STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 3/19/24 to conduct a recertification and complaint investigation survey and exited on 3/22/24. Additional information was obtained on 3/27/24. Therefore the exit date was changed to 3/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID EYSA11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 3/19/24 to conduct a recertification and complaint investigation survey and exited on 3/22/24. Additional information was obtained on 3/27/24. Therefore the exit date was changed to 3/27/24. Event ID# EYSA11. The following intakes were investigated: NC00206737, NC00203038, NC00214529, NC00205668, NC00207222, NC00208662, NC00211656, NC00206970, NC00202390, NC00205736, NC00208175, NC00208643, NC00214460, NC00207641, NC00211115. 14 of the 43 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		4/23/24

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

Electronically Signed | 04/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Psychiatric Nurse Practitioner interviews, the facility failed to protect 2 of 5 residents' rights to be free from physical abuse (Residents #114 and #29). All residents involved resided in the memory care unit. Resident #99 struck the back of Resident #114's head on 9/8/23 and hit Resident #114's left jaw twice on 10/11/23. Both incidents occurred after Resident #114 wandered into Resident #99's room. Resident #114 had redness and a small amount of swelling to the left side of face after the second incident. Resident #99 slapped Resident #29 on the cheek after Resident #29 touched Resident #99's pants in the activity room. Resident #29 sustained no injuries. A reasonable person would not expect to be physically abused in their home and would experience feelings such as intimidation, fear, humiliation, embarrassment, and anxiety. This was for 2 of 5 residents reviewed for abuse. 1. Resident #99 was admitted to the facility on 2/15/2022. Resident #99's diagnoses included nontraumatic brain dysfunction, dementia, paranoid schizophrenia, anxiety disorder, hypertension, hallucinations, and major depressive disorder. Resident #99's Quarterly Minimum Data Set (MDS) assessment dated 8/25/2023 revealed he	F 600	F 600 Free from Abuse/Neglect On 9/8/2023, Resident #114 was assessed for injuries by the hall nurse, physician services and resident representative (RR) notified and appropriate treatment put in place. Resident did not remember occurrence within hours of the occurrence. On 10/11/2023, Resident #114 was assessed by the hall nurse, physician services and resident representative (RR) notified, and appropriate treatment put in place. Resident #99 was placed on 1:1 supervision. On 2/26/2024, Residents #29 and #99 were separated by the NA. Resident #29 was assessed by the hall nurse with no injuries noted to face. On 4/19/2024, the Social Worker and Medical Records initiated interviews with all alert and oriented residents regarding abuse. The Social Worker and Medical Records will immediately report all concerns identified during the interviews to the Director of Nursing (DON) and Administrator for further investigating and/or reporting per facility protocol. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 was moderately cognitive impaired. Resident #99 was coded as exhibiting disorganized thinking and inattention. Resident #99's annual Minimum Data Set dated 12/21/23 revealed he was cognitively intact, and he was coded for supervision or independence for most activities of daily living. Resident #99's care plan initiated on 2/22/2022 had a focus on resident's ineffective coping characterized by ineffective coping, verbal/physical aggression or agitation, or combativeness related to cognitive impairment/dementia or aggressive to other residents who wander into his room. This focus had an intervention that included the resident was placed on 1:1 continuous observation on 10/11/2023. Resident #99's care plan last revised on 2/16/24 had a focus on resident's ineffective coping characterized by verbal/physical aggression agitation, or combativeness related to cognitive impairment/dementia or aggressive to other residents who wander into his room. This focus had an intervention that included the resident was placed on 1:1 continuous observation on 10/11/2023. Review of physician's orders revealed no orders for Resident #99 to have a 1:1 sitter. a. Resident #114 was admitted to the facility on 3/21/2023. Resident #114's diagnoses included dementia, anxiety, irritability, and anger. Resident #114's most recent Quarterly Minimum	F 600	interviews will be completed by 4/23/2024. On 4/19/2024, the hall nurses completed skin assessments on all non-alert residents for signs and symptoms of abuse to include but not limited to bruising, skin tears and signs/ symptoms of pain. There were no concerns identified during the assessments. On 4/19/2024, the Director of Nursing (DON) initiated an audit of progress notes for the past 30 days. This audit was implemented to identify any resident signs and symptoms of abuse to include but not limited to new bruising or skin injury and/or behaviors that had not been previously reported and addressed. The DON, Assistant Director of Nursing (ADON), and/or Unit Managers will address all concerns identified during the audit to include retraining. The audit will be completed by 4/23/2024. On 4/11/2024, the DON reviewed incident reports related to resident-to-resident abuse for the past 60 days to identify patterns and trends and ensure an appropriate intervention was put into place. Any areas of concern identified will be immediately addressed during the audit to include notification of MD or RR and behaviors care planned. The audit will be completed by 4/23/2024. On 4/11/2024, an in-service was initiated by the Assistant Director of Nursing (ADON) with all staff regarding managing residents with behaviors, reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 Data Set (MDS) assessment dated 1/12/2024 revealed he had severe cognitive impairment. The care plan created on 3/22/2023 indicated Resident #114 was allowed to wander on the unit and be redirected as needed from other residents' rooms. The Facility Reported Incident (FRI) dated 9/8/2023 revealed Resident #114 wandered into the room of Resident #99 leading to an altercation and Resident #99 reported to have struck Resident #114 at the back of the head. The report indicated Resident #114 was upset regarding the altercation but remained calm. The report revealed Resident #99 was placed om 1:1 monitoring, and Resident #114 placed on every 15 minutes check. The report further revealed a STOP sign was placed on Resident #99's door and that both resident's care plans were updated to reflect the additions. Resident #114's progress note completed by the Assistant Director of Nursing (ADON) on 9/8/2023 at 4:15 p.m. revealed she interviewed Resident #114 who disclosed being hit by Resident #99 and denied pain. The note further revealed the ADON completed a skin assessment and Resident #114 was noted with skin tear to right wrist and left base of head/neck. The note reveals she initiated a Neuro check and skin check placed. She further revealed she contacted the medical provider and responsible party for the resident. A review of the Facility Reported Incident (FRI) dated 10/11/2023 revealed Resident #114 wandered into the room of Resident #99 resulting in an altercation. Resident #99 hit Resident #114	F 600	behaviors, and prevention of resident-to-resident abuse. The in-service will be completed by 4/23/2024. After 4/23/2024, any staff that has not received the in-service will be educated prior to the next scheduled shift. All newly hired staff will receive the in-service during orientation by the Staff Development Coordinator (SDC) or the DON. All progress notes and behavior alerts will be reviewed by the Unit Manager, Quality Assurance (QA) Nurse, and RN Supervisor five times a week x 4 weeks, then monthly x 3 months, during the morning meeting utilizing the Behavior Monitoring tool. The purpose of the review is to ensure all behaviors are being addressed to include timely implementation of an intervention added to the care plan in attempt to prevent resident to resident altercations. The Administrator will review the Behavior Monitoring tool weekly x 4 weeks, then monthly x 3 months. Any areas of concern identified will be immediately addressed by the Administrator and/or the DON. The Administrator will forward the results of the Behavior Audit tools to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 4 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

twice on the left jaw to get him out of his room. Resident #114 was noted with redness and small amount of swelling to left side of face. Again, the report stated that Resident #99 was placed on 1:1 monitoring immediately, and Resident #114 placed on a 15-minute checks.

The nursing progress incident note dated 10/11/2023 at 18:10 p.m. by the ADON revealed she assessed Resident #114 who had his left side of face red and slightly swollen. She further documented that Resident #114 was placed on observation every 15 minutes and the medical provider was notified of the incident and no new orders were given at that time.

In an interview with Resident #114 on 3/19/2024 at 1:34 p.m. he stated he was fine and could not recall altercations he has been involved with Resident #99.

During an interview with Resident #99 on 3/19/2024 at 2:21 p.m. he revealed he did not remember hitting Resident #114, but revealed he yells at anyone invading his space and property. He stated he has hit some residents to make them leave his room.

In an interview with the Nurse Aide #8 (NA#8) on 3/21/2024 at 11:40 a.m. she revealed that on 10/11/2023 she was coming out of the shower room with another resident and saw Resident #114 stumble out of Resident #99's room backward. She revealed she caught the resident and sat him in the TV room. She stated Resident #99 reported Resident #114 wandered to his room and he had struck him twice on the side of the jaw to make him leave the room. NA#8 reported Resident #99 had removed the stop sign

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

from his door. She revealed that during incidents of 9/8/2023 and 10/11/2023 no on 1:1 monitoring.

During an interview with NA#8 on 3/21/2024 at 10:45 a.m. she stated Resident #114 and Resident #99 were not on 1:1 monitoring on 9/8/2023 and 10/11/2023, but they monitored the resident s as they went about. She revealed she was the medication technician during the incident of 9/8/2023 when a NA told her Resident #99 had hit Resident #114. She revealed she called a Nurse who attended to Resident #114. She further revealed there were no injuries during the two incidents and that Resident #99 had a psychiatric appointment on 10/23/2023 due to hitting resident #114 on 10/11/2023.

Resident #114's Psychiatric Nurse Practitioner (NP) note dated 10/12/2023 at 8:00 a.m. revealed Resident #114 did not have any injuries noted to his face, but had his left cheek was red with no bruising or swelling. The NP noted that Resident #114 denied pain and staff reported Resident #114 to be at baseline and stable.

An interview on 3/21/24 at 1:42 PM with the Psychiatric Nurse Practitioner (NP) revealed she had been notified of the incident between Resident #99 and Resident #29. She stated she had a meeting with the facility Administrator to discuss potential changes in Resident #99's care which included a move to a different facility. She stated that she was not aware he had a 1:1 sitter.

An interview was conducted with the Director of Nursing (DON) on 3/22/2024 at 12:19 p.m. She revealed that Resident #99 had been placed on a 1:1 supervision on 9/8/2023 and 10/11/2023 to ensure safety of other residents in the unit. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

revealed the changes for Resident #99 were care planned. She revealed the facility in coordination with the psychiatrist were working on moving Resident #99 to a larger area within the facility away from other residents on the dementia unit and possibly transfer to an inpatient psychiatric facility. The DON stated she was not sure when the 1:1 supervision for resident #99 stopped on both incidents. She revealed the 1:1 monitoring of Resident #99 at arm's length did not stop after the incident of 10/11/2023.

An interview was conducted with the Administrator on 3/22/2024 at 12:29 p.m. who stated she had been at the facility for 3 weeks. She revealed Resident #99 will remain on 1:1 supervision, keep the stop sign posted on his door, and in the interim move Resident #99 to a safer area in the facility where no resident is wandering. She revealed Resident #99 was supposed to have remained on 1:1 monitoring due to his behavior. She revealed she was not sure why 1:1 monitoring for Resident #99 was stopped and when.

Telephone calls to the prior Administrator on 3/20/2024 at 12:00 p.m. and 3:27 p.m., and on 3/21/2024 at 11:10 a.m. went unanswered.
b. Resident #29 was admitted to the facility on 12/20/23 with diagnoses that included traumatic brain injury and non-Alzheimer's dementia.

Resident #29's significant change Minimum Data Set dated 1/06/24 revealed he was severely cognitively impaired, and he was coded for assistance or independence for most activities of daily living.

A review of the Facility Reported Incident (FRI)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

dated 2/26/24 read in part Resident #29 was touching Resident #99 on the pant leg. Resident #99 stated "Do not touch me" and then slapped Resident #29 on the cheek. Staff separated both residents.

The FRI continued that Resident #99 had a Brief Interview for Mental Status (BIMS is an assessment tool used to screen and identify cognitive condition) score of 13 in December. A Saint Louis University Mental Status (SLUMS) was completed on 2/26/24 with a score of 10. (SLUMS is an assessment tool used to detect cognitive impairment. A score of 1-19 is defined as cognitive impairment and is indicative of dementia). A subsequent BIMS was also completed on 2/26/24 with a score of 6. (A score of 13-15 is cognitively intact and a score of 0-7 is severely impaired cognition.)

The FRI continued that Resident #29 was monitored throughout the day and did not have any change in his daily routine to indicate mental anguish.

An interview on 3/22/24 at 10:20 AM with Nursing Assistant (NA) #1 revealed she was the only facility staff person in the activities room during this incident. She stated she had not witnessed the incident as she was passing out the breakfast trays. She stated she heard the slap and turned to see what was going on. She then separated the residents and notified the nurse. NA #1 stated she thought that Resident #99's 1:1 sitter was out of the room in the hall.

An interview was attempted with NA #3 who was assigned as a 1:1 sitter for Resident #99 on 2/26/24 but was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

Nurse's progress note completed by Nurse #1 dated 2/26/24 at 10:53 AM for Resident #29 revealed no pain or skin concerns noted.

Nurse's progress note completed by Nurse #1 dated 2/26/24 at 12:32 PM revealed Resident #99 reported Resident #29 was touching his pants leg. Resident #99 stated he told Resident #29 not to touch him and then slapped him on the face. The Nursing Assistant was across the room passing breakfast trays and was unable to intervene quick enough to prevent the physical altercation. The residents were moved to separate tables.

An interview on 3/21/24 at 2:03 PM with Nurse #1 revealed she was the nurse on duty in the memory care unit on the day shift on 2/26/24. She stated she had not witnessed the incident between Resident #99 and Resident #29. She stated that Resident #99 had a 1:1 sitter due to a previous resident to resident incident and she did not know where Resident #99's 1:1 sitter was during the incident. Nurse #1 stated that Resident #29 quickly forgot what happened and had no injuries as a result of the slap.

An interview on 3/21/24 at 1:42 PM with the Psychiatric Nurse Practitioner (NP) revealed she had been notified of the incident between Resident #99 and Resident #29. She stated she had a meeting with the facility Administrator to discuss potential changes in Resident #99's care which included a move to a different facility. She stated that she was not aware he had a 1:1 sitter.

An interview on 3/22/24 at 8:10 AM with the Director of Nursing (DON) revealed that they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 were exploring options for Resident #99 to be relocated to a private room or to another facility, and his family had also discussed taking him home. She stated due to Resident #99's history of physical abuse the facility had continued the 1:1 sitter for Resident #99, and she felt they should continue the 1:1 sitter until they found another option for him. She stated that prior to the 2/26/24 incident Resident #99 had been in line-of-sight monitoring, but all staff had been educated to remain within arms' reach after the incident on 2/26/24. She clarified that staff were verbally educated that line-of-sight just meant to keep the resident within sight and arms reach meant to stay within physical reach of the resident. She stated this was just verbal instruction and the facility had no policy about 1:1 sitters. An interview on 3/22/24 at 8:33 AM with the Administrator revealed she believed that Resident #99 did not mean any harm, he just wanted Resident #29 to stop touching his pants leg. She stated that Resident #99's 1:1 sitter had been in line-of-sight and that was changed to within arms' reach after the incident on 2/26/24.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 10 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and submit an initial report for an abuse allegation within 2 hours of discovery to the state regulatory agency. The facility also failed to notify the police department, or Adult Protective Services (APS) for staff to resident abuse (resident #350) for 1 of 3 residents investigated for facility reported incidents. Findings included: A facility grievance form dated 10/10/23 was filed by SW#1 on behalf of resident #350. A review of the form revealed the resident stated her hair was pulled and that a bruise on her right hand was caused by NA #5 because the resident did not want to go to bed. Resident #350 further stated that her parents were outside the locked door,	F 609	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 11	F 609		

and no one would let them in. The form further revealed SW #1 reported the incident to the Assistant Director of Nursing (ADON) and Administrator #2 immediately after taking the report from the resident.

An interview with SW #1 on 3/20/24 at 11:10 AM revealed she visited Resident #350 on 10/10/23 and noticed a bruise on her right hand. SW #1 asked the resident how it happened, and the resident stated there was a fire drill in the night and NA#5 pulled her hand because she wanted the resident to go to bed but she didn't want to. SW #1 further stated she reported the concern for staff to resident abuse to the ADON and Administrator #3 on 10/10/23.

The incident was reported to the state regulatory agency by Administrator #2 on 12/14/23.

In an interview with the DON on 03/22/24 08:27 AM she stated she interviewed Resident #350 on 10/10/23 who stated there was a fire drill and NA #5 was trying to help her go to bed but she didn't want to go so the resident pulled her hand away. The DON asked Resident #350 if she thought NA #5 hurt her on purpose and she stated "no". The DON indicated that the incident was not reported to the state regulatory agency, the police department or APS because Resident #350 was prone to delirium and the fire drill agitated her to the point she received an as needed medication to help calm her at 1:36 AM on 10/10/23. The DON further stated they did not think the bruise came from NA #5, but from banging on the doors during the fire drill.

Administrators #2 and #3 were not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12	F 609		

Administrator #1 stated in an interview on 03/22/24 at 9:00 AM that although she was not employed at the time of the incident, she would report any accusation of employee to resident abuse within 2 hours to the state regulatory agency as that is the policy for this company. She further stated she would report any allegations of abuse to the local police department and APS.

The facility provided and implemented the following corrective action plan with a completion date of 1/2/24.

1. A police report was filed regarding abuse investigation for Resident #350 on 12/14/23 with no charges filed. APS was also notified on 12/14/23.

2. On 12/13/23, Quality Assurance (QA) nurse and Unit Manager initiated an audit of progress notes for the past 30 days to ensure all reportable events to include allegations of abuse and/or injuries of unknown origin were addressed and reported in a timely manner to the appropriate agencies. Any concerns identified during the audit would be immediately addressed by the Administrator and/or the Director of Nursing (DON) to include reporting appropriately to required agencies and providing retraining.

3. On 12/13/23, the Assistant Director of Nursing (ADON) and Unit Manager reviewed all risk management reports for the past 30 days to ensure all incidents meeting the criteria of reportable events were reported timely to the required agencies. Any concerns identified during the audit would be immediately addressed by the administrator and/or DON to include reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 13	F 609		

appropriately and providing retraining.

4. On 12/13/13, the Administrator initiated an audit of all reportable investigative folders for the past 30 days. This audit is to ensure all required reportable events were reported timely and per guidelines. The Administrator would address all areas of concern identified during the audit to include reporting events per guidelines.

5. On 12/13/23, the facility nurse consultant completed an in-service with the Director of Nursing (DON) regarding facility policy on reportable events to include but not limited to abuse allegations that require immediate reporting to state, police, and APS even if allegations are not substantiated during the initial investigation.

6. The Interdisciplinary Team (IDT) would review Nurse progress notes 5x weekly x 4 weeks for any allegations of abuse to include allegations of abuse and/or injuries of unknown origin. This audit is to ensure the event is investigated and reported in a timely manner per guidelines. The Administrator will address all areas of concern identified during the monitoring process.

7. Quality Assurance tasks: Facility Administrator to monitor concern forms weekly x4 weeks to ensure any potential abuse, neglect, or misappropriation are reported timely. Nursing administrative team to review weekly skin sheets during IDT for injuries of unknown origin x 4 weeks. Social services to perform safe surveys with A&O residents weekly x 4 weeks. Social services to ensure psychosocial needs of the identified resident are met. Facility to place staff at each exit door during fire drills or times of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 14 operation. The corrective action plan was reviewed on 3/22/24. Interviews confirmed all staff responsible for reporting initial allegations of abuse were educated to notify the police and the state regulatory agency of allegations of abuse. Administrator #1 stated there was always a member of management on call to ensure reports are made in a timely manner. Review of the monitoring tools, staff education, and Performance Improvement Plan were reviewed. The corrective action was verified as completed on 1/2/24.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Preadmission Screening Resident Review (PASRR) status, falls, and hospice status the Minimum Data Set assessment for 3 of 29 minimum data set assessments reviewed. (Resident #110, Resident #348, and Resident #68) Findings included: 1. Resident #110 was admitted to the facility on 9/22/22. Resident # 110's active diagnoses included psychophysiologic insomnia and bipolar disorder. Review of a PASRR Level II Determination	F 641	F 641 Accuracy of Assessments On 3/20/2024, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 1/18/24 comprehensive assessment for Resident #110 to reflect accurate coding for Level II PASRR. On 3/21/2024, the MDS Coordinator completed a modification of assessment dated 9/25/23 for Resident #68 to reflect accurate coding of hospice status. A modification of assessment dated 8/9/23 for Resident #348 to reflect	4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 15 Notification letter for Resident #110 dated 1/20/23 revealed Resident #110 was assessed to be a level II PASRR and Resident # 110's PASRR number ended in the letter B which meant Resident #110's Level II PASRR had no end date. Resident #110's most recent comprehensive Minimum Data Set (MDS) assessment dated 1/18/24 revealed she was coded to not be a level II PASRR. During an interview on 3/20/24 at 1:48 PM with the MDS Coordinator stated Resident #110 was a level II PASRR and the MDS dated 1/18/24 was coded in error. He concluded Resident #110 should have been coded as having a level II PASRR. During an interview on 3/20/24 at 1:57 PM Administrator #1 stated the PASRR should be coded accurately on the MDS assessment. 2. Resident #68 was admitted to the facility on 10/10/19 with diagnoses which included, in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A review of Resident #68's significant change Minimum Data Set (MDS), dated 09/25/23, indicated that Resident #68 was severely cognitively impaired. Hospice Care was not indicated. A review of Resident #68's Care Plan, last revised 12/13/23, revealed a problem of "has advanced directives" with an intervention of "resident/responsible party elected hospice." This intervention was initiated on 09/28/23. A review of Resident #68's Physician orders	F 641	accurate coding of fall risk was not completed due to Resident #348 was no longer in the facility. On 3/29/2024, the MDS Consultant initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS assessments section “A”, section “J” and section “O” for all residents to include Resident #110, Resident #68, and Resident #348 to ensure all MDS assessments completed are coded accurately for Level II PASRR, falls risk, and hospice services. The DON will address all concerns identified during the audit to include updating assessment when indicated. The audit will be completed by 4/16/2024. On 4/15/2024, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinators in the facility regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for Level II PASRR, falls risk and hospice services. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. 10% audit of completed MDS assessments, to include assessments for resident #110, resident #68 and resident # 348 utilizing the MDS Accuracy Audit Tool	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 16 revealed an order, dated 12/22/23, which read, "admit to hospice services effective 09/21/23." An interview was conducted with the MDS Coordinator nurse on 03/21/24 at 1:37 p.m. The nurse stated he completed the significant change MDS, dated 09/25/23, because Resident #68 was placed on hospice services. The nurse explained that he missed marking Hospice Care due to human error. A telephone interview was conducted with the Administrator on 03/27/24 at 8:38 a.m. The Administrator explained it was her expectation that a resident's MDS assessment accurately reflect a resident's current status. 3.a. Resident #348 was admitted to the facility on 6/20/23 with diagnoses that included abnormality of gait and mobility. A Nursing fall risk assessment dated 6/20/23 indicated Resident #348 was not at risk for falls. A review of Resident #348's Admission Minimum Data Set (MDS) dated 6/27/23 indicated antidepressant medication had been received. The Care Area Assessment (CAA) for falls was triggered by specific answers in the MDS, which required further assessment and decision as to whether or not to address in the care plan. The CAA revealed Resident #348 was at risk for falls due to having received antidepressant medication and indicated falls were not addressed for the Care Plan. Interview with Nurse #6 (MDS nurse) on 3/21/24 at 9:05 AM revealed falls were triggered in the CAA dated 6/27/23 but the box to check for care planning was not filled in. She was unable to	F 641	will be reviewed by the MDS consultant and/or Director of Nursing weekly x 8 weeks then monthly x 2 month to ensure accurate coding of the MDS assessment to include Level II PASRR, falls risk and hospice services. All identified areas of concern will be addressed immediately by the MDS consultant and/or DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 8 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Audit Tool to the QA Committee monthly x 3 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 explain why the falls had not been care planned based on the CAA. 3.b. Resident #348 was admitted to the facility on 6/20/23 with diagnoses that included abnormality of gait and mobility. Facility documentation dated 7/20/23 indicated Resident #348 had sustained a fall without injury. A review of Resident #348's Quarterly Minimum Data Set (MDS) dated 8/09/23 did not indicate any falls since the prior assessment. During an interview with Nurse #6 (MDS nurse) on 3/21/24 at 9:05 AM she stated a fall that Resident #348 had on 7/20/23 should have been captured by the quarterly MDS on 8/9/23 which would have triggered it to be added to the care plan. She further stated she did not know how she missed the fall on 7/20/23, and it was her responsibility to complete the quarterly MDS for Resident #348 and update the care plan with changes.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a person-centered care plan for 1 of 1 resident reviewed for respiratory services (Resident #37).	F 656	F 656 Develop/Implement Comprehensive Care Plan Resident #37 no longer resides in the facility, discharged on 6/23/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 The findings included: Resident #37 was admitted to the facility on 2/16/24 with diagnoses that included heart failure and shortness of breath. A review of Resident #37's physician orders revealed an order dated 2/16/24 for supplemental oxygen at 2 liters per minute by nasal cannula to keep the oxygen saturation above 90%. The admission Minimum Data Set (MDS) dated 2/22/24 revealed Resident #37 received continuous supplemental oxygen. A review of Resident #37's comprehensive care plan revealed no care plan was developed related to oxygen use from admission through 3/21/24. Interview with Nurse #6 (MDS nurse) on 3/21/24 at 9:05 AM revealed supplemental oxygen use was triggered on the admission MDS and should have been part of the care plan. She stated the mistake was made by human error. An interview with Director of Nursing (DON) on 3/21/24 at 11:59 AM revealed supplemental oxygen should have been part of the initial care plan as the admission MDS indicated Resident #37 was admitted with oxygen. In an interview with the Administrator on 3/22/24 at 10:00 AM, she stated supplemental oxygen use would be care planned.	F 656	On 4/11/2024, the Director of Nursing (DON) initiated an audit of care plans for all residents who utilize oxygen to ensure the care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident’s medical, nursing, and mental/psychosocial needs to include but not limited to use of supplemental oxygen. The DON will address all concerns identified during the audit to include updating the care plan when indicated and/or education of staff. The audit will be completed by 4/23/2024. On 4/11/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident’s medical, nursing, and mental/psychosocial needs to include but not limited to resident refusals of care, weight loss and nutritional interventions. In-service will be completed by 4/23/2024. After 4/23/2024, any nurse who has not completed the in-service will be in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Care Plans. The Unit Manager, Quality Assurance (QA) nurse, and RN supervisor will review 10% care plans for residents who receive supplemental oxygen to include Resident #37 weekly x 8 weeks, then monthly x 1 month, utilizing the Care Plan Audit Tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20	F 656	This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to residents who use supplemental oxygen. The Unit Manager, QA nurse, and RN supervisor will address all concerns identified during the audit to include updating care plan when indicated and re-education of staff. The DON will review the Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep a dependent resident's fingernails trimmed for 1 of 6 residents	F 677	F 677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 21 reviewed for activities of daily living care (Resident #69). Findings included: Resident #69 was admitted to the facility on 11/6/22. Her active diagnoses included contracture of left wrist, reduced mobility, lack of coordination, and diabetes mellitus. Review of Resident #69's Minimum Data Set assessment dated 2/20/24 revealed she was assessed as cognitively intact. She had no rejection of care documented in the assessment. She required maximal assistance with bathing, and moderate assistance with personal hygiene. Review of Resident #69's care plan dated 2/22/24 revealed she was care planned for activities of daily living care. The interventions included providing extensive physical assistance with personal hygiene and grooming. During observation on 3/19/23 at 3:54 PM Resident #69's left hand fingernails were observed to be long. During an interview on 3/20/24 at 8:20 AM Resident #69 stated she had asked for her nails to be cut on her left hand at some point recently, but it had not been done and she did not remember who she asked. She stated the nails on her left hand grew faster and needed to be trimmed more often but she was unable to trim her own nails due to her weakness, coordination, and inability to use her left hand. During observation on 3/20/24 at 8:20 AM Resident #69's left hand fingernails were	F 677	On 3/21/2024, Resident #69 received nail care to include trimming by the assigned hall nurse with oversight provided by the Director of Nursing (DON). On 3/26/2024, an audit of all dependent residents to include Resident #69 was completed by Unit manager and Treatment nurse to ensure nail care was received to include trimmed fingernails. Any negative findings were addressed immediately by the Director of Nursing (DON) to include providing assistance with nail care and trimming fingernails as appropriate. On 4/11/2024, an in-service was initiated by the Staff Development Coordinator (SDC) for all nurses and nursing assistants related to the requirement to assist dependent residents with nail care including trimming fingernails and to immediately notify the nurse if the task cannot be performed for any reason. The in-service will be completed by 4/23/2024. After 4/23/2024, any nurses and/or nursing assistants that have not received the in-service, will be educated prior to the next scheduled shift. All newly hired nurses and nursing assistants will be in-serviced during orientation by the DON or SDC regarding the requirement to assist dependent residents with nail care to include trimming fingernails and to immediately notify the nurse if the task cannot be performed for any reason. The Unit Manager, Quality Assurance (QA) nurse, and RN supervisor will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 22 observed to be long. During an interview on 3/20/24 at 11:04 AM Nurse Aide #10 stated Resident #69 was a diabetic so nurse aides could only file her nails down. She further stated nursing could clip diabetic resident's fingernails. She stated Resident #69 did not refuse to let her file her nails down in the past. Nurse aides should ask if residents want their nails done if they see residents' nails are long during morning care. The nurse aide stated she worked with Resident #69 on 3/16/24, 3/17/24, and 3/19/24 as well as today (3/20/24). She stated she did note that Resident #69's fingernails on her left hand were long on those days. She further stated she did not offer nail care or report the long nails to the nurse on those days. She stated she did not have a reason she did not offer nail care to Resident #69 or report to anyone that Resident #69 needed her nails done. During an interview on 3/20/24 at 11:13 AM the Director of Nursing stated even if an alert and oriented had long nails noted, she would want the aide to offer nail care. Upon observing Resident #69's nails she stated the left-hand fingernails were long especially compared to the resident's right hand and she or another nurse would trim them. She concluded nail care should have been offered to Resident #69 prior to now.	F 677	monitor 10 % of all dependent residents to include Resident #69 weekly for 8 weeks, then monthly for 1 month, utilizing the Resident Care Audit tool, to ensure all dependent residents who need assistance with nail care including trimming fingernails were provided these necessary services to maintain good grooming. Any concerns identified during the audit will be immediately addressed by the Unit Manager, QA Nurse, and RN Supervisor to include providing additional re-training. The DON will review the Resident Care Audit Tools for completion weekly x 8 weeks and monthly x 1 month to ensure all areas of concern are addressed. The Quality Assurance (QA) Nurse will forward the results of Resident Care Audit tool to the QAPI Committee monthly x 3 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to investigate and analyze falls to determine causative factors and implement targeted interventions to reduce risk of further falls for 1 of 3 residents (Resident #348) reviewed for accidents. The findings included: Resident #348 was admitted to the facility on 6/20/23 with diagnoses that included abnormality of gait and mobility. A fall risk assessment dated 6/20/23 indicated Resident #348 was not at risk for falls. A review of Resident #348's Admission Minimum Data Set (MDS) dated 6/20/23 indicated the resident was moderately cognitively impaired and had no fall history. He required extensive assistance with bed mobility and transfers, total assist with toileting, used a wheelchair for mobility and had no impairment in range of motion. The Care Area Assessment (CAA) dated 7/3/23 for the 6/20/23 MDS revealed Resident #348 was coded as at risk for falls due to having received antidepressant medication one or more of the last 7 days since admission. The CAA showed falls were not addressed in the Care Plan. Resident #348's comprehensive care plan that was developed based on the 6/20/23 admission MDS that triggered a CAA for fall risk, did not include any reference to fall risk.	F 689	F 689 Free of Accident Hazards/ Supervision/ Devices Resident #348 no longer resides in the facility. On 4/11/2024, the Director of Nursing (DON) initiated an audit of the past 30 days of all residents that have had a fall or residents at risk for falls. This audit is to ensure all falls have been investigated to determine the root cause, an incident report has been completed after each fall, interventions were initiated, a new fall assessment was completed after each fall if applicable, and the care plan was updated to reflect fall risk and new intervention if applicable. The audit will be completed by 4/23/2024. Any concerns identified during the audit will be immediately addressed by the Director of Nursing (DON) and/or Unit manager/RN supervisor to include additional retraining. On 4/11/2024, the Clinical Consultant conducted an in-service with the Administrator and DON regarding the Fall Risk Protocol, emphasizing the investigative process, identifying residents at risk for falls, and implementing interventions. On 4/11/2024, the Staff Development Coordinator (SDC) initiated an in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24 An interview with Quality Improvement (QI) Nurse on 3/22/24 at 9:14 AM revealed she was responsible for investigating fall incident risk management reports each day. These were sent to her when filled out by the Nursing staff and should be filled out after every fall. She stated that she finished the fall investigation if not complete. The QI nurse then took the incident report with investigation to the IDT meeting each morning where they discussed interventions and completed a root cause analysis. The interventions were then added to the care plan by MDS staff. Resident #348's Nurse progress note dated 7/20/23 at 4:32 PM revealed the resident had an unwitnessed fall and was found lying on the floor next to her bed by Nurse #4. The resident was assessed and was found to have no injury, but she did complain of right leg pain. The note then stated Resident #348 was sent to the hospital for evaluation. The resident's Responsible Party (RP) and Nurse Practitioner (NP) were notified. A review of a Nurse progress note dated 7/20/23 at 8:00 PM revealed Resident #348 returned from the hospital where they had found no fractures or other problems. There was no evidence an investigation into the cause of the fall had been completed for Resident #348's 7/20/23 fall. Nurse #5 was working with Resident #348 at the time of the fall on 7/20/23. In an interview with Nurse #5 on 3/22/24 at 10:05 AM, she stated she did not recall the resident.	F 689	with all nurses regarding the Fall Risk Protocol to include completing a new Fall Risk Assessment after each fall and completing an incident report in Risk Management after each fall occurs. The in-service will be completed by 4/23/2024. After 4/23/2024, any nurse that has not received the in-service will be educated prior to the next scheduled shift. All newly hired nurses will receive the in-service during orientation by the DON or the Staff Development Coordinator (SDC). All progress notes and incident reports will be reviewed during IDT meetings utilizing the Falls IDT Audit tool 5 times a week for 8 weeks, then monthly x 1 month to ensure with all falls the root cause has been identified, appropriate interventions were put into place, a new fall risk assessment completed, an incident report entered into Risk Management (if applicable), and the care plan and care guide updated with new intervention. Any concerns noted will be immediately addressed by the Administrator and/or the DON to include retraining. The DON will review the Falls IDT Audit tool for completion and ensure all areas of concerns are addressed 5x week for 8 weeks, then monthly x 1 month. The Administrator will forward the results of the Falls IDT Audit tool to the Quality Assurance Performance Committee monthly x 3 months to review, address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

incident report with investigation to the IDT meeting each morning where they discussed interventions and completed a root cause analysis. The interventions were then added to the care plan by MDS staff.

An interview with Director of Nursing (DON) on 3/21/24 at 11:59 AM revealed the system for fall reporting. The Nurse that was responsible for the resident filled out a risk management incident report after every fall, this report went to the QI Nurse, herself (the DON) and the Administrator. The risk management incident report was discussed in IDT each morning where interventions were discussed. QI Nurse completed any parts of the investigation that weren't completed such as interviews with witnesses. The risk management incident report was used to assess the reason a fall happened and to develop interventions to prevent future falls. The DON further stated Nursing was alerted on a quarterly basis for each resident to complete a fall assessment. The DON added that fall assessments were supposed to be completed after every fall. She explained that she did not know why Resident #348 only had one assessment done when a fall assessment should have been completed after each fall. The DON stated she did not know why no risk management incident reports were completed and that no one would know a fall needed to be investigated without the report.

In an interview with the Administrator on 3/22/24 at 10:00 AM, she stated all falls were documented by the Nurse on a risk management incident report and this was forwarded to the QI nurse, the DON, and herself. She further stated the incident reports were then taken to IDT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 meeting each morning to be evaluated for the reason for the fall and interventions to prevent further falls were discussed. Afterwards, the care plan was updated. The Administrator further stated she did not know why a risk management incident report was not completed and that this report is what triggered the fall to be investigated for causative factors including witness interviews.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to administer oxygen (O2) in accordance with the physician's order for 1 of 3 residents (Resident #44) reviewed for respiratory care. Findings included: Resident #44 was admitted to the facility on 2/1/24 with a diagnosis of dependence on supplemental oxygen. A review of Resident #44's admission Minimum Data Set (MDS) assessment dated 2/7/24 revealed he was cognitively intact. He was dependent for personal hygiene and required	F 695	F 695 Respiratory/ Tracheostomy Care and Suctioning On 3/21/2024, the Director of Nursing (DON) clarified the physician's order for the use of supplemental oxygen for Resident #44, updated the electronic record, and observed Resident #44's 02 concentrator had been adjusted to the correct setting as ordered by the physician. On 4/9/2024, the Director of Nursing initiated an audit of all residents with supplemental oxygen orders or residents utilizing supplemental oxygen. This audit	4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 27	F 695		

moderate assistance to go from lying to sitting. He received continuous oxygen therapy on admission and while a resident.

A review of Resident #44's medical record revealed in part a physician's order dated 3/15/24 for O2 3 liters (L) per minute via nasal cannula (NC).

On 3/19/24 at 3:13 PM an observation of Resident #44 revealed he was in bed. He was receiving O2 at 4L per minute via NC from an O2 concentrator that was positioned on his left side at the head of his bed. An interview with Resident #44 at that time indicated he was feeling well. He stated he thought he was supposed to be receiving O2 at 4L.

A review of Resident #44's comprehensive care plan revealed in part a focus area last on 3/20/24 of potential for or actual ineffective breathing pattern with O2 at 3L per minute via NC. The goal was for Resident #44 to demonstrate an effective respiratory pattern of depth, rate, and rhythm. An intervention was O2 therapy as ordered.

On 3/21/24 at 8:11 AM an observation of Resident #44 revealed he was asleep in his bed. He was observed to be receiving O2 at 4L per minute via NC from an O2 concentrator that was positioned on the left side at the head of his bed.

On 3/21/24 at 1:57 PM an observation of Resident #44 revealed he was asleep in his bed. He was observed to be receiving O2 at 4L per minute via NC from an O2 concentrator that was positioned on the left side at the head of his bed.

A review of Resident #44's March 2024

is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters and oxygen was administered per physician order. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician resident need for supplemental oxygen to include flow rate and monitoring parameters and/or education of staff. The audit will be completed by 4/23/2024.

On 4/11/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Administration of Oxygen with emphasis on ensuring resident utilizing supplement oxygen have a current physician order to include flow rate and monitoring parameters and that the oxygen is administered per physician orders. The in-service will be completed by 4/23/2024. After 4/23/2024 any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-service during orientation.

The Unit Manager and RN supervisor will review 10% of residents receiving supplement oxygen weekly x 4 weeks then monthly x 1 month utilizing Respiratory Audit Tool. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters and that the oxygen was administered per physician order. The Director of Nursing will address

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 28 Medication Administration record revealed in part documentation on 3/21/24 for the 7AM-3PM shift by Nurse #3 that Resident #44 was receiving O2 at 3L per minute via NC. On 3/21/24 at 2:00 PM an interview with Nurse #3 indicated she was caring for Resident #44 on the 7AM-3PM shift that day. She stated she had cared for him before and was familiar with him. She went on to say that Resident #44's physician's order for O2 therapy was 3L per minute via NC. Nurse #3 indicated her documentation on Resident #44's MAR for her shift indicated this was what he had received. During an observation of Resident #44's O2 concentrator flow rate with Nurse #3 at the time of the interview, she confirmed Resident #44's O2 concentrator was delivering O2 at 4L per NC. Nurse #3 stated she thought she had checked Resident #44's O2 concentrator flow rate at around 8:00 AM that morning and it was set at 3L per minute but maybe she had checked another resident's O2 flow rate. She went on to say Resident #44 should not be receiving O2 at 4L per minute. On 3/21/24 at 2:11 PM an interview with Nurse Aide (NA) #6 indicated she was caring for Resident #44 on the 7AM-3PM shift that day. She stated she was familiar with him. She went on to say she provided care to Resident #44 this shift but had not adjusted his O2 concentrator flow rate. NA #6 stated NAs were not allowed to do this. She went on to say Resident #44 had wanted to stay in bed today and had not been out of bed. She further indicated there wasn't no way Resident #44 could have reached his O2 concentrator to adjust the flow rate from his bed.	F 695	all concerns identified during the audit to include clarifying orders when indicated and administering oxygen per physician orders and/or re-training of staff. The Director of Nursing (DON) will review the Respiratory Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Respiratory Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review to determine issues and trend to include continued monitoring frequency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 29 On 3/21/24 at 3:10 PM an interview with the Director of Nursing (DON) indicated Nurse #4 should have checked Resident #44's O2 flow rate to ensure the flow rate of his O2 was correct and he was receiving what the physician ordered. On 3/22/24 at 12:06 PM an interview with the Administrator indicated physician's orders should be followed for the administration of O2.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 30 by: Based on observations and staff interviews the facility failed to secure resident medications stored in an unattended medication cart (the 700-hall medication cart) for 1 of 7 medication carts. The findings included: a. A continuous observation of the 700-hall medication cart was conducted on 03/21/24 from 8:32 AM to 9:01 AM. The 700-hall medication cart was located two resident doors away from the end of the 700-hall section where it transitioned to the 800 hall. The medication cart was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member at the medication cart. Several staff members, residents, and visitors were observed walking past the medication cart. Nurse #7 came out of a resident room and returned to the medication cart at 8:44 AM. Nurse #7 was asked to open the top drawer and realized she had left the medication cart unlocked. Nurse #7 stated she usually locks her cart. b. A continuous observation of the 700-hall medication cart was conducted on 3/22/24 from 8:45 AM to 8:54 AM. The 700-hall medication cart was located two resident doors away from the end of the short hall of the 700 section where it transitioned to the 100 hall. The medication cart was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member at the medication cart. Several staff members, residents, and visitors were observed walking past the medication cart. When Nurse #7 returned at 8:52 AM and realized she had left the cart unlocked. She stated she was just inside the next room	F 761	F 761 Label/Store Drugs and Biologicals On 3/21/2024, the Director of Nursing (DON) verbally educated Nurse #7 regarding Medication Storage with emphasis on ensuring the medication cart is locked when not directly supervised by the assigned nurse. On 4/11/2024, the Unit Manager, Quality Assurance (QA) nurse, and RN supervisor initiated an audit of all medication carts. The audit is to ensure all medication carts were locked when not directly supervised by assigned nurse. All identified areas of concern will be addressed by the Unit Manager, QA nurse, and RN supervisor during the audit to include but not limited to securing medications per facility protocol and education of staff. The audit will be completed by 4/23/2024. On 4/11/2024 an in-service was initiated by the Staff Development Coordinator (SDC) with all nurses and medication aides regarding Medication Storage with emphasis on securing medication cart when not directly supervised by the assigned nurse. In-service will be completed by 4/23/2024. Any nurse or medication aide that has not received the in-service by 4/23/2024, will be educated prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the SDC during orientation regarding Medication Storage. 10% Audit of all medication carts will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 31 down. She further stated she knew the medication cart should be locked when she was not in front of it. An interview with the Director of Nursing (DON) on 03/21/24 at 11:57 AM was completed. The DON stated the medication cart should have been secured and locked unless the nurse was present at the cart. The DON further stated that the nurse assigned to the medication cart was responsible for it and ensuring that it was secured. An interview with the Administrator on 3/21/24 at 12:15 PM revealed medication carts should not be unlocked unless the Nurse was standing in front of it. The Administrator stated the nurse assigned to that medication cart was responsible for it for their entire shift.	F 761	monitored by the Unit Manager, QA nurse, and RN supervisor three times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month utilizing the Medication Audit Tool. This audit is to ensure all medication carts were locked when not supervised by the assigned nurse. The nurse and/or medication aides will be immediately re-trained by the Unit Manager, QA nurse, and RN supervisor for any identified areas of concern. The DON will review the Medication Audit Tool for completion and to ensure all areas of concerns are addressed three times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month. The Administrator will forward the results of the Medication Audit Tools to the Quality Assurance Performance Committee monthly x 3 months to review, address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 32	F 867		

from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 33	F 867		

(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 34 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 1/7/22 and 3/3/23, and the complaint survey of 10/27/22. This was for 5 recited deficiencies in the areas of Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plans (F656), ADL Care Provided For Dependent Residents (F677), Free Of Accident/Hazards/Supervision/Devices (F689), Label/Store Drugs & Biologicals (F761) and Infection Control (F880). The continued failure during 2 or more federal surveys of record showed a pattern of the facility's inability to	F 867	F 867 QAPI/QAA Improvement Activities On 4/11/2024, the Facility Consultant initiated an audit of previous citations and action plans from 1/7/2022 to 3/3/2023 related to F641 Accuracy of Assessments, F656 Comprehensive Care Plans, F677 Activities of Daily Living, F689 Free of Accident/Hazards/Supervision, F761 Labe/Store Drugs & Biologicals and F880 Infection Control to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 35 sustain an effective Quality Assurance Program. The tag is cross-referenced to: F641 - Based on staff interviews and record review the facility failed to accurately code the Preadmission Screening Resident Review (PASRR) status, falls, and hospice status the Minimum Data Set (MDS) assessment for 3 of 29 minimum data set assessments reviewed. (Resident #110, Resident #348, and Resident #68) During the recertification and complaint survey of 3/3/23 the facility failed to accurately code the MDS for smoking. During the recertification and complaint survey of 1/7/22 the facility was cited for failing to accurately code the MDS for urinary bladder and bowel. F656 - Based on record review and staff interviews the facility failed to develop a person-centered care plan for 1 of 1 resident reviewed for respiratory services (Resident #37). During the recertification and complaint survey of 3/3/23 the facility was cited for failing to develop a comprehensive person-centered care plan with measurable goals and interventions. During the recertification and complaint survey of 1/7/22 the facility was cited for failing to develop a comprehensive person-centered care plan for a resident with a known history of wandering. F677- Based on observation, record review and staff interviews the facility failed to keep a	F 867	Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 4/23/2024. On 4/19/2024, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Unit Managers regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include updated advance directives. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. The in-service will be completed by 4/23/2024. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include F 641 Accuracy of Assessments, F 656 Comprehensive Care Plans, F 677 Activities of Daily Living, F 689 Free of Accident/Hazards/Supervision, F 761 Labe/Store Drugs & Biologicals and F 880 Infection Control will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Assurance Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 36 dependent resident's fingernails trimmed. During the complaint investigation on 10/27/22 the facility was cited for failing to 1a) assist a dependent resident with eating when a Nurse Aide was observed asking the resident if she wanted to eat instead of attempting to offer the food on the meal tray and instead offered a small amount of a nutritional supplement then placed the supplement on the bedside table and did not return to the resident; 1b) provide incontinence care to a dependent resident; and 2) provide an alternate meal choice during the lunch meal for a resident. F689 - Based on record review and staff interview, the facility failed to investigate and analyze falls to determine causative factors and implement appropriate interventions to reduce risk of further falls for 1 of 6 residents (Resident #348) reviewed for Supervision to Prevent Accidents. During the recertification and complaint survey of 3/3/23 the facility was cited for failing to comprehensively assess residents for fall risk, thoroughly investigate falls, and implement interventions to reduce the risk of falls for a resident with a history of falls, implementing interventions for a resident assessed as an unsafe smoker, secure smoking materials and assess the safety of a resident that was a known smoker. F761 - Based on observation and staff interview the facility failed to secure resident medications stored in an unattended medication cart (700 hall) for 1 of 7 med carts on 2 separate occasions.	F 867	The Quality Assurance committee will review the data and determine if a plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F 641 Accuracy of Assessments, F 656 Comprehensive Care Plans, F 677 Activities of Daily Living, F 689 Free of Accident/Hazards/Supervision, F 761 Labe/Store Drugs & Biologicals and F880 Infection Control and all current citations and that the QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and Unit Managers for any identified areas of concern. The results of all audits and consultant review will be presented to the Quality Assurance Performance Improvement Committee quarterly x 6 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 37	F 867		

During the recertification and complaint survey of 3/3/23 the facility was cited for failing to label multi dose oral inhalers with resident's names and failed to record open dates on oral inhalers and on an insulin pen.

F880 - Based on observations, record review and staff interviews the facility failed to implement their hand washing and alcohol-based hand sanitizer procedures as part of their infection control policies when Nurse Aide (NA) #4 failed to perform hand hygiene during meal delivery service after moving an overbed table and handling a bed control during 1 of 6 meal delivery service observations. This had the potential to result in cross contamination of microorganisms between residents.

During the recertification and complaint survey of 1/7/22 the facility was cited for failing to follow facility policy and the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment (PPE) for staff entering rooms with residents on Enhanced Droplet Contact Precautions (EDCP).

During an interview on 3/22/24 at 12:15 PM the Administrator stated she was unaware of the reasons for previous tags as she was new to the facility as of 2/26/24 and was reviewing all QAA/QI (Quality Improvement) aspects for compliance and improvement. The Administrator further stated the QAA committee met monthly and reviewed risks and monitored areas of concern by following standard monitoring guidelines. The Administrator explained that to maintain compliance, the QAA committee would review areas of concern and tracked the audit results for up to 6 months. The committee used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 38 trends identified from the Interdisciplinary Team Meeting held each weekday morning as one resource to identify new opportunities for improvement of care areas within the facility. The Administrator indicated she was making cultural changes in the facility that would hopefully improve reporting of incidents, screening residents and refining processes to prevent further repeat citations.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 Based on observations, record review and staff interviews the facility failed to implement their hand washing and alcohol-based hand sanitizer procedures as part of their infection control policies when Nurse Aide (NA) #4 failed to perform hand hygiene during meal delivery service after moving an overbed table and handling a bed control during 1 of 6 meal delivery service observations. This had the potential to result in cross contamination of microorganisms between residents. Findings included: A review of the facility's procedures titled "Handwashing Procedure" and "Alcohol Hand Sanitizer Procedure" dated 4/2023 revealed in part the following, "You should wash your hands before and after contact with residents [and] After handling contaminated items (soiled incontinent briefs, linens, trash etc.) An alcohol-based hand sanitizer may be used unless hands are visibly soiled." During a continuous observation of meal delivery service beginning on 3/19/24 at 12:33 PM on the 100 Hall NA #4 was observed to remove a meal from the meal cart, enter Resident #20's room and place his meal on his overbed table. NA #4 repositioned Resident #20's overbed table, handled Resident #20's bed control, and exited the room. Without performing hand hygiene NA #4moved the meal delivery cart farther down the 100 Hall, passing 2 hand sanitizer dispensers. She then removed Resident #112's meal from the delivery cart and was stopped after knocking on Resident #112's door before she entered Resident #112's room. An interview with NA #4 at that time indicated there had been hand sanitizer	F 880	F 880 Infection Prevention & Control On 4/19/2024, the Director of Nursing (DON) verbally educated nursing assistant #4 regarding handwashing before and after contact with residents, entering/exiting resident rooms and after handling contaminated items to include but not limited to delivery of meal trays. On 4/18/2024, the Staff Development Coordinator (SDC) initiated resident care audits regarding Handwashing with return demonstration with all nurses and nursing assistants (NA) to include NA #4 to ensure staff were following established infection control guidelines for hand hygiene to include before/after contact with residents, entering/exiting resident rooms and after handling contaminated items to include but not limited to delivery of meal trays. All areas of concern were immediately addressed by the SDC to include retraining of staff. Resident care audits will be completed by 4/21/2024. After 4/21/2024, any nurse or nursing assistant who has not completed the education or return demonstration will complete it upon the next scheduled work shift. On 4/18/2024, the SDC initiated in-service regarding Handwashing with emphasis on washing hands before and after contact with residents, upon entering/exiting rooms and after handling contaminated items. The in-service will be completed by 4/23/2024. After 4/23/2024, any nurse or nursing assistant who has not completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 available on the 100 Hall. She stated she knew she should have performed hand hygiene after handling Resident #20's overbed table and bed controls before she removed Resident #122's meal from the delivery cart but she had been moving quickly and forgot. She stated she had been educated on performing hand hygiene during meal delivery service. On 3/21/23 at 2:56 PM an interview with the Director of Nursing indicated NA #4 should have performed hand hygiene after touching things in Resident #20's room before she removed another meal from the delivery cart. She stated NA #4 had infection control training in May 2023 and hand hygiene was something that was included. On 3/22/24 at 12:06 PM an interview with the Administrator indicated NA #4 should be performing hand hygiene after contact with a resident's environment for infection control purposes to avoid the spread of germs.	F 880	the education will complete it upon the next scheduled work shift. All newly hired nurses and nursing assistants will be educated during orientation. The Unit Managers, Nursing Supervisor, and/or Quality Assurance (QA) nurse will complete 10 resident care audits regarding Handwashing weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff washed hands before and after contact with residents, upon entering/exiting rooms and after handling contaminated items. The UMs, Nursing Supervisor, and QA nurse will address all concerns identified during the audit to include re-training of staff. The DON will forward the results of the Handwashing Audits to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months for review to review the Handwashing Audit Tools for trends and/ or issues and to determine the continued need and frequency of monitoring.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		4/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 42	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 43 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to offer the flu vaccine during the flu season for 2 of 5 residents reviewed for immunizations (Resident #56, Resident #69). Findings included: 1. Resident #56 was admitted to the facility on 11/29/17. Review of Resident #56's minimum data set assessment dated 1/9/24 revealed he was assessed as cognitively intact. He was documented to have not been offered the flu vaccine. Review of Resident #56's health record on 3/19/24 revealed there was no documentation of the flu vaccine being offered to Resident #56. During an interview on 3/21/24 at 12:25 PM the Director of Nursing stated when she reviewed Resident #56's vaccine record on 3/20/24 she noted that Resident #56 had not been documented to have been offered the flu vaccine during the current flu season. She stated Nurse #8 was responsible for offering the flu vaccines this flu season for Resident #56's hall as the Infection Control Nurse was new to the position and was not involved. She stated their process was for the administrative nurses to begin offering	F 883	F 883 Influenza and Pneumococcal Immunizations On 3/20/2024, the Director of Nursing (DON) educated Resident #56 on the risk and benefits of receiving/declining the influenza vaccine. The DON updated the resident electronic record of education and preference for receiving vaccines. On 3/20/2024, the Nurse Supervisor educated Resident #69 on the risk and benefits of receiving/declining the influenza vaccine. The Nurse Supervisor updated the resident electronic record of education and preference for receiving vaccines. On 4/9/2024, the Administrator initiated an audit of Influenza immunizations for all current residents. This audit was to identify any resident who had not been provided the Influenza or have a documented refusal of immunization vaccine per facility protocol, to ensure residents/resident representative were educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record and that appropriate consent obtained prior to administering vaccines. The DON/Nurse Manager will address all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 44 flu consents around September and October and get consents or declinations to prepare for the flu season. Resident #56 was in the facility during the flu season and staff should document consent or refusal in the residents' chart. She concluded upon review of Resident #56's health record after their vaccination status was questioned, she discovered there was no documentation of the flu being offered to the resident during the current flu season and it should have been done. During an interview on 3/21/24 12:52 PM Resident #56 stated he was not offered the flu vaccine during the current flu season until yesterday, 3/20/24. During an interview on 3/21/24 at 4:02 PM Nurse #8 stated she got so many consents at the beginning of this flu season that she could not remember if she offered the flu vaccine to Resident #56 and did not document it or if she did not offer the vaccine at all because it was a long time ago and she interviewed many residents at that time. 2. Resident #69 was admitted to the facility on 11/6/22. Review of Resident #69's minimum data set assessment dated 2/20/24 revealed she was assessed as cognitively intact. She was documented to have not been offered the flu vaccine. Review of Resident #69's health record on 3/19/24 revealed there was no documentation of the flu vaccine being offered to Resident #69. During an interview on 3/21/24 at 12:25 PM the	F 883	concerns identified during the audit to include education of the resident/resident representative of risks/benefits of receiving/refusing of vaccine with documentation in the electronic record, obtaining appropriate consent, providing vaccine per resident preference and/or education of staff. Audit will be completed by 4/23/2024. On 4/11/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Immunizations. Emphasis is on educating resident/resident representative on the risks/benefits or receiving/refusing vaccines, obtaining appropriate consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 4/23/2024. After 4/23/2024, any nurse who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation by the SDC regarding Immunizations. The Unit Manager will audit 10% of resident immunization record weekly x 4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks/benefits of receiving/refusing Influenza and Pneumonia vaccines, appropriate consent and physician order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 45 Director of Nursing stated when she reviewed Resident #69's vaccine record on 3/20/24 she noted that Resident #69 had not been documented to have been offered the flu vaccine during the current flu season. She stated Nurse #9 was responsible for offering the flu vaccines this flu season for Resident #69 as the Infection Control Nurse was new to the position and was not involved. She stated their process was for the administrative nurses to begin offering flu consents around September and October and get consents or declinations to prepare for the flu season. Resident #69 was in the facility during the flu season and staff should document consent or refusal in the residents' chart. She concluded upon review of Resident #69's health record after their vaccination status was questioned, she discovered there was no documentation of the flu being offered to the resident during the current flu season and it should have been done. During an interview on 3/21/24 at 12:49 PM Resident #69 stated she did not remember if she was offered the flu shot prior to 3/20/24 during the current flu season. During an interview on 3/21/24 at 4:04 PM Nurse #9 stated she believed she did offer the flu vaccine to Resident #69 but could not remember when and did not know why it was not documented. It would have been during the time when flu was being offered to everyone in either in September or October of 2023 when the task was assigned. She thought that the resident declined the vaccine but could not remember and did not document it so she could not say with 100% confidence.	F 883	for vaccine obtained prior to administering vaccine, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The Unit Manager will address all concerns identified during the audit. The DON will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Immunization Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	