

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/12/2022
NAME OF PROVIDER OR SUPPLIER PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
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E 000	Initial Comments	E 000			
F 000	An unannounced Recertification survey and complaint investigation were conducted on 05/09/22 through 05/12/22. The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID # TRG511. INITIAL COMMENTS	F 000			
F 689 SS=D	A recertification survey and complaint investigation were conducted from 05/09/22 through 05/12/22. Event ID# TRG511. The following intake was investigated: NC00187237. 1 of the 1 complaint allegation was not substantiated. 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 secure smoking materials for an unsupervised smoker for 1 of 2 residents (Resident #12) who was reviewed for safe smoking practices. Findings included. A review of the facility Smoking Policy revised 07/17/19 revealed; residents who are	F 689	5/20/22		
			-Upon being notified of observation of resident with smoking materials in their possession, the items were obtained from resident and place in designated area. -Resident was re-educated on the smoking policy. -All other smokers were audited for smoking materials. -All residents who currently smoke were re-educated on the smoking policy and all		

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

TITLE

(X6) DATE

Electronically Signed

05/24/2022

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

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F 689	<p>Continued From page 1</p> <p>independent smokers will be able to smoke anytime in designated areas based on assessment of safety awareness, cognitive and functional capabilities, and smoking policy compliance. Nursing will maintain limited resident materials on the medication cart for all smokers.</p> <p>Resident # 12 was admitted to the facility on 08/27/21 with diagnoses to include in part; Non-Alzheimer's dementia, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>The Minimum Data Set (MDS) assessment dated 02/11/22 revealed Resident #12 had moderately impaired cognition. He had no behaviors and no rejection of care. He required supervision with transfers and activities of daily living (ADL's). He had no impaired range of motion and received oxygen.</p> <p>A smoking assessment conducted on 02/11/22 revealed Resident #12 was deemed safe to smoke without supervision. Resident #12 demonstrated the cognitive ability to comply with the facility policy and could verbalize and demonstrate awareness of the smoking rules. The assessment revealed Resident #12 needed the facility to store lighter and cigarettes.</p> <p>The IDT (Interdisciplinary team) decision following the smoking assessment on 02/11/22 revealed; Nurse was to keep cigarettes and lighter on the medication cart and give to resident when asked.</p> <p>A progress note dated 03/15/22 at 2:16 PM revealed Resident (#12) was agitated and yelling due to wanting to keep cigarettes in room. Per supervisor resident was caught smoking in his</p>	F 689	<p>signed attestation forms regarding same.</p> <p>-Working nursing staff were re-educated on the smoking policy and signed attestation forms regarding same on 5/10/22.</p> <p>-All new nursing hires will be educated on the smoking policy and will sign an attestation form on orientation. All remaining nursing staff who have not worked through completion date will be re-educated/oriented and will sign attestation forms prior to next tour of duty.</p> <p>-A smoking materials log was initiated on 5/10/22 to be kept on the nurse's med cart so that staff will be aware when a resident has been provided with smoking materials (independent smokers) in order to ensure retrieval of materials upon completing smoking activities. All supervised smokers will receive staff assistance/supervision for safety.</p> <p>- To ensure the deficient practice does not recur, smokers will be audited at random times M-F for possession of smoking materials daily x's 2 weeks, then twice weekly x's 2 weeks, then weekly x's 1 month.</p> <p>The Smoking Materials Log will be audited at random times for compliance of nursing staff daily M-F x's 2 weeks, then twice weekly x's 2 weeks, then weekly x's 1 month.</p> <p>- All audits and the compliance log was initiated on 5/11/22.</p>		

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F 689	<p>Continued From page 2</p> <p>room and due to safety of himself and other residents he cannot keep cigarettes in his room.</p> <p>A progress note dated 03/16/22 at 11:10 AM (late entry) revealed the Social Worker spoke with resident (#12) about the smoking policy. Resident stated he wanted to keep his cigarettes himself. Explained facility policy to resident that when he wanted a cigarette, to please come to nurse and ask for cigarettes. Explained it was for the safety of others. Resident voiced understanding. Will follow up as needed.</p> <p>An observation of Resident #12 was conducted on 05/10/22 at 10:10 AM. Resident #12 was observed ambulating in room. He was oriented to person and place. He stated he had cigarettes in the seat of his rollator which was observed along with a cigarette lighter. He stated he always went outside to smoke and does not smoke in his room. He stated he kept his cigarettes and lighter under the seat of his rollator. An oxygen concentrator was observed in his room but was not on. Resident #12 stated he only used oxygen sometimes.</p> <p>An interview was conducted on 05/10/22 at 10:30 AM with Nurse #3. She stated Resident #12 had short term memory deficit. She stated he ambulated independently with a rollator and required minimal assistance with ADL's. She stated Resident #12 was an independent smoker and she thought independent smokers kept their own cigarettes. She stated cigarettes and lighters were locked in the medication room for supervised smokers. She stated Resident #12 used oxygen as needed. She stated resident (#12) never smoked in his room per her knowledge and he was complaint care. She</p>	F 689	-Results will be forwarded to the QAPI Committee for further recommendations as necessary.		

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F 689	Continued From page 3 removed the smoking materials from his room at that time. An interview was conducted on 05/10/22 at 4:42 PM with the Director of Nursing (DON). She stated no resident was allowed to keep smoking materials in their room. She stated the smoking policy rule was that nursing would maintain limited resident materials (limited cigarettes and lighter) on medication carts for all smokers. An interview was conducted on 05/10/22 at 4:50 PM with the Administrator. She stated Resident #12 was not observed smoking in his room on 03/15/22. She stated the supervisor suspected him of smoking. She stated that Supervisor no longer worked at the facility. She indicated Resident #12 was assessed by the Social Worker and remained an unsupervised smoker. An interview was conducted on 05/11/22 at 9:40 AM with the Social Worker. She stated when residents go out to smoke, they go to the nurse to obtain smoking materials, after smoking they return cigarettes and lighter to the nurse. She stated Resident #12 was deemed an unsupervised smoker. She stated she spoke to Resident #12 last on 03/16/22 regarding the smoking policy because he wanted to keep his cigarettes with him. She stated she explained the rules and he voiced understanding. She stated she completed a smoking assessment on 05/10/22 and he was still considered to be an unsupervised smoker.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		5/20/22	

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F 695	<p>Continued From page 4</p> <p>tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and Nurse Practitioner and staff interview, the facility failed to obtain an order for oxygen administration and failed to administer oxygen per physician orders for 1 of 2 residents reviewed for respiratory care (Resident #50).</p> <p>Findings included:</p> <p>Review of facility oxygen policy dated October 2010 read in part: that prior to administration of oxygen, a physician's order was to be verified.</p> <p>Resident #50 was readmitted to the facility on 5/5/22. Resident #50's medical diagnosis included chronic respiratory failure with hypoxia, chronic systolic heart failure and chronic obstructive pulmonary disease.</p> <p>Review of Resident #50's Minimum Data Set (MDS) dated 4/21/22 revealed mild cognitive impairment. Oxygen was not used.</p> <p>Review of Resident #50's care plan dated 5/6/22 revealed a problem of altered respiratory status related to chronic obstructive pulmonary disease, chronic respiratory failure, and recent pneumonia. Interventions monitor for signs and symptoms of respiratory distress and report to physician including increased respirations and decreased</p>	F 695	<ol style="list-style-type: none"> Order was placed in electronic medical record for oxygen therapy on 5/10/22. Audited all residents in the facility on 5/10/22 for oxygen use and verified order in electronic medical record to ensure appropriate delivery system, when to administer, prescribed flow rate and monitoring was in place. Informal inservicing began on 5/10/22, however, formally inserviced staff on 5/19/22 on oxygen therapy to include: delivery system, equipment settings for prescribed flow rate and process to initiate standing order for oxygen therapy. <p>As of 5/10/22, Administrative Nursing team to complete Admission/Readmission Review for all residents to ensure Oxygen therapy orders are entered in electronic medical records for delivery system, equipment settings for prescribed flow rate.</p> <ol style="list-style-type: none"> DON or designee to audit all admissions for completion of Admission Review to ensure oxygen therapy orders 		

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F 695	<p>Continued From page 5 pulse oximetry.</p> <p>Review of the physician orders for Resident #50 from 5/5/22 through 5/9/22 revealed no order for oxygen.</p> <p>Review of Resident #50's medical record revealed the following monitoring of oxygen saturations:</p> <ul style="list-style-type: none"> - 5/5/22 at 8:39 PM 94% on oxygen via nasal cannula - 5/8/22 at 9:08 PM 100% on oxygen via nasal cannula - 5/9/22 at 5:35 PM 99% on oxygen via nasal cannula <p>Review of Resident #50's medical record revealed a physician order dated 5/10/22 at 2:47 PM entered by Nurse #1 for oxygen via nasal cannula at 3 liters for shortness of breath and congestive heart failure.</p> <p>Observations of Resident #50 revealed the following:</p> <ul style="list-style-type: none"> - 5/10/22 at 10:24 AM oxygen via nasal cannula at 4 liters - 5/11/22 at 8:41 AM oxygen via nasal cannula at 4 liters - 5/11/22 at 11:56 AM oxygen via nasal cannula at 4 liters <p>Interview with Nurse #1 on 5/10/22 at 2:32 PM revealed there was no physician order for oxygen for Resident #50 since he returned from the hospital on 5/5/22. Nurse #1 stated that a physician order was required for oxygen therapy. Nurse #1 further stated that Resident #50 was receiving oxygen via nasal cannula, so she entered it in the system.</p>	F 695	<p>are appropriate, if applicable. Audits were initiated on 5/19/22 upon first admission since survey.</p> <p>Administrative Nursing Team to do weekly random observations 3x's/week beginning 5/16/22 for 4 weeks to ensure ordered delivery system is in use, as well as, order flow rate.</p> <p>Results will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 695	Continued From page 6 Interview with the Director of Nursing (DON) on 5/11/22 at 8:59 AM revealed that each resident must have a physician order for oxygen to be administered. DON stated that her expectation was that staff follow physician orders as prescribed for correct liter flow of oxygen. DON stated that she was unaware that Resident #50 was receiving oxygen without a physician order. DON stated that an audit would be completed of physician orders for all residents receiving oxygen. Interview with the Nurse Practitioner (NP) on 5/11/22 at 9:45 AM revealed that upon readmission to the facility on 5/5/22, she ordered monitoring of Resident #50's oxygen saturations on room air and if within normal limits remain off oxygen. NP stated that she was not notified of order entered by Nurse #1 on 5/10/22 under her name for Resident #50 for oxygen at 3 liters per minute via nasal cannula for shortness of breath and congestive heart failure. NP further stated that 4 liters of oxygen was not indicated for a patient with chronic obstructive pulmonary disease.	F 695			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		5/20/22	

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F 761	Continued From page 7 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, manufacturer's instructions, and staff interviews the facility failed to a.) secure a controlled medication (Marinol) in the secured lock box in the medication storage room refrigerator in one of two medication storage rooms reviewed b.) failed to remove expired insulin pens and expired house stock medications (Fiber Stat and Geri Tussin) from 2 of 3 medications carts reviewed for medication storage. Findings included. a.) An observation of the North Hall medication storage room was conducted on 05/09/22 at 2:30 PM with Nurse #1. A bottle of Dronabinol (Marinol) 2.5 milligrams was found in the medication storage refrigerator and not in the locked box. The lock box was observed sitting beside of the refrigerator on the counter of the medication room and was not securely	F 761	A) Marinol count/drug verified by 2 nurses; removed card from North Cart Controlled Substance Log Book and card and medication moved to South End Med Fridge Lock Box and card placed in South Cart Controlled Substance Log book with Nurse (SJ) on 5/9/22. Lock Box replaced in North Med Fridge. 5/10/22. B) Expired medications removed from medication cart and discarded per policy on 5/9/22. A) All Controlled Substance Count Books reviewed and cross referenced with card in book to controlled substances in carts. Medication Fridges were audited for functioning lock boxes and audited for refrigerated Controlled Substances on 5/9/22. B) All Medication Carts audited or expired medications by consultant pharmacist and		

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F 761	<p>Continued From page 8</p> <p>attached/fixated to the refrigerator. The lock box did not have medications in it. The DON (Director of Nursing) was notified immediately. Nurse #1 along with the DON acknowledged the Dronabinol was a controlled medication and should be locked in the lock box. The DON removed the medication from the refrigerator and counted the pills with a second nurse. She stated she counted 26 pills in the bottle and stated none were missing. She stated she was taking the medication to the south hall med storage room lock box until the North hall lock box was repaired.</p> <p>An interview was conducted on 05/09/22 at 3:00 PM with Nurse #1. She stated she missed counting the Dronabinol during shift change that morning because the declining inventory sheet was placed behind another section of the narcotic book so therefore it was overlooked. She stated the off going nurse didn't mention the Dronabinol either and it was an oversight. She stated the medication should have been secured in the lock box in the medication storage room refrigerator.</p> <p>An interview was conducted on 05/11/22 at 3:29 PM with the DON. She stated the lock box on the North hall medication storage room was repaired and was now permanently attached to the medication storage room refrigerator. She stated controlled medications should always be maintained securely locked in the lock box in the refrigerator of the medication storage room or locked in the secured lock boxes on the medication carts.</p> <p>b.) During an observation with Nurse #1 on 05/09/22 at 1:00 PM a Lantus insulin injectable pen was observed opened on the medication cart</p>	F 761	<p>pharmacy nurse consultant on 5/9/22.</p> <p>A) Initiated Controlled Substance Log for fridge that is to be completed at shift change by 2 nurses/medication aides 5/13/22. B) Initiated Expired Medication Check Off Log - Night Shift nurse to review all medications for expiration on 5/13/22. Pharmacy Consultant directed to supply expiration tags with "Opened" date and "Expiration" date for all insulins, eye drops, nasal and respiratory medications on 5/10/22.</p> <p>Nursing staff inserviced on new process for ensuring proper medication storage and labeling on 5/12/22. All new nursing staff will be educated/inserviced during orientation.</p> <p>DON or Administrative Nurse designee to review monthly Pharmacy Consultant Medication Review Reports to analyze trends and bring to QAPI as necessary.</p> <p>A) Controlled Substance Card Log and Controlled Substance Fridge will be audited daily x 2 weeks, then 2 x's/week x's 2 weeks, then twice weekly x's 2 weeks, then weekly ongoing. B) Member of nursing admin team to review expired medication check off log for completion daily M-F x's 2 weeks, then twice weekly x's 2 weeks, then weekly ongoing.</p> <p>Member of Nursing Admin Team to audit all medication carts for expired</p>		

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F 761	<p>Continued From page 9</p> <p>located on the North hall. The insulin pen had a handwritten opened date of 03/01/22 and a handwritten expiration date of 03/28/22. The manufacturers label directed to discard 28 days after opening. A house stock medication Fiber-Stat was opened and had a manufacturer's expiration date of 01/16/22.</p> <p>An interview was conducted on 05/09/22 at 1:00 PM with Nurse #1. She stated the last dose administered from the expired insulin pen was on 05/08/22 at 8:00 PM. She stated Lantus was not scheduled to be administered on her shift and therefore she had not looked at the expiration date. She acknowledged the Lantus insulin expired on 03/28/22. She stated Fiber Stat had not been administered for a while and could not recall what resident received Fiber Stat. She acknowledged the Fiber Stat was expired. She stated nurses were to check insulin expiration dates prior to administering the dose and should have identified that the insulin pen was expired and stated the expired house stock medication should have been removed from the medication cart.</p> <p>During an observation with Nurse #2 on 05/09/22 at 1:30 PM a Lantus insulin injectable pen was observed opened on the medication cart located on the South hall. The insulin pen had a handwritten opened date of 04/06/22. The manufacturer's label directed to discard 28 days after opening. A house stock medication Geri Tussin was opened and had a manufacturer's expiration date of 04/2022.</p> <p>An interview was conducted on 05/09/22 at 1:30 PM with Nurse #2. She stated the last dose of Lantus insulin was administered on 05/08/22 at</p>	F 761	<p>medications twice weekly x's 2 weeks, then weekly x's 1 month, then bi-weekly.</p> <p>All results will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 761	Continued From page 10 8:00 PM and she did not administer any during her shift. She stated the expiration date should be checked prior to administering the insulin. She acknowledged both the Lantus insulin pen and the bottle of liquid Geri Tussin were expired. An interview was conducted on 05/11/22 at 3:50 PM with the DON. She stated she expected all expired medications to be removed from medication carts.	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer.	F 812	The Sanitation (Red) Bucket was immediately emptied and refilled by the Certified Dietary Manager with water and sanitation solution upon being made	5/20/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/12/2022
NAME OF PROVIDER OR SUPPLIER PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 11</p> <p>Findings included:</p> <p>During kitchen observations on 05/09/22 at 11:35 AM the Dietary Manager (DM) said the staff used the solution in the red bucket to wipe down the main food preparation table area after lunch food preparation and prior to manning the tray line. DM said their stainless-steel food preparation table was wiped down using the sanitizing solution kept in a red sanitizing bucket kept in the kitchen.</p> <p>At 11:45 PM on 05/09/22 strips were used to check the sanitizing solution in the kitchen's only red sanitizing bucket. The solution in the bucket registered 0-parts per million (PPM) of quaternary sanitizer. DM reported she or her staff did not check the strength of the sanitizing solution in the bucket when it was filled.</p> <p>DM was interviewed on 05/12/22 at 10:20 AM said she preferred the quaternary solution in the red sanitizer bucket to register 200 - 300 PPM when checked with the appropriate strips. She reported when the strength was less than this there was a chance that the surfaces being wiped down were not properly disinfected. She commented the strength of the solution in the bucket should be checked when the bucket was made up and should not have registered 0-PPM.</p>	F 812	<p>aware that it did not meet the appropriate strength for sanitizing solutions (150-400 PPM). New solution was tested and it registered between 300-400 PPM, which was acceptable strength.</p> <p>Dietary staff were inserviced on appropriate strength of sanitizing solution and demonstrated competency in testing for appropriate strength on 5/10/22. All new hires will be inserviced/educated on proper sanitizing strength during orientation.</p> <p>A log sheet has been placed on the clipboard near the test strips and staff have been educated on proper result levels and logging the readings to ensure daily compliance.</p> <p>To ensure the deficient practice does not recur, the Dietary Manager will audit logs/test the solution in the Sanitation Buckets daily, 2 x's per day (a.m. and p.m.) for 4 weeks, then 1 x weekly, 2 x's/day (a.m. and p.m.) x's 4 weeks. The Registered Dietician will also test and report findings upon her monthly sanitation audits and reports given to the Dietary Manager and Administrator ongoing.</p> <p>Results will be forwarded to the QAPI Committee for further review and changes as necessary.</p>		