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	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 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 [DATE]. 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 [DATE] revealed he was moderately cognitive impaired. Resident #99 was coded as exhibiting disorganized thinking and inattention. Resident #99's annual Minimum Data Set, dated dated dated [DATE] 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. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. Resident #114 was admitted to the facility on [DATE]. Resident #114's diagnoses included dementia, anxiety, irritability, and anger. Resident #114's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] 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 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 from his door. She revealed that during incidents of 9/8/2023 and 10/11/2023 no on 1:1 monitoring. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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. 40200 b. Resident #29 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and non-Alzheimer's dementia. Resident #29's significant change Minimum Data Set, dated dated dated [DATE] 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) 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 St. 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. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview on 3/22/24 at 8:10 AM with the Director of Nursing (DON) revealed that they 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48230 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, 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. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 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 [DATE]. Resident # 110's active diagnoses included psychophysiologic insomnia and bipolar disorder. Review of a PASRR Level II Determination 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 [DATE] 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 [DATE] 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. 35930 2. Resident #68 was admitted to the facility on [DATE] 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 [DATE], 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 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 [DATE], because Resident #68 was placed on hospice services. The nurse explained that he missed marking Hospice Care due to human error. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48230 3.a. Resident #348 was admitted to the facility on [DATE] with diagnoses that included abnormality of gait and mobility. A Nursing fall risk assessment dated [DATE] indicated Resident #348 was not at risk for falls. A review of Resident #348's Admission Minimum Data Set (MDS) dated [DATE] 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 explain why the falls had not been care planned based on the CAA. 3.b. Resident #348 was admitted to the facility on [DATE] 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 [DATE] 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 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). The findings included: Resident #37 was admitted to the facility on [DATE] 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 [DATE] 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on observations, record review, and staff interviews the facility failed to keep a dependent resident's fingernails trimmed for 1 of 6 residents reviewed for activities of daily living care (Resident #69). Findings included: Resident #69 was admitted to the facility on [DATE]. 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 [DATE] 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 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.

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	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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 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 [DATE] with diagnoses that included abnormality of gait and mobility. A fall risk assessment dated [DATE] indicated Resident #348 was not at risk for falls. A review of Resident #348's Admission Minimum Data Set (MDS) dated [DATE] 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. 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. (continued on next page)

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	345217	A. Building B. Wing	03/27/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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	345217	A. Building B. Wing	03/27/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 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 [DATE] with a diagnosis of dependence on supplemental oxygen. A review of Resident #44's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He was dependent for personal hygiene and required 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 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. (continued on next page)

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	345217	A. Building B. Wing	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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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	345217	A. Building B. Wing	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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48230 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 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.

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	345217	A. Building B. Wing	03/27/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48230 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 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 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. (continued on next page)

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	345217	A. Building B. Wing	03/27/2024

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Premier Nursing and Rehabilitation Center	225 White Street Jacksonville, NC 28546

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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.

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	345217	A. Building B. Wing	03/27/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41009 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 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.

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	345217	A. Building B. Wing	03/27/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 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 [DATE]. Review of Resident #56's minimum data set assessment dated [DATE] 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 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 [DATE]. Review of Resident #69's minimum data set assessment dated [DATE] 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. (continued on next page)

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	345217	A. Building B. Wing	03/27/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/24 at 12:25 PM the 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.