PRINTED: 07/26/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345217	B. WING _		C 06/30/2022	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2022	
DDEMED	NUIDOINO AND DELLADI	ITATION OFNITED		225 WHITE STREET		
PREMIER	NURSING AND REHABII	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 000	INITIAL COMMENTS		F 0	00		
	to conduct a complair on 06/16/22. The surv facility on 06/30/22 to information and exited LND911. The following intakes NC00189934, NC001 NC00189604. 3 of the 4 complaint a substantiated resultin Immediate Jeopardy of CFR 483.25 at tag F6 (K) CFR 483.45 at tag F7 (J) CFR 483.70 at tag F8 (K)	d on 06/30/22. Event ID# were investigated: 89819,NC00189665, illegations were g in deficiencies.				
	The tag F684 constitu	ited Substandard Quality of				
	and was removed on Immediate Jeopardy to and was removed on Immediate Jeopardy to and was removed on	for F756 began on 5/20/22 6/30/22. for F835 began on 5/19/22 6/30/22. for F925 began on 6/12/22				
F 684 SS=K	A partial extended sur Quality of Care CFR(s): 483.25	rvey was conducted.	F6	84	7/22/22	
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	

Electronically Signed 07/22/2022

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345217	B. WING		C 06/30/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/30/2022	
				225 WHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 684	Continued From page	e 1	F 68	4		
	§ 483.25 Quality of care is a further applies to all treatments facility residents. Base assessment of a resident residents receives accordance with profipractice, the compressore plan, and the resident resident, administer of listed on the hospital medication orders with blood sugars for a resident #3 was unresident resident #3 was unresident resident resulting physician's order for used to treat diabetes day. Immediate Jeog 6/30/22 when the facint residented an accession residented an accession residented an accession residents and residents resident resulting physician's order for used to treat diabetes day. Immediate Jeog 6/30/22 when the facint residented an accession residents residented an accession residents residented an accession residents	are Indamental principle that Int and care provided to led on the comprehensive dent, the facility must ensure the treatment and care in lessional standards of lensive person-centered sidents' choices. This is not met as evidenced liew and interviews with staff, lurse Practitioner and failed to review a history and lepital for a newly admitted diabetes medications as discharge summary, clarify the the physician, and monitor lied hospitalization in the lied hospitalization		F684 Quality of Care Resident #3 no longer resides in the facility. On 6/29/22, the Pharmacist reviewed current residents admitted between 5/19/22 to 6/28/22 medications, including diabetic medications. The Pharmacist checked the resident discharge summand compare it to facility medication orders to ensure medications were transcribed accurately to the medicationadministration record upon admission. The Pharmacist notified the director onursing with all findings. The director nursing contacted the physician for an necessary clarifications and/or further recommendations for any errors identified the director of nursing contacted the physician for an necessary clarifications and/or further recommendations for any errors identified the director of Nursing supports of All States (Not 1997) (ding the nary tion the nary tion the nary tiff tiff tiff tiff tiff tiff tiff tif	
	compliance at the lov	he facility remains out of ver level of scope and ure education is completed		reviewed all diabetic residents to ensi orders for finger sticks are in place as ordered by the physician. The Quality	;	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345217	B. WING _			1	C / 30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	OUIZUZZ
					25 WHITE STREET		
PREMIER	NURSING AND REHAE	BILITATION CENTER			ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CTATEMENT 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pag	ge 2	F	684			
		ems in place are effective.			Assurance Nurse, Nurse Supervisor,		
					Nurse Facilitator, and Director of Nursi	-	
	The findings include				will contact the physician for any reside on diabetic medications identified with	out	
		#3's discharge summary			a fingerstick order to validate need for		
		the hospital revealed a			monitoring. A justification note will be	_	
	_	n list which included the is used to treat diabetes:			documented in the clinical record by th Quality Assurance Nurse, Nurse	е	
	•	is used to treat diabetes. igrams twice per day and			Supervisor, Nurse Facilitator, and Dire	ctor	
		cation used to treat diabetes)			of Nursing for any diabetic resident wh		
	_ ,	ct under the skin one time			physician does not want a blood sugar		
		dation was listed to follow up			obtained. Orders will be written for all		
		ysician for optimal control of			other diabetic residents that require blo	ood	
	diabetes. Blood suga	ar monitoring was not			sugars. The audit was completed by		
	ordered.				6/29/22.		
		mitted to the facility on			On 6/29/22, the Quality Assurance Nu		
		l diagnoses which included in			Nurse Supervisor, Nurse Facilitator, ar		
	-	s, congestive heart failure and			Director of Nursing will review medicat	ion	
	pneumonia.				administration records from 6/1/22 to		
	Davious of the facility	, physician orders entered on			6/28/22 for all current diabetic resident	S to	
	•	y physician orders entered on Manager revealed metformin			ensure diabetic medications were administered per physician orders. The	2	
		mouth twice per day was not			physician will be contacted, and an	,	
	listed on the facility	· · · · · · · · · · · · · · · · · · ·			incident report will be initiated by the		
		,			Quality Assurance Nurse, Nurse		
	Interview with the U	nit Manager on 6/16/22 at			Supervisor, Nurse Facilitator, and Dire	ctor	
		e orders were entered from			of Nursing for any identified areas of		
	the medication list in	n the discharge summary.			concern. The audit was completed by		
	_	eported she called the doctor			6/29/22.		
		ders as needed. The Unit					
		all requesting clarification of			On 6/29/22, the Staff Development		
		s. She indicated there was			Coordinator initiated an in-service with	all	
	•	ood sugars on admission for			nursing assistants, nurses, dietary,	ınto	
		tes. The Unit Manager			housekeeping, medical records, accou	IIIS	
	_	st entered the medications discharge summary or			receivable, accounts payable, maintenance, social work, receptionists	c	
		. She was unable to explain			admissions, Administrator and therapy		
) mg twice daily was not			regarding Signs and Symptoms of		
	,	J	1		0 0 0 7 0 1		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDI			l ,	С
		345217	B. WING				30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	00.2022
				22	25 WHITE STREET		
PREMIER	NURSING AND REHABI	ILITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 684	Continued From page	e 3	F	684			
	entered into the facili	ty's orders as indicated in			Hyperglycemia per the Mayo Clinic		
		the discharge summary.			guideline include but are not limited to		
					elevated blood sugar, nausea, vomiting	J,	
	Review of Resident #	#3's care plan dated 5/23/22			shortness of breath, dry mouth,		
	revealed a problem of	of diabetes with goal of will			weakness, frequent urination, increase	d	
	adhere to treatment r	regimen through next review.			thirst, blurred vision, fatigue, headache	,	
		d fingerstick blood sugar as			and confusion. In-service will be		
		col, observe for signs and			completed by 7/22/22. All newly hired		
		cemia or hyperglycemia (low			nursing assistants, nurses, dietary,		
	, ,	and administer medication			housekeeping, medical records, accou	nts	
	as ordered by the ph	ysician.			receivable, accounts payable,		
					maintenance, social work, receptionists		
	Review of Resident #				admissions, Administrator and therapy		
		d (MAR) for May 2022			be in-serviced during orientation regard		
		ion metformin was not listed.			Signs and Symptoms of Hyperglycemia	1.	
		de 0.75 milligrams, a once ontrol blood sugar, was on			On 6/20/22, the Staff Dayslanment		
		ented on 5/24/22 as not			On 6/29/22, the Staff Development Coordinator initiated an in-service with	all	
	given due to not avai				nurses regarding:	ali	
	given due to not avai	iabic.			Clarify the need for blood sugar		
	Review of Registered	d Dietician progress note			monitoring orders when a resident		
		ted Resident #3's intake was			receiving diabetic medication is admitte	h-d	
		sumed 0-100% of meals.			to the facility without orders in place for		
					glucose monitoring.		
	Review of a physicial	n progress note for Resident			2. Clarify orders for medications and		
	l	icated that the discharge			blood sugar monitoring to include		
		tch the current regimen and			admission medication orders from the		
		ced the need to discuss with			discharge summary with a physician if		
	staff clarification of m	etformin on the discharge			they are not clear and precise before		
	summary medication	list that was not listed on the			transcribing to the MAR.		
	facility orders.				3. Obtain blood sugars when an acut	е	
					change in condition is observed on a		
		#3's 5-day Minimum Data Set			diabetic resident.		
		25/22 revealed a diagnosis			4. If a medication is unavailable, and		
		in, injectable medication for			in the emergency medication kit, notify		
	· ·	ministered. Resident #3 had			pharmacy to obtain medication. If unab		
	_	npairment and received			to obtain medication from pharmacy ar	d	
	speech therapy servi	ces.			administer during the scheduled time,		
	1				notify the physician for alternative orde	rs.	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(
		345217	B. WING _			06/	30/2022
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	NUDONO AND DELIADI	LITATION OFNITED		225 V	VHITE STREET		
PREMIER	NURSING AND REHABI	LITATION CENTER		JAC	KSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 4	F 6	84			
	written by Nurse #1 or revealed the following to verbal stimuli, cool blood sugar of "HI.", if of greater than 400 m	#3's nursing progress note lated 5/25/22 at 9:30 AM g: resident was unresponsive and clammy to touch with indicating a blood sugar level hilligrams per deciliter. The P) was notified and gave		d	n-service will be completed by 7/22/22 All newly hired nurses will be in-service luring orientation. On 06/29/2022 the administrator initiate on in-service with the Director of Nursin Quality Assurance Nurse, Nurse	ed ed	
	5/25/22 for Resident diabetes with hyperonal life-threatening con who experiences high caused by infection of	ency department note dated #3 revealed a diagnosis of smolar hyperglycemic state, dition in a diabetic patient n blood glucose levels or illness which can develop		F C r n ii	Supervisor, Staff Development Coordinator and Nurse Facilitator on the Process for Completion of the Admission Checklist to include medication econciliation for new admissions and notify the physician of any discrepancion the clinical meeting. The Director of Jursing, Quality Assurance Nurse, Nur	on es	
	10:56 AM indicated F level was 711milligra #3 required admissio care unit, required int	Lab report dated 5/25/22 at Resident #3's blood glucose ms per deciliter. Resident n to the hospital intensive travenous insulin to lower his sived treatment for sepsis, a due to pneumonia.		r a s tl	Supervisor, Staff Development Coordinator and Nurse Facilitator to eview all new admissions utilizing the admission check list during the next scheduled clinical meeting held Monda brough Friday to ensure the admission process was completed. In-services wise completed by 7/22/22. All newly hire	า 	
	10:16 AM revealed si 5/20/22 to 5/25/22 du swallowing foods and communication defici revealed that she obs morning of 5/25/22 at	eech Therapist on 6/16/22 at the treated Resident #3 from the to dysphagia (difficulty diquids) and cognitive and tts. The Speech Therapist served Resident #3 on the and noted he had no gag or		E N E F	Director of Nursing, Quality Assurance Nurse, Nurse Supervisor, Staff Development Coordinator and Nurse Facilitator will be in-serviced during prientation regarding Process for Completion of the Admission Checklist		
	Resident #3's change in transfer to the hos Interview with the phy PM revealed he did r	the Nurse Practitioner of e in condition which resulted potal for evaluation. ysician on 6/16/22 at 2:58 not recall being asked to		r C to	The Administrative team to include QA durse, Nurse Supervisor, MDS nurse, Staff Facilitator and Nurse Facilitator was eview the Day of Admission Checklist/Orders Listing Report compart or resident Discharge Summary 5 time week x 4 weeks then weekly x 4 weeks	rill red s a	
		onitoring for Resident #3. stated he became aware on			nen monthly x 1 month Monday-Friday luring clinical meeting. This audit is to	/	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		
			A. BOILDI	NG _		n rge ith to , , per r the g	_
		345217	B. WING			l	
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	NUDCING AND DELIAD	II ITATION CENTED		22	25 WHITE STREET		
PREIMIER	NURSING AND REHAB	ILITATION CENTER		J	ACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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)		COMPLETION
F 684	summary list of meditranscribed to the fact intended to discuss to Resident #3 was disc 5/25/22. The physicia would not have preveblood sugar reading hospitalization. Sepsitalization sugar reading. The physicial informed of the pharmal Resident #3 dated 5/25/22 at 4:16 PM rof 5/25/22 Resident and diaphoretic, his blood indicated elevated blood to the hospital for evidence in the pharmal for the	in was on the discharge cations but was not cility orders. He indicated he his with staff however charged to the hospital on an stated that metformin ented Resident #3's elevated on 5/25/22 which resulted in is, or widespread infection, highly elevated blood sugar an stated he was not macy recommendation for 1/20/22 regarding metformin. Inse Practitioner (NP) on evealed that on the morning #3 was clammy and the sugar registered "HI" which lood sugar and he was sent alluation. NP did not recall Resident #3 had been on alization or a request for an sugars. NP was unaware sted on the hospital	F	684	ensure the facility follows the admission process to include review of the discha summary, verifying admission orders we the physician to include but not limited blood glucose monitoring for diabetic residents, ensuring medications are transcribed accurately to the MAR/TAR and that medications are administered physician orders. The QA nurse, Nurse Supervisor, MDS nurse, Staff Facilitate and Nurse Facilitator will address all concerns identified during the audit to include but not limited to completion of Day of Admission Checklist, transcribin medications and administering medications per physician orders, and notification of the physician for any discrepancies for further recommendations. The DON will review the Day of Admission Checklist/Orders listing report/Discharge Summary Audit times a week x 4 weeks then weekly x weeks then monthly x 1 month to ensurall concerns were addressed.	rge ith to c, per the g	
	the facility medication	n list and was not listed on nadministration record. rector of Nursing (DON) on			The QA nurse will review all review the discharge summary for all new admissions/readmissions 5 times a wex 4 weeks, weekly x 4 weeks then mon	ek	
	summary was used f from the hospital. Th discharge summary paper copy on admis entered the orders fr including the dischar	revealed the discharge for orders for new admissions e facility received the by fax prior to admission or a esion. The unit manager om the discharge summary ge medication list. The DON cian orders for Resident #3			x 1-month Monday-Friday utilizing the Glucose Monitoring Audit Tool. This au is to ensure all residents admitted with diagnosis of diabetes has blood glucos monitoring orders in place and/or valida with the physician need for blood gluco monitoring. The QA nurse will address concerns identified during the audit to	e ate se all	
		y a second nurse to ensure ption as this practice was not			include notification of the physician for discrepancies. The Director of Nursing will review Glucose Monitoring Audit To	١	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING				20/2022	
NAME OF D	ROVIDER OR SUPPLIER	040217	1	٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	30/2022	
NAIVIE OF FI	NOVIDER OR SUFFLIER							
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET			
				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	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 6	F 6	84				
	The Administrator wa Jeopardy on 6/28/22	s notified of Immediate at 2:12 PM			5 times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month Monday-Friday to ensure all concerns were addressed.			
	On 6/29/22 the facility credible allegation of removal:	y provided the following Immediate Jeopardy			The DON will present the findings of th Day of Admission Checklist/Orders list report/Discharge Summary Audit and Glucose Monitoring Audit Tool to the			
		suffered or are likely to rse outcome as a result of			Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the D	av		
	with slurred speech. I Vascular Accident, Ty	rt and oriented on admission Diagnosis include Cerebral vpe II diabetes, congestive			of Admission Checklist/Orders listing report/Discharge Summary Audit and Glucose Monitoring Audit Tool to			
	Hypertension, obesity hemorrhage, and Atri	major depressive disorder, /, insomnia, non-traumatic al fibrillation. On 5/19/22, nitted to the facility with an			determine trends and/or issues that manneed further interventions put into plact and to determine the need for further frequency of monitoring.			
	order for metformin 1	000 mg per tab, one tab by admitting nurse did not			inequency of mornioring.			
	administration record summary. There was	per the hospital discharge no order on the discharge agar monitoring, blood sugar						
	was checked on adm On 5/20/22, the pharr	ission and noted to be 177. macist consultant conducted gimen review and identified						
	the medication Metfor	rmin was not listed on orders. On 5/24/22, the						
	physician completed assessment of the remedications and iden							
		cation would remain on hold						
	function and nutritionathe dulaglutide was n	is received on swallowing al intake. On 5/24/2022, ot administered due to						
	medication not being	available. The nurse did						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345217	B. WING _		,	C 06/30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 225 WHITE STREET JACKSONVILLE, NC 28546	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 684	however, she did not an order to give whe did not exhibit signs hyperglycemia at the to the hospital on the to the physician obtas swallowing function before the medication morning of 5/25/22, unresponsive to verto touch and blood sourse practitioner were sident's condition. examined the resides send Resident #3 to further evaluation. 9 resident was transfeper the physician's conditionad in the physician was transfeper the physician's conditionad in the physician source of the medications, including the physician source of the physician orders to the total pharmacist checked summary and composite medication orders to transcribed accurate administration recompliance of the physician for any side of the physician side of	ey to have it sent that evening, at notify the physician to obtain an the dose came in. Resident mor symptoms of at time. The resident was sent a morning of 05/25/2022 prior aining clarification on and nutritional intake, and on was received. On the Resident #3 was call stimuli, cool and clammy sugar listed as "high." The as on site and aware of the The nurse practitioner and gave new order to the emergency room for 11 was called, and the gred to the emergency room for 11 was called, and the gred to the emergency room for 11 was called, and the gred to the emergency room for 11 was called, and the gred to the emergency room for 11 was called, and the gred to the emergency room for 12 was called, and the gred to the emergency room for 13 was called, and the gred to the emergency room for 14 was called, and the gred to the emergency room for 15 was called, and the gred to the emergency room for 16 was called, and the gred to the emergency room for 17 was called, and the gred to the emergency room for 18 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to the emergency room for 19 was called, and the gred to	F 6	84		

NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER CAU D	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PREMIER NURSING AND REHABILITATION CENTER CAU D			345217	B. WING _			1	30/2022	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 8 physician completed documentation for any errors identified. The audit was completed by 6/29/22. On 6/29/22, the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, Director of Nursing, and Pharmacist reviewed all diabetic residents to ensure orders for finger sticks are in place as ordered by the physician. The Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing contacted the physician for any residents on diabetic medications identified without a fingerstick order to validate need for monitoring. A justification note was documented in the clinical record by the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing for any diabetic resident whose physician did not want a blood sugar obtained. Orders were written for all other diabetic residents that require blood sugars. The			ILITATION CENTER		225 WHITE STREET		, ,		
physician completed documentation for any errors identified. The audit was completed by 6/29/22. On 6/29/22, the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, Director of Nursing, and Pharmacist reviewed all diabetic residents to ensure orders for finger sticks are in place as ordered by the physician. The Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing contacted the physician for any residents on diabetic medications identified without a fingerstick order to validate need for monitoring. A justification note was documented in the clinical record by the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing for any diabetic resident whose physician did not want a blood sugar obtained. Orders were written for all other diabetic residents that require blood sugars. The	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD B CED TO THE APPROPRIA		(X5) COMPLETION DATE	
audit was completed by 6/29/22. On 6/29/22, the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing reviewed medication administration records from 6/1/22 to 6/28/22 for all current diabetic residents to ensure diabetic medications were administered per physician orders. The physician was contacted, and an incident report was initiated by the Quality Assurance Nurse, Nurse Supervisor, Nurse Facilitator, and Director of Nursing for any identified areas of concern.	F 684	physician completed errors identified. The 6/29/22. On 6/29/22, the Qual Supervisor, Nurse Fa and Pharmacist revieensure orders for fing ordered by the physic Nurse, Nurse Superv Director of Nursing cany residents on dial without a fingerstick monitoring. A justification the clinical record Nurse, Nurse Superv Director of Nursing for whose physician didobtained. Orders were diabetic residents the audit was completed On 6/29/22, the Qual Supervisor, Nurse Fa Nursing reviewed merecords from 6/1/22 to diabetic residents to were administered pophysician was contact was initiated by the Control of Nurse Supervisor, Nurs	documentation for any audit was completed by ality Assurance Nurse, Nurse acilitator, Director of Nursing, ewed all diabetic residents to ger sticks are in place as cian. The Quality Assurance visor, Nurse Facilitator, and contacted the physician for cetic medications identified corder to validate need for ation note was documented by the Quality Assurance visor, Nurse Facilitator, and cor any diabetic resident not want a blood sugar re written for all other at require blood sugars. The by 6/29/22. Itity Assurance Nurse, Nurse acilitator, and Director of edication administration of 6/28/22 for all current ensure diabetic medications er physician orders. The ceted, and an incident report Quality Assurance Nurse, curse Facilitator, and Director	F					
Actions taken by the facility to alter the process or system failure to prevent a serious adverse outcome for occurring or recurring: On 6/29/22, the Staff Development Coordinator		system failure to prevoutcome for occurring	vent a serious adverse g or recurring:						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	, ,	MPLETED
		345217	B. WING _			C 06/30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		7013012022
(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	nurses, dietary, house accounts receivable, maintenance, social admissions, Adminis 1. Signs and sympto Mayo Clinic guideling to elevated blood surshortness of breath, frequent urination, in fatigue, headache, at On 6/29/22, the Staffinitiated an in-service 1. Clarify the need for orders when a reside medication is admitted orders in place for glassical physician if they are transcribing to the Massician is observed 4. If a medication is emergency medication betain medication. If from pharmacy and scheduled time, notion orders. On 06/29/2022 the at in-service with the Dassurance Nurse, Nurse, Nurse, Nurse, Nurse, Nurse, Nurse, Include received in the process for contecklist to include received in the process for content in the process for the process for content in the process for the process	e with all nursing assistants, sekeeping, medical records, accounts payable, work, receptionists, strator and therapy regarding: ms of hyperglycemia per the e include but are not limited gar, nausea, vomiting, dry mouth, weakness, creased thirst, blurred vision, and confusion. If Development Coordinator with all nurses regarding: or blood sugar monitoring ent receiving diabetic ed to the facility without ucose monitoring. medications and blood sugar enarge summary with a not clear and precise before	F	884		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		PLETED
		345217	B. WING			1	C 30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	BILITATION CENTER	•	2	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Nurse, Nurse Super Coordinator and Nurse, Nurse Super Coordinator and Nurse admissions util during the next sche Monday through Fri process was completed in the complete of the coordinate of t	sing, Quality Assurance rvisor, Staff Development rse Facilitator to review all izing the admission check list eduled clinical meeting held day to ensure the admission eted. ompleted by 6/29/22. After strator will ensure the es for staff who have not received the in-services are I with instructions to review, and return to the Staff linator or Director of Nursing	F	684			
	received training reg	garding signs and symptoms Staff received training either in					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					TREET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE STREET		c
		345217	B. WING			06/	30/2022
	ROVIDER OR SUPPLIER NURSING AND REHABII	LITATION CENTER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 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		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 756 SS=J	staff interviews verified provided to all nursess monitoring orders, class orders to ensure that discharge summary at transcribed to the me record, and steps to the not available. Inserving administrator provides administrative nurses the admission checklist reconciliation for new of the physician of an review revealed that in by 6/29/22. Interview education was provided Jeopardy removal data Drug Regimen Review CFR(s): 483.45(c)(1)(1)(1)(2)(2)(1)(3)(2)(3)(3)(4)(4)(4)(4)(4)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(6)(5)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	mail. A review of the sign in sheets as well as dight that education was regarding blood sugar diffication of medication medications orders from the reaccurately and precisely dication administration aske when a medication was been expected indicated that the dight education to the regarding the process of set to address medication admissions and notification admissions and notificated that the dedication admissions and notification admissions an		756			7/22/22

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345217	B. WING _		C 06/30/2022		
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		0/30/2022	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	separate, written repattending physician adirector and director minimum, the resider and the irregularity the (iii) The attending phresident's medical reirregularity has been action has been take be no change in the physician should doo the resident's medical selection with the physician should doo the resident's medical selection when the process and step when he or she identified urgenires urgent action. This REQUIREMENT by: Based on record revand the physician, the consultant pharm Medication Regimen identified Metformin treatment of diabetes listed on the hospital omitted from the faci resulting in 12 misses 1 of 2 residents revier (Resident #3). Resid verbal stimuli on 5/25 #3 was cool and clars.	ast be documented on a cort that is sent to the and the facility's medical of nursing and lists, at a nt's name, the relevant drug, he pharmacist identified. Spician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending nument his or her rationale in all record. Cility must develop and all procedures for the monthly that include, but are not as for the different steps in as the pharmacist must take of the pharmacist must take if it is not met as evidenced and interviews with staff the facility failed to act upon the facil	F 7	F756 Drug Regimen Review Resident #3 no longer resides facility. On 6/29/22, the Pharmacist recurrent residents admitted betw 5/19/22 to 6/28/22 medications diabetic medications. The Pharchecked the resident discharge and compare it to facility medicorders to ensure medications we transcribed accurately to the madministration record upon administration.	viewed all ween s, including rmacist e summary cation vere ledication mission.		
	#3 was cool and clar sugar of "Hi," indicati a level greater than 4			1	mission. director of irector of		

PRINTED: 07/26/2022 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	
						,	С
		345217	B. WING _			06/	/30/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMIED	NUDGING AND DELL	ABILITATION CENTER		2	225 WHITE STREET		
PREWIER	NUKSING AND REDA	ABILITATION CENTER		J	JACKSONVILLE, NC 28546		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
F 756	Continued From page	age 13	F7	756			
	-	with a diagnosis of			necessary clarifications. The clarificati	on	
		te with a blood sugar reading of			orders will be obtained, and the physic		
	711 milligrams per				will complete documentation for any		
	J				errors identified. The audit was complete	eted	
	Immediate Jeopar	dy began on 5/20/22 when the			on 6/29/22.		
		upon the Consultant			On 6/29/22, the Quality Assurance Nu	rse	
	Pharmacist's initial	Medication Regimen Review			and the Nurse Supervisor initiated a		
	(MRR) that identifi	ed metformin 1000 milligrams			review of the Consultant Pharmacist's		
	twice per day was not listed on the facility's				New Admission Medication Regimen		
		Immediate Jeopardy was			Review for all current residents admitt		
		22 when the facility provided			between 5/19/22 to 6/28/22 to ensure		
		an acceptable plan of			potential clinically significant medication		
		dy removal. The facility			issues identified by the Pharmacist we		
		npliance at a lower scope and			addressed. The Quality Assurance Nu	rse	
		" to ensure that education is initoring systems in place are			and Nurse Supervisor will address all concerns identified during the audit by	,	
	effective.	illioning systems in place are			obtaining clarification orders from the		
	Checuve.				physician. The audit was completed by	V	
	The findings include	ded:			6/29/22.	,	
					On 6/29/22, the Administrator initiated	an	
	Review of Resider	nt #3's discharge summary			in-service with the Director of Nursing		
		n the hospital revealed a			Medical Records Director and the		
	discharge medicat	ion list which included the			Minimum Data Set Nurses regarding t	he	
	following medication	on used to treat diabetes:			process for reviewing the Consultant		
	metformin 1000 m	illigrams twice per day.			Pharmacist New Admission Medicatio		
					Regimen Review upon receipt to ensu	re	
		idmitted to the facility on			all potential clinically significant		
		cal diagnoses which included in			medication issues identified by the		
	1 '	es, congestive heart failure and			pharmacist were addressed. In-service		
	pneumonia.				will be completed by 7/22/22. All newly	/	
	Poviou of a pharm	agey admission Medication			hired Director of Nursing, Medical Records Director and Minimum Data S	2ot	
		nacy admission Medication dated 5/20/22 at 3:48 PM for			Nurses will be in-serviced during) હ ા	
		led, in part, the following:			orientation regarding Consultant		
		y significant medication issue:			Pharmacist New Admission Medicatio	n	
		mary listed order for metformin			Regimen Review.	•	
	_	mouth twice per day was not			The Quality Assurance Nurse (QA) an	d	
		y physician orders. Instructions			the Nurse Supervisor will review the		
		MRR form indicated to act on			Consultant Pharmacist's New Admissi	on	

Facility ID: 923022

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			C 06/30/2022	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	06/30/2022	
				225 WHITE STREET			
PREMIER	NURSING AND REHA	ABILITATION CENTER		JACKSONVILLE, NC 2854	46		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE	
F 756	Continued From page	age 14	F7	756			
F 750	the potential issue and the response to chart or electronic changes were made notified by sending pharmacy. Review of physicial Resident #3 dated discharge summar regimen and the production of the facility. Review of Resider Administration Recrevealed the median resulting in 12 missues with staff of the facility. Review of Resider Administration Recrevealed the median resulting in 12 missues with the production resu	s and place a copy of this form taken into the resident's paper health record. If order de, the pharmacy was to be a complete order to the an history and physical note for 5/24/22 indicated that the y did not match the current hysician referenced the need to clarification of metformin on the y medication list that was not y orders. In #3's Medication cord (MAR) for May 2022 coation metformin was not listed		Medication Regimen admissions weekly x monthly x 1 month. T all potential clinically medication issues ide Pharmacist were add Assurance Nurse and will address all conce the audit by obtaining from the physician. T review the New Admi Regimen Review we monthly x 1 month to concern were address The QA Nurse will provide the New Admission of the New Admission of Review to the Execution Medical Review to determine that may need furthe into place and to determine the further frequency of respective to the second of the	8 weeks then This audit is to ensure significant entified by the dressed. The Quality of Nurse Supervisor erns identified during clarification orders. The Administrator with ission Medication ekly x 8 weeks there of ensure all areas of esed. The Administrator with item of the Administrator with ission Medication expenses the findings of Medication Regimentive Quality emittee monthly for a country and review the country and review th	g g s sill of n 3 vill he	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCT	TION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING _				C 30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		225 WHITE ST	ESS, CITY, STATE, ZIP CODE REET LLE, NC 28546	1 00/	30/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		BE.	(X5) COMPLETION DATE
F 756	who experiences hig caused by infection of over days or weeks. 10:56 AM indicated I level was 711 milligra #3 required admissic care unit, required in blood sugar and rece widespread infection. Interview with the ph PM revealed he becametformin was on the medications but was orders during his rout to discuss this with swas discharged to the physician stated that prevented Resident reading on 5/25/22 whospitalization. Seps could account for a high reading. The physician informed of the pharmal reading on the pharmal reading on the pharmal reading of the pharmal readin	h blood glucose levels or illness which can develop Lab report dated 5/25/22 at Resident #3's blood glucose ams per deciliter. Resident on to the hospital intensive travenous insulin to lower his eived treatment for sepsis, a due to pneumonia. ysician on 6/16/22 at 2:58 ame aware on 5/24/22 that e discharge summary list of not transcribed to the facility tine evaluation. He intended taff however Resident #3 e hospital on 5/25/22. The metformin would not have #3's elevated blood sugar //hich resulted in is, or widespread infection, highly elevated blood sugar an stated he was not macy admission Medication Resident #3 dated 5/20/22	F	756	DEFICIENCY)		
	6/16/22 at 3:32 PM r admission MRR for r her email as well as nurse's email. A cop facility. The DON wa the MRR was sent to problems with the fac DON revealed that s her email and give to address. The Unit M	rector of Nursing (DON) on evealed that the pharmacy new residents were sent to the Minimum Data Set by was also sent via fax to the as unsure which fax machine of as she stated there were at machines in the facility. The he was to print the MRR from the Unit Manager to lanager was responsible for macy recommendations. The					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345217	B. WING _			C 06/30/2022		
NAME OF PROVIDE		BILITATION 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 PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
DON was over rever for eaddress address to be in Man record for Fress the part of the part	sent to her email looked it and did laded that the exact newly admit ressed as soon at the with the Unit PM revealed the with the pharm greceived and alager stated some medical record to the facility. Ill addressing the Resident #3. The ident #3 may hap harmacy record to the facility is record to the facility. It is a serious adversary on 6/28/22 the facility is a serious adversary on a serious adversary as erious as erious as erious and erious eriou	nission MRR for Resident #3 iil on 5/20/22 and she d not address it. The DON pectation was that the MRR tted resident would be as possible. nit Manager on 6/16/22 at at there had been an ongoing nacy recommendations not addressed. The Unit netimes the pharmacy ere sent via email to the ords or sometimes they were The Unit Manager did not e pharmacy recommendation a Unit Manager stated that we been discharged prior to nmendation being addressed. as notified of Immediate 2 at 2:12 PM. ty provided the following f Immediate Jeopardy e suffered or are likely to erse outcome as a result of	F	756				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING		C 06/30/2022	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 25 WHITE STREET ACKSONVILLE, NC 28546	, 33.00.2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 756	mouth 2 x daily. The transcribe the order administration reconsummary. On 5/20/c conducted an administration administration administration administration and administration and administration administration and administration administration administration administration administration administration administration administration and clammy to as "high." The nurse aware of the reside practitioner examine order to send reside for further evaluation resident was transfeper the physician's admitted to the host diagnosis of sepsis resident representation at the emergency roor administration and the potential to practice. Actions taken to alter failure to prevent a occurring or recurring or recurring or foliamedications, including administration admitted a medications, including administration admitted and administration adm	e admitting nurse did not to the medication or d per the hospital discharge 22, the pharmacist consultant ssion drug regimen review and lation Metformin was not listed sion orders. This was Admission Medication orm by the pharmacist and cotor of Nursing on 05/20/22. dication Regimen Review was be Director of Nursing due to a lang of the process. On 5/25/22, horesponsive to verbal stimuli, at touch and blood sugar listed to practitioner was on site and ent's condition. The nurse led the resident and gave new lent #1 to the emergency room order. The resident was pital with the primary due to pneumonia. The tive was notified of transfer to m for evaluation. The newly admitted to the facility of the process or system serious adverse outcome for	F 756			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING		06	C / 30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546	1 00	130/2022
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 756	orders to ensure meraccurately to the meraccurate of nursing with any necessary clarification orders will be obtained complete documents. The audit will be consumed to the meraccurate of	dications were transcribed dication administration record a Pharmacist will contact the lith all findings, and the lill contact the physician for cations. The clarification ed, and the physician will ation for any errors identified. Inpleted by 6/29/22. Ility Assurance Nurse and the I review the Consultant dmission Medication all current residents 19/22 to 6/28/22 to ensure all gnificant medication issues reacist were addressed. The lurse and Nurse Supervisor erns identified during the arification orders from the will be completed by 6/29/22. Inistrator initiated an irector of Nursing, Medical dethe Minimum Data Set eviewing the Consultant mission Medication Regimen to ensure all potential medication issues identified ere addressed.	F 75	6		
	worked or have not r mailed certified mail sign the in-service, a	trator will ensure the s for staff who have not eceived the in-services are with instructions to review, and return to the staff ctor of nursing prior to next				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345217	B. WING _		,	C 06/30/2022
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546		7575072022
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 756	Continued From page scheduled work shift.		F 7	56		
		eopardy Removal date:				
F 835 SS=K	Jeopardy was validat Record review and in Consultant Pharmacic completed of all resid to 6/28/22 medication medications. Audit of Regimen Reviews for between 5/19/22 to 6 6/29/22. Interview wit (DON), Unit Manager Coordinator verified to completed as of 6/29, and inservice sign in interviews verified that the Administrator to the Director and Minimum the process for review Pharmacist New Adm Review. Inservice recompleted as of 6/29, Jeopardy removal da Administration CFR(s): 483.70 §483.70 Administration A facility must be admenables it to use its reefficiently to attain or practicable physical, well-being of each resident and succession of the second consultation of the second consulta	new admission Medication recurrent residents admitted /28/22 was completed as of the Director of Nursing and Staff Development that 100% of the audits were /22. A review of inservices sheets as well as staff at education was provided by the DON, Medical Records in Data Set nurses regarding of the Consultant hission Medication Regimen cords revealed this was /22. The facility's Immediate the of 6/30/22 was validated.	F 8	35		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345217	B. WING			1	C / 30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2022
					25 WHITE STREET		
PREMIER	NURSING AND REHAI	BILITATION CENTER			ACKSONVILLE, NC 28546		
	OLIMAN PV	TATEMENT OF REFIGIENCIES			·		0.17)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From pa	ge 20	F	835			
	Based on record re	eview and interviews with the			F835 Administration		
		ractitioner, Speech Therapist,			On 06/29/2022 the Corporate Clinical		
		Administration failed to			Director completed a root cause analyst	sis	
		and oversight to ensure			to determine what led to the	510	
	1 -	vere in place for reviewing			administration failures of:		
		Is from the hospital for newly			Accurately transcribe admission		
		administering diabetes			orders from the hospital discharge		
		ed on the hospital discharge			summary.		
		medication orders with the			2. Administer diabetes medications a	as	
	physician, monitorin	ng blood sugars for a resident			listed on the hospital discharge summa	ary.	
	with diabetes, and a	acting upon recommendations			3. Clarify medication orders with the		
	contained in the Co	nsultant Pharmacist ' s new			attending physician or nurse practition	er.	
		on Regimen Review (MRR)			4. Monitor blood sugars for a resider	ıt	
		(Resident #3) reviewed for			with Diabetes.		
	diabetes care.				5. Address the consultant pharmacis		
		5/40/00 1 11			Admission Medication Regime Review		
		y began on 5/19/22 when the			The mark account of the marks and the bank	ul	
	_	e an effective system in place			The root cause was determined to be t	ne	
		and physical from the hospital ting in the omission of the			lack of administrative oversight as a second check to ensure the facility was	•	
		or metformin (a medication			compliant for the below identified	5	
	• •	es) 1000 milligrams twice per			processes and systems. This review		
		opardy was removed on			included assessment of processes and	1	
	6/30/22 when the fa				systems in place for Administration	•	
		ceptable plan for Immediate			oversight to include clinical meetings,		
		The facility remains out of			admission process, medication		
		ower level of scope and			administration, pharmacy services and		
		sure education is completed			physician notifications.		
	and monitoring syst	ems in place are effective.					
					The changes implemented from the		
	The findings include	ed:			review are:		
					The clinical team to include the		
	This tag is cross ref				Director of Nursing, Quality Assurance		
		ord review and interviews with			Nurse, Nurse Facilitator, Nursing		
		pist, Nurse Practitioner and			Supervisor, and Staff Development		
		y failed to review a history and			Coordinator will review new admission		
	• •	ospital for a newly admitted			medications to include diabetic		
		diabetes medications as			medications and blood sugar monitorin	ıg,	
	listed on the nospita	al discharge summary, clarify			physician notifications for medications		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345217	B. WING			06	/30/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
		A D.U. ITATION, OF NITED		22	5 WHITE STREET			
PREMIER	NURSING AND REH	ABILITATION CENTER		JA	CKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ON SHOULD BE HE APPROPRIATE		
F 835	Continued From p	age 21	F	835				
	-	with the physician, and monitor	' '		unavailable, and medication omission			
		resident with diabetes.			report during clinical meeting 5 times			
	_	unresponsive to verbal stimuli			week to ensure accuracy of orders ar			
		quired hospitalization in the			administration of medications as orde			
		t with a diagnosis of			2. The pharmacist will now call the			
		te with a blood sugar reading of			Director of Nursing with any medication	ons		
		r deciliter. This was for 1 of 2			omitted from the discharge summary			
	residents (Reside	nt #3) reviewed for diabetes			are identified during the new Admission	on		
	care.				Medication Regimen Review. The Dir			
					of Nursing will forward any discrepand	cies		
		ecord review and interviews with			to the attending physician or nurse			
		ician, the facility failed to act			practitioner.			
		ant Pharmacist's new admission			On C/20/22 the Administrator comple	4		
		en Review (MRR) that			On 6/29/22, the Administrator comple			
		in (a medication used in the etes) 1000 milligrams twice daily			an in-service with the Director of Nurs Medical Records Director and the	ing,		
		ital discharge summary was			Minimum Data Set Nurses regarding	the		
		acility's physician orders			process for reviewing the Consultant			
		ssed doses of the medication for			Pharmacist New Admission Medication	n		
	_	viewed for diabetes care			Regimen Review upon receipt to ensu			
	(Resident #3). Re	sident #3 was unresponsive to			all potential clinically significant			
	verbal stimuli on 5	5/25/22 at 09:30 AM. Resident			medication issues identified by the			
		lammy to touch with a blood			pharmacist were addressed. All newly	/		
		cating an abnormal reading with			hired Director of Nursing, Medical	_		
		ın 400 milligrams per deciliter.			Records Director and Minimum Data	Set		
		red hospitalization in the			Nurses will be in-serviced during			
		t with a diagnosis of			orientation regarding process for	Nlave		
	711 milligrams pe	te with a blood sugar reading of			reviewing the Consultant Pharmacist Admission Medication Regimen Review			
	7 11 milligrams per	deciliter.			Admission Medication Regimen Revie	5VV.		
	The Administrator	was notified of Immediate			On 6/29/22, the Corporate Clinical			
	Jeopardy on 6/28/	/22 at 2:12 PM.			Director in-serviced the Administrator	and		
					Director of Nursing regarding:			
		ed a credible allegation of			 The process for providing oversign 	jht		
		dy on 6/29/22. The allegation of			through the clinical meeting			
		dy removal indicated:			a. Transcription of newly admitted			
	Resident #3 was a			resident medications per discharge				
		ch. Diagnosis include Cerebral			summary to the medication administra	ation		
	⊢Vascular Accident	, Type II diabetes, congestive			record by reviewing the Admission			

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(0
		345217	B. WING _			06/	30/2022
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDEMED	AULDONIO AND DELLADI	LITATION OF NED		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)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	F 8	335				
		major depressive disorder,			Checklist, resident discharge summary		
	_	y, insomnia, non-traumatic			and resident medication administration		
		al fibrillation. On 5/19/22,			record.		
		nitted to the facility with an			b. The nurse's responsibility to clarify	,	
		000 mg per tab, one tab by			orders for medications and blood sugar		
		admitting nurse did not			monitoring to include admission		
	transcribe the order to				medication orders from the discharge		
		per the hospital discharge			summary with a physician or nurse		
		no order on the discharge			practitioner if they are not clear and		
	summary for blood su	ugar monitoring, blood sugar			precise before transcribing to the MAR		
	was checked on adm	ission and noted to be 177.			c. Monitoring blood sugars for reside	nt	
	On 5/20/22, the phar	macist consultant conducted			with diabetes.		
		gimen review and identified			d. The Director of Nursing's		
		rmin was not listed on			responsibility to review and follow		
	physician admission	orders. This was			recommendations of the Consultant		
	documented on the A				Pharmacist New Admission Medication		
	_	n by the pharmacist and			Regimen Review.		
		or of Nursing on 5/20/2022.					
		cation Regimen Review was			In-service will be completed by 7/22/22		
	-	Director of Nursing due to a			All newly hired Administrator and/or		
		g of the process. On 5/24/22,			Director of Nursing will be in-serviced		
		ted an initial admission			during orientation in the process for		
	assessment of the re	sident and residents itified Metformin as listed on			providing oversight of facility process		
	the discharge summa				through the clinical meeting. The Corporate team to include Regional	al.	
		cation would remain on hold			Vice President (RVP), Clinical Consulta		
		is received on swallowing			and/or Corporate Clinical Director will	aiit	
		al intake. On 5/24/2022,			monitor Clinical meeting outcomes		
		ot administered due to			through onsite visits and/or remote revi	ew	
	_	available. The nurse did			of the following audit tools: Day of		
	-	to have it sent that evening,			Admission Checklist/Orders listing		
		notify the physician to obtain			report/Discharge Summary Audit, Gluc	ose	
	i i	n the dose came in. Resident			Monitoring Audit Tool, and the New		
	did not exhibit signs r				Admission Medication Regimen Review	v	
		t time. The resident was sent			weekly x 4 weeks then monthly x 2		
		morning of 05/25/2022 prior			months to ensure effective systems are	in	
	to the physician obtai	-			place for reviewing history and physica		
		and nutritional intake, and			from the hospital for newly admitted		
		n was received. On the			residents, administering diabetes		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		С		
		345217	B. WING _	B. WING			/30/2022	
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
				22	25 WHITE STREET			
PREMIER	NURSING AND REH	ABILITATION CENTER		J	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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 835	Continued From p	page 23	F	835				
	morning of 5/25/2	2, Resident #3 was			medications listed on hospital discharg	е		
	_	erbal stimuli, cool and clammy			summary, clarifying medication orders			
		d sugar listed as "high." The			with the physician, monitoring blood			
		was on site and aware of the			sugars for residents with diabetes, and			
		on. The nurse practitioner			acting upon recommendations contained			
	examined the resi	ident and gave new order to			in the Consultant Pharmacist 's new			
		to the emergency room for			admission Medication Regimen Review	٧.		
	further evaluation	. 911 was called, and the			The RVP, Clinical Consultant and/or			
	resident was trans	sferred to the emergency room			Corporate Clinical Director will address	all		
	per the physician'			concerns identified during the review to)			
	admitted to the ho			include but not limited to re-training of				
	diagnosis of seps			staff and/or review of systems for furthe				
		tative was notified of transfer to			recommendations and or monitoring. T			
	the emergency ro	om for evaluation.			RVP, Clinical Consultant and/or Corpor Clinical Director will provide the facility			
		y admitted from the hospital and			written summary of each review and/or			
		diabetes have the potential to be			recommendations.			
	affected by the de				The QA Nurse will present the findings			
		alter the process or system			the Corporate Review to the Executive			
		a serious adverse outcome for			Quality Assurance (QA) committee			
	occurring or recur	ring:			monthly for 3 months. The Executive C Committee will meet monthly for 3 mon			
	On 06/29/2022 the	e Corporate Clinical Director			and review the Corporate Review to			
		cause analysis to determine			determine trends and/or issues that ma	ıy		
	what led to the ad	lministration failures of:			need further interventions put into place	e		
	1. Accurately tran	scribe admission orders from			and to determine the need for further			
	the hospital disch	arge summary.			frequency of monitoring.			
	2. Administer diab	etes medications as listed on						
	the hospital disch	arge summary.						
	3. Clarify medicat	ion orders with the attending						
	physician or nurse	e practitioner.						
		sugars for a resident with						
	Diabetes.							
		nsultant pharmacist Admission						
	Medication Regim	ne Review.						
	The root cause wa	as determined to be the lack of						
	administrative over	ersight as a second check to						
	ensure the facility	was compliant for the below						

AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		PLE CONSTRUCTION G	, ,	ATE SURVEY DMPLETED				
		345217	B. WING _			C 06/30/2022		
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 225 WHITE STREET JACKSONVILLE, NC 28546				
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 835	included assessme	s and systems. This review nt of processes and systems stration oversight to include:	F 8	35				
	1. The clinical team Nursing, Quality As Facilitator, Nursing Development Coord admission medication medications and ble physician notification unavailable, and medications as ord 2. The pharmacist Nursing with any medischarge summary new Admission Medicator of Nursing Wirsing Wirsing Medicator of Nursing	edication omission report ing 5 times per week to orders and administration of						
	in-service with the I Records Director at Nurses regarding: 1. The process for I Pharmacist New Ad Review upon receip	ministrator initiated an Director of Nursing, Medical and the Minimum Data Set reviewing the Consultant Imission Medication Regimen of to ensure all potential medication issues identified						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING				3 0/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		225	EET ADDRESS, CITY, STATE, ZIP CODE WHITE STREET CKSONVILLE, NC 28546	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	in-serviced the Admi Nursing regarding: 1. The process for proclinical meeting a. Transcription of not medications per discommedication administrated Admission Checklist summary and reside record. b. The nurse's responsed admission medications and bloom include admission medications and bloom include admission medications and bloom include admission medication if they are before transcribing to c. Monitoring bloods diabetes. d. The Director of Nureview and follow reconsultant Pharmace Medication Regiment In-services will be consultant Pharmace Medication Regiment In-services will be consulted or have not a mailed certified mail sign the in-service, a facilitator and/or direscheduled work shift	corate Clinical Director inistrator and Director of roviding oversight through the rewly admitted resident charge summary to the ration record by reviewing the resident discharge int medication administration resident discharge int medication administration resident discharge of sugar monitoring to redication orders from the with a physician or nurse re not clear and precise of the MAR. resident with resing's responsibility to commendations of the rist New Admission Review. repleted by 6/29/22. After trator will ensure the resident with ensure the resident with ensure the resident will ensure the rewline will ensure the r	F	335			
		ble Allegation of Immediate as validated by onsite					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345217	B. WING		C 06/30/2022
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546	00/00/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 925 SS=J	verification. Interview (DON) revealed that were reviewed 5 time clinical meetings. Int Pharmacy Consultan called with any medic discharge summary to the admission Medicareview of inservices as well as interviews provided by the Corp Administrator and DO providing oversight thand the responsibility new admission Medic Inservice records rev of 6/29/22. The facilit removal date of 6/30/Maintains Effective PCFR(s): 483.90(i)(4) §483.90(i)(4) Maintai program so that the frodents. This REQUIREMENT by: Based on record rev facility staff, Medical and Vascular Surgeo maintain an effective resulting in maggot in wound for 1 of 2 residence in the medical with sepsic complication of an information of an information of an informatical states.	with the Director of Nursing new admission medications as per week during the erview with the Regional at revealed that the DON was eations omitted from the hat were identified during ation Regimen Review. A and inservice sign in sheets everified that education was corate Clinical Director to the DN regarding the process for arough the clinical meeting of the DON regarding the eation Regimen Reviews. Ealed this was completed as y's Immediate Jeopardy 22 was validated. East Control Program In an effective pest control acility is free of pests and interviews with Director, Nurse Practitioner, in, the facility failed to pest control system affestation of a resident's dents wounds (Resident #1) atrol. Resident #1 was ergency room (ER) on only distress. He presented to	F 92		dit e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(С	
		345217	B. WING _			06/	30/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
			22		25 WHITE STREET			
PREMIER	NURSING AND REH	ABILITATION CENTER		JA	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 925	Continued From p	age 27	F S	925				
	1	en Resident #1's dressings		20	On 6/16/2022 100% audit of all reside	nt		
		d the wounds inspected, the left						
		with maggots. Resident #1 had			rooms, common areas and all entrance	;5		
					to the facility was completed by the			
		tests (xrays, CT scans,			Maintenance Director to identify any concerns related to pest control. There			
		t was determined the left heel urce of the infection.			were no other areas of concern identifi			
	Would was the so	dice of the infection.			during the audit.	5u		
	Immediate leonar	dy began on 6/12/22 when the			On 06/16/2022, the Maintenance Direct	tor		
		physician removed Resident			contacted the Pest Control Company for			
		is left leg lower extremity and			additional treatment.	<i>J</i> 1		
	_	as infested with maggots. The			On 06/16/2022 the Administrator			
		dy was removed on 6/18/22			contacted Support Services to order ai	r		
		rovided and implemented an			curtains for the courtyard doors			
		le allegation of Immediate			(completed order 06/17/2022), front			
		. The facility remains out of			entrance, kitchen exit door, and side do	oor		
		ower scope and severity level of			leading to the dumpster to aide in the			
		with a potential for minimal			prevention of flies entering the center.	The		
	,	nmediate Jeopardy) to			air curtains arrived 07/01/2022 and we			
	implement fly redu	uction measures to include fly			installed on 07/12/2022. On 07/18/202	2		
	lights, air curtains	and handicap accessible doors			the electric company completed			
	to the courtyard.				installation of the fly fans with the final			
					electrical work.			
	The findings inclu	ded:			On 06/16/2022 the contracted pest cor	ıtrol		
					company arrived and treated the			
		arge summary dated 5/24/22			perimeter of the building as well as the			
	indicated Residen	t #1 was admitted to the			perimeter of the internal courtyards wit	h a		
		for Sepsis secondary to leg			broadcast spray chemical solution to k	.II		
		cellulitis of bilateral lower legs			and deter flies. Wall mounted fly lights			
		ted heels wounds, severe			were ordered on 06/16/2022 by the per	st		
		e disease (COPD), and venous			control company, for the junction of			
		rogress note written by the			corridors, and near frequently used exi			
		stomy Care Nurse (WOCN)			doors. The fly lights arrived on 6/30/20			
		ealed the posterior left heel			and were installed by the Maintenance			
		as unstageable but surrounded			director on 06/30/2022.			
		moist, pink skin; necrotic tissue			Temporary wall mounted fly traps were			
		l is thick, soft, black, and	mounted by the Maintenance Director at					
		There was no odor or redness			the frequently used exit doors on			
		charged to the facility for wound			06/17/2022.			
	care and subacute	e rehab in anticipation of home			The administrator will oversee the proc	ess		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED							
		345217	B. WING				3 0/2022					
NAME OF P	ROVIDER OR SUPPLIER	0.02.1.		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	30/2022					
TVAINE OF T	TOVIDER OR OUT FIELD				25 WHITE STREET							
PREMIER	NURSING AND REHABI	LITATION CENTER			ACKSONVILLE, NC 28546							
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE					
F 925	Continued From page	e 28	F	925								
	peripheral vascular di nonhealing heel ulcer Review of Resident #	nitted to the facility on es to include to include isease and bilateral			to ensure timely completion of the rece and installation of the wall mounted ligh On 06/16/2022 quizzes were initiated v 100% of staff to include part time and contracted staff, by the Staff Developm Coordinator regarding what to do if you observe pests to include flies. Quizzes be completed by 7/22/2022. On 6/16/2022 100% in-service to include	nts. vith eent u						
	#1 was cognitively int assistance with activit Two venous ulcers we	act and required extensive ties of daily living (ADL's). ere present on admission.			part time and contracted staff, was initiated by the Staff Facilitator with the Administrator, Medical Records, Account Receivable, Nurses, Nursing Assistants	ınts						
	record (EMR) revealer 6/1/22 by the Vascular bilateral lower extremmis a compressive dress leaving only the toes extend up the leg to just consists of a special cand hardens as it dries	ed a physician's order dated ar Surgeon to change ity unna boot (the unna boot essing that fits like a boot exposed and the wraps ust below the knee; it dressing that is applied wet es to conform to the leg, this	t							Housekeeping staff, Social Worker, Accounts Payable, Therapy Staff, Maintenance Staff, receptionist, Medica Records and Supply Clerk in regards to Pest Control to include (1) Prevention of pest control concerns and (2) reporting pest control concerns into the electroni work order system and notification of Administrator, Director of Nursing and	of c the	
	self-adherent wrap wl apply compression) w Cleanse right lower e cleanser, pat dry with to open areas on hee gauze pads and wrap once a week.	4x4 gauze, apply xeroform Is and cover with thick with unna boot dressing			Maintenance Director (3) The process flies laying eggs and transitioning to maggots. In-services will be completed 7/22/22. All newly hired Administrator, Medical Records, Accounts Receivable Nurses, Nursing Assistants, Housekeeping staff, Social Worker, Accounts Payable, Therapy Staff, Maintenance Staff, receptionist, Medical	by						
	record (TAR) revealed left lower extremity (L pat dry with 4x4 gauz area on left heel, cove and wrap with unna b needed was signed o	c1's treatment administration d the treatment to cleanse (LE) with wound cleanser, e, apply xeroform to open er with large gauze pads, coot every week and as ff by the Wound Care Nurse tent for the right lower			Records and Supply Clerk will be in-serviced during orientation regarding Pest Control. On 6/16/2022 an in-service was initiate by the Staff Development Coordinator 100% of all nurses, CNAs, and therapis to include part time and contracted staf regarding observation and reporting of	ed, with st						

	DF DEFICIENCIES CORRECTION	L IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING_			C 06/30/2022		
NAME OF P	ROVIDER OR SUPPLIER	2.12		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/-	30/2022	
TO TWIL OF TH	TO VIDER OR GOLF EIER				, , ,			
PREMIER	NURSING AND REHABI	LITATION CENTER			25 WHITE STREET			
				J	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 925	Continued From page	e 29	F 9	925				
	by the Wound Care N				wound concerns to include dressing coming off and larvae observed in a resident's wound bed. In-services will be			
		1's emergency room record			completed by 7/22/2022. All newly hire			
		note dated 6/12/22 by the naggot infestation of the left			nurses and CNAs, and therapist will be			
		t #1 was treated at the			in-serviced during orientation regarding wound dressings.	,		
		e body's overwhelming and			The Quality Assurance Nurse (QA) will			
		nse to an infection that can			provide oversight of the treatment nurs			
		e, organ failure death) with			by observing 5 residents with wounds			
	intravenous (IV) fluids				weekly x 8 weeks then monthly x 1 mo	nth		
	, ,				utilizing a Wound Care Audit Tool. The			
	An interview with the Wound Care Nurse (WCN)				audit is to ensure that any wounds with	1		
	was conducted on 6/	15/22 at 2:55 PM. She			concerns to include larvae are being			
		as admitted to the facility			reported and addressed. Any areas of			
		unds and a wound on top of			concern identified during the audits will	be		
	_	on right lower leg. She			addressed by the QA nurse to include			
		ssing change order was to			providing additional staff training, and			
		heel wounds and wrap in			physician notification with documentati	on		
	unna boot (dressing t	-			in the clinical records. The DON will			
		it dries), and then wrap in			review and initial the Wound Care Audi			
		ith a self-adherent wrap			Tools weekly x 8 weeks then monthly x			
		and apply compression once he had changed Resident			month for completion and to ensure all areas of concern were addressed.			
		22 and his heels had been			The Maintenance Director will complete	_		
	_	reas and serosanguinous			an audit of all resident care areas for	,		
	-	age. She indicated she			signs and symptoms of pest to include	but		
		gots would have gotten in			not limited to flies and fly larvae weekly			
		he had not seen any flies			8 weeks then monthly x 1 month. This	,		
		ressing. She stated she			audit is to identify any concerns related	l to		
		ould have gotten in the			pests. The Maintenance Director will			
	dressing.	-			address all concerns identified during t	he		
					audit to include notification of the			
		ervation were conducted			Administrator and/or Director of Nursin	g		
		6/16/22 at 10:00. She stated			of all concerns identified and/or			
		her room a lot. She further		notification of pest control company for				
		. A fly was observed in the			treatment of all resident areas identified			
		s right leg, foot and toes.			as having pests. The Administrator will			
	Resident #2 was observed to have a dressing on				review all environmental rounds			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345217	B. WING			C 06/30/2022		
NAME OF D	DOMEST OF CURRY	343217	B: *******	0.7	EDEET ADDRESS SITY STATE ZID SODE	06	3/30/2022	
NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
PREMIER	NURSING AND REH	ABILITATION CENTER			5 WHITE STREET			
				JA	ACKSONVILLE, NC 28546			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 925	Continued From p	age 30	F 9	925				
F 925	the right foot. The of the dressing and dressing. An interview was a AM with the Activity every year in the sasking for fly swath the residents had Resident Council shared the informateam (IDT) the neswatters had been member and she residents that required an interview was Director on 6/16/2 contracted pest contract	fly was observed on the edge d drainage was noted on the conducted on 6/16/22 at 10:15 ties Director (AD). She stated spring the Residents would start ters. She further stated when complained at the May 2022 Meeting about flies, she had ation with the interdisciplinary at morning. AD indicated the fly in donated by a resident's family was passing them out to uested them. Conducted with the Maintenance 2 at 10:25 AM. He stated the entrol company came to the entrol came to came to company came to the entrol company came to the en	F 9	9925	completed for pests weekly x 8 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will forward the Wound Care Audit Tool and the Environmental Rour completed by the Maintenance Director the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 month. The Executive QAPI Committee will review Wound Care Audit Tool and the Environmental Rounds monthly for 3 months to determine trends and / or issues that may need further interventing put into place and to determine the need for further and / or frequency of monitoring.	nds r to ons		
	Director (MD) on 6 he saw Resident # stated Resident #	conducted with the Medical 6/16/22 at 10:45 AM. He stated #1 for a history and physical. He 1 had been admitted with eral chronic nonhealing heel						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING _				30/2022
	ROVIDER OR SUPPLIER NURSING AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 225 WHITE STREET JACKSONVILLE, NC 28546	DE	, 33	V
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 925	wounds. The MD ind admitted to the facilit and an order by the value of the dressings boots. The MD stated wanted to perform the office on 5/31/22. The the wounds or the dreat the hospital it would happened during the the unna boot would from the outside. He maggots were not in Care Nurse changed have reported it to make an abnormal find should not have been an another to make an abnormal find should not have been and the transport of the trans	cated Resident #1 was y with bilateral unna boots /ascular Surgeon not to s on the heels or the unna d the Vascular Surgeon had e first dressing change in his e MD stated he never saw essing change. The MD nots were found in the wound d have had to have dressing change because be very hard to penetrate stated that obviously the wound when the Wound the dressing or she would e. He indicated maggots ding in a heel wound and in there. ducted with Unit Manager 800 halls on 6/16/22 at 1:10 dent #1 had been on rs due to his vaccination ated he was confined to his ff the quarantine hall for 3 scharged to the hospital. She e outside with his family a	FS	025			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345217	B. WING		_	C 06/30/2022		
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, ST 225 WHITE STREET JACKSONVILLE, NC 28		00/00/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREIT	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)			
F 925	maggots were found stated he did not us practice. He further under the unna boo occurred during the Vascular Surgeon's maggots had cause they certainly could. The Administrator, I and Regional Nurse Immediate Jeopard. On 6/17/22 the facilic credible allegation of Removal: F925 Recipients who have suffer, a serious addithe non-compliance On 06/12/22 at app #1 had a change in status, respiratory in unresponsive to ver arousable, very agit sleep". The nurse morder to send to the evaluation. At 7:44 to notify the family. approximately 11:00 called the hospital the emergency room nureceive continuation.	d read in the ER notes that d in the left heel wound. He se medical maggots in his stated that if maggots were t dressing it had to have dressing change. The tated he was unsure if the d the wound infection, but have contributed to it. Director of Nursing (DON), a Consultant were notified of y on 6/16/22 at 2:05 PM. Dity provided the following of Immediate Jeopardy e suffered or are likely to werse outcome as a result of the condition, altered mental ansection, and was altered to made the physician aware with emergency room for pm the nurse made attempts	F	925				
	Pulmonary Disease also communicated	d Chronic Obstructive . The emergency room nurse that maggots were identified heel wound. The 3-11:00 pm						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345217	B. WING			1	3 0/2022	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	•	22	REET ADDRESS, CITY, STATE, ZIP CODE 5 WHITE STREET ACKSONVILLE, NC 28546	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 925	Continued From pag	e 33	F:	925				
	morning of 06/13/20: Administrator and Di investigation to determaggots. There was no fly nor nor on the resident of with the application of physician order. The dressing that is not was able to move be mobile throughout the well as had an outing discharge to the ER	rector of Nursing on the 22. On 06/13/2022, the rector of Nursing initiated an rmine the root cause of the larva observed in the room luring the dressing change of the unna boot per unna boot is a permeable racuum sealed. The resident of the lower extremities, was a facility and grounds, as g with his family prior to on 06/12/2022. Therefore the odetermine when or how a fly						
	non-compliance with control system. On 6/13/2022 the Di Wound Care Nurse i all current residents to ensure there were worsening of the wowound bed. There we concern identified du. On 6/16/2022 100% common areas and a was completed by the identify any concerns. There were no other during the audit. On Maintenance Director Company for addition.	audit of all resident rooms, all entrances to the facility e Maintenance Director to s related to pest control. areas of concern identified 06/16/2022, the or contacted the Pest Control nal treatment.						
	There were no other during the audit. On Maintenance Directo Company for additio	areas of concern identified 06/16/2022, the or contacted the Pest Control nal treatment.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345217	B. WING _			1	C / 30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 WHITE STREET JACKSONVILLE, NC 28546			30/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 925	courtyard doors (confront entrance, kitcheleading to the dumps of flies entering the cindicated that the air approximately 07/20, order, with subseque Services after receip will oversee the processory of the receip will oversee the processory arrived and building as well as the courtyards with a brosolution to kill and delights were ordered control company, for near frequently used company indicated the arrive approximately Maintenance Director (ly lights once received fly traps were mounted (lights were ordered of the lights once received (ly traps were mounted (ly lights) once received (ly lig	enpleted order 06/17/2022), en exit door, and side door ster to aide in the prevention senter. Support Services curtains will arrive by //2022 due to being a special ent installation by Support to fitems. The administrator ess to ensure timely seipt and installation of the air contracted pest control at treated the perimeter of the see perimeter of the internal seadcast spray chemical eter flies. Wall-mounted fly on 06/16/2022 by the pest the junction of corridors, and exit doors. The pest control ne wall mounted fly lights will	FS	925			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345217	B. WING _		_	C 06/30/2022
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER		STREET ADDRESS, CITY, ST 225 WHITE STREET JACKSONVILLE, NC 2		,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)	
F 925	the staff developmer Nursing prior to next staff unable to succe two attempts will not further retraining is of to answer correctly. Actions taken to alter failure to prevent a succurring or recurring On 6/16/2022 100% time and contracted Staff Facilitator with Records, Accounts Fassistants, Houseke Accounts Payable, Tassistants, Houseke Accounts Payable, Tassistant	ant coordinator or Director of scheduled work shift. Any essfully answer the quiz after be allowed to work until completed and they are able or the process or system erious adverse outcome from a grin-service to include part staff, was initiated by the the Administrator, Medical Receivable, Nurses, Nursing eping staff, Social Worker, Therapy Staff, Maintenance ledical Records and Supply lest Control to include (1) control concerns and (2) of concerns into the electronic	F	025		

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			06/3	; 80/2022
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	•	STREET ADDRESS, 225 WHITE STREE JACKSONVILLE		1 00/0	7012022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 925	o6/17/2022, the Admin-services are mailed has not worked and with instructions to reand return to the stand return to next staff member will we education has been a limmediate Jeopardy. The facility alleges the Jeopardy on 6/18/22. On 6/20/22 the credit Jeopardy removal we retification. Record Nurse interview verification. Record Nurse interview verification. This audit wings or symptoms of and no larvae in the were identified durin. Record review, obsetthe Maintenance Dirall resident rooms, contrances to the facility and control. Review of the Summary of Service sprayed for flies on 6 lights were ordered and installed wall mounted fly ligh Maintenance Directed doors on 6/17/22. At 1975 and 1975 are maintenance Directed doors on 6/17/22. At 1975 and 1975 are maintenance of the standard returns and the sta	ces will be completed inistrator will ensure the ed to any remaining staff who not received the in-service eview, sign the in-service, ff facilitator or Director of scheduled work shift, no rk after 06/17/2022 until completed. Removal Date-6/18/22 The removal of Immediate as validated by onsite review and Wound Care fied an audit was completed are all current residents with was to ensure there were no of worsening of the wound wound bed. No concerns	F	025			

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			C 06/30/2022	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 225 WHITE STREET JACKSONVILLE, NC 28546	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 925	Continued From pag	ge 37	F	925			
	Support Services we curtains for the cour entrance, kitchen exto dumpster to aide entering the facility. Summary and Orde curtains had been of the curtains as well as standard part time and Development Coorder system and not prevention of pest control concern order system and not prevention of the proof transitioning to mag completed on 6/17/2 any remaining staff received the in-service, and callitator or Director scheduled work shift allowed to work after been completed. On 6/16/22 an in-second contracted and reporting of work and the curtains and contracted and reporting of work and the curtains and contracted and reporting of work and the curtains are curtains as the curtains and contracted and reporting of work and the curtains are curtains as the curtains are curta	it door, and side door leading in the prevention of flies Review of the Order r Confirmation verified the air rdered. Sees, and in-service sign in aff interviews verified ded to 100% of staff to d contracted staff by the Staff					
	resident's wound be completed on 6/17/2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345217	B. WING _			C 06/30/2022	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP 225 WHITE STREET JACKSONVILLE, NC 28546	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 925	received the in-serv sign, and return to the prior to next schedu member will work at completed.	have not worked and not ice with instructions to review, he Staff Facilitator or the DON led work shift, no staff iter 6/17/22 until education is eval date of 6/18/22 was	FS	925			