naire. After		
	per staff interview; 3	staff members assisted		8/2/18, all nurses and nursing a	assistants		
		ne toilet when her feet		that have not completed the qu	estionnaire		
	slipped off mechanic			will not be allowed to work until	I the		
		y's incident log for Resident		questionnaire is completed.			
		ident report had been		On 8/1/18, return demonstratio			
	completed after the 6	6/23/2018 incident.		mechanical lift transfer was init			
				100% of all nurses and nursing			
	During an interview v			by the Staff Facilitator. The pur	•		
		RP) on 7/31/2018 at 2:00 PM,		return demonstrations are to er			
		6/23/2018 he came to visit		staff are checking the resident			
		und her almost "choked" on		for the correct number of perso			
		s straps. The RP indicated		for transfers and that the mech			
		stant (NA), NA #3, had been esident #37's room and		being utilized per manufacture			
				specifications during the transfer			
	assisted in getting he			8/2/18, all nurses and nursing a that have not completed the ref			
		et seat. The RP reported he about Resident #37's safety		demonstration will not be allow			
		ed on a mechanical lift. He		until the return demonstration is			
		staff did not follow the		completed.			
		d while using the mechanical		On 8/1/18 an audit of all reside	nt's		
		oticed on the day of the		incident reports to include resident			
		en transferred by one nurse		from 6/23/18 to 8/1/18 was initi			
		The RP further reported		MDS nurses and the treatment	-		
		of been wearing shoes or		ensure all incidents have been			
		e care guide and the strap		investigated to determine the re			
		s had not been applied.		and appropriate interventions in			

CENTER	S FOR MEDICARE &	WEDICAID SERVICES			OND NO. 0930-0	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345217	B. WING		08/03/2018	}
NAME OF PI	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 OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD BE COMPLE	TION
		,		DEFICIENCY)		
F 600	Continued From page	e 11	F 60	00		
				prevent further incidents. This ar	udit was	
	During an interview v	vith NA #1 on 8/1/2018 at		completed by 8/2/18. The QI nu	rse	
	10:00 AM, NA # 1 rep			investigated the incident, implen		
	assigned to work with	•		interventions, and updated the r		
	6/23/2018. She indic	cated before lunch, she had		care plan and care guide by 8/2	/18 for all	
	been transferring the	resident from the bed to the		identified areas of concern.		
	toilet with the sit-to-s	tand (mechanical lift) by		On 8/1/18 an audit of all residen	ťs	
	herself. NA #1 report	ed Resident #37 started to		progress notes to include reside	nt #37	
	slip from the lift befor	re getting on the toilet. NA#		from 6/23/18 to 8/1/18 was initia	ted by the	
		mber had arrived for a visit		QI nurse and the Registered Nu	rse (RN)	
	and found Resident #	#37 had slipped from the		supervisor to ensure that all doc	umented	
	mechanical lift. NA #	f1 stated the RP had started		incidents have an incident repor	t, was	
	1	from falling but had been		investigated to determine the ro	ot cause	
	I	sident from slipping and the		and appropriate interventions we		
		ught at the resident 's neck.		implemented to prevent further i		
		t Resident # 37 on the lift in		This audit was completed by 8/2		
		more help from another staff		QI nurse investigated the incide		
		en in another resident 's		implement interventions, and up		
	room at the end of th			resident care plan and care guid	-	
	,) # 1 also came by the		8/2/18 for all identified areas of o		
		but stood by the resident 's		On 8/01/18, an in-service was in		
	_	itional assistance to get the		100% of all staff to include nurse	· ·	
	I .	nanical lift. NA #1 stated prior and been in a panic to get		nursing assistants, housekeepin therapy, maintenance, payroll, b		
	I .	bathroom before the family '		keeper, social workers, was initial		
		dded the family of Resident		the Staff Facilitator regarding Ne	·	
		ident # 37 up in the mornings		include examples of neglect and	_	
	and she had no othe			prevention of neglect. This inser		
		Ided the day the resident had		completed by 8/02/18. After 8/2/		
	I .	ity had been short of staff		staff to include nurses, nursing a		
	I .	d anyone to assist her with		housekeeping, dietary, therapy,	,	
	I .	t # 37 on the mechanical lift.		maintenance, payroll, book keep	per, social	
		nt #37 is always "dancing"		workers that have not worked ar		
		ding) while being transferred		received the in-services was ma		
	1 -	t, making it a more difficult		in-service via certified mail by th	e Payroll	
	transfer.	_		Bookkeeper. Instructions include		
				inservice packet to read, sign the		
	During an interview v	vith NA #2 on 8/1/2018 at		inservice, call the Staff Facilitate		
	_	ated he came down to		Director of Nursing with any que	stions,	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				CIVID INC	7. U930 - U391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						1 (2
		345217	B. WING _				03/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00/2010
				22	25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
1110		,			DEFICIENCY)		
F 600	Continued From page		F 6	300			
		after he finished giving			and return the signed inservice to the		
		nt. He had been told he			Staff Facilitator or Director of Nursing p		
	•	lent # 37 who had been left			to next schedule shift. Staff were not b	е	
	dangling from the me				permitted to work until the signed		
		d arrived at Resident # 37's			inservices were received.		
	· ·	ticed the resident 's face			On 8/1/18 an in-service was initiated by	y	
		d the lift 's straps were by			the Staff Facilitator with 100% of all		
		NA # 2 reported he did not			nurses and nursing assistants regardin		
		ent # 37 's knees were			the safe handling and movement policy	/-	
	touching the floor or r			This in-service included reading the			
	happened so fast. He				resident care guide to identify the num		
		ed towards the front of her			of person required for resident transfer	,	
		after he had assisted the			reporting to the nurse when a transfer		
		position on the toilet the			method is no longer safe, lowering the	d=	
		er face returned to normal.			resident and not leaving the resident w		
		ident 's family member had			sliding in the lift and how to safely strap		
		had not assisted with getting			and transfer resident in the mechanica		
		echanical lift. NA #2 added			per the manufacture specifications. The		
		with getting Resident # 37 off			manufacture specification was printed	-	
	the lift. He indicated N				the Staff Facilitator and reviewed with		
	Resident # 37 after th				during the inservice. This in-service wa	ıS	
		echanical lift and had been			completed by 8/2/18. After 8/2/18, all		
	placed on the toilet.				nurses and nursing assistants that hav	е	
	.	''I BAA ''A O'A'OOAO A AO			not worked and/or not received the	.,	
	_	vith MA #1 on 8/1/2018 at 10:			in-services were mailed via certified ma	-	
	· ·	NA#1 had come out of			by the Payroll Bookkeeper. Instructions		
		and stated she needed			included in the inservice packet to read		
		he had entered Resident #			sign the inservice, call the Staff Facilita		
		oticed the resident had been			or Director of Nursing with any question	ns,	
		oped down with her feet off			and return the signed inservice to the		
	-	. MA # 1 indicated she had			Staff Facilitator or Director of Nursing p	rior	
	_	1 to get more help as the			to next schedule shift. Staff were not		
	-	stantly slipping. MA #1			permitted to work until the signed		
		s face had turned red in color			inservices were received.		
		lift. MA # 1 indicated the			The Administrator, Director of Nursing,		
	strap had slipped by	the resident 's neck.			and Quality Improvement nurse was in		
					serviced on the process of investigating	-	
		vith Nurse #1 on 8/1/2018 at			incidents on 8/1/18 by the Facility Nurs	e.	
	11:10 AM, Nurse # 1	stated she had been			Consultant. The in-service included to		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						,	c
		345217	B. WING				03/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	00/2010
				2:	25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER			ACKSONVILLE, NC 28546		
0401-	CLIMMADY CT	TATEMENT OF DEFICIENCIES			<u> </u>		0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 600	Continued From page	e 13	F	600			
	assigned to care for I	Resident #37 on 6/23/2018.			review the incident reports 5 days per		
	Nurse #1 stated NA #	# 1 reported to her they had			week, how to pull a report from the risk		
		ansfer of Resident #37 from			management portal in the electronic		
		sing the mechanical lift.			records to identify incidents that have		
		dent # 37 had slid off the lift			been documented by the nurses, printi	•	
		ed to use the leg straps and			the incident reports from the electronic		
	nonskid socks or sho				records, flagging the incident for follow	up,	
	resident to slip some from the lift. Nurse #1				reading progress notes to identify all		
	reported NA # 1 had been using the lift with no assistance. She further stated she had expected				incidents, discussing incidents in the	41	
		•			clinical morning meetings, determining		
		sked for assistance when dicated the lift required 2			root cause of the incident, completion of incident reports, and implementing and		
	-	tated the use of nonskid			monitoring interventions.	1	
	•	llways been required to			An inservice was completed with the		
		eet from slipping off the lift			Director of Nursing on 8/2/18 regarding	1	
		n used by NA # 1. Nurse #1			requirements for re -evaluating resider		
		elt the sit to stand lift was not			for change in transfer methods by the		
	appropriate for Resid				Facility Nurse Consultant.		
		sessed Resident #37 after			On 8/1/18 an in-service was initiated b	У	
	she had been transfe	erred to the toilet by the NA's			the Staff Facilitator with 100% of all		
	and stated she did no	ot notice any injury to			nurses regarding completion of incider	ıt	
	Resident #37. Nurse	# 1 indicated she did not			reports and collecting witness stateme	nts.	
	report the incident to	the physician or the Director			After 8/2/18, all nurses that have not		
		cause she did not think of			worked and/or not received the in-serv		
	'	on the mechanical lift as an			will be mailed the in-service via certifie	d	
		Nurse #1 stated in looking			mail by the Payroll Bookkeeper.		
		ppened to the resident, she			Instructions will be included in the		
	should have reported				inservice packet to read, sign the		
	physician, DON and	completed an incident report.			inservice, call the Staff Facilitator or		
	During on interview	ith the Dhysisian as			Director of Nursing with any questions,		
	During an interview w	•			and return the signed inservice to the	orior	
		1, the Physician indicated he ware of Resident #37's			Staff Facilitator or Director of Nursing parts to next schedule shift. Staff will not be	лЮ	
		3. The physician indicated his			permitted to work until the signed		
		ive been for the facility staff			inservices are received.		
		of the incident emphasizing			The decision to monitor the system for		
		ent had turned purple blue			prevention of accidents was made on		
	during the incident.	on the tarrior parpio blue			8/1/2018 by the Administrator and Dire	ctor	
			1				

of Nursing. The RN Supervisor, the Staff

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 BOILES			، ا	2
		345217	B. WING				03/2018
NAME OF PI	ROVIDER OR SUPPLIER	<u>I</u>	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	. 00/	03/2010
					25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		J	ACKSONVILLE, NC 28546		
(V4) ID	QUIMMADV ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 14	F	600			
	During an interview w	vith the MDS nurse on			Facilitator, Treatment nurse, Unit		
	8/2/2018 at 9:30 AM,	the MDS nurse reported			Facilitator and/or the QI nurses, will au	ıdit	
	Resident #37 had his	story of being unstable while			10% of all residents requiring mechanic	cal	
	being transferred on	a sit to stand lift because her			lifts for transfers to include resident #37	' to	
		ng (both of knees give out).			ensure staff are checking the resident		
		ed the family had insisted on			care guide and utilizing the number of		
		tand lift even though the staff			person identified on the care guide, sta	ff	
	-	en aware it had not been			are utilizing the mechanical lift per		
	appropriate for Resid	lent # 37.			manufacture specification during the		
					transfer, and ensure the current lift is the		
		n of a mechanical lift transfer			safest method of transfer 3 x a week for		
		10:30 AM, Resident # 37's			four weeks, then weekly for x 4 weeks,		
		vith the instructions given her			then monthly x 1 month utilizing a Lift	orn	
		e mechanical lift 's sling bar. een noticed to be unsteady			Transfer Audit Tool. Any areas of conc will be immediately addressed by the R		
	while standing on the				Supervisor, the Staff Facilitator, the Un		
	write standing on the	, iiit.			Facilitator and/or the QI nurses to inclu		
	During an interview w	vith NA #4 on 8/2/2018 at			staff retraining. The Director of Nursing		
		orted Resident #37 had			will review and initial the Lift Transfer A	•	
	· ·	on the lift but she had been			Tools weekly x 8 weeks then monthly x		
	transferred using the	sit to stand lift for a long			month.		
		d Resident # 37 had usually			The RN Supervisor, the Staff Facilitato	۲,	
	been assisted to the	toilet before breakfast and			Treatment nurse, Unit Facilitator and/o	ſ	
	lunch.				the QI nurses will review all incidents		
					reports and progress notes 3 x a week	for	
		with the Staff Development			4 weeks, then weekly for x 4 weeks, th		
		n 8/2/2018 at 11:30 AM, the			monthly x 1 month utilizing the Incident		
		eported to her, during the			Audit Tool to ensure all identified incide	nts	
		tion of the incident involving			have been thoroughly investigated,		
	· ·	he had been asked to assist			incidents reports completed, and		
		n 6/23/2018, she had seen			appropriate interventions implemented	เบ	
		rned purple blue and the			prevent further accidents. The RN		
	dangled on the mech	ged on her neck while she			Supervisor, the Staff Facilitator, Treatment nurse, Unit Facilitator and/o	r	
	_	ought a supervisor had			the QI nurses will investigate the incide		
		lent after it happened on			implement interventions, and provide	111,	
	_	d overheard a conversation			retraining for all identified areas of		
		ound the time it happened.			concern during the audit. The Director	of	
		I not recall the exact date or			Nursing will review and initial the Incide		

	ND DLAN OF CORRECTION \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		' '	X3) DATE SURVEY COMPLETED		
7.1.12 . 27.1.1 0.	00111.2011011	.52	A. BUILDING	G		
		345217	B. WING			C 08/03/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		30,00,20,10
				225 WHITE STREET		
PREMIER	NURSING AND REHAB	ILITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETION DATE
F 600	Continued From pag	e 15	F 60	00		
	the name of the supe	ervisor. The SDC stated she		Audit Tool weekly x 8 weeks	then monthly	
	had not been the SD	C at the time of Resident #		x 1 month.		
	37 's mechanical 's	lift accident.		The Quality Improvement Or	rganization	
				was contacted by the Direct	or of Nursing	
		with the DON on 8/2/2018 at		on 8/02/18 for assistance in	evaluation of	
	'	reported she had not been		specific steps to be taken to		
	aware of Resident #37's incident of 6/23/2018			neglect and prevention of ac		
	when the resident had slipped off the lift. The			training, staff position/title de	-	
	DON indicated her expectation of nursing staff would have been to have completed an incident			be responsible for the steps,		
				accomplishment of the steps	· •	
	report so she could have started an in-service training on the proper use of a mechanical lift.			methodology to be used to e plan's success, and frequen		
	training on the prope	use of a mechanical lift.		monitoring the effects of the	•	
	During an interview v	with the Administrator on		The DON will present the fin		
	_	M, the Administrator reported		Lift Transfer Audit Tools and	-	
		about the incident of Resident		Audit Tools to the Executive		
	#37's slip off the med			Assurance (QA) committee i		
	-	his expectation would have		months. The Executive QA (
	been for the staff to h	nave reported the accident to		meet monthly for 3 months a	and review the	
	the DON immediately	y so they could have begun		Lift Transfer Audit Tools and	the Incident	
	an in-service on the	proper use of the mechanical		Audit Tools to determine trer	nds and/or	
	lift.			issues that may need further		
				put into place and to determ		
		irector of Nursing and Facility		for further frequency of moni	-	
	's nurse consultant v			decision to review the monito	-	
	Immediate Jeopardy	on 8/1/2018 at 4:30 pm.		prevention of accidents during		
	O- 0/0/0040 # f:			assurance committee meetin	-	
		lity provided an acceptable		by the Administrator and Dire	ector of	
	removal that include	r immediate jeopardy		Nursing on 8/01/2018.		
	Terrioval triat iricitude	a the following.		The Administrator and DON	was	
	Corrective Actions			responsible for the implement		
		s were initiated by the Social		corrective actions to include		
		t and oriented residents.		audits, in services, and mon		
		n process will be followed by		to the plan of correction.	J 212.22 2	
		d Administrator for all				
identified areas of concern by 8/2/18.						
	On 8/1/18, a transfer	observation of 100% of all				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345217	B. WING		C 08/03/2018	
	ROVIDER OR SUPPLIER NURSING AND REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	residents to include remechanical lifts was in Data Set (MDS) coordinators to ensure that the remechanical lift use is transfer. The audit will transfer method, updated and care guide, and coordinators of all nurses are Quality Improvement questionnaire will be MDS coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method, updated and care guide, and coordinator will transfer method work uncompleted. On 8/1/18, return dendiff transfer was initiated and nursing assistant that staff are concerned to the correct of transfers and that utilized per manufaction transfer. After, 8/2/18 assistants that have resident in the purpose of the concerned to the correct of transfers. After, 8/2/18 assistants that have resident in the purpose of the concerned to the correct of transfers. After, 8/2/18 assistants that have resident in the purpose of the concerned to the correct of the correct	esident # 37 utilizing nitiated by the Minimum dinator, MDS nurses and e purpose of the observation esident 's current the safest method of Il be completed by 8/2/18. If will re-evaluate the resident ate the resident care plan complete a therapy referral ntified areas of safety uring the audit. In maire was initiated with and nursing assistants by the (QI) nurse. This completed by 8/2/18. The re-evaluate the resident ate the resident care plan complete a therapy referral ntified areas of safety during the questionnaire. The sand nursing assistants ted the questionnaire will not not the questionnaire will not not the questionnaire is monstrations of mechanical ed with 100% of all nurses as by the Staff Facilitator. The properties of person to utilize the mechanical lift is being the specifications during the and nurses and nursing the completed the return to be allowed to work until the	F 600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345217	B. WING			C 08/03/2018
	ROVIDER OR SUPPLIER NURSING AND REHA		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		00/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	reports to include re 8/1/18 was initiated treatment nurse to thoroughly investigated cause and appropri prevent further incide completed by 8/2/1	of all resident 's incident esident # 37 from 6/23/18 to by the MDS nurses and the ensure all incidents have been ated to determine the root tate interventions initiated to dents. This audit will be 8. The QI nurse will investigate	F 60	00		
	the resident care pl for all identified are On 8/1/18 an audit notes to include res 8/1/18 was initiated Registered Nurse (all documented inci was investigated to appropriate intervel prevent further incid completed by 8/2/1 the incident, implent the resident care pl for all identified are	of all resident 's progress sident # 37 from 6/23/18 to by the QI nurse and the RN) supervisor to ensure that dents have an incident report, determine the root cause and nations were implemented to dents. This audit will be 8. The QI nurse will investigate ment interventions, and update an and care guide by 8/2/18 as of concern.				
	of all staff to include housekeeping, diet roll, book keeper, s the Staff Facilitator examples of neglectory this in-service was 8/2/18, all staff to in assistants, houseked maintenance, pay reworkers that have rethe in-services will	ervice was initiated for 100% enurses, nursing assistants, ary, therapy, maintenance, pay ocial workers, was initiated by regarding Neglect to include at and prevention of neglect. completed by 8/02/18. After include nurses, nursing deping, dietary, therapy, oll, book keeper, social not worked and/or not received be mailed the in-service via Payroll Bookkeeper.				

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '			(X3) DATE SURVEY COMPLETED		
		345217	B. WING				C 03/2018	
NAME OF P	ROVIDER OR SUPPLIER	I		S1	FREET 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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	packet to read, sign t Facilitator or Director questions, and return Staff Facilitator or Dir schedule shift. Staff v until the signed in ser On 8/1/18 an in-servi	cluded in the in-service he in-service, call the Staff of Nursing with any the signed in-service to the ector of Nursing prior to next vill not be permitted to work	F	600				
	assistants regarding a movement policy. This reading the resident of number of person recording to the nurse no longer safe, lower leaving the resident whow to safely strap as mechanical lift per the specifications. The molecular be printed by the Stat with staff during the inbe completed by 8/2/and nursing assistant and/or not received the via certified mail by the Instructions will be incompacket to read, sign the Facilitator or Director questions, and return Staff Facilitator or Director schedule shift. Staff wuntil the signed in ser The Administrator, Director Quality Improvement the process of investi	the safe handling and is in-service included care guide to identify the puired for resident transfer, when a transfer method is ing the resident and not when sliding in the lift and indictant transfer resident in the emanufacture anufacture specification will if Facilitator and reviewed in-service. This in-service will as. After 8/2/18, all nurses is that have not worked in ein-services will be mailed in e Payroll Bookkeeper. Cluded in the in-service he in-service, call the Staff of Nursing with any the signed in-service to the ector of Nursing prior to next will not be permitted to work vices are received.						
	the Facility Nurse Co	gating incidents on 8/1/18 by nsultant. The in-service e incident reports 5 days per						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345217	B. WING_			C 08/03/2018	
	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	identify incidents that the nurses, printing electronic records, fup, reading progress incidents, discussin morning meetings, of the incident, completing and incident, completing and incident, completing and incident methods by the Factor of a completion of incident with a since worked and will be mailed the inthe Payroll Bookkes included in the inservice, call the Solution of incident included in the inservice, call the Solution of incident included in the inservice, call the Solution of incident in the Payroll Bookkes included in the inservice, call the Solution of incident in the Payroll Bookkes included in the inservice, call the Solution of the State Nursing with any quinservice to the State Nursing prior to next be permitted to work are received. The decision to more of accidents was maddinistrator and Expervisor, the State Unit Facilitator and 10% of all residents		F	500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345217	B. WING _			C 8/03/2018
	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		0/00/2010
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F 600	staff are utilizing the manufacture specific ensure the current I transfer 3 x a week for x 4 weeks, then Lift Transfer Audit To be immediately add the Staff Facilitator, QI nurses to include of Nursing will revie Audit Tools weekly amonth. The Registered Nur Facilitator, Treatme and/or the QI nurse reports and progres weeks, then weekly 1 month utilizing the all identified inciden investigated, inciden appropriate interver further accidents. The Facilitator, Treatme and/or the QI nurse implement intervent	on identified on the care guide,	F	500		
	Incident Audit Tool very monthly x 1 month. The Quality Improve contacted by the Difor assistance in every taken to address neaccidents and training designated to be re-	ement Organization will be rector of Nursing on 8/02/18 aluation of specific steps to be reglect and prevention of ng, staff position/title sponsible for the steps, lishment of the steps, specific				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345217	B. WING _			C 8/03/2018
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		0.00.2010
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F 600	Continued From pa	ge 21	F 6	00		
	, ,,	used to evaluate the plan's ency of monitoring the effects				
	Transfer Audit Tools to the Executive Que committee monthly QA Committee will and review the Lift Incident Audit Tools issues that may need into place and to defrequency of monitor the monitoring of presenting on 8/01/20. Final date of compliant The Administrator as for the implementation include all 100% audit monitoring related to the Credible Allegaremoval was validated removed the Immediation validation process in ursing staff presenting of the proper Reviews of the in-seaudits performed ar					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WING		C 08/03/2018	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546	1 00,00,20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 COMPLETION	
F 656 F 656 SS=D	CFR(s): 483.21(b)(1 §483.21(b) Compreh §483.21(b)(1) The faimplement a compre care plan for each reresident rights set fo §483.10(c)(3), that in objectives and timefinedical, nursing, anneeds that are identifus assessment. The condescribe the following (i) The services that or maintain the residing physical, mental, and required under §483.24, §483 provided due to the runder §483.10, inclustreatment under §48 (iii) Any specialized serenabilitative service provide as a result or recommendations. If findings of the PASA	comprehensive Care Plan densive Care Plans cility must develop and hensive person-centered esident, consistent with the rth at §483.10(c)(2) and collides measurable rames to meet a resident's did mental and psychosocial fied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable did psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required decented by the services of rights ding the right to refuse 3.10(c)(6). dervices or specialized services or specialized services or speciality will final part of the part of	F 65	6	8/15/18	
	resident's representa (A) The resident's go desired outcomes. (B) The resident's pr future discharge. Far whether the resident community was asse	th the resident and the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(×	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 225 WHITE STREET JACKSONVILLE, NC 28546	E	00.00.00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From page entities, for this purp		F 6	56			
	plan, as appropriate, requirements set for section. This REQUIREMEN by: Based on record restaff interviews, the care plan and care guse of 2 person assisthe use of mechanic use of nonskid footwaresidents (Resident: The findings Include Resident # 37 was adiagnoses of Alzheir cerebrovascular disemuscle weakness, partice weakness, parti	in accordance with the th in paragraph (c) of this T is not met as evidenced views, family interview and facility failed to implement uide interventions indicating stance while transferring with all lift (sit to stand) and the rear for 1 of 5 sampled # 37) d: dmitted on 11/12/2014 with ner's disease, ease, dementia, generalized ain and abnormal posture. The paragraph of the		F656 100% audit was initiated on 8. residents to include resident # observation for method of trar include mechanical lifts, will b to ensure the care plan is following include the number of requiremeded to transfer the resider Director of Therapy and three Data Set Nurses. Retraining conducted during the audit by of Therapy and three Minimur Nurses with assigned nursing and licensed nurse for any ideof concern. An in-service for 100% of all linurses and nursing assistants initiated on 7/31/2018 by the Seculitator regarding following plan/care guide to include the required staff needed to transfer the regarding following the care puside to include the number of staff needed to transfer the rewill be completed by 8/2/2018 10% of residents to include recon observation for method of include mechanical lifts, will be to ensure the care plan is following mechanical lifts, will be to ensure the care plan is followed.	#37 on insfers, to be reviewed to distaff int, by the inside Minimum will be a the Director Data Set assistant entified area icense icense in the care in number of fer the sed nurses in-serviced if Facilitator plan/care of required esident, and its esident #37 transfers, to be reviewed	or as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345217	B. WING _			08	3/03/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				22	25 WHITE STREET			
PREMIER	NURSING AND REH	IABILITATION CENTER		J	ACKSONVILLE, NC 28546			
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 656	Continued From p	page 24	F	656				
	term memory defi	icits, physical			include the number of required staff			
		nbulatory, weakness, unsteady			needed to transfer the resident utilizing	ga		
	balance during tra	ansitions." The interventions			care plan audit tool by the RN Supervi	sor,		
	included the follow	wing: monitor for safety			the Staff Facilitator and/or QI nurses			
	awareness, trans	fers using mechanical lift (sit to			weekly times 8 weeks then monthly tin	nes		
		of 2 persons, report to nurse			1 month. The nursing assistant and			
	1	ability to transfer safely and			licensed nurse will be reeducated by the			
	monitor for safety	awareness.			RN Supervisor, the Staff Facilitator an	d/or		
					QI nurses for any identified areas of	_		
		ent #37's Care Guide, updated			concern during the audit. The Director			
		dicated the following: the			Nursing will review and initial the Care			
	· ·	Activity of Daily Living (ADL)			plan audit tool weekly for 8 weeks then			
		2 person assist with toileting. Inical lift (sit to stand lift; vest			monthly for 1 month for completion an ensure all areas of concern were	u to		
		erson assist. The resident			addressed.			
	required non-skid				The Executive QI committee will meet			
	Toquired from onta	nootwodi.			monthly and review the Care plan aud			
	A review of a nurs	se's note, dated 6/23/2018,			tool and address any issues, concerns			
		nt # 37 exhibited difficulty			and\or trends and to make changes as			
	standing with a si	t-to-stand lift per staff interview;			needed, to include continued frequenc			
	3 staff members a	assisted Resident # 37 onto the			monitoring for 3 months.			
	toilet when feet sl	ipped off mechanical lift.			The Administrator and the DON will be	;		
					responsible for the implementation of			
	_	ew with Resident #37's			corrective actions to include all 100%			
		y (RP) on 7/31/2018 at 2:00 PM,			audits, in services, and monitoring rela	ited		
		on 6/23/2018 he came to visit			to the plan of correction.			
		I found her almost "choked" on						
		fft's straps. The RP indicated						
	_	ssistant (NA), NA #3, had been						
		Resident #37's room and						
		g her safely down to the						
		toilet seat. The RP reported he ned about Resident #37's safety						
		ferred on a mechanical lift. He						
		the staff did not follow the						
		uired while using the mechanical						
		ad noticed on the day of the						
		been transferred by one nurse						
		o. The RP further reported						

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		345217	B. WING _			C 98/03/2018	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 225 WHITE STREET JACKSONVILLE, NC 28546	•	0/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	nonskid socks per th	ge 25 of been wearing shoes or ne care guide and the strap gs had not been applied.	F	556			
	10:00 AM, NA # 1 re assigned to work wi 6/23/2018. She indibeen transferring the toilet with the sit-to-sherself. NA #1 reports lip from the lift beforms 1 stated a family meand found Resident mechanical lift. NA to assist to keep her unable to stop the restrap from getting cannot not strap from getting c	with NA #1 on 8/1/2018 at exported she had been the Resident # 37 on cated before lunch, she had a resident from the bed to the stand (mechanical lift) by ted Resident #37 started to be getting on the toilet. NA# of the mber had arrived for a visit #37 had slipped from the #1 stated the RP had started of from falling but had been esident from slipping and the aught at the resident 's neck. If the Resident #37 on the lift in more help from another staff the en in another resident 's neck hall. NA #1 stated					
	resident's bathroom room waiting for add resident off the med to the incident she had no the visit. She further ad #37 had wanted Reand she had no other assistance. NA #1 at the accident the fact and she could not fit transferring Resider NA #1 stated Reside (unsteady while star	A) # 1 also came by the but stood by the resident 's litional assistance to get the hanical lift. NA #1 stated prior ad been in a panic to get bathroom before the family's ded the family of Resident sident # 37 up in the mornings or person to ask for dded the day the resident had lity had been short of staff and anyone to assist her with at # 37 on the mechanical lift. ent #37 is always "dancing" ading) while being transferred ft, making it a more difficult					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING _			08/0) 3/2018	
	OVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 225 WHITE STREET JACKSONVILLE, NC 28546	DE	,		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
t	10:20 AM, NA # 2 sta Resident # 37's room care to another patier needed to help Resid dangling from the me indicated once he had bathroom, he had not was purplish blue and resident 's neck. NA recall whether Reside touching the floor or reappened so fast. He resident head was tilt body. NA # 2 stated a resident to a seated president 's color in he NA # 2 stated the resident in the room but the resident off the m NA # 1 assisted him with the lift. He indicated in Resident # 37 after the removed from the me placed on the toilet. During an interview with the sident was a difficulty during the track the bed to the toilet under the staff failed honskid socks or sho resident to slip some	with NA #2 on 8/1/2018 at ted he came down to after he finished giving ht. He had been told he ent # 37 who had been left chanical lift. NA #2 di arrived at Resident # 37's iced the resident 's face if the lift's straps were by the #2 reported he did not ent # 37's knees were not because everything had further indicated the ed towards the front of her effect returned to normal. Ident 's family member had had not assisted with getting echanical lift. NA #2 added with getting Resident # 37 off furse # 1 assessed he resident had been chanical lift and had been resident #37 on 6/23/2018. It is tated she had been Resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018. It is tated she had been resident #37 on 6/23/2018.	F6	56				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (225 WHITE STREET JACKSONVILLE, NC 28546	•	0/03/2010		
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F 656	the NA # 1 to have using the lift. She persons. Nurse # socks or shoes had prevent residents but they had not be stated she had also appropriate for Resident #37. Nur report the incident of Nursing (DON) Resident # 37 's an incident or accolooking back at we resident, she shouthe physician, DO report. During an intervied 12:30 PM, the DO aware of Resident when the resident DON indicated he would have been report so she coutraining on the proshe also stated he to follow the care. During an intervied 8/2/2018 at 12:40 he had just learned #37's slip off the red Administrator states.	auther stated she had expected a sked for assistance when a indicated the lift required 2 1 stated the use of nonskid ad always been required to ' feet from slipping off the lift been used by NA # 1. Nurse #1 so felt the sit to stand lift was not esident # 37. Nurse # 1 assessed Resident #37 after asserted to the toilet by the NA's donot notice any injury to urse # 1 indicated she did not at to the physician or the Director because she did not think of slip on the mechanical lift as ident. Nurse #1 stated in that had happened to the full have reported the incident to the N and completed an incident when with the DON on 8/2/2018 at the N reported she had not been at #37's incident of 6/23/2018 at the N reported she had not been at #37's incident of 6/23/2018 at the N reported she had not been at the N reported	F	656				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345217	B. WING _		C 08/03/2018		
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(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 656 F 689 SS=J	the DON immediately an in-service on the p lift. He indicated his e to follow the care plan Free of Accident Haz	r so they could have begun proper use of the mechanical expectation was for the staff n. ards/Supervision/Devices	F 6		8/15/18		
	as free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on record revinterview, physician in the facility failed to at mechanical lift's leg sper manufacturer's guimplement care plan interventions indicatir assistance while transmechanical lift (sit to the resident had on n sampled residents received mechanical lift which slip around the resident #37 slipped mechanical lift which slip around the resident #37 was as found to have no phy Immediate Jeopardy 6/23/2018 when the resident was as found to have no phy	sident environment remains sizards as is possible; and estance devices to prevent is not met as evidenced iews, observations, family neterview and staff interviews, tach and tighten the traps around the lower legs sidelines and failed to and care guide and use of 2 person eferring with the use of stand) and failed to ensure on-skid footwear for 1 of 5 viewed for accidents. during a transfer from the allowed the lift's straps to ent's neck which caused the purplish blue in color.		F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) On 6/23/18 on 7-3 shift Nursing A (NA) #1 was transferring resident the sit to stand lift with one perso from the chair to the bathroom. R #37 started to slip while in the sit lift. NA #1 retrieved assistance from NA #3 to transfer resident #3 slipping while in the sit to stand lift Resident #37 was noted purplish the face during transfer. Nurse #1 assessed resident #37 the bathroom with no injuries not A thorough investigation was initi 8/1/2018 by the Administrator and of Nursing to identify the root cau failure of prevention of accident r resident #37. During the investigation	t #37 with on assist Resident to stand om NA #2 87 due to fft. blue in while in ed. iated on d Director use of the related to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING				C (03/2048	
NAME OF DE	ROVIDER OR SUPPLIER	0.40217		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	/03/2018	
NAME OF T	COVIDEIX OIX 301 1 EIEIX				25 WHITE STREET			
PREMIER	NURSING AND REHAE	BILITATION CENTER						
				J	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	ge 29	F	689				
	mechanical lift and s	staff failed to properly secure			was found that the Director of Nursing			
		sure she was wearing			failed to appropriately investigate the			
		e lift 's straps slipped around			incident after reading the documentation	on		
		causing the resident 's face			of the incident note in the clinical recor			
		. Immediate Jeopardy was			on 6/25/18 due to failure to flag the			
	remove on 8/2/2018	when the facility provided an			incident for follow up. The Director of			
	acceptable credible	allegation of Immediate			Nursing failed to assure re-assessmen	t of		
	Jeopardy removal. T	The facility will remain out of			resident #37 for a different method of I	ft		
	-	pe and severity of D (not			transfer to prevent accident since being	3		
	•	ential for more than minimal			unable to stand on 6/23/18. It was also			
		nediate Jeopardy) to allow for			determined by the Administrator that the	e		
	ongoing in- servicing	g or monitoring to be			Nursing assistant failed to follow the			
	accomplished.				resident care guide for 2 person assist			
	TI 6 1 1 1				related to rushing to get the resident	.,		
	The findings include	a:			dressed and out of bed before the fam	-		
	A review of the man	ufacturar' a manual			came to the room. Per interview with the	ie		
		nechanical lift used at the			nursing assistant on 8/2/18, nursing	_		
		013, included the following			assistant #1 stated she failed to pull th call bell cord and left the resident in a	5		
		on the mechanical lift and			compromising position in an attempt to			
		ne base, so that the patient's			get assistance faster. The Administrat			
	•	on the footrest. The lower			determined that the Nursing Assistant	J.		
		es) should be parallel to the			failed to adhere to education that was			
	-	Adjust the horizontal and			provided regarding emergency lift			
	~	ne pad for comfortable			procedures on 4/9/18.			
	resistance just below	v the kneecaps. Attach and			Nursing Assistant #1 was removed from	n		
	tighten the strap aro	und the lower legs."			the schedule on 8/1/18 by the Director	of		
					Nursing pending an investigation of			
	Resident # 37 was a	admitted on 11/12/2014 with			resident #37 incident. A 24 hour report			
	diagnoses of Alzheir				was completed and sent to the Health			
		ease, dementia, generalized			Care Personnel Registry by the			
	muscle weakness, p	pain and abnormal posture.			Administrator on 8/2/18.			
					Corrective Actions			
		um Data Set (MDS), dated			On 8/01/18, interviews were initiated b	y		
		Resident # 37's cognition			the Social Workers with all alert and			
	had been severely impaired and she had required				oriented residents with questions in			
		e of one person for bed			regards to:			
	mobility. Resident #				A 11 4 5- 39 6 3 11	•		
	dependent with the	assistance of 2 staff for			Has the facility failed to provide care	?		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(C	
		345217	B. WING _			08/	03/2018	
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	NURSING AND REHAE	RII ITATION CENTER		225 WHITE STREET				
PREMIER	NORSING AND REHAL	SILITATION CENTER		J	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From pag	ge 30	F	689				
		and toileting. The MDS			2. If yes please explain?			
		#37 was not steady when			2. If yes please explain:			
		ed position to a standing			The resident concern process was			
		ly able to stabilize with staff			followed by the social worker and			
	·	OS indicated Resident #37			Administrator for all identified areas of			
		n moving on and off the toilet			concern by 8/2/18.			
		able to stabilize with staff			•			
	assistance. The MD	OS indicated Resident #37			On 8/1/18, a transfer observation of 10	0%		
		eting program and she had			of all residents to include resident #37			
		ontinent of her bowels and			utilizing mechanical lifts was initiated by			
	bladder.				the Minimum Data Set (MDS) coordina			
	Resident # 37's care plan, dated 5/23/2018 purpose		MDS nurses and therapy manager. The					
					purpose of the observation is to ensure			
		# 37 required "assistance for			that the resident's current mechanical I	π		
	term memory deficit	aging process, short and long			use was the safest method of transfer. The audit was completed by 8/2/18. The	0		
	_	ulatory, weakness, unsteady			MDS coordinator re-evaluated the	C		
		sitions." The interventions			resident transfer method, updated the			
		ng: monitor for safety			resident care plan and care guide, and			
		s using mechanical lift (sit to			completed a therapy referral by 8/2/18	for		
		2 persons, report to nurse			any identified areas of safety concerns			
		lity to transfer safely and			observed during the audit.			
	monitor for safety av	wareness			On 8/1/18, a questionnaire was initiated	b		
					with 100% of all nurses and nursing			
	A review of Residen	t #37's current Care Guide			assistants by the Quality Improvement			
		licated the following: the			(QI) nurse with questions regarding:			
	•	ctivity of Daily Living (ADL)			Do you feel any resident transfer			
		person assist with toileting.			method, to include type of mechanical	ift,		
		cal lift (sit to stand lift; vest			needs to be changed?	h0		
		on assist. The resident			2. If yes, what resident and reason w	ily :		
	required non-skid fo	olweai.			This questionnaire was completed by 8/2/18. The MDS coordinator re-evalua	ted		
	A review of a nurse!	s note, dated 6/23/2018 and			the resident transfer method, updated t			
		, indicated Resident # 37			resident care plan and care guide, and			
		tanding with a sit-to-stand lift			completed a therapy referral by 8/2/18	for		
	•	3 staff members assisted			any identified areas of safety concerns			
				expressed during the questionnaire. Af	ter			
	slipped off mechanic				8/2/18, all nurses and nursing assistant			
					that have not completed the questionna			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		PLETED
		345217	B. WING _				C /03/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				22	25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued Francisco	- 04					
F 689	Continued From page		F 6	689			
		's incident log for Resident			will not be allowed to work until the		
	# 37 revealed no incid	•			questionnaire is completed.		
	completed after the 6	/23/2018 incident.			On 8/1/18, return demonstrations of		
					mechanical lift transfer was initiated wi		
	During an interview w				100% of all nurses and nursing assista		
		P) on 7/31/2018 at 2:00 PM,			by the Staff Facilitator. The purpose of		
	<u>'</u>	6/23/2018 he came to visit			return demonstrations are to ensure the		
		ind her almost "choked" on			staff are checking the resident care gu for the correct number of person to util		
		straps. The RP indicated stant (NA), NA #3, had been			for transfers and that the mechanical li		
	_	sident #37's room and			being utilized per manufacture	11.15	
	assisted in getting he				specifications during the transfer. After	•	
		et seat. The RP reported he			8/2/18, all nurses and nursing assistan		
		about Resident #37 ' s			that have not completed the return	10	
		nsferred on a mechanical			demonstration will not be allowed to we	ork	
		ed the staff did not follow the			until the return demonstration is		
		d while using the mechanical			completed.		
	-	oticed on the day of the			On 8/1/18 an audit of all resident's		
		n transferred by one nurse			incident reports to include resident #37	•	
	aide instead of two. T	he RP further reported			from 6/23/18 to 8/1/18 was initiated by	the	
	Resident #37 had not	been wearing shoes or			MDS nurses and the treatment nurse t	0	
	nonskid socks per the	e care guide and the strap			ensure all incidents have been thoroug	ıhly	
	around the lower legs	s had not been applied.			investigated to determine the root caus	se	
					and appropriate interventions initiated	to	
] . 5	vith NA #1 on 8/1/2018 at			prevent further incidents. This audit wa	IS	
	10:00 AM, NA # 1 rep				completed by 8/2/18. The QI nurse		
	assigned to work with				investigated the incident, implement		
		ated before lunch, she had			interventions, and updated the residen		
		resident from the bed to the			care plan and care guide by 8/2/18 for	all	
		and (mechanical lift) by			identified areas of concern.		
		ed Resident #37 started to			On 8/1/18 an audit of all resident's		
		e getting on the toilet. NA#			progress notes to include resident #37		
		nber had arrived for a visit			from 6/23/18 to 8/1/18 was initiated by		
		37 had slipped from the			QI nurse and the Registered Nurse (RI		
		1 stated the RP had started			supervisor to ensure that all document	eu	
		from falling but had been			incidents have an incident report, was	••	
	-	sident from slipping and the ught at the resident's neck.			investigated to determine the root cause and appropriate interventions were	-C	
		Resident # 37 on the lift in			implemented to prevent further inciden	ts	
			1	- 1	implemented to prevent further filefacil	ω.	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _		١ ,		
		345217	B. WING				03/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDEMIED	NUDCING AND DELIADI	LITATION CENTED	225 WHITE STREET					
PREMIER	NURSING AND REHABI	LITATION CENTER		J	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	member who had bee	e 32 nore help from another staff en in another resident's room NA #1 stated Medication	F	689	This audit was completed by 8/2/18. The QI nurse investigated the incident, implement interventions, and updated the second control of the co			
	waiting for additional resident off the mech to the incident she ha Resident # 37 to the s visit. She further ad	y the resident 's room			resident care plan and care guide by 8/2/18 for all identified areas of concerr On 8/01/18, an in-service was initiated 100% of all staff to include nurses, nursing assistants, housekeeping, dieta therapy, maintenance, payroll, book keeper, social workers, was initiated by the Staff Facilitator regarding Neglect to	n. for ary,		
	the accident the facili and she could not fine transferring Resident NA #1 stated Resider (unsteady while stand	r person to ask for ded the day the resident had ty had been short of staff d anyone to assist her with # 37 on the mechanical lift. Int #37 is always "dancing" ding) while being transferred to making it a more difficult			include examples of neglect and prevention of neglect. This inservice was completed by 8/02/18. After 8/2/18, all staff to include nurses, nursing assistant housekeeping, dietary, therapy, maintenance, payroll, book keeper, soo workers that have not worked and/or not received the in-services was mailed the in-service via certified mail by the Payron.	nts, sial ot e		
	10:20 AM, NA # 2 sta Resident # 37's room care to another patiel needed to help Resid dangling from the me indicated once he had bathroom, he had no was purplish blue and	with NA #2 on 8/1/2018 at steed he came down to after he finished giving ont. He had been told he lent # 37 who had been left schanical lift. NA #2 d arrived at Resident # 37 's ticed the resident 's face d the lift 's straps were by NA # 2 reported he did not			Bookkeeper. Instructions included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing permitted to work until the signed inservices were received. On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all	rior e		
	recall whether Reside touching the floor or in happened so fast. He resident head was till body. NA # 2 stated a resident to a seated president 's color in he	ent # 37 's knees were not because everything had			nurses and nursing assistants regardin the safe handling and movement policy. This in-service included reading the resident care guide to identify the number of person required for resident transfer reporting to the nurse when a transfer method is no longer safe, lowering the resident and not leaving the resident w	oer		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			c l	
		345217	B. WING			1	/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				22	25 WHITE STREET			
PREMIER	NURSING AND REH	ABILITATION CENTER		J	ACKSONVILLE, NC 28546			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 689	Continued From p	page 33	F	689				
		but had not assisted with getting			sliding in the lift and how to safely stra	-		
		e mechanical lift. NA #2 added			and transfer resident in the mechanica			
		im with getting Resident # 37 off			per the manufacture specifications. The			
		ed Nurse # 1 assessed			manufacture specification was printed			
		er the resident had been			the Staff Facilitator and reviewed with			
		mechanical lift and had been			during the inservice. This in-service wa	as		
	placed on the toile	et.			completed by 8/2/18. After 8/2/18, all			
	, .	*** *** *** ***			nurses and nursing assistants that have	re		
		w with MA #1 on 8/1/2018 at 10:			not worked and/or not received the	. "1		
	· ·	ated NA # 1 had come out of			in-services were mailed via certified m			
		oom and stated she needed			by the Payroll Bookkeeper. Instruction			
	•	ed she had entered Resident #			included in the inservice packet to rea			
		e noticed the resident had been			sign the inservice, call the Staff Facility			
		slipped down with her feet off left. MA # 1 indicated she had			or Director of Nursing with any question	115,		
		IA # 1 to get more help as the			and return the signed inservice to the Staff Facilitator or Director of Nursing	nrior		
	_	constantly slipping. MA #1			to next schedule shift. Staff were not	וטווטו		
	·	it's face had turned red in color			permitted to work until the signed			
		the lift. MA # 1 indicated the			inservices were received.			
		by the resident 's neck.			The Administrator, Director of Nursing			
	on up nua onppou	by the resident of heart.			and Quality Improvement nurse was ir			
	During an intervie	w with Nurse #1 on 8/1/2018 at			serviced on the process of investigating			
	_	# 1 stated she had been			incidents on 8/1/18 by the Facility Nurs			
		for Resident #37 on 6/23/2018.			Consultant. The in-service included to			
		IA # 1 reported to her they had			review the incident reports 5 days per			
		e transfer of Resident #37 from			week, how to pull a report from the risl	<		
		et using the mechanical lift.			management portal in the electronic			
	Nurse #1 stated R	Resident # 37 had slid off the lift			records to identify incidents that have			
	because the staff	failed to use the leg straps and			been documented by the nurses, print	ing		
	nonskid socks or	shoes which caused the			the incident reports from the electronic	;		
		me from the lift. Nurse #1			records, flagging the incident for follow	up,		
	reported NA # 1 h	ad been using the lift with no			reading progress notes to identify all			
		urther stated she had expected			incidents, discussing incidents in the			
		e asked for assistance when			clinical morning meetings, determining			
	_	indicated the lift required 2			root cause of the incident, completion			
	'	1 stated the use of nonskid			incident reports, and implementing and	t		
		ad always been required to			monitoring interventions.			
		feet from slipping off the lift but			An inservice was completed with the			
	they had not been	used by NA # 1. Nurse #1			Director of Nursing on 8/2/18 regarding	g		

	OF DEFICIENCIES CORRECTION	` IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING _				C 03/2018	
NAME OF PR	ROVIDER OR SUPPLIER	ı	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
				2	25 WHITE STREET			
PREMIER	NURSING AND REHABI	LITATION CENTER	JACKSONVILLE, NC 28546		ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 34	F6	689				
F 689	stated she had also for appropriate for Residindicated she had assishe had been transfer and stated she did not Resident #37. Nurse report the incident to of Nursing (DON) becomesident #37 's slip incident or accident. It back at what had hap should have reported physician, DON and complete the physician, DON and complete the physician of the p	elt the sit to stand lift was not ent # 37. Nurse # 1 sessed Resident #37 after red to the toilet by the NA's of notice any injury to a # 1 indicated she did not the physician or the Director cause she did not think of on the mechanical lift as an Nurse #1 stated in looking opened to the resident, she the incident to the completed an incident report. With the Physician on I, the Physician indicated he ware of Resident #37's B. The physician indicated his we been for the facility staff of the incident emphasizing ent had turned purple blue With the MDS nurse on the MDS nurse reported tory of being unstable while a sit to stand lift because hering (both of knees give out). In the family had insisted on the the fa	F6	689	requirements for re -evaluating residen for change in transfer methods by the Facility Nurse Consultant. On 8/1/18 an in-service was initiated by the Staff Facilitator with 100% of all nurses regarding completion of inciden reports and collecting witness statemen After 8/2/18, all nurses that have not worked and/or not received the in-servi will be mailed the in-service via certified mail by the Payroll Bookkeeper. Instructions will be included in the inservice packet to read, sign the inservice, call the Staff Facilitator or Director of Nursing with any questions, and return the signed inservice to the Staff Facilitator or Director of Nursing pto next schedule shift. Staff will not be permitted to work until the signed inservices are received. The decision to monitor the system for prevention of accidents was made on 8/1/2018 by the Administrator and Dire of Nursing. The RN Supervisor, the St Facilitator, Treatment nurse, Unit Facilitator and/or the QI nurses, will au 10% of all residents requiring mechanic lifts for transfers to include resident #37 ensure staff are checking the resident care guide and utilizing the number of person identified on the care guide, state are utilizing the mechanical lift per manufacture specification during the transfer, and ensure the current lift is the safest method of transfer 3 x a week for four weeks, then weekly for x 4 weeks, then monthly x 1 month utilizing a Lift	t toraff ctoraff dit cal to		
	made on 8/2/2018 at appeared confused w by NA # 4 to grasp th	10:30 AM, Resident # 37's vith the instructions given her e mechanical lift's sling bar. een noticed to be unsteady			safest method of transfer 3 x a week fo four weeks, then weekly for x 4 weeks,	ern		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIEICATION NILIMPED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245247	D WING			С	
		345217	B. WING		•	3/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER	NURSING AND REHAB	ILITATION CENTER		225 WHITE STREET			
	NONO NO 7 NO NELIZAD			JACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pag	ne 35	F 68				
	During an interview of 10:40 AM, NA# 4 replaced unstable while transferred using the time. NA #4 indicates been assisted to the lunch. During the interview Coordinator (SDC) of SDC stated NA # 2 ro 08/01/2018 investigated the resident #37, when with Resident #37 of the resident 's face resident 's veins bull dangled on the mechanicated she had the investigated the incident are She added she could the name of the supphad not been the SD 37's mechanical 's light During an interview of 12:30 PM, the DON aware of Resident #4 when the resident had DON indicated her ewould have been to report so she could the support of the supphad not she could the name of the supphad not been the SD 37's mechanical 's light DON indicated her ewould have been to report so she could the support so she	with NA #4 on 8/2/2018 at corted Resident #37 had on the lift but she had been e sit to stand lift for a long at Resident # 37 had usually toilet before breakfast and with the Staff Development on 8/2/2018 at 11:30 AM, the reported to her, during the ation of the incident involving the had been asked to assist in 6/23/2018, she had seen turned purple blue and the ged on her neck while she manical lift. The SDC ought a supervisor had dent after it happened on doverheard a conversation round the time it happened. It do not recall the exact date or ervisor. The SDC stated she occar at the time of Resident #		Supervisor, the Staff Facilitato Facilitator and/or the QI nurse staff retraining. The Director of will review and initial the Lift Tools weekly x 8 weeks then remonth. The RN Supervisor, the Staff I Treatment nurse, Unit Facilitate the QI nurses will review all increports and progress notes 3 of 4 weeks, then weekly for x 4 weeks, then weekly for x 4 weeks, then weekly for x 4 weeks, then weekly incidents reports completed, a appropriate interventions imple prevent further accidents. The Supervisor, the Staff Facilitate Treatment nurse, Unit Facilitate the QI nurses will investigate to implement interventions, and pretraining for all identified area concern during the audit. The Nursing will review and initial the Audit Tool weekly x 8 weeks the x 1 month. The Quality Improvement Organs contacted by the Director on 8/02/18 for assistance in expecific steps to be taken to an eglect and prevention of acciditation, staff position/title desibe responsible for the steps, in accomplishment of the steps.	s to include of Nursing ransfer Audit nonthly x 1 Facilitator, or and/or cidents a week for weeks, then Incident ed incidents ated, and emented to RN r, for and/or the incident, provide as of Director of the Incident then monthly anization of Nursing valuation of ddress dents and ignated to meline for specific aluate the		
	8/2/2018 at 12:40 PM	with the Administrator on M, the Administrator reported about the incident of Resident		monitoring the effects of the pl The DON will present the findi Lift Transfer Audit Tools and th	ngs of the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WING			C 08/03/2018	
NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
				2	25 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 689	Continued From page	e 36	F 6	689			
F 089	Continued From page 36 #37's slip off the mechanical lift. The Administrator stated his expectation would have been for the staff to have reported the accident to the DON immediately so they could have begun an in-service on the proper use of the mechanical lift. The Administrator, Director of Nursing and Facility's nurse consultant were notified of the Immediate Jeopardy on 8/1/2018 at 4:30 pm. On 8/2/2018 the facility provided an acceptable credible allegation for immediate jeopardy removal that included the following: Corrective Actions: On 8/01/18, interviews were initiated by the Social Workers with all alert and oriented residents. The resident concern process will be followed by the social worker and Administrator for all identified areas of concern by 8/2/18. On 8/1/18, a transfer observation of 100% of all			589	Audit Tools to the Executive Quality Assurance (QA) committee monthly for months. The Executive QA Committee meet monthly for 3 months and review Lift Transfer Audit Tools and the Incide Audit Tools to determine trends and/or issues that may need further interventic put into place and to determine the need for further frequency of monitoring. The decision to review the monitoring of prevention of accidents during the qual assurance committee meeting was ma by the Administrator and Director of Nursing on 8/01/2018. The Administrator and DON was responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring rela to the plan of correction.	will the nt ons ed e lity de	
	Data Set (MDS) coordinated the rapy manager. The is to ensure that the rapechanical lift use is transfer. The audit will the MDS coordinator transfer method, updates.	nitiated by the Minimum dinator, MDS nurses and e purpose of the observation esident 's current the safest method of II be completed by 8/2/18. will re-evaluate the resident ate the resident care plan					
	by 8/2/18 for any ider concerns observed d On 8/1/18, a question						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING			C 08/03/2018		
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, S 225 WHITE STREET JACKSONVILLE, NC 2		,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	MDS coordinator will transfer method, upd and care guide, and by 8/2/18 for any idea concerns expressed After 8/2/18, all nurse that have not complete allowed to work use completed. On 8/1/18, return der lift transfer was initiate and nursing assistant. The purpose of the reensure that staff are guide for the correct for transfers and that utilized per manufact transfer. After, 8/2/18 assistants that have demonstration will not return demonstration. On 8/1/18 an audit of reports to include res 8/1/18 was initiated by treatment nurse to enthoroughly investigat cause and appropriar prevent further incides completed by 8/2/18, the incident, implementation all identified areas. On 8/1/18 an audit of resident care plan for all identified areas.	(QI) nurse. This completed by 8/2/18. The re-evaluate the resident ate the resident care plan complete a therapy referral ntified areas of safety during the questionnaire. See and nursing assistants ated the questionnaire will not ntil the questionnaire will not ntil the questionnaire is the staff Facilitator. Set with the staff Facilitator are number of person to utilize the mechanical lift is being the specifications during the set, all nurses and nursing the set allowed to work until the is completed. If all resident's incident sident # 37 from 6/23/18 to be the MDS nurses and the neure all incidents have been set to determine the root the interventions initiated to ents. This audit will be the QI nurse will investigate and care guide by 8/2/18	F	889				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345217	B. WING	B. WING		C 08/03/2018			
NAME OF F	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET ACKSONVILLE, NC 28546				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 689	Continued From page	e 38	F	689					
L 009	was initiated by the C Nurse (RN) supervised documented incident was investigated to dappropriate interventing prevent further incided completed by 8/2/18. The incident, implementation in the resident care plantaged for all identified areas. On 8/01/18, an in-serving of all staff to include a housekeeping, dietar roll, book keeper, soot the Staff Facilitator resexamples of neglect and the staff to include a housekeeping, dietar roll, book keeper, soot the Staff Facilitator resexamples of neglect and the sin-service was consistents, housekeen maintenance, pay roll workers that have not the in-services will be certified mail by the Finstructions will be in packet to read, sign the facilitator or Director questions, and return Staff Facilitator or Director questions, and return Staff Facilitator with 100% assistants regarding movement policy. The reading the resident on umber of person recreporting to the nurse	all nurse and the Registered or to ensure that all is have an incident report, etermine the root cause and ons were implemented to ents. This audit will be in the QI nurse will investigate ent interventions, and update in and care guide by 8/2/18 is of concern. Invice was initiated for 100% nurses, nursing assistants, y, therapy, maintenance, pay stall workers, was initiated by egarding Neglect to include and prevention of neglect. Completed by 8/02/18. After ude nurses, nursing ping, dietary, therapy, I, book keeper, social the worked and/or not received emailed the in-service via payroll Bookkeeper. Coluded in the in-service he in-service, call the Staff of Nursing with any the signed in-service to the rector of Nursing prior to next will not be permitted to work vices are received. Ce was initiated by the Staff of all nurses and nursing the safe handling and		689					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345217		B. WING			C 98/03/2018		
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIE 225 WHITE STREET JACKSONVILLE, NC 28546		10/03/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	how to safely strap ar mechanical lift per the specifications. The m be printed by the Staf with staff during the ir be completed by 8/2/and nursing assistant and/or not received the via certified mail by the Instructions will be incepacket to read, sign the Facilitator or Director questions, and return Staff Facilitator or Director questions, high process of investions and return Staff Facilitator or Director questions, and retur	when sliding in the lift and and transfer resident in the emanufacture anufacture specification will a fracilitator and reviewed anservice. This in-service will be mailed a fracilitator and worked are in-services will be mailed are Payroll Bookkeeper. Coluded in the in-service are in-service, call the Staff of Nursing with any the signed in-service to the fractor of Nursing prior to next will not be permitted to work wices are received. The ector of Nursing, and an anurse was in serviced on gating incidents on 8/1/18 by a fincident reports 5 days per proof from the risk and the electronic records to have been documented by the incident reports from the gging the incident for follow anotes to identify all incidents in the clinical aftermining the root cause of for of incident reports, and anitoring interventions. In pleted with the Director of larding requirements for refor change in transfer	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345217	B. WING	B. WING			C 08/03/2018	
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER			1	225	REET ADDRESS, CITY, STATE, ZIP CODE S WHITE STREET CKSONVILLE, NC 28546	1 001	00/2010	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Facilitator with 100% completion of incider witness statements. In has not worked and/o will be mailed the instended in the inservice, call the St Nursing with any que inservice to the Staff Nursing prior to next be permitted to work are received. The decision to moni of accidents was man Administrator and Discupervisor, the Staff Unit Facilitator and/o 10% of all residents in transfers to include mare checking the resist the number of persor staff are utilizing the manufacture specific ensure the current lift transfer 3 x a week for x 4 weeks, then muse the staff Facilitator, to be immediately address to include of Nursing will review Audit Tools weekly x month. The Registered Nurse includes the Staff Facilitator of the Registered Nurse in the Registered Nurse	ce was initiated by the Staff of all nurses regarding at reports and collecting After 8/2/18, all nurses that or not received the in-service service via certified mail by over. Instructions will be vice packet to read, sign the aff Facilitator or Director of estions, and return the signed of Facilitator or Director of schedule shift. Staff will not until the signed in services tor the system for prevention de on 8/1/2018 by the rector of Nursing. The RN Facilitator, Treatment nurse, or the QI nurses, will audit requiring mechanical lifts for resident # 37 to ensure staff dent care guide and utilizing in identified on the care guide,	F	689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345217	B. WING		C 08/03/2018		
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546	08/03/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 689	and/or the QI nurses reports and progress weeks, then weekly 1 month utilizing the all identified incident investigated, incident appropriate intervent further accidents. The Facilitator, Treatment and/or the QI nurses implement interventifor all identified area The Director of Nurs Incident Audit Tool with monthly x 1 month. The Quality Improve contacted by the Director of Nurs Incident Audit Tool with a designated to be restimeline for accomplimethodology to be usuccess, and freque of the plan initiation. The DON will preser Transfer Audit Tools to the Executive Quaccommittee monthly for QA Committee will mand review the Lift Tincident Audit Tools to issues that may need into place and to det frequency of monitor	will review all incidents anotes 3 x a week for 4 for x 4 weeks, then monthly x Incident Audit Tool to ensure as have been thoroughly the reports completed, and the ions implemented to prevent the RN Supervisor, the Staff the nurse, Unit Facilitator will investigate the incident, the ions, and provide retraining as of concern during the audit ing will review and initial the eachly x 8 weeks then the ions of Supervisor will be each of Supervisor will	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		345217	B. WING _			03/2018
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546	00/03/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Final date of complia The Administrator an for the implementation include all 100% audinonitoring related to the Credible Allegating removal was validated removed the Immediate validation process in nursing staff present. The staff confirmed to training of the proper Reviews of the in-sequidits performed and made. Observations completed. Label/Store Drugs and CFR(s): 483.45(g) Labeling Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of the in-sequinostructions, and the applicable.	attrator and Director of B. Ince is 8/02/2018. Ince is 9/02/2018. Ince is 8/02/2018. Ince is 8/02/2018. Ince is 8/02/2018. Ince is 8/02/2018. Ince is 9/02/2018. Ince is 9/02/2018	F 6			8/15/18
	Federal laws, the fac	ility must store all drugs and compartments under proper				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED	
		345217	B. WING _			C 08/03/2018
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP (225 WHITE STREET JACKSONVILLE, NC 28546	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 761	§483.45(h)(2) The fallocked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug district quantity stored is mile readily detected. This REQUIREMEN by: Based on observatif facility failed to disport medications in 1 of 3 (Front Medication R carts observed (300 Cart). The findings included During an observatirefrigerator in the Front 124 pre-filled syring vaccine) with an expublic process of the syring and observation and the syring and observation and the syring vaccine) with an expublic process of the syring and observation and the syring and observation cart for the syring and observation and the syring and the syring and observation and the syring and observation and the syring and th	acility must provide separately affixed compartments for I drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit aution systems in which the nimal and a missing dose can T is not met as evidenced on and staff interview, the ose/discard expired a medication storage rooms from) and in 1 of 4 medication //400 Hall Medication Aide d: on of the medication ont Medication Room on and, the refrigerator contained as of Fluvirin (influenza or interview) are formed to the medication date of May 2018.	F	F761 Label/Store Drugs a CFR(s): 483.45(g)(h)(1)(2) 100% audit was completed of 100, 200, 300, and 400 medication rooms and four carts, 800 hall medication medication carts, and 700 room and medication cart, medication rooms and the Quiliprovement (QI) nurses of the concerns were that time.	d on 8/15/2018 halls r medication room and two hall medication to ensure all dication carts, nedications that I nurse and/or I supervisor, uality on 8/15/2018. re addressed at	
	Relief May 2018 and 2018.	d Omega XL expired July with Nurse #1 on 07/30/18 at		medication aides on check rooms and medication cart meds, and discarding expirately, was initiated by the Staff Facilitator and	king medication ts for expired red medications If on 8/14/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345217		B. WING	B. WING			C 08/03/2018	
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER				22	TREET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE STREET ACKSONVILLE, NC 28546	1 00/	03/2010	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F			ed on d. vill ses on the the		
					medication aides, by the Director of Nursing and completed on 8/15/2018. Medication Carts will be monitored usin Medication carts and Med rooms/Expir medications QI Tool to ensure all medication rooms and medication carts do not have expired medications, by th RN supervisor, Unit Facilitator, Staff Facilitator and the QI nurses, 3 times a week for 4 weeks, then weekly for 4 weeks then monthly for 1 month. The licensed nurse and medication aides w be immediately re-trained by the audito RN supervisor, Unit Facilitator, Staff Facilitator and the QI nurses, for any identified areas of concern. The Director of Nursing will review and initial the Medication cart/Expired medications Q	ed s e e ill or,		

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345217	345217 B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	J43217		STREET ADDRESS, CITY, STATE, ZIP COD		8/03/2018
TVAINE OF T	NOVIDER OR OUT FEEL			225 WHITE STREET	_	
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From page	e 45	F 76	Tool for completion and to ensure as of concerns were address for 8 weeks and monthly for 1 The Executive QI committee or review the Medication cart and rooms/expired medications QI monthly for 3 months to deter and trend to include continued frequency.	will meet to d medication I tool mine issues	