STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345185	A. BUILDING _____ B. WING _____	C 07/02/2020

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

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness Survey was conducted on 06/30/20 - 07/02/20. The facility was found to be in compliance with 42 CFR 483.73 related to E0024 (b)(6) for Event ID#SDH511.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted at this facility from 06/30/20 - 07/02/20. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations to prepare for COVID-19. An additional complaint investigation was also conducted during this survey. 1 out of 4 allegations was substantiated with deficiency for Event ID SDH511.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply nonskid socks to 2 of 2 residents (Resident #1 and Resident #2) observed for accidents who were known to get out of the bed on their own without assistance and sustained a fall. Findings included:	F 689	Resident #1 was discharged on 3/11/20. Resident #2's Care Plan and has been reviewed to ensure accuracy and appropriate fall interventions are in place. All other residents and residents assessed to be at risk for falls have been audited to ensure Care Plan reflects	7/22/20

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

Electronically Signed | 07/17/2020

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F 689	Continued From page 1 1) Resident #1 was admitted to the facility on 06/18/18. Diagnoses included, in part, dementia, history of falls, muscle weakness, lack of coordination, unsteadiness on feet and difficulty walking. The Minimum Data Set (MDS) dated 03/11/19 discharge assessment revealed the resident was cognitively impaired. Resident #1 required limited assistance with one person physical assistance with bed mobility, extensive assistance with two person physical assistance with transfers, extensive assistance with one person physical assistance with walking in the room. Resident #1 required extensive assistance with one person physical assistance with locomotion on and off the unit and with dressing, toileting and personal hygiene. Resident #1 was not steady but able to stabilize without staff assistance with moving from seating to standing position, walking, turning around, moving on / off toilet and surface to surface transfers. He had no impairments and used a walker and wheelchair. Resident #1 had one fall with major injury during this assessment period. A review of the care plan revealed Resident #1 had a plan of care in place for falls updated on 10/01/19. The care plan indicated the resident was at risk for falls related to use of psychotropic medications, and a diagnoses of weakness, unsteady gait, and lack of coordination. An intervention included to apply nonskid soled shoes every day. A nursing note written by Nurse #1 on 03/11/20 at 1:40 AM revealed the resident was observed in the hallway across from the dining room on his	F 689	appropriate interventions. Residents will be assessed for fall risk upon Admission, Quarterly, Significant Change In Condition and Post Fall Incidents. Care Plans will be updated to reflect any individualized fall interventions for each resident. The nursing assistant Kardex has been modified to reflect fall interventions. Inservices will be held to re-educate nursing/nursing assistant staff regarding the importance of applying appropriate footwear and fall interventions and where to locate this information on the Care Plan and Kardex. Admissions, Quarterly, Significant Change In Condition and Post-Fall Care Plans will be audited to ensure updates have been entered correctly weekly x's 6 weeks. 7 random visual audits of at-risk residents will be performed weekly x's 6 weeks to ensure identified interventions are in place. Nurses and Nursing Assistants will be audited randomly x's 6 weeks for appropriate utilization of the Care Plan and Kardex. Results will be forwarded to the QAPI Committee for further recommendations as necessary. The Director of Nursing is responsible.	

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F 689	Continued From page 2	F 689		

buttocks with legs stretched out in front of him. The note stated the resident was actively bleeding with visible lacerations to his forehead and across the bridge of his nose. The note reported the resident stated "I don ' t know what happened."

A review of the incident report dated 03/11/20 documented under "other info" by Nurse #1 revealed a note indicating the resident did not have skid proof socks on, the resident had on his socks and the resident had ambulated to an unfamiliar area approximately 75 feet from his room near the dining room. The note indicated there were no witnesses. The incident report stated the resident was observed in the hallway across from the dining room on his buttocks with his legs stretched out in front of him. The resident was actively bleeding with visible lacerations to his forehead and across the bridge of his nose. The incident report revealed the resident stated "I don ' t know what happened" and Nurse #1 applied pressure to the bleeding areas and called 911. The incident report indicated the resident sustained injuries to his face and the resident was alert and oriented to person with impaired memory and confusion. The incident report revealed the predisposing situation factors that were checked off by Nurse #1 included the resident had been ambulating without assistance and had on improper footwear.

An interview was conducted with Nursing Assistant (NA) #1 via phone on 06/30/20 at 3:25 PM. She stated she did not remember working with Resident #1 on the night of 03/10/20 during the 3:00 to 11:00 PM shift. NA #1 stated she was familiar with Resident #1 and when she took care of him she assisted him to the bathroom. She

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F 689	Continued From page 3	F 689		

stated he could ambulate, but he did require assistance at times, but he had a steady gait and used a walker and a wheelchair. NA #1 stated he was alert and some days he was more oriented than others. NA #1 added when she got him ready for bed on her shift she would check to see if he needed to use the bathroom, remove his dentures, and put on his night clothes. NA #1 reported whenever she worked with him she put on his nonskid socks because he would sometimes get out of bed without letting staff know, so she would put them on as a safety measure. NA #1 reported Resident #1 would bring himself to the bathroom, at times, unassisted.

An interview was conducted with NA #2 on 07/01/20 at 2:46 AM via phone. NA #2 stated she was familiar with Resident #1. NA #2 reported during the night shift rounds she did not have to change Resident #1 because he would get up and use the bathroom on his own. NA #2 stated there was not much she had to do for him and if he got up in the middle of night, she would not know. NA #2 stated the resident understood the use of the call bell. NA #2 reported that other than his own socks, she was not aware of any footwear that he should have been wearing. NA #2 reported on the night of 03/11/20 she was next door (316B) and heard her nurse (Nurse #1) hollering down the hallway that she needed help and towels. NA #2 stated she saw Resident #1 on the floor. NA #2 stated she could not recall what the resident was wearing for clothes but stated he had no socks or shoes on his feet.

An interview was conducted with Nurse #2 via phone on 07/01/20 at 3:05 PM. Nurse #2 worked on the 3:00 to 11:00 PM shift on 03/10/20. Nurse

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F 689	Continued From page 4	F 689		

#2 reported Resident #1 was alert and oriented, but he was starting to decline some with his dementia. Nurse #2 stated he would get up to use the bathroom independently and he had a wander guard but he did not usually wander at night; it was more so during the day. Nurse #2 stated on the 3:00 to 11:00 PM shift, he stayed in his room except to get up and go to the bathroom. Nurse #2 reported the resident did not like to wear pajamas and he liked to be in his own clothes when he went to bed. Nurse #2 stated he always wore nonskid socks because he would get up by himself independently during the night. Nurse #2 stated she did not know if NA #1 put on his nonskid socks during the 3:00 to11:00 PM shift on 03/10/20.

An interview was conducted with Nurse #1 via phone on 07/02/20 at 9:25 AM. Nurse #1 stated she was familiar with Resident #1. Nurse #1 reported on the night of 03/11/20 when she got down the hall, she saw Resident #1 up against the wall and blood was on the floor. Nurse #1 stated she noted he had on his khaki slacks and a button up shirt and his white socks that had no grip on them. Nurse #1 stated there was blood on his face. Nurse #1 stated Resident #1 should have had nonskid socks on to prevent him from slipping since he did get out of bed without assistance. Nurse #1 stated she documented that he had improper footwear because he did not have nonskid socks on. Nurse #1 stated as part of the fall protocol we were trained to try and figure out how a resident had a fall and to document what we observed on the scene. Nurse #1 stated the fall was unwitnessed and she was not sure how he fell.

An interview was conducted with the Director of

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F 689	Continued From page 5	F 689		

Nursing (DON) at 12:30 PM via phone on 07/02/20. The DON reported Resident #1 was care planned to have nonskid soled shoes on during the day and should have had a specific care plan to have nonskid socks at night since he would ambulate without assistance. The DON reported nonskid sole shoes was an intervention that was in place for the ambulatory residents for ambulatory purposes to prevent them from slipping and we would want them to have on nonskid footwear whether it was day or night. The DON reported she would have expected Resident #1 to have nonskid footwear on to prevent a slip with ambulation whether it was day or night.

2) Resident #2 was admitted to the facility 09/08/17. Diagnoses included, in part, stroke, Parkinson ' s disease, encephalopathy, history of falls, muscle weakness, and difficulty in walking.

A review of the MDS quarterly assessment dated 04/06/20 revealed Resident #2 was moderately cognitively impaired and required extensive assistance with two person physical assistance with bed mobility and one person physical assistance with transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. Resident #2 was assessed as not being steady and only able to stabilize with staff assistance when moving from a seated to standing position and moving on and off the toilet. Resident #2 had an impairment to one side to the upper extremity and to both sides of the lower extremities and used a wheelchair. He was frequently incontinent of bladder and always incontinent of bowel. He was coded as having a fall during this assessment period - two or more with no injury and one with injury not major.

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F 689	Continued From page 6	F 689		

A review of the care plan updated on 02/10/20 revealed the resident had a plan of care in place for history of falls and at risk for falls related to the diagnoses of general muscle weakness, lack of coordination, difficulty walking, unsteadiness and weakness following a stroke. One of the interventions in place was to ensure the resident was wearing appropriate nonskid shoes or nonskid socks every day.

An incident note written on 05/04/20 by Nurse #3 revealed, in part, the NA called the nurse to the resident ' s room. The resident was found in a sitting positon on the bathroom floor in front of the toilet. The resident was holding on to the handrail with both hands. The resident's wheelchair was sitting behind him. The resident stated he was going to the bathroom and lost his balance as he was trying to pull up his brief. The resident had on a string alarm but had unhooked it before getting up. The resident was wearing regular socks and no shoes.

A review of an incident reported dated 05/04/20 revealed a NA called the nurse to the resident ' s room. The resident was found in a sitting position on the floor in the bathroom. The resident was holding onto the handrail beside the toilet. His wheelchair was behind him. The resident stated he was going to the bathroom and lost his balance as he was trying to pull his brief up. The immediate action taken revealed the resident was observed for any injuries and none were noted. The resident was assisted back into the wheelchair with 3 staff members. The resident was encouraged to wait for assistance before going to the bathroom alone. The predisposing physiological factors that were

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F 689	Continued From page 7	F 689		

checked off by Nurse #3 included gait imbalance, impulsive behavior, and lower extremity weakness. The predisposing situation factors that were checked off by Nurse #3 included hurrying to the restroom, ambulating without assistance and improper footwear.

An interview was conducted via phone with NA #3 on 07/01/20 at 12:45 PM. NA #3 stated she was very familiar with Resident #2 and took care of him often. NA #3 stated the resident was known to wander and constantly tried to get up out of bed even with his string alarm. NA #3 stated he would remove the alarm and bring himself to the bathroom. NA #3 stated on the evening of 05/04/20 she was Resident #2 ' s NA that evening. She stated she heard the resident call for help and found him on the floor in the bathroom. NA #3 stated she did not remember which socks she put on his feet that night. NA #3 stated he should wear the nonskid socks to help prevent him from slipping.

An interview was conducted with Nurse #3 via phone on 06/30/20 at 4:00 PM. Nurse #3 reported she was notified by NA #3 Resident #2 was on the floor in the bathroom on the evening of 05/04/20. Nurse #3 stated the resident had a string alarm that attached to his shirt if he should get up and also a fall mat by his bedside. Nurse #3 stated he would remove the alarm and frequently tried to get out of bed on his own. Nurse #3 stated Resident #2 usually wore his regular socks to bed and would put his own shoes on if they were close enough. Nurse #3 stated as part of the facility fall protocol, the nursing staff was trained to assess the situation/scene to try and determine how and why a resident fell. Nurse #3 stated he should have

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F 689	Continued From page 8 had his nonskid shoes or nonskid socks on because he did get up without assistance and they may have prevented him from slipping. An interview was conducted via phone with the DON on 07/02/20 at 12:30 PM. The DON reported the plan of care indicated the resident should wear nonskid shoes or socks every day and she added that "every day" would be at all times through the day and night. The DON stated her expectation of the nursing staff would have been to ensure the resident had nonskid socks on to prevent him from slipping since he frequently tried to get out of bed unassisted.	F 689		