PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING				I-C
NAME OF PI	ROVIDER OR SUPPLIER	040002		STR	REET ADDRESS, CITY, STATE, ZIP CODE	03/	/14/2016
					5 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		IND	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	3	{F 0	00}			
	02/25/16. The facility jeopardy on 02/24/16 F-226 (J), F-282 (J), which began on 02/1 was conducted on 02 was present and rem completion of the sur 483.13 (F 223) at J Immediate Jeopardy Nurse Aide (NA) #1 s on the face and agair #6). Each incident of the secure unit and w #2 did not immediate administrative staff th abuse against Reside this Resident and oth unit from further abuse	s conducted on 02/22/16 to was notified of immediate at F-223 (J), F-225 (J), F-490 (J), and F-520 (J) 6/16. An extended survey 6/25/16. Immediate jeopardy ained ongoing at the vey.  began on 02/16/16 when slapped a combative resident on the right thigh (Resident physical abuse occurred on vas witnessed by NA #2. NA ly intervene or report to lat she witnessed physical ent #6 and failed to protect per residents on the secure					
	Nurse Aide (NA) #2 ft that she witnessed pl resident (Resident #6 resulted in further phy witnessed NA #1 slap but did not immediate protect the Resident remained on the secu unsupervised and was	Resident #6 on the face, ely report the abuse or from further abuse. NA #1					
ABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

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

**Electronically Signed** 

03/21/2016

AND DEAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING_		_	R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STA 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	)	03/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION DATE
{F 000}	abuse to the Health	ty failed to report physical Care Personnel Registry the investigation of the	{F 0	00}		
	Nurse Aide (NA) #1 face when the Resid during nursing care. abuse but did not im to administrative sta protection to Reside which led to a secont toward Resident #6. Resident #6 on the f did not immediately remained on the secunsupervised and second 16/16, NA #2 with #6 on the right thigh The facility failed to Health Care Persont	•				
	Nurse Aide (NA) #1 on the face and agai #6). Each incident of the secure unit and #2 did not immediate Resident #6 and oth unit from physical at	began on 02/16/16 when slapped a combative resident in on the right thigh (Resident physical abuse occurred on was witnessed by NA #2. NA ely intervene to protect er residents on the secure puse. Resident #6 was ened discoloration to her right				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(×	(3) DATE SURVEY COMPLETED
		345502	B. WING			R-C
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	ı	03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 000}	Continued From pa	ge 2	{F 00	00}		
	Nurse Aide (NA) #1 face and the witnes did not immediately for protection of Re A second incident of 02/16/16 when NA right thigh and the intervene for the production of Re As 3.75 (F 520) at J Immediate jeopard Nurse Aide (NA) #1 face and the witnes did not immediately for protection of Rephysical abuse occusions apped Resident #	y began on 02/16/16 when slapped Resident #6 on the is, NA #2 did not intervene and ir report to administrative staff sident #6 and other residents. If physical abuse occurred on #1 slapped Resident #6 on the witness, NA #2 did not otection of Resident #6.  If began on 02/16/16 when slapped Resident #6 on the is, NA #2 did not intervene and ir report to administrative staff sident #6. A second incident of urred on 02/16/16 when NA #1 is on the right thigh and the not intervene for the protection				
	Centers for Medica	d the State Agency and the re and Medicaid with an on of compliance on 03/08/16.				
	verification of the facompliance and to ongoing Immediate Jeopardy was removed. At the time of the eremained out of core F-226, F-282, F-49 and severity of (D) potential for more to	s conducted on 03/14/16 for acility's allegation of determine the status of the Jeopardy. Immediate oved on 03/14/16 at 7:15 PM. xit on 03/14/16, the facility impliance at F-223, F-225, 0, and F-520 at a lower scope isolated, no actual harm with than minimal harm that is not y, while the facility continues				

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		345502	B. WING			R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	<u>'</u>	33/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 000}	Continued From page the process of monitor their corrective action 483.10(e), 483.75(I)(4	oring the implementation of as.	{F 00			3/18/16
SS=D	The resident has the confidentiality of his crecords.	right to personal privacy and or her personal and clinical				
	medical treatment, we communications, per meetings of family an	sonal care, visits, and and resident groups, but this facility to provide a private				
	section, the resident	n paragraph (e)(3) of this may approve or refuse the nd clinical records to any facility.				
	and clinical records d	o refuse release of personal loes not apply when the d to another health care release is required by law.				
	contained in the residence the form or storage market release is required by	/ transfer to another ; law; third party payment				
	by: Based on an observa	is not met as evidenced ation, staff interviews and v, the facility failed to provide		A resident has the right to pers		

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		345502	B. WING				-C
NAME OF P	ROVIDER OR SUPPLIER	0.0002		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2016
TO WILL OF TH	NOVIDER OR GOLF ELER				315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 164}	Continued From page	e 4	{F 1	64}			
	blinds and the privacy administration and wl product was administ residents reviewed fo (Resident #36)  The findings included Resident #36 was ad	mitted to the facility on			personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications personal care, visits and meetings of family and resident groups, but this doe not require the facility to provide a priva- room for each resident.	es	
	artificial opening of di obstruction, and perit On 02/24/16 at 05:35	included cognitive deficit, gestive tract, intestinal onitis.  AM Resident #36 was in I of the bed elevated to			Since 2/24/16 resident#36 has been provided privacy by closing the blinds at the privacy curtain during medication administration and when eternal feeding.	and	
	approximately 30 deg AM, the enteral feeding was empty and the en noted beeping. Nurse the enteral feeding point in the enteral feeding point in the enteral feeding bour on the enteral feeding bour of the enteral feeding bour	grees. On 02/24/16 at 05:48 and bottle of Glucerna 1.2 anteral feeding pump was a #7 was observed to turn off amp per the request of as noted to gather supplies Resident #36 which included attle of Glucerna 1.2. On I, Nurse #7 lifted the shirt of exposed her brief, torso, and ath her breast area. Nurse ications to Resident #36 via arted the enteral feeding curtain was open, the ant in the room, the room are blinds were open. The first bed next to the room in the room faced the There was car activity noted in the parking lot.			product is administered.  2) On 2/26/16 Nurse#6 and Nurse#7 were in-serviced by staff facilitator relato providing privacy during medication administration and when enteral feedin administration to tube fed resident to include closing blinds and pulling the privacy curtain. Privacy is being provide to all tube fed residents by closing the blinds and the privacy curtain during medication administration and when eternal feeding product is administered 3) On 2/26/16 the staff facilitator initiate in-servicing with all nursing staff related providing privacy (pulling curtains, clos blinds etc.) during care including during medication administration and enteral feeding administration to the tube fed	ed ited	
		ewed on 02/24/16 at 6:10 AM lined to provide privacy			resident. All new hires will continue to receive in-service during orientation		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING				-C
NAME OF D	ROVIDER OR SUPPLIER	343302	B: Willo	STREET ADDRESS, CITY, STATE, ZIP	CODE	03/	14/2016
NAIVIE OF F	ROVIDER OR SUFFLIER				CODE		
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 164}	Continued From page when he administered privacy curtain betwee sure the blinds were providing privacy to Fadministered her med.  The Interim Director of interviewed on 02/25, interview she stated to leave room doors of provided unless the ritheir door closed. The expected staff to provided when the provided to provided unless the ritheir door closed. The expected staff to provided when the provided unless the provided unless the provided staff to provided when the provided unless	d medications by closing the en residents and to make closed; he apologized for not Resident #36 when he dications.  of Nursing (DON) was /16 at 8:48 AM. During the chat due to the recent use, staff were encouraged open when care was esident requested to have the Interim DON stated she wide privacy to a resident by urtain between residents and	{F 10	DEFICIEN	ent privacy will trative staff pervisor, staff privacy, staff pervisor, staff pervisor, staff pervisor, activities ector, ical records, eeping ve staff is nee for pulling ng window blives being be fed resider nitoring to diduring administration heelchair audie solutions are will be compleing week to eks, then 10 weeks, then 10 weeks, then 10 to make sure reding privacy in the sure reding privacy	I be  f s  g of inds  nts  nteed  ON  dit	DATE
				The monthly QI committee results of the "Privacy/Choices/ADL's/V tool monthly for 6 months of trends, actions taken a the need for and/or freque continued monitoring, and recommendations for mon	Vheelchair au for identificat nd to determinency of d make	idit tion	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONST IG		(X3) DATE	SURVEY PLETED	
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		345502	B. WING _			03/	/14/2016	
	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 164}	Continued From page	6	{F 10	The the mor	tinued compliance.  e administrator and/or DON will presignations and recommendations of the thing of the committee to the quarterly cutive QA committee for further commendations and oversight.			
{F 166} SS=D	RESOLVE GRIEVANO A resident has the rig facility to resolve griev	O PROMPT EFFORTS TO CES  Int to prompt efforts by the vances the resident may with respect to the behavior	{F 10				3/18/16	
	by: Based on record revi interviews the facility regarding bed baths f for grievances. (Resio The findings included Resident #24 was rea 12/18/15 with diagnos hypertension, anxiety and weakness. Revie quarterly Minimum Da 01/25/16 indicated tha cognitively intact and assistance with activit MDS further indicated identified. Review of the facility's through 02/24/16 for I Resident #24 had rec	idmitted to the facility on sis that included depression, dysphagia, who of the most recent at a Set (MDS) dated at Resident #24 was required extensive dies of daily living (ADL). The land behaviors were shathing log dated 01/28/16 Resident #24 revealed that derived no type of bathing or 121 of the last 30 days.		by the residence of the	esident has the right to prompt efforthe facility to resolve grievances the dent may have, including those with pect to the behavior of other residence of the behavior of other resident #24 was reviewed by the DON to discuss over related to bathing schedule. Sident #24 is satisfied with receiving the behavior of the past thirty days to ensidents and/or the resident RP are sfied with the resolution and follow-	e h nts.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		TE SURVEY MPLETED
							R-C
		345502	B. WING _			o	3/14/2016
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REH	ABILITATION CENTER		ı	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 166}	Continued From pag	ge 7	{F 1	66}			
	02/04/16 revealed F	Resident #24's friend and	,	·	Any areas of concern were addressed		
		RP) filed a grievance on			immediately.		
	1	alf that read in part Resident					
		baths this is not including bed			3) On 3/1/16 the administrator initiated	an	
	baths given by hospice on Tuesdays and				in-service for the administrative staff or		
		ected outcome stated that			Follow Up to Resident Concerns which		
Resident #24 would receive an extra bath weekly.				included:			
	The resolution to the						
	Resident #24 would			1) When addressing resident concerns	s,		
	for a total of 3 baths	per week and Resident # 24			you must include detailed information f	or	
	was satisfied with th			resolution of concern to include a date			
	02/08/16. The "Resi			2) Any needed audits or observations	to		
	signed by the Director of Nursing (DON) and the				support monitoring should be		
	Administrator.				documented.		
		lent #24 on 02/23/16 at 3:02					
		was waiting to get his bath			4) The administrator and/or DON will		
		it #24 stated that he had not			review resident concerns weekly utilizi	ng a	
		all and was waiting on the			"Resident Concern" monitoring tool to		
	_	come and wash him.			ensure concern have been addressed	and	
		tated that he did not take			the resolution reviewed with the		
		onic pain, so he took bed			resident/RP in a timely manner to inclu		
	_	and Thursdays when the			a written response on the concern form		
		and assisted him. Resident			and details of the follow up that occurre	ed	
		ne days that hospice is not			with a date.		
		off is "supposed to wash me			The administrator and the DON will are	4	
		Resident #24 further stated			The administrator and/or DON will pres		
		ppy with 3 bed baths per			all findings at the monthly QI committe		
		4 stated the he remembered			meeting. The QI committee will review		
		by his friend and RP on his ution was fine if he was			minutes of the resident council meeting monthly and "Resident Concern" audit	-	
		e 3 bed baths per week but			for 6 months for identification of trends		
	he was not.	c o bed battis per week but			actions taken, and to determine the ne		
		I Worker Assistant (SWA) on			for and/or frequency of continued	cu	
		I stated the resident concern			monitoring, and make recommendation	าร	
		utside her office and on			for monitoring for continued complianc		
		and families are notified			is: Mornioring for continued complianc	٥.	
		ted. When a resident or family			The administrator and/or DON will pres	sent	
	_	laced on the "Resident			the findings and recommendations of t		
		then she routed it to the			monthly QI committee to the quarterly	-	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345502	B. WING _		R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	03/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
{F 223} SS=D	recalled the grievand stated that he was in resolution of adding no other follow up w Resident #24 was re would be up the mar concern was routed Interview with the inf (DON) on 02/24/16 a had received the grie had spoken with the bath was scheduled receive 3 bath per w agreement with this. no further follow up I Resident #24 had re further stated that sh week or 2 later to se satisfied with the resident has the sexual, physical, and punishment, and inv  The resident has the sexual, physical, and punishment, and inv  The facility must not or physical abuse, or involuntary seclusion  This REQUIREMEN by:  Based on staff interfacility failed to prote from physical abuse	ent for resolution. The SWA ce filed by Resident #24 and a agreement with the the 3 bath per week but that as done to determine if eceiving the bath or not, that hager for the department that too. Ferim Director of Nursing at 5:51 PM revealed that she evance from the DON and shower team and an extra so that Resident #24 would eek and he was in The interim DON stated that had been done to determine if ceived 3 baths per week, she he should have went back a he if Resident #24 was colution at that point.  (1)(i) FREE FROM ARY SECLUSION  Fright to be free from verbal, d mental abuse, corporal coluntary seclusion.  Use verbal, mental, sexual, proporal punishment, or	{F 16	executive QA committee for further recommendations and oversight.	3/18/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(	X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	I IP CODE	03/14/2010	$\neg$
				3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETIO DATE	N
{F 223}	twice when a staff me face and then on the	ent was physically abused ember slapped her on the right thigh for 1 of 1	{F 22	F 223 1) On 2/16/16, Resident		ed	
	#6). Immediate Jeopardy Nurse Aide (NA) #1 s on the face and again #6). Each incident of the secure unit and w #2 did not immediate administrative staff th abuse against Reside this Resident and oth unit from further abus assessed with redder thigh. The immediate jeopa The facility provided Centers for Medicare	began on 02/16/16 when alapped a combative resident in on the right thigh (Resident physical abuse occurred on was witnessed by NA #2. NA ly intervene or report to last she witnessed physical ent #6 and failed to protect er residents on the secure se. Resident #6 was need discoloration to her right order in the State Agency and and Medicaid an acceptable ince (AOC) on 03/08/16.		by the Medical Director. were received. On 2/16/ was assessed by Nurse a head to toe assessme revealed a reddened are thigh and small healing #6 still resides in the fact NA #1 was suspended f for physically abusing R terminated on 2/22/16.  2) Because all residents potential to be affected if physical and mental abu punishment, and involur 2/16/16 staff nurses core body audit on all cogniti residents in the facility f abuse. No negative find identified. On 2/16/16, ti interviewed all alert and	/16 Resident #6 e #1 which include ent. The findings ea on upper right bruises. Reside cility. On 2/16/16 from employment resident #6 and s have the by verbal, sexua use, corporal entary seclusion of mpleted 100% evely impaired for evidence of lings were he social worker	t nt t	
	determine the status Jeopardy. The facility review of the followin Skin audits for all cogdated 02/16/16 Documentation of intall cognitively intact in Documentation of in-(identifying/reporting with dementia) for all completed by 03/07/2 Documentation of ab which began on 02/2	erviews regarding abuse for esidents dated 02/16/16 services abuse, caring for residents currently employed staff		related to abuse and resonegative responses. On was disciplined for failur immediately allegation of to the Abuse policy and was terminated for not president #6.  3) On 2/16//16 all facility Administrative and currespresent were re-educate Administrator or Directo (DON) on the Abuse Poconstitute abuse. Abuse tolerated, to ensure imm	n 2/19/16 NA#2 re to report of abuse accordir on 2/25/16 NA # providing safety f  y staff including ent contract staff ed either by or of Nursing blicy and what e will not be	or	

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						R-C
		345502	B. WING _		03	3/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
LAKEDA	DE NUIDEING AND DE	THARM STATION CENTER		3315 FAITH CHURCH ROAD		
LAKE PAR	KK NUKSING AND KI	EHABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETION DATE
{F 223}	Continued From p	age 10	{F 2:	23}		
	on 03/03/16 and a	in allegation of neglect on		all residents and removing th	e accused	
	02/27/16	ů ů		from resident care area imme		
	A 24 hour/5 day re	eport for Resident #6 for the		2/18/16 staff facilitator starte	•	
		of abuse which had not		in-service for all staff entitled	d Being with a	
	previously been re	eported to the Health Care		Person with Dementia: Action	ns and	
	Personnel Registr	y (HCPR). Both reports were		Reactions." On 2/26/16, 2/29	/16, 3/1/16	
	faxed the the HCF	PR on 02/25/16		and/or 3/2/16 all staff and co	ntract staff	
		all staff hired since 02/16/16 to		attended a Directed □in-serv	•	
		ackground checks, reference		by the Regional Ombudsmar		
		e Registry checks, license		Agency on Aging. Titled: Ider		
	checks, and abuse training The facility's Abuse Policy			Prevention of Elder Abuse. C		
				Staff facilitator started an in-s		
			nurses and nursing assistants on following resident care plans and care			
		ursing care, interviews with		- ·		
		esidents, interviews with family,		guides. No staff will take an a until these in-services has be	-	
		staff present in the facility on of all documentation to support			en	
		views with the facility's		completed.		
		ector of Nursing and the Nurse		On 3/4/16 an in-service was	held for all	
		led sufficient evidence to		staff by The Geriatric and Ad		
		action by the facility to remove		Health Specialty Team titled		
		pardy at F-223. The immediate		Challenging Behaviors." Qua		
	1	oved on 03/14/16 at 7:15 PM.		in-services will be offered to		
		ned out of compliance at F-223		Specialty Team. All newly hir	•	
		and severity of (D) isolated, no		employees will continue to re	ceive training	
	actual harm with p	otential for more than minimal		on the Abuse policy through	written, video,	
	harm that is not in	nmediate jeopardy, while the		and verbal education. New h	ires, prior to	
	facility continues t	he process of monitoring the		taking an assignment will wa	atch the video	
	implementation of	their corrective action.		series "Hand in Hand," a sei	ries providing	
				training on caring for residen		
				dementia and on preventing	abuse.	
	The findings include	ded:				
				4) The DON, ADON, Departr		
		admitted to the facility on		and administrative staff on a		
	_	ses included dementia with		staff rounds will continue to r		
		affective disorder, cognitive		complete abuse observations		
		ficit, paranoid delusional beliefs		residents per shift to be com		
		esident #6 was currently being		days a week three times a da		
	i treated and follow	ed by ongoing psychiatric		each shift per week x4 weeks	s, 10	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C <b>03/14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	1 0.0002		STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2016
				3315 FAITH CHURCH ROAD	
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
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{F 223}	physician orders day (antianxiety) 2 millig injection as needed 1 mg every 8 hours  A quarterly Minimum assessed Resident cognition, required of persons for activities include mobility, tran physically and verba impairments in rang  A care plan dated 1: Resident #6 had pro characterized by ineverbal and physical treatment/care as every swinging arms and of plan's goal specified resident's safety. The included the following slowly from the from provide diversion and ADL routine to acco care is refused, leave Review of the "Resistaff were encourag in a calm, reassuring refused, to approach  A progress note date practitioner (NP) revereferred by nursing agitation and perseven	ew revealed Resident #6 had ted 08/31/15 for Ativan rams (mg) IM (intramuscular) for pain and 11/16/15 Ativan as needed for agitation.  In Data Set dated 12/29/15 #6 with severely impaired extensive staff assistance of 2 sof daily living (ADL) to ensfers, dressing and toileting, ally abusive and without e of motion.  2/29/15 recorded that oblematic behavior effective coping behaviors of abuse, resistive to widenced by yelling, cursing, delusional behavior. The care of that staff were to ensure the extensional space, estivity, allow for flexibility in mmodate mood, and when we and return in 5-10 minutes. In the determinant of the care was	{F 223	residents bi-weekly for 8 weeks and 10 residents monthly x3 months usi Abuse/Neglect audit tool called "Wa For and Responding to an Incident. monthly QI committee will review re of the Abuse/Neglect audit tool resumonthly for 6 months for identification trends, actions taken and to determine need for and/or frequency of continuonitoring, and make recommendation for monitoring for continued compliation and the findings and recommendations monthly QI committee to the quarte executive QA committee for further recommendations and oversight.	ng the atching " The sults on of ine the ued tions ance. oresent of the

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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IVEEDVE	RK NURSING AND REHA	ARII ITATION CENTER		3315 FAITH CHURCH ROAD			
LANE PAI	N NORSING AND REDA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 223}	agitated primarily in to note recorded that Rine NP to be very agitate Medications were adjusted to monitor.  A Skin Monitoring Re 02/15/16 did not recorded that Reside towards at 4:49 PM February 2016 Medic recorded that Reside towards staff that day she administered Atineeded for agitation positive effects and to needed for pain at 12 effects.  A nursing progress n PM by Nurse #1 recorded that Reside towards are when the The Medical Director the Resident. Nurse assessment for Residented area to the A Skin Monitoring Recompleted by Nurse #6 had redness to he advanced and significant to the Residented area to the Residented area to the Residented by Nurse #6 had redness to he advanced and significant reduced to the Residented area to the Residented by Nurse #6 had redness to he advanced and significant reduced to the Residented area to th	the morning. The progress resident #6 was noted by the d, angry, and confused. I justed and staff were to solview for Resident #6 dated and any changes or concern to progress note dated written by Nurse #1 and the cation Administration Record and #6 was very combative or Nurse #1 documented that or name in a transport of the cation Administration Record and #6 was very combative or Nurse #1 documented that or name in a transport of the cation Administration Record and 1 mg by mouth as at 7:40 AM with some in the Ativan 2 mg IM as 2:10 PM with slight positive solved that nursing assistant the slapped Resident #6 and assessed #1 performed a full body dent #6 and noted a deep Resident's right upper thigh.  Eview dated 02/16/16, #1, recorded that Resident in inner thighs and an	{F 2:	<u>'</u>			
	completed by Nurse #6 had redness to he irregular reddened at long to the front of he An incident report da completed by the Dir	#1, recorded that Resident er inner thighs and an ea, approximately 3 inches					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ELE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		3/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 223}	Continued From page #6 on the leg and aff noted with red marks.  A written statement recorded that NA #1 leg on 02/16/16 arou #6 become combatin #1.  Review of a Health (HCPR) 24 Hour Init completed by the Act 02/16/16 at 10:00 Al Resident #6 on her I pulling her hair. Resmark on her upper riverse with the statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was asked if she was witnessed NA #1 statement by 02/19/16, which record putty Sheriff on 02 was aske	terwards the Resident was a across the right thigh.  by NA #1 dated 02/16/16 struck Resident #6 on her and 10:00 AM when Resident we and pulled the hair of NA  Care Personnel Registry ital Report dated 02/16/16 ministrator, recorded that on M, NA #1 stated she struck eg to stop the Resident from ident #6 was noted with a red	{F 22:	DEFICIENCY)		
	witnessed NA #1 sla 02/16/16 around 8:0 thigh above her knee Resident became co Written statements k recorded that on 02/ witnessed Resident morning care and Na the left side of her fa leave the Resident's	p Resident #6 on the face on 00 AM and again on the right e at 10:00 AM, when the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· /	(X3) DATE SURVEY COMPLETED	
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		345502	B. WING _			3/14/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	·E		
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER		3315 FAITH CHURCH ROAD			
_,	THE TOTAL PROPERTY OF THE PARTY	ASILITATION CLATER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
{F 223}	Continued From pag	e 14	{F 22	23}			
{F 223}	#6. Later in the more 02/16/16, while in the witnessed Resident NA #1 slapped Resident then witnessed NA # report the incident to Review of a HCPR 5 02/19/16, completed recorded on 02/16/1 immediately reported combative resident of care. The physical a was immediately sus called at 6:00 PM, the substantiated and N An interview with NA 02/24/16 at 10:30 AI received a lot of abuthat if she witnessed nurse/supervisor, resident.	aining around 9:45 AM on the shower room, NA #2 #6 grab the hair of NA #1 and the shower room and the leave the shower room and to Nurse #1 and Nurse #2.  Working Day Report dated by the Administrator, 6 at 10:00 AM, NA #1 that she slapped a that she start she that she that she should that she that she should tell the that she should tell the that she should tell the that she should that she should that she should tell the that she should that she she should that she should that she she should that she should that she she should that she she should that she should that she she she should that she she she she should that she	{F 22	23}			
	go into any resident 02/16/16 around 7:3 cooperate with staff during morning care	or and don't let the perpetrator rooms. NA #2 stated that on 0 AM Resident #6 would not and became combative (kicking, yelling and hitting).					
	#1 twice, then witnes on the left side of he going to stop that." It more than just a pat hard slap. NA #2 staupset and remained	tnessed Resident #6 hit NA ssed NA #1 slap Resident #6 r face and said "You are NA #2 stated the slap was on the face, but it wasn't a ted Resident #6 was already upset. Both NAs continued					
	wheelchair and NA # dining room. NA #1 s dining room, NA #1 s	dressed, placed her in her  1 took Resident #6 to the  stated that on the way to the  stopped at the nurse's station  popped (Resident #6)" and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		33 <sup>.</sup>	REET ADDRESS, CITY, STATE, ZIP CODE 15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 223}	out later that Nurse is statement. NA #2 sta slapped Resident #6 definition of abuse, It to separate NA #1 fr further stated she diagain and thought Na the incident and wor further stated that la AM, both NA #1 and Resident #6 in the same con NA #1 bent down to and Resident #6 grawhen NA #1 slapped thigh. NA #2 stated thear, but she didn't I #6 released her grip finished pulling up the transferred her to the Resident #6 to the dishe observed NA #1 nurse's station and that she "popped" R #2 immediately left to DON returned to the talk to the DON and the unit. NA #2 stated 02/16/16 what happed that NA #1 slapped I her face about 8:00 thigh about 10:00 AI informed the police of interviewed her that the Administrator on her on the phone.	NA #2 stated that she found #1 did not hear NA #1's ated she felt that when NA #1 to that the incident fit the but that she didn't know how from Resident #6. NA #2 d not think it would happen lurse #1 heard NA #1 report all take care of it. NA #2 ter that morning around 10:00 INA #2 were toileting hower room when the simple the Resident's pants abbed NA #1's hair. That's draw Resident #6 on her right the slap was loud enough to know what to do. Resident on NA #1 hair and they	{F 2	223}			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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LAKERA	NA MILIDONIC AND DELLA	ADILITATION CENTER		3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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{F 223}	Continued From page	e 16	{F 2	223}			
	at 12:55 PM with NA	#1. She stated that she					
	worked on the facility	's secure unit as her					
		nt and had recently received					
	_	1 stated she was trained on					
	how to identify abuse						
		d remove the perpetrator					
		I law enforcement or the					
		ake sure the perpetrator and					
		atched. NA #1 stated that on,					
		S slapped her on the face					
	and she responded b						
		said "Let's don't do that." NA					
		ned her face with my hand"					
		ent. NA #1 stated she went to					
	the nurse's station af	Nurse #1 that the Resident					
		she did not report touching					
	l '	e did not think there was					
		stated there was no mark left					
	, ,	e. NA #1 stated later that					
		0 AM, she and NA #2 were					
	_	in the shower room and the					
		mbative, worse this time. NA					
		she was pulling up the					
		Resident grabbed her hair,					
		s up on my tip toes", so "I					
		right knee to get her to stop,					
		topped." NA #1 stated she					
		ause it was not her nature to					
		nt #6 continued yelling and				ſ	
	hitting, we got her dre	essed and took her to the				ĺ	
	day room. NA #1 stat	ted afterwards, she reported				ĺ	
	to Nurse #1 and Nurs	se #2 that she struck				ĺ	
	Resident #6 on the le	eg, the DON came and took				ĺ	
	a statement from her	and she was suspended.					
	A telenhone interview	www.vwas conducted on 02/24/16					
		llow up interview was				ſ	
		16 at 3:30 PM with Nurse #1.					
			1		I .		1

CLIVILIN	STOR WEDICARE &	VIEDICAID SERVICES				CIVID IVC	7. 0930 <del>-</del> 0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE DAE	NA NUIDOINO AND DELLA	DII ITATION OFNITED		33	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
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{F 223}	02/16/16 there were a unit. Around 10:00 or her that while NA #1 a Resident #6 in the she became combative ar hair. NA #1 stated she get her to let go. Nurse (supervisor) was also conversation. NA #1 swith Nurse #1, while incident to the DON. took a statement from suspended. Nurse #1 with all residents on the trivial residents on the trivial residents of abuse resistated she had not be witnessed NA #1 slap earlier that morning. In was combative at time to give her care. Nurse trained that when resistaff should give the resistaff should give the resident was earlier that day ar needed) twice on her and later for pain. Nur did not cooperate inition and Ativan was given Resident #6 was calmassessment was comand she was noted with the should was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the should give the resident #6 was calmassessment was comand she was noted with the she was noted with th	Nurse #1 stated that on 14 residents on the secure 10:15 AM, NA #1 informed and NA #2 provided care to ower room, the Resident and grabbed NA #1 by the e "popped" Resident #6 to se #1 stated Nurse #2 present and heard the stayed at the nurse's station Nurse #2 reported the The DON came to the unit, in NA #1 and she was stated that NA #1 worked the secure unit that day from as suspended around 10:30 is not aware of any prior garding NA #1. Nurse #1 then informed that NA #2 in Resident #6 on the face Nurse #1 stated Resident #6 es, usually required 2 staff the #1 stated that staff were dents became combative, the esident #6 was very and received Ativan (as shift that day for agitation rise #1 stated Resident #6 ally with a skin assessment, to calm her down. Once	{F 2	223}	DEFICIENCY)		
	changes noted to her	ed there were no other skin or face.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0.40002		STREET ADDRESS, CITY, STATE, ZIP COD		)3/14/2016	
				3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 223}	3:52 PM. She stated around lunch time on "popped" Resident # room and reported hadministrator that N she had started cominvestigation. The A around 6:00 PM. The went to see Resider around 7:00 PM who be and the post #6 without any mark Administrator stated 9:00 PM, the police she knew about and happened earlier that stated she was not at the DON's investistated she called NA morning on 02/17/16 from her over the phof physical abuse the on 02/16/16 and repadministrator asked statements about with Nurse #2 was interval. Nurse #2 was interval. Nurse #2 and Nurse #3 and Nurse #4 and Nurs	as interviewed on 02/24/16 at I that the DON informed her in 02/16/16 that NA #1 if 6 on the knee in the shower iterself. The DON told the A #1 was suspended and that impleting interviews for the diministrator called the police in the police of the first time that day the police of	{F 22	,			
	#6 because the Res #2 stated she asked station. Nurse #2 we	ident pulled her hair. Nurse  NA #1 to stay at the nurse's ent to find the DON and report  DON came to the secure unit,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE : COMPL	
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	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	)E		
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{F 223}	suspended. Nurse #2	from NA #1 and she was stated she was not aware ents of abuse between NA	{F 2	223}			
{F 225} SS=D	jeopardy on 02/24/16	was conducted on 02/25/16. c)(2) - (4)	{F 2	(25)			3/18/16
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowle court of law against a indicate unfitness for other facility staff to the or licensing authoritie.  The facility must ensuinvolving mistreatment including injuries of unisappropriation of resimmediately to the act to other officials in act through established patterns and the state survey and certain the state of	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a memployee, which would service as a nurse aide or ne State nurse aide registry is.  The state all alleged violations int, neglect, or abuse, inknown source and esident property are reported iministrator of the facility and cordance with State law procedures (including to the					
	The facility must have	e evidence that all alleged					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				33	15 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER		IN	DIAN TRAIL, NC 28079			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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{F 225}	prevent further poter	ghly investigated, and must ntial abuse while the	{F 2	25}				
	to the administrator of representative and to with State law (include certification agency) incident, and if the all	estigations must be reported						
	by: Based on staff intervistaff failed to immedistaff of a witnessed i which a resident was notified, the facility faphysical abuse to the Registry in 24 hours	T is not met as evidenced views and record review, the lately notify administrative neident of physical abuse in a slapped on the face. Once alled to report the incident of the Health Care Personnel and the investigative findings of 1 of 1 sampled residents.			F225 Investigation/Report allegations/individuals  The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation in progress and the results of all investigations must be reported to the administrator or his designated			
	Nurse Aide (NA) #2 that she witnessed president (Resident #1 resulted in further phwitnessed NA #1 slabut did not immediat protect the Resident remained on the secunsupervised and wa 02/16/16, by NA #2, right thigh. The facilit	p Resident #6 on the face, ely report the abuse or from further abuse. NA #1			administrator or his designated representative and to other officials in accordance with Stat law( including to State Survey and certification agency) within 5 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  1) On 2/16/16, Resident #6 was assess by the Medical Director. No new ordwere received. On 2/16/16, Resident #6 was assess by Nurse #1 which included a head to assessment. The findings revealed a	sed ers ed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L TOENTIEICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
IAKEDAI	DK NIIDGING VND DEI	ABILITATION CENTER		33	315 FAITH CHURCH ROAD			
LANE PAI	KK NUKSING AND KEI	ABILITATION CENTER		IN	NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 225}	Continued From pa	ge 21	{F 2	25}				
	within 24 hours and	I the investigation of the			reddened area on the upper right thigh			
	physical abuse with	•			and small healing bruises. Resident #6			
	'	g ,			still resides in the facility. On 2/16/16 N			
	The immediate jeor	pardy is present and ongoing.			#1 was suspended from employment a			
					terminated on 2/22/16.			
		d the State Agency and			On 2/16/16, staff nurses completed			
		re and Medicaid an acceptable			100% body audit on all cognitively			
	allegation of compli	ance (AOC) on 03/08/16.			impaired residents in the facility for			
					evidence of abuse. No negative finding	js		
	_	s conducted on 03/14/16 to			were identified. On 2/16/16, the social	al .		
		s of the ongoing Immediate ity provided documentation for			worker interviewed all alert and oriente			
	review of the follow				residents related to abuse and resulting no negative responses.	9 111		
		ognitively impaired residents			On 2/19/16 NA#2 was disciplined for			
	dated 02/16/16	ogmavely impaired recidente			failure to report immediately allegation			
	Documentation of in	nterviews regarding abuse for			abuse according to the Abuse policy ar			
		residents dated 02/16/16			on 2/25/16 NA #2 was terminated for n			
	Documentation of in	n-services			providing safety for Resident #6.			
	(identifying/reportin	g abuse, caring for residents						
	1	all currently employed staff			2) On 2/16/16 administrator submitted	the		
	completed by 03/07				24 hour report to DHSR Health Care			
		buse monitoring on each shift			Registry. On 2/22/16 administrator			
		/26/16 and remained ongoing			submitted the 5 day report to DHSR			
		rts for an allegation of abuse			Health Care Registry for initial abuse	. 40		
	02/27/16 and an	allegation of neglect on			investigation of NA#1 striking Resident	. #10		
		oort for Resident #6 for the			on the thigh. On 2/25/16 administrator submitted a	24		
		abuse which had not			hour report to DHSR Health Care Regi			
		ported to the Health Care			for NA#1 alleging slapping Resident #6	•		
		(HCPR). Both reports were			the face. On 2/25/16 administrator			
	faxed the the HCPF				submitted 5 day report to DHSR Health	ı		
		all staff hired since 02/16/16 to			Care Registry for allegation identified			
	include criminal bad	ckground checks, reference			during investigation of initial abuse			
		Registry checks, license			involving NA#1 and NA#2 not reporting	j		
	checks, and abuse				immediately 8:00 AM physical abuse			
	The facility's Abuse	Policy			slapping incident.			
	Observations of				2) On 2/40/40 IIThe Heart in Heart A			
		rsing care, interviews with sidents, interviews with family,			<ol> <li>On 2/18/16 "The Hand in Hand: A Training Series for Nursing Homes", or</li> </ol>	า		

OL. VILI	C . C	WEDIO/ WE CEITTIOLO				<del></del>	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
			7 11 201221			R	-C
		345502	B. WING			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER			315 FAITH CHURCH ROAD		
	T			II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 225}	Continued From pag	e 22	{F 2	251			
(1 220)	, ,	aff present in the facility on	ا ا	.20}	Person-Centered Care of Persons with		
		ill documentation to support			Dementia and Prevention of Abuse,	ı	
	the AOC and intervie				Module Four- Being with a Person with	1	
		or of Nursing and the Nurse			Dementia: Actions and Reactions was	•	
		sufficient evidence to			viewed by all staff.		
	support corrective ac	tion by the facility to remove			On 2/26/16, 2/29/16, 2/1/16 or 3/2/16 a	all	
	the immediate jeopar	rdy at F-225. The immediate			staff and contract staff attended a		
		ed on 03/14/16 at 7:15 PM.			Directed-in-service presented by the		
	,	out of compliance at F-225			Regional Ombudsman Area Agency or		
	•	d severity of (D) isolated, no			Aging Title: Identification and Preventi	on	
	· ·	ential for more than minimal			of Elder Abuse.		
		ediate jeopardy, while the process of monitoring the			On 2/25/16 administrator received an		
	implementation of the	· ————————————————————————————————————			in-service from the corporate Vice		
	in promonation of the	on contoure deach.			President of Operations. The in-service	9	
					included the following:		
	The findings included	d:			The facility must ensure that all		
					alleged violations involving mistreatme	nt,	
		nitted to the facility on			neglect, or abuse, including injuries of		
		included dementia with			unknown source and misappropriation	of	
		ective disorder, cognitive			resident property are reported		
		it, paranoid delusional beliefs			immediately to the administrator of the		
		dent #6 was currently being by ongoing psychiatric			facility and to other officials in accordary with State law through established	iice	
	services.	by origoning payernatric			procedures (including to the State surv	ev.	
	00111000.				and certification agency)	<b>.</b> ,	
	A quarterly Minimum	Data Set dated 12/29/15			The facility must have evidence th	at	
		6 with severely impaired			all alleged violations are thoroughly		
		xtensive staff assistance of 2			investigated, and must prevent further		
		of daily living (ADL) to			potential abuse while the investigation	is	
	1	sfers, dressing and toileting,			in progress.		
		lly abusive and without			The results of all investigations mu		
	impairments in range	e of motion.			be reported to the administrator or his/		
	A puroing progress =	ata datad 02/16/16 at 4:56			designated representative and to other	-	
		ote dated 02/16/16 at 4:56			officials in accordance with State law		
	assistant (NA #1) ver	#1 recorded that nursing			(including to the State survey and certification agency) within 5 working d	lave	
	1	ight thigh during care when			of the incident, and if the alleged violat	-	
	the Resident pulled h				is verified appropriate corrective action		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: ` ´		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	-C	
NAME OF P	ROVIDER OR SUPPLIER	343302		-	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2016	
TVAINE OF T	NOVIDEN ON OUT FIEN				3315 FAITH CHURCH ROAD			
LAKE PA	RK NURSING AND RE	HABILITATION CENTER			NDIAN TRAIL, NC 28079			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
{F 225}	Continued From pa	age 23	{F 2	25}				
	A Skin Monitoring F	Review dated 02/16/16,			must be taken. A 24 hour and 5 day report is requ	ıired		
		e #1, and an incident report npleted by the Director of			for each allegation, including allegation identified during an investigation and/o			
		orded that Resident #6 had			additional allegations occurring on the			
		er thighs and an irregular			same day and/or involving the same			
	the front of her upp	proximately 3 inches long to			employee/resident.			
	the noncorner upp	er right triigh.			4) The Corporate staff, i.e. corporate			
	A written statemen	t by NA #1 dated 02/16/16			nursing consultant and/or regional vice	<b>:</b>		
	recorded that NA #	1 struck Resident #6 on her			president will continue to review all			
	1 -	ound 10:00 AM when Resident			allegations of abuse and interventions			
		tive and pulled the hair of NA			when reported to the administrator in			
	#1.				accordance with the abuse policy and			
	A Consultation Per	port dated 02/16/16, completed			Elder Justice Act including appropriate agencies notifications. The monthly Q			
		ded a concern that NA #2 did			committee will review results of any	1		
		nmediately, remove the			allegations of abuse i.e. 24 hour/5 day			
		abuse situation and report to			report monthly for 6 months for			
		when the charge nurse was			identification of trends, actions taken a			
	advised of abuse, I	but did not respond.			determine the need for and /or frequer of continued monitoring and make	су		
	Review of a Health	Care Personnel Registry			recommendations for monitoring for			
		nitial Report dated 02/16/16			continued compliance. The administration			
		Administrator, recorded that on			and/or DON will present the findings a	nd		
		AM, NA #1 stated she struck			recommendation to the quarterly			
		r leg to stop the Resident from			executive QA committee for further			
		A #1 was immediately port did not include the			recommendations and oversight.			
		t occurred on 02/16/16 at 8:00						
	AM.	1 0 0 0 0 1 0 0 1 0 0 0 0 0 0 0 0 0 0 0						
	Review of the facili	ty's investigation revealed a						
		by the Administrator, dated						
		corded that she spoke to the						
		02/16/16 around 9:00 PM and						
		as aware that NA #2 also						
		lap Resident #6 on the face on						
	02/16/16 at about 8	3:00 AM. The written statement						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			R-C <b>3/14/2016</b>	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		14,2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 225}	The Administrator NA #2 on 02/17/16 witnessed NA #1 s 02/16/16 around 8 thigh above her kn Resident became  Written statements recorded that on 0 witnessed Resider morning care and the left side of her leave the Resident at the nurse's stati #6. NA #2 stated the witnessed physical because she thought's statement. La AM on 02/16/16, witnessed Resider NA #1 slapped Resident witnessed NA report the incident #2 stated she did incident of staff to time.  Written statements and the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #2 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the Administrate recorded that Nurse aware that NA #4 with the NA wi	Administrator was not aware. documented that she spoke to and was informed that NA #2 slap Resident #6 on the face on 8:00 AM and again on the right lee at 10:00 AM, when the	{F 2:	25}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING				-C
NAME OF P	ROVIDER OR SUPPLIER	0.10002		STF	REET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2016
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
{F 225}	care. The physical ab was immediately susp called at 6:00 PM, the substantiated and NA report did not include abuse that occurred of the course of the cours	by the Administrator, at 10:00 AM, NA #1	{F 2	25}	DEFICIENCY)		
	· ·	ut that she didn't know how m Resident #6. NA #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R.	-C	
		345502	B. WING			03/	14/2016	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		33 <sup>.</sup>	REET ADDRESS, CITY, STATE, ZIP CODE  15 FAITH CHURCH ROAD  DIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 225}	again and thought Not the incident and wou further stated that lat AM, both NA #1 and Resident #6 in the sh Resident became con NA #1 bent down to pand Resident #6 gral when NA #1 slapped thigh. NA #2 stated thear, but she didn't ke #6 released her grip finished pulling up the transferred her to the Resident #6 to the dishe observed NA #1 nurse's station and to that she "popped" Reference with the DON. Not the DON and then Not unit. NA #2 stated the 02/16/16 what happed that NA #1 slapped Ference about 8:00 A thigh about 10:00 AN informed the police of interviewed her that the Administrator on her on the phone.  A telephone interview at 12:55 PM with NA worked on the facility permanent assignment assignment.	Inot think it would happen arse #1 heard NA #1 report Id take care of it. NA #2 er that morning around 10:00 NA #2 were toileting lower room when the imbative again. During care, bull up the Resident's pants obed NA #1's hair. That's Resident #6 on her right he slap was loud enough to now what to do. Resident on NA #1 hair and they er Resident's pants, wheelchair and NA #2 took ining room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 esident #6 on the leg. Nurse he unit and returned to the NA #2 observed NA #1 talk to NA #1 was escorted off the er DON asked her on aned and she told the DON desident #6 on the left side of NA mand then on her right 1. NA #2 stated she also fficer on 02/16/16 when he evening on the phone and 02/17/16 when she talked to was conducted on 02/24/16 #1. She stated that she is secure unit as her int and had recently received it stated she was trained on	{F 2	225}				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	NO		R	-C
		345502	B. WING				14/2016
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	33	REET ADDRESS, CITY, STATE, ZIP CODE 115 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 225}	Administrator, and a resident were both 02/16/16 Resident she responded by g face and said "Let's just touched her face was present. NA #1 nurse's station after and told Nurse #1 tif full, but she did not because she did not it. NA #1 stated the Resident's face. NA around 10:00 AM, s Resident #6 in the sbecame combative, that while she was the Resident grabbe was up on my tip to right knee to get he stopped." NA #1 stated the stopped." NA #1 stated afterwards, s Nurse #2 that she stated afterwards, s Nurse #2 that she sthe DON came and and she was susper A telephone interview 02/16/16 there were unit. Around 10:00 her that while NA # Resident #6 in the stated after the stated afterwards and the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the pool of the stated afterwards and she was susper the st	all law enforcement or the make sure the perpetrator and watched. NA #1 stated that on, #6 slapped her in the face and gently touching the Resident's don't do that." NA #1 stated "I be with my hand" and NA #2 stated she went to the providing care to Resident #6 that the Resident was a hand report touching her face of think there was anything to be was no mark left on the was no mark left on the was no mark left on the worse this time. NA #1 stated pulling up the Resident's brief, and her hair, pulling so hard "I be the struck her gently her nature to hurt anyone. We we got ok her to the day room. NA #1 she reported to Nurse #1 and struck Resident #6 on the leg, took a statement from her	{F 2	25}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
		345502	B. WING			R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	1 1111		STREET ADDRESS, CITY, STATE, 2 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ZIP CODE	03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
{F 225}	get her to let go. Nui (supervisor) was als conversation. NA #1 with Nurse #1, while incident to the DON. took a statement from suspended. Nurse # with all residents on 7:00 AM until she way AM, but Nurse #1 way incidents of abuse restated she had not be witnessed NA #1 slate earlier that morning.  The Administrator way 3:52 PM. She stated around lunch time on "popped" Resident # room and reported hadministrator that Nashe had started compinious tigation. The Administrator that Nashe had started compinious tigation. The Administrator that Administrator that Administrator that Administrator called PM. The Administrator called PM. The Administrator Resident #6 for the for PM when law enforces.	ne "popped" Resident #6 to ree #1 stated Nurse #2 or present and heard the stayed at the nurse's station. Nurse #2 reported the. The DON came to the unit, m NA #1 and she was 1 stated that NA #1 worked the secure unit that day from as suspended around 10:30 as not aware of any prior agarding NA #1. Nurse #1 reen informed that NA #2 p Resident #6 on the face.  The DON informed her in 02/16/16 that NA #1 as suspended and that pleting interviews for the dministrator continued and sometime before 4:00 and sometime before she left that the Written statements and inistrator did not review the the DON left because she done everything. The law enforcement around 6:00 or stated she went to see first time that day around 7:00 ement arrived. Both she and observed Resident #6	{F 2	25}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		C	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			R-C <b>03/14/2016</b>	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ZIP CODE	03/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATI	(X5) COMPLETION DATE	
{F 225}	9:00 PM, law enforce she knew about and happened earlier that stated she was not at the DON's investig stated she called NA morning on 02/17/16 from her over the phof physical abuse the on 02/16/16 and rep Administrator asked statements about what Administrator stated HCPR 24 Hour Initia 5 Day Working Reponot report the incide occurred on 02/16/1 was included in her administrator further that both incidents of been reported to the Nurse #2 was interval. Nurse #2 stated Supervisor on the 7/4 Nurse #2 and Nurse station on the secure 10:00 AM when NA to know that I just power than the state of the s	later that evening, around ement called her and asked if ther incident of abuse that at day, but the Administrator aware and she had not looked gation. The Administrator at 2 sometime the next one regarding both incidents at were witnessed by NA #2 orted to the DON. The NA #2 to provide written hat she saw. The she completed/faxed the Il Report on 02/17/16 and the ort on 02/22/16, but she did not of physical abuse that around 8:00 AM because it investigation. The said that now she realized of physical abuse should have HCPR.  I she was the Nurse AM - 3PM shift on 02/16/16.  #1 were both at the nurse's equinit on 02/16/16 around #1 said "I just want everybody apped (named Resident)." NA of that she "popped" Resident ident pulled her hair. Nurse NA #1 to stay at the nurse's ent to find the DON and report DON came to the secure unit, at from NA #1 and she was 2 stated she was not aware lents of abuse between NA	{F 2	(25)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY LETED
		345502	B. WING _			-C <b>14/2016</b>
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079		14,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD    CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)	BE.	(X5) COMPLETION DATE
{F 225} {F 226} SS=D	jeopardy on 02/24/16	the DON were s notified of immediate at 5:27 PM. vas conducted on 02/25/16.	{F 2:			3/18/16
	policies and procedur mistreatment, neglect and misappropriation  This REQUIREMENT by:	, and abuse of residents		E226 Davelanment/Implementation		
	facility failed to immersher when a resident (Resto protect the resident physical abuse, intervals observed, and in perpetrator from a consecure unit. The facility witnessed incident of Care Personnel Registinvestigation in 5 worth to follow their abuse pareas of prevention, patraining and reporting abuse investigation resident.	diately stop nursing care ident #6) became combative t and prevent an incident of the vene when physical abuse inmediately remove the imbative resident on a ty failed to report a physical abuse to the Health stry in 24 hours and the king days. The facility failed policy and procedures in the protection, identification, of physical abuse for 1 of 1		F226 Development/Implementation Policies for Abuse/Neglect  1)On 2/16/16, Resident #6 was asses by the Medical Director. No new order were received. On 2/16/16 Resident # was assessed by Nurse #1 which inclea head to toe assessment. The finding revealed a reddened area on upper rightligh and small healing bruises. Resident #6 still resides in the facility. On 2/16/16 NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. On 2/16/16 Na was re-educated on the Abuse Policy include immediately intervene and sto abuse, remove the perpetrator and	s 6 uded ys ght dent 16 ent d A #2 to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X	3) DATE SURVEY COMPLETED
						R-C
		345502	B. WING _			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
LAKEDA	DE MUDEING AND DE	HADII ITATION CENTED		3315 FAITH CHURCH ROAD		
LAKE PAR	KK NUKSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{F 226}	during nursing care abuse but did not into administrative st protection to Resid which led to a second toward Resident #6 Resident #6 on the did not immediately remained on the second unsupervised and 02/16/16, NA #2 w #6 on the right thing The facility failed to Health Care Perso and the investigation 5 working days.	ident became combative a. NA #2 witnessed the physical mmediately intervene or report raff. This resulted in a lack of lent #6 and other residents and incident of physical abuse b. NA #2 witnessed NA #1 slap a face during morning care, but by report the abuse. NA #1	{F 22	immediately report.  2) Because all residents hat potential to be affected by verification physical and mental abuse, a punishment, and involuntary 2/16/16 staff nurses complet body audit on all cognitively residents in the facility for evabuse. No negative findings identified. On 2/16/16, the so interviewed all alert and orier related to abuse and resulted negative responses. On 2/19 was disciplined for failure to immediately allegation of abuse to the Abuse policy and on 2 was terminated for not provide Resident #6.	erbal, sexual, corporal seclusion on ted 100% impaired vidence of were ocial worker anted resident d in no 9/16 NA#2 report use according 2/25/16 NA #2	s g
	The facility provide Centers for Medica allegation of complemental of the state of	d the State Agency and are and Medicaid an acceptable iance (AOC) on 03/08/16.  s conducted on 03/14/16 to us of the ongoing Immediate lity provided documentation for ving: cognitively impaired residents anterviews regarding abuse for at residents dated 02/16/16 in-services ag abuse, caring for residents all currently employed staff		3) On 2/16//16 all facility start Administrative and contract swere re-educated either by A or DON on the Abuse Policy constitute abuse. Abuse will tolerated, to ensure immedia all residents and removing the from resident care area immediated 2/18/16 Staff facilitator started in-service for all staff entitled a Person with Dementia: Act Reactions." On 2/26/16, 2/29 3/2/16 all staff and contract so a Direct □in-service presented Regional Ombudsman Area Aging. Titled: Identification and Elder Abuse.	staff present Administrator and what not be ate safety of the accused lediately. On ed a video d "Being with tions and 9/16, 3/1/16 of staff attended ed by the Agency on and Preventio	or I

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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LAKE PAF	RK NURSING AND REHA	BILITATION CENTER	3315 FAITH CHURCH ROAD				
				II.	NDIAN TRAIL, NC 28079		
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{F 226}	Continued From page	e 32	{F 2	26}			
{F 220}	on 03/03/16 and an a 02/27/16 A 24 hour/5 day repo 8:00 AM incident of a previously been repo Personnel Registry (If faxed the the HCPR of Personnel files for all include criminal back checks, Nurse Aide Richecks, and abuse the The facility's Abuse P	Illegation of neglect on It for Resident #6 for the buse which had not Ited to the Health Care ICPR). Both reports were ICPR on 02/25/16 ISTAIR STAIR	{F 2	26}	nurses and nursing assistants on following resident care plans and care guides.  On 3/4/16 an in-service was offered for staff by The Geriatric and Adult Mental Health Specialty Team titled "Managing Challenging Behaviors." Quarterly in-services will be provided to all staff to the Specialty Team.  Staff Facilitator will continue to provide ongoing annual abuse and neglect education through written, video and verbal education.	g by	
	interviews with all sta 03/14/16, review of a the AOC and interview Administrator, Director Practitioner provided support corrective active immediate jeopar jeopardy was removed The facility remained at a lower scope and actual harm with poter harm that is not immediate.	ff present in the facility on I documentation to support ws with the facility's or of Nursing and the Nurse sufficient evidence to tion by the facility to remove dy at F-226. The immediate d on 03/14/16 at 7:15 PM. out of compliance at F-226 severity of (D) isolated, no intial for more than minimal ediate jeopardy, while the process of monitoring the			All newly hired employees will continue receive training on the Abuse policy through written, video, and verbal education. Prior to taking an assignme new hires will watch the video series "Hand in Hand:" a series providing train on caring for residents with dementia a on preventing abuse.  4) The DON, ADON, Department Heal and administrative staff on administrative staff rounds will continue to monitor an complete abuse observations on 10 residents per shift to be completed sev	nt ning and ds ve d	
	revised 11/01/06, incl do whatever is in its o	abuse, Neglect, or esident Property Policy", uded in part: The facility will control to prevent i, and abuse of our residents			days a week three times a day to include each shift. per week x4 weeks, 10 residents bi-weekly for 8 weeks and the 10 residents monthly x3 months using Abuse/Neglect audit tool called "Watch for and responding to an Incident." The monthly QI committee will review result of the Abuse/Neglect audit tool results monthly for 6 months for identification of	en the ning e ts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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TO THE STATE OF THE PARTY OF TH				15 FAITH CHURCH ROAD		
LAKE PARK NURSING AND REHAB	BILITATION CENTER			DIAN TRAIL, NC 28079		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
neglect, or misapproprioccurred, will immediate incident to their supervice report the incident to the will be initiated to previous while the investional Administrator is responsible to the appropriate ager State and Federal regulis responsible to direct to ensure that approprias indicated. Training: include: Indicators of reabuse and related interfacility will provide supinappropriate behavior. The facility will assess residents with needs a lead to abuse, neglect, property. Protection: Edirectly involved in alle or misappropriation of immediately from emploutcome of the investig.  Review of the facility's Misappropriation of Rerevealed a definition of included.  Resident #6 was admit 04/10/14. Diagnoses in behaviors, mood affect communicative deficit,	istion of property has tely report the alleged risor, who will immediately ne Administrator. Measures ent any further potential igation is in progress. The hisible to review the results of report the alleged incident incies in accordance with ulations. The Administrator the investigation process tate agencies are notified, Training programs may esident vulnerability to reventions. Prevention: The ervision to staff to identify s, such as rough handling. Care plan, and monitor and behaviors that might a or misappropriation of imployees accused of being gations of abuse, neglect, property will be suspended loyment pending the gation.  Abuse, Neglect or esident Property policy of physical abuse was not included dementia with tive disorder, cognitive paranoid delusional beliefs and #6 was currently being	{F 2:	26}	trends, actions taken and to determine need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance.  The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	ns e. sent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345502	B. WING		R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	03/14/2010
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{F 226}	Continued From pa	ge 34	{F 226	}	
	physician orders da (antianxiety) 2 milliq injection as needed physician's order da every 8 hours as ne A quarterly Minimur	ew revealed Resident #6 had ted 08/31/15 for Ativan grams (mg) IM (intramuscular) for pain and another ated 11/16/15 for Ativan 1 mg eded for agitation.  m Data Set dated 12/29/15 #6 with severely impaired			
	cognition, required persons for activitie include mobility, tra	extensive staff assistance of 2 s of daily living (ADL) to nsfers, dressing and toileting, ally abusive and without			
	practitioner (NP) re referred by nursing agitation and perse reported that Resid agitated primarily in note recorded that NP to be very agita	ted 02/05/16 by the nurse wealed Resident #6 was for evaluation of morning vering behaviors. Nursing ent #6 was noted increasingly the morning. The progress Resident #6 was noted by the ted, angry, and confused. djusted and staff were to			
		Review for Resident #6 dated cord any changes or concerns			
	02/16/16 at 4:49 PM February 2016 Med recorded that Resid towards staff that di she administered A needed for agitation	p progress note dated  If by Nurse #1 and the dication Administration Record lent #6 was very combative ay. Nurse #1 documented that tivan 1 mg by mouth as at 07:40 AM with some then Ativan 2 mg IM as			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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{F 226}	effects.  A nursing progress of PM by Nurse #1 recogned that NA #1 leg on 02/16/16 arou #6 become combati #1. A Disciplinary W completed by the Dorecorded that NA #1 leg on 02/16/16 arou #6 become combati #1. A Disciplinary W completed by the Dorecorded that NA #1 leg on 02/16/16 arou #6 become combati #1. A Disciplinary W completed by the Dorecorded that NA #1 leg on 02/16/16 arou #6 become combati #1. A Disciplinary W completed by the Dorecorded that NA #1 inappropriate way o behavior.  A Consultation Report of the Dorecorded that NA #1 inappropriate way or behavior.	2:10 PM with slight positive  note dated 02/16/16 at 4:56 orded that nursing assistant she slapped Resident #6 e Resident pulled her hair. or was notified and assessed #1 performed a full body ident #6 and noted a deep e Resident's right upper thigh.  eview dated 02/16/16, e #1, recorded that Resident er inner thighs and an area, approximately 3 inches her upper right thigh.  ated 02/16/16 at 5:03 PM rector of Nursing (DON), stated she struck Resident ferwards the Resident was	{F 2	26}		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	DDE	1 03/	14/2016	
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{F 226}	(HCPR) 24 Hour Initial completed by the Adr 02/16/16 at 10:00 AM Resident #6 on her lepulling her hair. Resident won her upper rigimmediately suspendinclude the incident of occurred on 02/16/16.  Review of the facility' written statement by 02/19/16, which record law enforcement on 02 and was asked if she witnessed NA #1 slap about 8:00 AM. The withat the Administrator Administrator docume #2 on 02/17/16 and witnessed NA #1 slap 02/16/16 around 8:00 thigh above her knee Resident became cordinated with the entry of the recorded that on 02/1 witnessed Resident # morning care and NA the left side of her facilieave the Resident's at the nurse's station #6. NA #2 did not repabuse against Reside the nursing staff hear	are Personnel Registry al Report dated 02/16/16 ministrator, recorded that on I, NA #1 stated she struck ag to stop the Resident from dent #6 was noted with a red and thigh. NA #1 was ed. The report did not f physical abuse that at 8:00 AM.  Is investigation revealed a the Administrator, dated and that she spoke to the 12/16/16 around 9:00 PM I was aware that NA #2 also a Resident #6 on 02/16/16 I was not aware. The ented that she spoke to NA I was informed that NA #2 a Resident #6 on the face on D AM and again on the right at 10:00 AM, when the	{F 2	26}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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{F 226}	#6 grab the hair of N Resident #6 on the left leave the shower to Nurse #1 and Nurse with the Administrator recorded that Nurse aware that NA #2 with #6 on the left side of AM. NA #1 did self-recorded the recorded that not not not not not not not not not no	NA #2 witnessed Resident A #1 and NA #1 slapped eg. NA #2 then witnessed NA room and report the incident se #2.  by Nurse #1 dated 02/16/16 r dated 02/19/16 both #1 stated she was not made tnessed NA #1 slap Resident her face on 02/16/16 at 8:00 eport that she "popped" ight thigh on 02/16/16 around  by Working Day Report dated by the Administrator, by the Administrator, by the Sapped a on the leg during resident by knew what she did was abuse was witnessed, NA #1 spended, law enforcement M, the allegation of abuse and NA #1 was terminated. Clude the witnessed physical on 02/16/16 at 8:00 AM.  #2 was conducted on M. NA #2 stated that she se training recently and knew abuse she should tell the move the resident from harm, r and don't let the perpetrator	{F 22				
	02/16/16 around 7:36 cooperate with staff during morning care	rooms. NA #2 stated that on 0 AM Resident #6 would not and became combative (kicking, yelling and hitting).					

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{F 226}	Continued From page	e 38	{F 2	226}			
, ,		sed NA #1 slap Resident #6		,			
	· ·	face and said "You are					
		A #2 stated the slap was					
		on the face, but it wasn't a					
		ed Resident #6 was already					
		upset. Both NAs continued					
		lressed, placed her in her					
	0	1 took Resident #6 to the					
	dining room. NA #1 s	tated that on the way to the					
	_	topped at the nurse's station					
		copped (Resident #6)" and					
	Nurse #1 said "Ok." N	NA #2 stated that she found					
	out later that Nurse #	1 did not hear NA #1's					
	statement. NA #2 sta	ted she felt that when NA #1					
		that the incident fit the					
	definition of abuse, b	ut that she didn't know how					
	to separate NA #1 fro	om Resident #6. NA #2					
	further stated she did	not think it would happen					
	again and thought Nu	ırse #1 heard NA #1 report					
	the incident and woul	ld take care of it. NA #2					
	further stated that late	er that morning around 10:00					
	AM, both NA #1 and	NA #2 were toileting					
	Resident #6 in the sh	ower room when the					
	Resident became cor	mbative again. During care,					
	NA #1 bent down to p	oull up the Resident's pants					
	and Resident #6 grat	obed NA #1's hair. That's					
	when NA #1 slapped	Resident #6 on her right					
		ne slap was loud enough to					
		now what to do. Resident					
	#6 released her grip	on NA #1 hair and they					
	finished pulling up the						
		wheelchair and NA #2 took					
	Resident #6 to the dir	ning room. NA #2 stated that					
	she observed NA #1	immediately go to the					
		old Nurse #1 and Nurse #2					
	that she "popped" Re	sident #6 on the leg. Nurse					
	#2 immediately left th	e unit and returned to the					
	unit with the DON. No	A #2 observed the DON talk					
	to NA #1 and NA #1 \	was escorted off the unit. NA					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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{F 226}	Continued From page		{F 2	26}				
( y	#2 stated the DON as happened and she to slapped Resident #6 about 8:00 AM and the 10:00 AM. NA #2 state enforcement on 02/16 her that evening on the Administrator on 02/17 on the phone.  A telephone interview at 12:55 PM with NA worked on the facility permanent assignme abuse training. NA #1 how to identify abuse witnessed, she should from the resident, cal Administrator, and ma resident were both was 02/16/16 Resident #6 and she responded b Resident's face and s #1 stated "I just touch	sked her on 02/16/16 what Id the DON that NA #1 on the left side of her face en on her right thigh about ed she also informed law 6/16 when he interviewed he phone and the 7/16 when she talked to her was conducted on 02/24/16 #1. She stated that she s secure unit as her nt and had recently received stated she was trained on and if abuse was d remove the perpetrator I law enforcement or the ake sure the perpetrator and atched. NA #1 stated that on, slapped her on the face	(1 2	20)				
	the nurse's station aft Resident #6 and told was a hand full, but s							
	anything to it. NA #1 son the Resident's factor morning around 10:00 toileting Resident #6 Resident became cor #1 stated that while son Resident's brief, the Factor in th	stated there was no mark left e. NA #1 stated later that o AM, she and NA #2 were in the shower room and the inbative, worse this time. NA						
	smacked her on the r	ight knee to get her to stop, opped." NA #1 stated she						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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{F 226}	Continued From page	e 40	{F 2	26}				
{F 226}	struck her gently becahurt anyone. Resident hitting, we got her dreday room. NA #1 statt to Nurse #1 and Nurse Resident #6 on the leastatement from her  A telephone interview at 11:10 AM and a fol conducted on 02/25/10 During the interviews 02/16/16 there were unit. Around 10:00 or her that while NA #1 Resident #6 in the shecame combative at hair. NA #1 stated she get her to let go. Nurse (supervisor) was also conversation. NA #1 with Nurse #1, while I incident to the DON. took a statement from suspended. Nurse #1 with all residents on to 7:00 AM until she was AM, but Nurse #1 waincidents of abuse registated she had not be witnessed NA #1 slap earlier that morning. It was combative at time to give her care. Nurse trained that when res	ause it was not her nature to at #6 continued yelling and essed and took her to the ed afterwards, she reported se #2 that she struck eg, the DON came and took and she was suspended.  Was conducted on 02/24/16 llow up interview was 16 at 3:30 PM with Nurse #1.  Nurse #1 stated that on 14 residents on the secure 10:15 AM, NA #1 informed and NA #2 provided care to ower room, the Resident and grabbed NA #1 by the e "popped" Resident #6 to se #1 stated Nurse #2 present and heard the stayed at the nurse's station Nurse #2 reported the The DON came to the unit, an NA #1 and she was stated that NA #1 worked he secure unit that day from as suspended around 10:30 so not aware of any prior garding NA #1. Nurse #1 een informed that NA #2 or Resident #6 on the face Nurse #1 stated Resident #6 es, usually required 2 staff se #1 stated that staff were idents became combative,	{F 2	26}				
	try to redirect and cor care. Nurse #1 stated	resident time to calm down, me back later to provide I Resident #6 was very nd received Ativan (as						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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				INDIAN TRAIL, NC 28079				
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{F 226}	Continued From pag	e 41	{F 22	26}				
{F 226}	needed) twice on her and later for pain. No did not cooperate initiand Ativan was giver Resident #6 was call assessment was corrand she was noted wright thigh about 3 in shape. Nurse #1 statchanges noted to he  The Administrator wa 3:52 PM. She stated around lunch time or "popped" Resident #room and reported hadministrator that Nashe had started cominvestigation. The Adworking in her office PM she obtained the the DON to complete Report. The DON lef but informed the Administrator called PM. The Administrator called PM. The Administrator called PM. The Administrator called PM. The Administrator called PM when law enforcement obsany marks to either t stated later that ever	r shift that day for agitation arse #1 stated Resident #6 tially with a skin assessment, in to calm her down. Once m, a full body skin appleted, around 12:30 PM with a reddened area to her ches long and irregular in ted there were no other r skin or face.  As interviewed on 02/24/16 at that the DON informed her in 02/16/16 that NA #1 6 on the knee in the shower erself. The DON told the A #1 was suspended and that pleting interviews for the diministrator continued and sometime before 4:00 necessary information from the HCPR 24 Hour Initial that the written statements and inistrator did not review the the DON left because she did one everything. The law enforcement around 6:00 per stated she went to see arst time that day around 7:00 per stated she went to see arst time that day around 9:00 PM, law	{F 22	26}				
	about another incide earlier that day, but t	er and asked if she knew nt of abuse that happened he Administrator stated she he had not looked at the						

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	3/14/2010
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{F 226}	called NA #2 some 02/17/16 and obtathe phone regarding abuse that were with the DON. The Aprovide written state The Administrator HCPR 24 Hour Into 5 Day Working Renot complete a sephysical abuse that 8:00 AM because investigation. The now she realized habuse should hav Nurse #2 was into AM. Nurse #2 state Supervisor on the Nurse #2 and Nurstation on the sec 10:00 AM when Note to know that I just #1 proceeded to some #2 stated she ask station. Nurse #2 what occurred. The obtained a statem suspended. Nurse of any previous in #1 and Resident #4 Attempts to interviunsuccessful.	on. The Administrator stated she etime the next morning on sined a statement from her overing both incidents of physical vitnessed by NA #2 and reported administrator asked NA #2 to stements about what she saw. stated she completed/faxed the stial Report on 02/17/16 and the eport on 02/22/16, but she did parate report for the incident of at occurred on 02/16/16 around it was included in her Administrator further said that that both incidents of physical eleben reported to the HCPR.  Arviewed on 02/25/16 at 10:28 and she was the Nurse 7AM - 3PM shift on 02/16/16. se #1 were both at the nurse's ure unit on 02/16/16 around A #1 said "I just want everybody popped (named Resident)." NA any that she "popped" Resident esident pulled her hair. Nurse ed NA #1 to stay at the nurse's went to find the DON and report the DON came to the secure unit, ent from NA #1 and she was a #2 stated she was not aware cidents of abuse between NA #6.  Was notified of immediate	{F 2	26}		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	BILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	1 03/	14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 226}	Continued From page	e 43 vas conducted on 02/25/16.	{F 2	26}				
{F 242} SS=D	-	ERMINATION - RIGHT TO	{F 2	42}			3/18/16	
	schedules, and health her interests, assessr interact with members inside and outside the about aspects of his care significant to the r	right to choose activities, a care consistent with his or ments, and plans of care; sof the community both a facility; and make choices or her life in the facility that resident.						
	the choice of bathing residents sampled for The findings included Resident #24 was rea 12/18/15 with diagnos hypertension, anxiety and weakness. Revie comprehensive signif set (MDS) dated 11/0 very important to Resbetween a tub bath, sbath. This MDS also i required total assistan bathing. The MDS fuwere identified. Review of Resident #12/2015 that was kep not identify his bathin Review of a care plant	failed to assess and honor frequency for 1 of 3 choices. (Resident #24) choices. (Resident #24) choices that included depression, dysphagia, who for the most recent from the change minimum data 6/15 indicated that it was ident #24 to choose hower, bed bath, or sponge indicated Resident #24			The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care, interawith members of the community both inside and outside the facilt5iy, and machoices about aspects of this or her life the facility that are significant to the resident.  F 242 Self-Determination-Right to Make Choices  1) On 2/25/16, the Director of Nursing (DON) spoke with resident # 24 to asseand confirm his choice of bathing frequency in order to honor his right to make a choice. The DON then updated resident # 24 □s bathing preference schedule to include Saturday a full bed bath in addition to being provided a full bed bath by Hospice services on	ake e in e esss		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 242}	related to impaired m limitations. The goal Resident #24 would I through the next revie included: one person assistance with bathi #24 to participate in s Review of the facility revealed Resident #2 scheduled on Wedne second shift. Review of the facility through 02/24/16 for Resident #24 had rec bathing assistance for Interview with Resident PM revealed that he for the day. Resident been washed up at a nursing assistant (NA Resident #24 also sta showers due to chror baths on Tuesdays a hospice staff came a #24 stated that on the there, the facility staf up and they do not." that he would be hap week. Interview with NA #4 revealed she was tak and that hospice staff Tuesdays and Friday sure. NA #4 stated th scheduled to receive was not sure if he wo on hospice services.	self-sufficiency for bathing obility and physical of said care plan stated that be neat, clean, and odor free ew period. Interventions to provide some physical ing and encourage Resident self-care as ability permitted. Is master shower schedule ext's bed baths were sadays and Saturdays on so bathing log dated 01/28/16 Resident #24 revealed that seived no type of bathing or ar 21 of the last 30 days. First #24 on 02/23/16 at 3:02 was waiting to get his bath it was waiting on the last occurred that he did not take incipain, so he took bed and Thursdays when the indice as the days that hospice is not it is "supposed to wash me Resident #24 further stated py with 3 bed baths per on 02/24/16 at 8:49 AM ing care of Resident #24 frompleted his bed baths on she believed but was not	{F 2	42}	Tuesdays and Thursdays.  2) On 2/26/16, the social worker completed a 100% audit of all interviewable residents to assess their choice of bathing frequency. The resul of the 100% audit was given to the DOI to update the bathing preference sched on 2/26/16.  3) On 2/26/16 the administrator inserviced the admissions coordinator regarding asking the resident and/or resident 's family about the resident bathing preference as part of the admission preference as part of the admission coordinator will then give a copy of the Bathing Preference questionnaire. The admission coordinator will then give a copy of the Bathing Preference questionnaire to the nursing departments of the shower team can schedule the resident bathing preference in order honor his/her choice.  On 3/14/16, the Staff facilitator and sock worker in-serviced regarding Self-Determination for all licensed nurs and certified nursing assistants. The Self-Determination in-service included: Residents have the right to make choice about aspects of his or her life in the facility that are significant to the resider 2. Each resident has the right to make choices about his or her bathing preference. All future employees will be in-serviced during their orientation process.  4) On 3/10/16, the DON and/or Social	N dule s es	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NI IMBED: `		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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{F 242}	Continued From pag	ge 45	{F 2	42}				
{F 242}	frequency, NA #4 jubed baths twice a w In a follow up intervi 02/24/16 at 8:57 AM received his bed bathe hospice staff car stated that the NA h while doing his bed trimmed his own naithe only bed baths hospice staff provide Thursdays, and this when he was able hollow Interview with NA #5 revealed that she wand that Resident #2 week on Saturday and Thursdays and Thursdays, she was Resident #24 was a Saturdays, she was shower day, NA#5 w #24's bathing preferor preference of bed Interview with the in (DON) on 02/24/16 admission showers/room number and if something different know and they woul schedule. The interithe Admissions Dire laundry and hair ser	st knew that hospice provided eek. ew with Resident #24 on In he stated that he had finally th yesterday at 4:00 PM when me to do it. Resident #24 also ad shaved him yesterday bath, and that he had ils. Resident #24 stated that he received were the ones that he received were the ones that he received were the ones that he redily bothered him because e took a shower once a day. For on 02/24/16 at 9:48 AM has a part of the shower team 24 was showered once a high that hospice staff came on sadays but was not aware of 24 received a bed bath or a not aware of whether ctually showered on aware that was his scheduled was not aware of Resident hences in regards to frequency if bath due to severe pain. The terim Director of Nursing at 5:51 PM revealed that on bed baths are assigned by	{F 2·	42}	Service utilized a Bathing Preference Audit Tool to ensure residents are receiving their choice of bathing preference. The "Bathing Preference Audit Tool" will be completed weekly x twelve weeks, then monthly x three months. Any negative findings will be addressed immediately.  The monthly QI committee will review results of the "Bathing Preference Audit Tool" monthly for 6 months for identification of trends, actions taken a to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance.  The administrator and/or DON will prest the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	nd I for sent		
	She further stated the change in the showed did not request a ch	ne resident could request a er/bathing schedule but if they ange then the resident would e that was assigned by room						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 242} {F 253} SS=E	and was not aware the and care needed to be resident. Interview with the Adrat 10:46 AM revealed obtained every quarte 10% of the residents practices. Admission provide any record of survey being complet would have included 483.15(h)(2) HOUSE MAINTENANCE SER The facility must proving maintenance services sanitary, orderly, and	DON was new to this role at preferences on activities e obtained from each mission Director on 02/25/16 bathing preferences were er when they interviewed for satisfaction on facility Director was unable to Resident #24's satisfaction ed in the last year which bathing preferences.  KEEPING & RVICES  ide housekeeping and a necessary to maintain a comfortable interior.	{F 2			3/18/16	
	by: Based on observation facility failed to mainta of 11 wheelschairs or of 6 halls (Rooms 20°204 B, 300 and 305 E. The findings included On 2/22/2016 at 10:2 9:55 AM, tour of the finding was conducted. The win rooms 201 B, 202 and 305 B were observed food particles, food or spots. On 2/22/2016 at 10:2 wheelchair, which believed in the spots of the spots.			The facility must provide houseker and maintenance services necessar maintain a sanitary, orderly, and comfortable interior.  F 253 Housekeeping & Maintenance Services  1) On 2/25/16, the housekeeping st cleaned the wheelchairs for Rooms 202A, 202B, 203A, 204B, 300, and 2) On 2/26/16, the housekeeping supervisor completed a 100% audit resident wheelchairs for cleanlines	e aff 201B, 305B.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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{F 253}	Continued From page	age 47	{F 2	53}			
	seat and frame wa	s dirty with food particles and		wheelchairs that were ider	ntified as not		
		s of dirt and food observed on		being clean were immedia	tely scheduled		
	the wheelchair we	re dried and dusty.		for cleaning by the housek	eeping staff.		
	On 2/22/2016 at 1	0:27 AM, an observation of the					
		belonged to the resident who		3) On 2/26/16, a system w	as put in place		
		2 A revealed the wheelchair's		by the housekeeping supe			
		is dirty with food particles, dirt		cleaning wheelchairs. All r			
	-	dirt and food observed on the		wheelchairs are to be clea	•		
	wheelchair were d	,		as needed during first and			
		0:27 AM, an observation of the		the housekeeping staff. A			
		belonged to the resident who		Log will be completed by t			
		2 B revealed the wheelchair's		housekeeping staff after w cleaned. The completed W			
		s dirty with food particles, dirt dirt and food observed on the		will then be given to the fa	•		
	wheelchair were d			administrator and the region	=		
		1: 32 AM, an observation of the		housekeeping director.	Silai		
		belonged to the resident who		On 2/26/16, the houseke	eepina		
		00 revealed the wheelchair's		supervisor in-serviced the			
	seat and frame wa	is dirty with food particles, dirt		staff on cleaning wheelcha	. •		
		dirt and food observed on the					
	wheelchair were d	ried and dusty.		4) On 3/1/16, the Maintena	ance Director		
	On 2/22/2016 at 1	1:40 AM, an observation of the		began auditing the Wheel	Chair Log on a		
	wheel chair which	belonged to the resident who		weekly basis and ongoing.	. The		
		3 A revealed dried hard dirt		Maintenance director will r			
		air's frame and food particles in		proper completion and foll			
	the seat of the who			Wheel Chair Log tool by in	•		
		1:53 AM, an observation of the		bottom right hand corner of	of the audit tool.		
		pelonged to the resident who					
		05 B revealed the wheelchair's		The Environmental Supervised in the Supervised Supervis			
		is dirty with food particles, dirt		findings of the Wheel Chai			
	wheelchair were d	dirt and food observed on the		monthly QI committee mee			
		:56 AM, an observation of the		results of the monitoring fo			
		pelonged to the resident who		compliance.	n continueu		
		01 B revealed the wheelchair's		Compilation.			
		shion was dirty with dried dirt,		The monthly QI committee	will review the		
		icles along the edges of the		results monthly for 6 mont			
	seat cushion.			identification of trends, act			
		: 56 AM, an observation of the		to determine the need for			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345502	B. WING _			03/	14/2016
	ROVIDER OR SUPPLIER	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079		315 FAITH CHURCH ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 253} SS=D	resided in room 203 A seat and frame was de and dust. Spots of dir wheelchair were dried On 2/24/2016 at 9:58 wheelchair which below resided in room 300 meat and frame was deand dust. Spots of dir wheelchair were dried On 2/24/2016 at 9:58 wheelchair which below resided in room 305 E seat and frame was deand dust. Spots of dir wheelchair were dried On 2/25/2016 at 8:41 were conducted with and the housekeeping 300 halls to observe the 201 B, 202 A, 202 B, B. The housekeeping was rewheelchairs. He stated be cleaned on a routing he stated that the whout to the rear of the below resided in room 305 E seat and frame was deand dust. Spots of dir wheelchair were dried On 2/25/2016 at 8:41 were conducted with and the housekeeping was rewheelchairs. He stated be cleaned on a routing he stated that the whout to the rear of the B and then the housekeeping was them and them to the resident's supervisor stated that schedules for specific	anged to the resident who a revealed the wheelchair's irty with food particles, dirt than dood observed on the dand dusty.  AM, an observation of the onged to the resident who evealed the wheelchair's irty with food particles, dirt than dood observed on the dand dusty.  AM, an observation of the onged to the resident who do a revealed the wheelchair's irty with food particles, dirt than dood observed on the dand dusty.  AM, an observation of the onged to the resident who do a revealed the wheelchair's irty with food particles, dirt than dood observed on the dand dusty.  AM, environmental rounds the maintenance director grupervisor on the 200 and the wheelchairs for rooms 203 A, 204 B, 300 and 305 supervisor stated that sponsible for cleaning do that wheel chairs were to the schedule every Tuesday, eelchairs were to be brought on the schedule every Tuesday, eelchairs were to be brought of the particles of the pa	{F 2		frequency of continued monitoring, and make recommendations for monitoring continued compliance.  The administrator and/or DON will press the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	for ent ne	3/18/16
SS=D	PERSONS/PER CAR	E PLAN					

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LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
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{F 282}	Continued From page	e 49	{F 282	2}	
	must be provided by	d or arranged by the facility qualified persons in h resident's written plan of			
	by: Based on staff intervial facility failed to follow resident became con Staff failed to immedit the resident became resident at a later timincidents of physical residents reviewed waddressed problemation of the face and again #6). Each incident of the secure unit and w#2 did not immediate Resident #6 and other unit from physical abassessed with redder thigh.  The immediate jeopath The facility provided and Centers for Medicare allegation of compliant A revisit survey was desident was assessed with survey was designed to follow the secure unit and the unit from physical abassessed with redder thigh.	abuse for 1 of 3 sampled with care plans which tic behaviors (Resident #6).  began on 02/16/16 when slapped a combative resident in on the right thigh (Resident physical abuse occurred on was witnessed by NA #2. NA ly intervene to protect er residents on the secure use. Resident #6 was need discoloration to her right and with the state Agency and and Medicaid an acceptable ince (AOC) on 03/08/16.		F282 Services by Qualified persons/care plan The services provided or arranged by facility must be provided by qualified persons in accordance with each resident □s written plan of care  1) On 2/1/16 and 2/22/16 Resident #6 care plan and care guide were review by the Minimum Data Set Nurse (MDS and found to be accurate and up to downwithout any concerns. The resident caplan includes problematic behavior characterized by ineffective coping behaviors of verbal and physical abuse resistant to care/treatment as evidence by yelling, cursing, swinging arms and delusional behavior. The care plan go specify staff are to ensure resident sath The care plans interventions include: approach resident calmly and slowly the front, respect personal space, prodiversional activity, allow for flexibility Activity of Daily Living (ADL) routine to accommodate mood, and when care refused, leave and return in 5-10 minimals.  2) On 3/4/16, the MDS nurse reviewed 100% of the care plans and care guides.	the  Sis  yed Sis  ate are  se, ced d bals fety.  from vide in o is utes.
	determine the status	of the ongoing Immediate  or provided documentation for			es

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LAKE PAI	RK NURSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079		
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{F 282}	Continued From particles of all codated 02/16/16 Documentation of all cognitively intact Documentation of (identifying/reporting with dementia) for completed by 03/0 Documentation of which began on 02/24 hour/5 day reporting on 03/03/16 and an 02/27/16 A 24 hour/5 day reporting on 03/03/16 and an 02/27/16 A 24 hour/5 day reporting on 03/03/16 and an 02/27/16 Completed by 03/0 Personnel Registry faxed the the HCP Personnel Registry faxed the the HCP Personnel files for include criminal backnecks, and abused The facility's Abused Observations of nucleon cognitively intact registry inta	age 50 cognitively impaired residents interviews regarding abuse for it residents dated 02/16/16 in-services ag abuse, caring for residents all currently employed staff 7/16 abuse monitoring on each shift t/26/16 and remained ongoing orts for an allegation of abuse in allegation of neglect on  port for Resident #6 for the f abuse which had not ported to the Health Care or (HCPR). Both reports were R on 02/25/16 all staff hired since 02/16/16 to ckground checks, reference to Registry checks, license	{F 2	DEFICI	ddressed on the e to include uring staff dent. Ongoing, the e to identify through the MDS d care guides are ent MDS nt change in  acilitator nurses and ed to following d care plans to provided quality ained. During oyees nurses and ontinue to be ance of following d care guides and  urses, DON, staff nurse began udit tool "Following care guides are e interventions	
	Practitioner provide support corrective the immediate jeop jeopardy was remote facility remained to a lower scope a actual harm with puharm that is not im	ctor of Nursing and the Nurse ed sufficient evidence to action by the facility to remove bardy at F-282. The immediate eved on 03/14/16 at 7:15 PM. ed out of compliance at F-282 and severity of (D) isolated, no otential for more than minimal mediate jeopardy, while the		residents identified with  Random audit of 20% of identified behaviors will weekly x 4 weeks, biwee then monthly x 3 months  The monthly QI committ results of the "Following any trends, actions take	f residents with be reviewed ekly x8 weeks s. ree will review Care Guide" for	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	03/14/2010
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{F 282}	Continued From pag		{F 282	the need for and /or frequence	-	
	The findings include	d:		continued monitoring and ma recommendations for monitor continued compliance.		
	04/10/14. Diagnoses behaviors, mood affection communicative deficient and psychosis. Residual communicative deficience and psychosis.	mitted to the facility on included dementia with ective disorder, cognitive etit, paranoid delusional beliefs dent #6 was currently being by ongoing psychiatric		The administrator and/or DOI the findings and recommenda quarterly executive QA comm further recommendations and	ation to the nittee for	
	physician orders dat (antianxiety) 2 milligrinjection as needed another physician's o	w revealed Resident #6 had ed 08/31/15 for Ativan rams (mg) IM (intramuscular) for pain. The resident had order dated 11/16/15 for hours as needed for				
	assessed Resident # cognition, required e persons for activities include mobility, tran	n Data Set dated 12/29/15 #6 with severely impaired extensive staff assistance of 2 of daily living (ADL) to asfers, dressing and toileting, ally abusive and without error of the of motion.				
	Resident #6 had pro characterized by ine verbal and physical a treatment/care as ev swinging arms and o plan's goal specified resident's safety. The included the following	ffective coping behaviors of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		3/14/2016
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{F 282}	ADL routine to accordance is refused, leaved Review of the "Residual staff were encouraged in a calm, reassuring refused, to approach A progress note date practitioner (NP) revereferred by nursing for a gitation and persevereported that Residual agitated primarily in the note recorded that RNP to be very agitated Medications were addications were addicated by the second were addicated by the second were additionally addit	ivity, allow for flexibility in amodate mood, and when a and return in 5-10 minutes. In the care guide" revealed and to approach Resident #6 manner and if care was the Resident later.  If 02/05/16 by the nurse caled Resident #6 was or evaluation of morning ering behaviors. Nursing and #6 was noted increasingly the morning. The progress resident #6 was noted by the ed, angry, and confused. Justed and staff were to progress note dated written by Nurse #1 and the cation Administration Record and #6 was very combative of Nurse #1 documented that wan 1 mg by mouth as at 7:40 AM with some then Ativan 2 mg IM as 2:10 PM with slight positive oute dated 02/16/16 at 4:56 #1 recorded that nursing	{F 28	2}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER			33	REET ADDRESS, CITY, STATE, ZIP CODE  15 FAITH CHURCH ROAD  DIAN TRAIL, NC 28079	1 03/	14/2016
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{F 282}	Continued From page	e 53	{F 2	82}			
	completed by the Dirrecorded that NA #1: #6 on the leg and after noted with red marks  A written statement be recorded that NA #1: leg on 02/16/16 aroun #6 become combative  Review of a written statement be she became aware of that NA #2 also witnes #6 on the face on 02/written statement recorded that she and was informed that she and was informed that slap Resident #6 on the 8:00 AM and again of the statement recorded that she and was informed that she and was informed that slap Resident #6 on the side of the side o	·					
	recorded that on 02/1 witnessed Resident # morning care and strucare continued and R combative. During the Resident #6 on the let the morning around 9 the shower room, Recombative and struck continued and NA #2	/ NA #2, dated 02/17/16, 6/16 at 7:30 AM, NA #2 66 become combative during uck NA #1 twice. Nursing resident #6 continued to be e care, NA #1 slapped ft side of her face. Later in 1:45 AM on 02/16/16, while in 1:45 AM on 02/16/16, while in 1:45 AM on 02/16/16, while in 1:45 AM again became 1:45 AM again became 1:45 AM 1. Nursing care 1:45 AM 1. Nursing care 1:46 AM 1. Nursing care 1:47 AM 1. Nursing care 1:48 AM 1. Nursing care					

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	ROVIDER OR SUPPLIER  RK NURSING AND RE	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ODE		
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{F 282}	Continued From pa	nge 54	{F 2	282}			
	02/24/16 at 10:30 A 02/16/16 around 7: cooperate with staf during morning car NA #2 stated she w #1 twice, then with on the left side of h going to stop that." already upset and continued getting F her in her wheelcha to the dining room. when NA #1 slappe fit the definition of a how to separate NA further stated she c again. NA #2 further around 10:00 AM, toileting Resident # the Resident becar NA #1. During care the Resident's pant NA #1's hair. That's Resident #6 on her didn't know what to grip on NA #1 hair Resident's pants, to wheelchair and NA dining room.  A telephone intervicat 12:55 PM with N worked on the facil permanent assignm 02/16/16 Resident and she responded	A #2 was conducted on AM. NA #2 stated that on 30 AM Resident #6 would not f and became combative e, kicking, yelling and hitting. Vitnessed Resident #6 hit NA essed NA #1 slap Resident #6 er face and said "You are NA #2 stated Resident #6 was remained upset. Both NAs Resident #6 dressed, placed air and NA #1 took Resident #6 NA #2 stated she felt that ed Resident #6 that the incident abuse, but that she didn't know A #1 from Resident #6. NA #2 did not think it would happen er stated that later that morning both NA #1 and NA #2 were eff in the shower room when he combative again and struck et and Resident #6 grabbed is when NA #1 slapped er ight thigh. NA #2 stated she do. Resident #6 released her and they finished pulling up the ransferred her to the #2 took Resident #6 to the example of the said "Let's don't do that." NA #1 stated that on, #6 slapped her on the face I by gently touching the disaid "Let's don't do that." NA					

	S FOR MEDICARE 6	NIEDICAID SERVICES				OIVID INC	7. 0930-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  RK NURSING AND REH	ABILITATION CENTER		33 <sup>-</sup>	REET ADDRESS, CITY, STATE, ZIP CODE 15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079			
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{F 282}	#1 stated "I just toud and NA #2 was prest the nurse's station a Resident #6 and told was a hand full. NA around 10:00 AM, s Resident #6 in the sbecame combative, that while she was puber the Resident grabbe was up on my tip touright knee to get her stopped." NA #1 stated the continual her dressed and too stated she was train resident time to calm but Resident #6 usu #1 stated that Resident #6 usu #1 stated that Resident dressed and this often worked offering her chocola 02/16/16. NA #1 corproviding nursing car Resident became and this often worked offering her chocola 02/16/16. NA #1 corproviding nursing car Resident dressed and the was no #2 was not much her was no #2 was not much her was no #2 was not much her was not much h	ched her face with my hand" sent. NA #1 stated she went to after providing care to d Nurse #1 that the Resident a #1 stated later that morning he and NA #2 were toileting shower room and the Resident worse this time. NA #1 stated bulling up the Resident's brief, ed her hair, pulling so hard "I les", so "I smacked her on the r to stop, I said stop and she atted she struck her gently her nature to hurt anyone. Hed yelling and hitting, we got lish her to the day room. NA #1 hed to allow a combative in down and come back later, hally worked well with her. NA hent #6 liked chocolate milk her to Resident #6 when the regitated, as she had been continued and completed the her stated she knew striking to the right thing to do, but NA help and so striking Resident her combative, was just a  www. was conducted on 02/24/16 collow up interview was /16 at 3:30 PM with Nurse #1.  www. was conducted that on con or 10:15 AM, NA #1 hile NA #1 and NA #2	{F 2	82}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE COMP	SURVEY
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{F 282}	#1 by the hair. NA Resident #6 to get that NA #1 worked secure unit that day suspended around not aware of any pregarding NA #1. No been informed that Resident #6 on the Nurse #1 stated Retimes, usually requinaresidents became of the resident time to come back later to Resident #6 was ventures #1 heard Recare both around 8 #1 stated Resident meeded) twice on hand later for pain. No assist the NAs with reported to her that and thought the profor agitation was eff.  The Administrator volumes 3:52 PM. The Administrator volumes #1 heard Recare both around 8 #1 stated Resident #6 requires the Administrator volumes #1 heard Recare both around thought the proformal to her that and thought the proformal that the proformal that the her that and thought the proformal that the her that and the her	me combative and grabbed NA #1 stated she "popped" her to let go. Nurse #1 stated with all residents on the y from 7:00 AM until she was 10:30 AM, but Nurse #1 was rior incidents of abuse lurse #1 stated she had not NA #2 witnessed NA #1 slap face earlier that morning. esident #6 was combative at ired 2 staff to give her care. at staff were trained that when combative, staff should give calm down, try to redirect and provide care. Nurse #1 stated ery combative that day and sident #6 yelling at staff during :00 AM and 10:00 AM. Nurse #6 received Ativan (as er shift that day for agitation Nurse #1 stated she did not nursing care as it was only at Resident #6 was a hand full an Ativan Resident #6 received fective.  Was interviewed on 02/24/16 at inistrator stated that it was her aff ensure the safety of s during nursing care and if ed the assistance of 2 nursing and on whether or not the staff I bell would determine whether all for additional assistance	{F 2	82}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY
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{F 309} SS=D	day, struck a staff me was witnessed to stril Director stated that he Resident #6 and knew combative, resistive thand try to hit at staff. he expected nursing nursing care if a residual and approach later.  Attempts to interview unsuccessful.  The administrator was jeopardy on 02/24/16  An extended survey 483.25 PROVIDE CAMIGHEST WELL BEIL Each resident must reprovide the necessar or maintain the higher mental, and psychosoless.	on 02/16/16 and was not #6 was combative that ember and the staff member ke back. The Medical e was very familiar with w that at times she was quite o care and would strike out The Medical Director stated staff to immediately stop dent became combative, e to calm down, to notify the ince, to continue to monitor the DON were  s notified of immediate at 5:27 PM.  was conducted on 02/25/16.  JRE/SERVICES FOR NG  ecceive and the facility must y care and services to attain st practicable physical,	{F 28			3/18/16
	by: Based on observatio medical record review	is not met as evidenced  ns, staff interviews and v, the facility failed to her wheel chair with foot/leg		Each resident must receive and the facility must provide the necessary care and services to attain or maintain the	9	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	,
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{F 309}	1 of 3 sampled resid (Resident #80).  The findings included Resident #80 was accopy of the findings included Resident #80 was accopy of the findings included	decline in range of motion for ents reviewed for well-being  d:  Imitted to the facility on included rhabdomyolysis, neral muscle weakness, and mobility, history of falling, to behavioral disturbances,  Data Set, dated 12/10/15 80 with severely impaired isorganized thinking, rance of 1 person for raff assistance of 2 persons omotion, not steady, only staff assistance when to standing and surface to chair for mobility.  Journal of the company of the com	{F 309	highest practicable physical, mental ar psychosocial well-being in accordance with the compressive assessment and plan of care.  F309  1) On 2/25/16, the administrator direct the nursing assistant to place foot rest Resident #80' swheelchair so the resident les legs were no longer dangli and her feet were not pointing towards floor.  On 2/25/16, the MDS nurse reviewer Resident #80 scare plan. The care palready included having Resident #80 legs elevated. The MDS nurse on 3/3 added to the care plan on and care gut to have leg rests on wheelchair with fer placed on pedals. The MDS nurse plathe updated care guide in Resident #80 closet.  2) On 2/29/16, the Director of Nursing (DON) completed a 100% audit of all residents, using a resident roster, to identify any resident in need of leg rest with foot pedals added to their wheelch Any residents in need of leg rests and foot pedals were addressed.  3) On 3/1/16, 100% of nursing staff we in-serviced to follow the resident care plans and care guides. On 3/14/16, stafacilitator in-serviced all nurses and nursing assistants regarding positioning resident seet while in a wheelchair.	ed son ing sthe dolan sold state dolan sold sold sold sold sold sold sold sold

NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION	C	X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 309) Continued From page 59  02/22/16 10:52 AM Resident #80 was in her wheelchair, seated on a thick cushion, in her room while receiving water from a staff member, facing the television, wheelchair positioned parallel to her bed, both feet pointed downward towards the floor.  When her feet were relaxed, both feet pointed downward towards the floor.  02/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet pointed downward towards the floor.  02/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet hung approximately 4 inches off the floor. When her feet were  1D PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRE							R-C	
CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   The audit tool for Privacy/ Choices/ADL□s/Wheelchair, seated on a thick cushion, in her room while receiving water from a staff member, facing the television, wheelchair positioned parallel to her bed, both feet crossed at the ankle, hanging approximately 4 inches off the floor.   O2/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet pointed downward towards the floor.   O2/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet pung approximately 4 inches off the floor.   The Administrator, DON and/or ADON will review each Privacy/Choices/ADL□s/Wheelchair Audit   Provincy/Choices/ADL□s/Wheelchair Audit   Provincy/Choices/ADL□s/Wheelchair Audit   Provincy/Choices/ADL□s/Wheelchair Audit   Provincy/Choices/ADL□s/Wheelchair Audit   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO NEGATION SHOULD BE CROSS-REFERENCE TO NEGATION SHOULD BE CROSS-REFERINCE TO NEGATION SH			345502	B. WING _			03/14/2016	
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(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 309)  Continued From page 59  02/22/16 10:52 AM Resident #80 was in her wheelchair, seated on a thick cushion, in her room while receiving water from a staff member, facing the television, wheelchair positioned parallel to her bed, both feet pointed downward towards the floor.  When her feet were relaxed, both feet pointed downward towards the floor.  02/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet hung approximately 4 inches off the floor. When her feet were    No					3315 FAITH CHURCH ROAD			
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 309)  (F 309	LAKE PAI	RK NURSING AND REI	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
02/22/16 10:52 AM Resident #80 was in her wheelchair, seated on a thick cushion, in her room while receiving water from a staff member, facing the television, wheelchair positioned parallel to her bed, both feet crossed at the ankle, hanging approximately 4 inches off the floor.  When her feet were relaxed, both feet pointed downward towards the floor.  When her feet were relaxed, both feet pointed downward towards the floor.  02/23/16 4:36 PM Resident #80 was in her wheelchair, seated on a thick cushion, in her room, facing the television, wheelchair positioned parallel to her bed, both feet hung approximately 4 inches off the floor. When her feet were	PREFIX	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AI CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATI	(X5) COMPLET DATE	TION
relaxed, both feet pointed downward towards the floor.  02/24/16 6:39 AM Resident #80 was in her wheelchair, seated on a thick cushion, at the nurse's station, both feet crossed at the ankles, hanging approximately 4 inches off the floor. When her feet were relaxed, both feet pointed downward towards the floor.  On 02/24/16 at 06:39 AM, Nurse #6 stated he worked routinely with Resident #80 on the 11PM − 7 AM shift. Nurse #6 stated that Resident #80 on the 140 he had not observed Resident #80 with foot/leg rests to her wheelchair as long as he had worked with her, but sometimes staff placed a chair in front of her to elevate her legs, so she did not kick her feet. Nurse #6 stated staff were concerned that she would kick her feet so hard that she might overturn in her wheelchair. Nurse #6 saked Resident #80 to relax her feet and noted that both feet pointed in a downward  tool weekly to verify completion and correct any identified concerns.  The monthly QI committee will review results of the Privacy/Choices/ADL□s/ Wheelchair audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.  The monthly QI committee will review results of the Privacy/Choices/ADL□s/ Wheelchair audit tool results monthly for 6 months for identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.  The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA  The administrator and/or DON will present the findings and recommendations of the monthly QI committee will review results of the Privacy/Choices/ADL□s/ Wheelchair audit tool results on the 19 for and/or frequency of continued compliance.  The administrator and/or DON will present the findings and recommendations of the monthly QI commit	{F 309}	02/22/16 10:52 AM wheelchair, seated room while receivin facing the television parallel to her bed, hanging approxima When her feet were downward towards 02/23/16 4:36 PM F wheelchair, seated room, facing the tel parallel to her bed, 4 inches off the floorelaxed, both feet pfloor. 02/24/16 6:39 AM F wheelchair, seated nurse's station, both hanging approxima When her feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approxima When her feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approxima When her feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approxima When her feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approxima When her feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approximation would be the feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approximation would be feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approximation would be feet were downward towards On 02/24/16 at 06:39 AM F wheelchair, seated nurse's station, both hanging approximation wheelchair, seated nurse's station, both hanging approximation, both hanging approximation wheelchair, seated nurse's station, both	Resident #80 was in her on a thick cushion, in her g water from a staff member, n, wheelchair positioned both feet crossed at the ankle, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, in her evision, wheelchair positioned both feet hung approximately or. When her feet were wointed downward towards the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion, at the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion at the stafe of the floor.  Resident #80 was in her on a thick cushion in the floor.  Resident #80 was in her on a thick cushion in the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion in the floor.  Resident #80 was in her on a thick cushion in the heat crossed at the ankles, tely 4 inches off the floor.  Resident #80 was in her on a thick cushion in the floor.  Resident #80 was in her on a thick cushion in her wheelchair. Nurse #80 to relax her feet and the floor.	{F 3	4) The audit tool for Priva Choices/ADL s/Wheelch monitored by administratistaff during rounds to enslegs are not dangling, fee place if needed and feet down while sitting in their audit will be completed dweeks, 1x a week x8 weemonth x3 months.  The Administrator, DON will review each Privacy/Choices/ADL s/tool weekly to verify completed and tool weekly to verify complete and tool weekly to verify complete and tool weekly to verify complete and tool weekly tool weekly to verify complete and tool weekly to verify complete and tool weekly to	acy/ hairs will be ive staff/nursing sure residents  et rest are in are not pointing wheelchair. Th aily 5x a week x eks and 1x per  I and/or ADON Wheelchair Aud pletion and icerns.  ee will review bices/ADL s/ ults monthly for of trends, action ne need for nued monitoring ons for compliance.  DON will prese endations of the	geneek4	

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{F 309}	Continued From page	e 60	{F 3	09}			
	nor had he referred h	nad not noticed that before er to therapy due to a lack of a she was in her wheelchair.					
	Aide (NA) #6 reveale #80 routinely on the occasionally on other Resident #80 to her w #6 stated she was no was to have her legs wheelchair. NA #6 ful Resident's feet/legs e seated in the wheelch	shifts and assisted wheelchair that morning. NA it aware that Resident #6 elevated while in the other stated that the either hung while she was nair or she kicked her feet.					
	Therapy Manager reversely Resident #80 used a without foot/leg rests in her wheel chair with floor. The Therapy M #80 liked to put her forests or on her bed. It that Resident #80 count at aff should positive elevate her legs. The that Resident #80 shorests or be positioned her feet up on a bed seated in her wheelch range of motion. The that the family of Resservices since admission the facility's list of receive therapy services.	A/16 at 11:53 AM with the vealed she was aware that low seated wheel chair and had observed Resident h her feet hanging above the anager stated that Resident eet up on a chair, on foot/leg The Therapy Manager stated uld elevate her legs herself cion her to allow her to Therapy Manager stated ould have a chair, leg/foot is such that she could prop in a low position while mair to prevent a decline in Therapy Manager stated ident #80 declined therapy sion and Resident #80 was residents that could not ces due the family's request. For stated that Resident #80 lichair for her, with the seat					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _		1	-C <b>14/2016</b>	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	, 33		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309} {F 312} SS=E	thinner cushion to see to reach the floor.  An interview on 02/25 Interim Director of Nu Resident #80 kicked I her wheel chair, but Ii Interim DON stated th #80 to be positioned i her feet reached the f elevated when in her prevent a decline in ra 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives the search of the foundation of the control of the foundation of the foundation of the floor	but staff had not tried a e if that would allow her feet  6/16 at 08:48 AM with the rsing (DON) revealed her feet routinely when in ked to prop her feet up. The hat she expected Resident in her wheel chair such that floor or to have her feet wheel chair for safety and to lange of motion. RE PROVIDED FOR	{F 3·			3/18/16	
	by: Based on observatio and staff interviews the bed baths and failed to 2 of 5 residents samp living (ADL) (Residen The findings included 1. Resident #24 was 12/18/15 with diagnos hypertension, anxiety and weakness. Revie quarterly Minimum Da 01/25/16 indicated tha	: readmitted to the facility on sis that included: , depression, dysphagia, w of the most recent ata Set (MDS) dated		F 312 ADL Care Provided for Depend Residents  1) On 2/25/16, Resident #24 was prova bed bath, shave, clothing change. On 2/25/16, Resident #112 was provided assistance with nail care.  2) On 2/26/16 a 100% audit of all residents□ shower reviews for the pasthree days were completed by the Dire of Nursing.	ided		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDII				l-C
		345502	B. WING				-⊖ /14/2016
NAME OF P	ROVIDER OR SUPPLIER	0.0002		ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/	14/2016
TO AVIL OF TH	NOVIDER OR COLL FIER				15 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER			DIAN TRAIL, NC 28079		
					<u> </u>		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 312}	Continued From page	e 62	{F 3	12}			
,	one person for bathin		"	,	On 2/26/16 a 100% audit of all		
	indicated no behavior	_			residents ☐ fingernails was completed b	w	
		n dated 12/18/15 read in part			the Director of Nursing and staff nurse.	-	
	-	quired assistance to restore			Any resident requiring assistance with		
		self-sufficiency for bathing			bath, shower, shaving, fingernail care,	_	
	related to impaired m				activity of daily living (ADL)care was		
		of said care plan stated that			provided at time of audit.		
		be neat, clean, and odor free			•		
	through the next revie	ew period. Interventions			3) On 3/10/16 the staff facilitator		
	included: one person	to provide some physical			in-serviced nurses and nursing assista	าts	
	assistance with bathi	ng and encourage Resident			regarding assistance with ADL care.		
		self-care as ability permitted.					
		s master shower schedule			4) The "Privacy/Choice/ADLs/Wheelch	air	
	revealed Resident #2				Audit Tool" will be monitored by the		
		sdays and Saturdays on			administrative staff team. Administrative		
	second shift.				staff team (administrator, DON, ADON		
	-	s bathing log dated 01/28/16			staff facilitator, MDS, admissions, socia		
		Resident #24 revealed that			worker, activity director, dietary manag		
		ceived no type of bathing or			housekeeping supervisor, maintenance		
	_	or 21 of the last 30 days.			director) will notify assigned nursing sta		
		ent #24 on 02/23/16 at 3:02			of any ADL care needed. Nursing staff		
		nt #24 was lying in the bed			provide ADL care at the time the need care is identified. To make sure ADL	Oi	
		ad not been shaved with ely a quarter inch long and			solutions are sustained, monitoring will	he	
		earing the same red t-shirt			done 5x a week x4 weeks, 1x a week x		
	l	mbroidered on the lower left			weeks and 1x per month x 3 months.		
		at he was wearing the			noone and maper menant of menance		
	previous day.				The administrator, DON, ADON, and/o	٢	
	I -	ent #24 on 02/23/16 at 3:02			staff facilitator will review the ADL audit		
		was waiting to get his bath			tools at least once weekly to verify		
		#24 stated that he had not			completion, ensure residents are		
	been washed up at a	ll and was waiting on the			receiving bathing, shaving, nail care, a	nd	
		A) to come and wash him.			clothing change and solutions are		
		ated that he does not take			sustained.		
		nic pain, so he took bed					
		nd Thursdays when the			The monthly QI committee will review		
	· ·	nd assisted him. Resident			results of the audit tools results monthl	-	
		e days that hospice is not			for 6 months for identification of trends		
	there, the facility staff	f is "supposed to wash me			actions taken and to determine the nee	:d	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING		_	
		345502	B. WING			R-C <b>3/14/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		5/14/2010	
				3315 FAITH CHURCH ROAD			
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER					
				INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 312}	Continued From page	e 63	{F 31:	2}			
,	up and they do not."		, , , , ,	for and/or frequency of cont	tinuad		
		on 02/24/16 at 8:49 AM		monitoring, and make recor			
		king care of Resident #24		for monitoring for continued			
		f completed his bed baths on		lor monitoring for continued	compliance.		
		s she believed but was not		The administrator and/or D0	ON will present		
	sure. NA #4 stated th			the findings and recommen	•		
		a bed bath today but she		monthly QI committee to the			
		ould get one because he was		executive QA committee for			
	on hospice services.	dud get one because ne was		recommendations and over			
	•	ew with Resident #24 on		recommendations and ever	oigint.		
	-	he stated that he had finally					
		yesterday at 4:00 PM when					
		ne to do it. Resident #24 also					
	· ·	id shaved him yesterday					
	while doing his bed b						
	_	s. Resident #24 stated that					
	the only bed baths he	e received were the ones that					
	-	d for him on Tuesdays and					
		really bothered him because					
	-	took a shower once a day.					
	Interview with NA #5	on 02/24/16 at 9:48 AM					
	revealed that she wa	s a part of the shower team					
	and that Resident #2	4 was showered once a					
	week on Saturday an	nd that hospice staff came on					
	Tuesdays and Thurso	days but was not aware of					
	whether Resident #2	4 received a bed bath or a					
	shower.						
		erim Director of Nursing					
	(Interim DON) on 02/	24/16 at 5:51 PM revealed					
	that on admission she						
	, ,	mber and if the resident					
	_	fferent they needed to let					
		ey would rearrange their					
		e Interim DON stated that it					
		that if hospice performed					
		lys and Thursdays the staff is				<b> </b>	
		ll bed baths on the other					
		d record them on the bathing					
	log in their computer	system. The Interim DON					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			R-C 03/14/2016	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	DDE	03/14/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 312}		ge 64 ne was not aware that the ning the bed baths like she	{F 3	12}			
	10/23/15 with diagnor disease, Cerebrovas hemiplegia. Review of the quarte 01/22/16 revealed R cognitively impaired assistance with personal the care process of the c	erly Minimum Data Set dated esident #112 was moderately and required extensive onal hygiene and was ag.  Islan dated 01/28/16 revealed red assistance to restore or function of self-sufficiency for aracterized by the following mouth care, daily maintaining ed to impaired mobility. The ant #112 to be neat, clean and enext review. The ed providing constant esical assistance.  Island Fingernails on both mately 1/4 inch long with brown ternails.  In PM Fingernails on both mately 1/4 inch long with brown ternails.  In PM Fingernails on both mately 1/4 inch long with brown ternails.  In PM Fingernails on both mately 1/4 inch long with brown ternails.  In PM Fingernails on both mately 1/4 inch long with brown ternails.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R-C	
		345502	B. WING			03/	14/2016
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
I VKE DVE	RK NURSING AND REHA	BII ITATION CENTED		:	3315 FAITH CHURCH ROAD		
LANL FAN	IN NONSING AND INLINA	BILITATION CENTER		ı	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORT OR I	130 IDENTIFY TING INFORMATION)	TAG		DEFICIENCY)	VIE.	
			1				
{F 312}	Continued From page	e 65	{F 3	312			
	Responsible Party (R	P) on 02/22/16 at 12:45 she	,	•			
		for the facility to keep					
	Resident #112's finge	rnails cleaned and trimmed.					
	She stated she could	not recall staff cleaning or					
	trimming Resident #1	<del>-</del>					
		ed with nurse aide (NA) #3					
		AM revealed nail care was					
	to be done during res						
		I she gave Resident #112					
		ed under his fingernails with					
		ted she could not trim his					
	_	e was a diabetic and the I to trim nails on a resident					
		ated the nurses did nail care					
	on residents with diab						
	An interview conducte						
		revealed nail care was to					
		As during showers and as					
		sident had diabetes and					
	then the nurse should	l provide nail care as					
		d NA#3 were accompanied					
		om on 02/25/16 at 10:30 AM					
		ingernails and confirmed					
		ris underneath each nail and					
	trimmed.	have been cleaned and					
		onducted on 02/25/16 at					
	_	Director of Nursing stated it					
		or nail care to be performed					
		needed by NAs and as					
	needed by nurses for	residents with diabetes.					
{F 315}	483.25(d) NO CATHE	ETER, PREVENT UTI,	{F 3	315}	+		3/18/16
SS=G	RESTORE BLADDER	₹					
	Based on the residen						
	assessment, the facili						
	resident who enters the	•					
	mowening cameter is	not catheterized unless the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	03/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
{F 315}	catheterization was who is incontinent o treatment and service	ndition demonstrates that necessary; and a resident f bladder receives appropriate ses to prevent urinary tract tore as much normal bladder	{F 315	5}	
	by: Based on record re interviews the facility indwelling urinary Fo order for 1 of 1 resic care (Resident #112 The findings include Resident #112 was 10/23/15 with diagnoral disease, cerebrovas and neurogenic blac Review of the quarte 01/22/16 revealed Fo cognitively impaired catheter. Review of the care p Resident #112 had a elimination with an in was at risk for infect Resident #112 to be infection through the included catheter ca change Foley cather and/or facility protoc Review of physician	d: admitted to the facility on oses of peripheral vascular cular accident, hemiplegia Ider. erly Minimum Data Set dated resident #112 was moderately and had an indwelling urinary olan dated 01/28/16 revealed an altered pattern of urinary indwelling Foley catheter and ion. The goal was for free from urinary tract a next review. Interventions are per facility protocol and ter per physician orders		F 315 No Catheter, Prevent UTI, ReBladder  1) On 2/25/16, the staff nurse contal Resident #112'□s physician and obtain updated Foley catheter order.  On 2/25/16, Resident #112'□s Folicatheter was changed according to Foley catheter order dated 2/25/16.  2) On 3/7/16, the Director of Nursing (DON) audited all residents with a for catheter to ensure they were being changed as ordered. No negative findings.  3) On 3/7/16 the DON initiated an in-service for 100% of nurses regard the timely and accurate transcription physician orders to the medication administration records(MAR) or the treatment administration records(TA include orders to change a Foley catheter Audit utilize the "Foley Catheter Audit"	ding n of  AR),to atheter.

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				OIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						l R	:-C
		345502	B. WING			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				33	315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 315}	Continued From pag	e 67	{F 3	15}			
	Resident #112 revea			٠,	the new months. The audit will be		
		n 11/30/15 - change the Foley			completed within 5 days of the		
	_	ys. Documented on TAR as			end-of-month MAR and TAR reconcilia	ition	
	changed on 11/08/15	-			and continue monthly for 6 months.		
	· 12/01/15 through	h 12/31/15 - no order to					
		theter every 30 days on TAR.					
	_	h 01/31/16 - no order to			The DON/ADON, nursing supervisor,		
		theter every 30 days on TAR.			and/or staff facilitator will review the		
		h 02/25/16 - no order to			completed "Foley Catheter Audit Tool"	to	
		theter every 30 days on TAR. s notes from 10/23/15			ensure proper transcription of Foley catheter orders are completed. The		
		ealed no note that Resident			DON/ADON and/or nursing supervisor	will	
	1 -	catheter had been changed.			initial the bottom right corner of the "Fo		
		s note dated 01/14/16 at 6:25			Catheter Audit Tool" with the date for a	•	
	AM revealed Nurse #	\$5 deflated the balloon of			period of six months.		
	Resident #112's urina	ary Foley catheter and					
	-	atheter out some due to			The DON/ADON, nursing supervisor,		
		external urethra. Review of			and/or staff facilitator, will monitor the		
		1/15/16 at 11:36 PM revealed			TARs using the "Foley Catheter Audit		
		n episode of vomiting and an			Tool" to ensure catheter changes have		
		on was administered. Vital s: blood pressure - 140/78,			been completed as ordered. The audit be completed weekly x 4 weeks, biwee		
	•	ns - 18, temperature - 103			times 8 weeks, then monthly x 3 month		
	1 '	e dated 01/16/16 at 12:20 AM			unics o weeks, then monthly x 5 month	3.	
	revealed Resident #				The DON will present all findings from	the	
		emergency management			"Foley Catheter Audit Tools" to the		
	system.	<b>-</b>			monthly QI committee meetings for		
		al discharge summary			recommendations as appropriate to		
		112 was admitted to the			maintain continued compliance.		
		epsis most likely due to					
		urinary tract infection from			The administrator and/or DON will pres		
		catheter. Resident #112 was asive care unit with sepsis			the findings and recommendations of t monthly QI committee to the quarterly	пе	
	, ,	ved at discharge back to the			executive QA committee for further		
	facility on 01/21/16.	ved at discharge back to the			recommendations and oversight.		
		e on 02/22/16 at 11:30 AM			recentifications and oversignt.		
		112 had an indwelling					
		draining clear, yellow urine.					
		ted with Nurse #4 on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	R-C
NAME OF B	201/1050 00 01/1001/150	345502	B. WING			03	/14/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
I AKE PAE	K NURSING AND RE	HABILITATION CENTER		3	3315 FAITH CHURCH ROAD		
				l	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 315}	Continued From pa	age 68	{F 3	315}			
	·	M revealed she did not know		,			
		12's urinary Foley catheter had					
		. She stated the last					
		ry foley catheter change on the					
		and there were no orders on					
		15, 01/2016 and 02/2016 to					
		Foley catheter every 30 days.					
		e order to change the urinary					
		ry 30 days did not get					
		TAR after 11/2015 so she					
		wn it needed to be changed.					
		ucted with Nurse #3 on					
	02/25/16 at 10:15	AM revealed she normally					
	worked the 3:00 P	M to 11:00 PM shift with					
	Resident #112. Sh	e reviewed the February 2016					
	TAR for Resident #	#112 with the surveyor and					
	confirmed there wa	as no order to change Resident					
	#112's urinary Fole	ey catheter every 30 days. She					
	stated she did not	know when Resident #112's					
	urinary Foley cathe	eter had last been changed					
	because it had not	been documented on the TAR					
	for February 2016	and stated it should have been					
		what day of the month and					
		t #112's urinary Foley catheter					
		d. Nurse #5 further stated each					
		was assigned a couple of					
		to transcribe orders from the					
		the next month to the TAR and					
		one checked the orders behind					
	the person that tra						
		ucted with the facility Physician					
		1 PM revealed he was not					
	,	Foley catheter order had not					
	-	e TAR for 12/2015, 01/2016					
		tated he expected the urinary					
		anged every 30 days as					
		ician further stated there was					
		nfection from an indwelling					
	unmary Foley cathe	eter and not changing the					

PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING				-C 14/2016
	ROVIDER OR SUPPLIER	L		3	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	1 03/	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 315} {F 441} SS=D	infection leading to Rihospitalization on 01/A phone call was attee PM with Nurse #5 due employed by the facil Nurse #5 did not return During an interview of Director of Nursing (EPM she revealed the #112's urinary cathetes been transcribed to the and 02/2016 and she documentation in the urinary Foley cathetes 11/08/15. The Interiminaterviewed nurses the #112 and none of the Resident #112's urinary stated Resident #112's urinary stated Resident #112 should have been character to change the conduction of the Table 183.65 INFECTION CONTRIBUTION CO	ould have caused the esident #112's 16/16. mpted on 02/25/16 at 2:45 et to her no longer being ity. A message was left but rn surveyors call. onducted with the Interim DON) on 02/25/16 at 3:00 order to change Resident er every 30 days had not ne TAR in 12/2015, 01/2016 could not find any medical record of the r being changed since DON further stated she had at provided care to Resident m recalled changing ary Foley catheter. The DON is urinary Foley catheter anged every 30 days and the atheter should have been AR.	{F 3				3/18/16
	of disease and infecti (a) Infection Control F The facility must esta Program under which (1) Investigates, contri in the facility;	on.  Program  blish an Infection Control					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345502	B. WING _			R-C 03/14/2016
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	3071-72010
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{F 441}	(3) Maintains a reactions related to (b) Preventing Sp (1) When the Infedetermines that a prevent the spreasisolate the resider (2) The facility mucommunicable disfrom direct contact will (3) The facility muhands after each hand washing is in professional practice) Linens Personnel must he	to an individual resident; and cord of incidents and corrective infections.  read of Infection ction Control Program resident needs isolation to d of infection, the facility must nt. set prohibit employees with a sease or infected skin lesions at with residents or their food, if transmit the disease. It require staff to wash their direct resident contact for which indicated by accepted	{F 4-4	41}		
	by: Based on observinterviews the factoric precautions while resident on contactoric contact isolation of hall (Resident #137 was 01/20/16 with diagonal diff), bacteria that life-threatening in the interview of the same of			F 441 Infection Control  1) On 2/26/2016 the Director (DON) reviewed resident # 1 and physician sorder to enisolation precautions were in correct signage for contact pwas on the resident sdoor, the door storage bin for pers protective equipment (PPE) with needed supplies to incluand gloves.	I37□'s chart sure correct inplemented, precautions and the over sonal was stocked	

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD	2016
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD	2016
3315 FAITH CHURCH ROAD	
LAKE PARK NURSING AND REHABILITATION CENTER	
INDIAN TRAIL, NC 28079	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 441) Continued From page 71 dated 09/2014 revealed contact isolation precautions were to be followed by all staff. An observation made on 02/22/16 at 12:30 PM revealed Resident #137 s room had a red Contact isolation sign on the door that read in part: wear gloves when entering room. Wear a gown if expected to be solied in any way. An observation made of Nurse #4 setting up the lunch tray for Resident #137 so 02/22/16 at 12:40 PM revealed Nurse #4 taking the lunch tray from the cart, knock on Resident #137's door and enter her room with her lunch tray. Nurse #4 did not don gloves when entering Resident #137's room. Nurse #4 placed the meal tray on Resident #137's over bed table for Resident #137 to reach her tray. Nurse #4 took the lid off of the plate, removed silverware from the packet and opened the straw for Resident #137. Nurse #4 then exited Resident #137's room without washing her hands. Nurse #4 used hand sanitizer from her pocket when she came out into the hall and proceeded to take another tray from the lunch cart to give to another resident.  An interview conducted with Nurse #4 on 12/22/16 at 12:55 PM revealed she did not war gloves during the set-up of Resident #137's lunch tray because she did not touch anything but the tray while she was in the room. Nurse #4 stated she used hand sanitizer for her pocket when she came out into the hall and proceeded to take another tray from the lunch cart to give to another resident.  An interview conducted with Nurse #4 on 12/22/16 at 12:55 PM revealed she did not wear gloves during the set-up of Resident #137's lunch tray because she did not touch anything but the tray while she was in the room. Nurse #4 stated she used hand sanitizer between passing meal trays instead of handwashing because it took less time.  During an interview conducted with the lnterim Director of Nursing (DON) on 02/23/16 at 11:30 AM she stated she expected staff to wear gloves when entering a resident. Is room who is on contact precautions to prevent the spread of infection to anoth	

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		345502	B. WING _			03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
I AKE DAE	RK NURSING AND REHA	BII ITATION CENTER		3315 FAITH CHURCH ROAD			
LANE PAR	KK NUKSING AND KEHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
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{F 441}	Interim DON further s kill c diff and that was	e 72 tated hand sanitizer did not why it was important to use andwashing before leaving	{F 44	employee will work until in-servi completed. All future employees continue to be in-serviced during orientation process.  4) On 2/26/16 the DON and/or serviced.	s will g their		
				facilitator utilized a "Resident Ca Tool" to ensure staff follows isolo precautions for residents who at contact precautions. The "Resid Audit Tool" will be completed fiv weekly x 4 weeks, twice weekly weeks, weekly x 4 weeks, and r 12 weeks. Any negative finding addressed immediately by the D and/or staff facilitator by providing retraining.	are Audit ation re on dent Care re times x 4 monthly x gs will be DON	•	
				The DON will present all finding monthly QI committee meeting. monthly QI committee will review results of the "Resident Care Aumonthly for 6 months for identifit trends, actions taken, and to de the need for and/or frequency or continued monitoring, and make recommendations for monitoring continued compliance.	The w the udit Tool" cation of termine f		
{F 490} SS=D	l	ESIDENT WELL-BEING	{F 4\$	The administrator and/or DON version the findings and recommendation monthly QI committee to the quexecutive QA committee for furt recommendations and oversight	ons of the arterly her		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	CO	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		1	R-C <b>3/14/2016</b>	
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		3/14/2016	
	1011211 011 001 1 21211			3315 FAITH CHURCH ROAD	_		
LAKE PAR	RK NURSING AND R	EHABILITATION CENTER		INDIAN TRAIL, NC 28079			
0(0) 15	CLIMMAD	Y STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PRECTION	0(5)	
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{F 490}	Continued From p	page 73	{F 49	0}			
	enables it to use i efficiently to attain	administered in a manner that ts resources effectively and n or maintain the highest cal, mental, and psychosocial n resident.					
	This REQUIREMI	ENT is not met as evidenced					
	records, the facilit create and impos would be protecte would implement procedures to inte report abuse whe resident experien abuse without improtection and im	terviews and review of facility by administrative staff failed to the a culture that all residents and from abuse and that staff the facility's abuse policy and the revene, protect and immediately an witnessed. A combative the decense of physical the decense of the companion of		A facility must be administere manner that enables it to use resources effectively and effic attain or maintain the highest physical, mental, and psychos well-being of each resident.  F490  1) On 2/16/16, Resident#6 was by the Medical Director. No nowere received.	its iently to practicable social as assessed		
	Nurse Aide (NA) at face and the without immediate for protection of FA second incident 02/16/16 when Nuright thigh and the intervene for the page 18 face and 18 face	dy began on 02/16/16 when #1 slapped Resident #6 on the ess, NA #2 did not intervene and ely report to administrative staff Resident #6 and other residents. To f physical abuse occurred on A #1 slapped Resident #6 on the existence witness, NA #2 did not protection of Resident #6.		On 2/16/16, Resident#6 was by Nurse #1 which included a assessment. The findings revereddened area on the upper ri and small healing bruises. Restill resides in the facility.  On 2/16/16 NA #1 was suspemployment and terminated of 2) On 2/16/16, staff nurses co	head to toe ealed a ght thigh esident #6 eended from n 2/22/16.		
	The facility provid Centers for Medic allegation of comp A revisit survey w determine the sta	ed the State Agency and care and Medicaid an acceptable pliance (AOC) on 03/08/16.  as conducted on 03/14/16 to to tus of the ongoing Immediate cility provided documentation for		2) Off 2/16/16, stall hurses co 100% body audit on all cogniti impaired residents in the facili evidence of abuse. No negative were identified.  On 2/16/16, the social worked interviewed all alert and orient related to abuse and resulting negative responses.	ively ty for ve findings er ted residents		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	345502	B. WING _			3/14/2016	
NAME OF PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE BARK MUROING AND BE	HARU ITATION OF NITER		3315 FAITH CHURCH ROAD			
LAKE PARK NURSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
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dated 02/16/16 Documentation of all cognitively intace Documentation of (identifying/reporting with dementia) for completed by 03/00 Documentation of which began on 02/24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 25 hour/5 day reporting on 03/03/16 and a 02/27/16 A 26 hour/5 day reporting on 03/03/16 and a 02/27/16 A 27/16 and incident of previously been reporting on 100/16/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16 A 26 hour/5 day reporting on 03/03/16 and a 02/27/16 A 24 hour/5 day reporting on 03/03/16 and a 02/27/16	ving: cognitively impaired residents interviews regarding abuse for it residents dated 02/16/16 in-services ing abuse, caring for residents all currently employed staff 7/16 abuse monitoring on each shift t/26/16 and remained ongoing ints for an allegation of abuse in allegation of neglect on  port for Resident #6 for the if abuse which had not ported to the Health Care if (HCPR). Both reports were if on 02/25/16 all staff hired since 02/16/16 to ckground checks, reference is Registry checks, license	{F 49	On 2/19/16 NA#2 was discipling failure to report immediately alles abuse according to the Abuse POn 2/25/16 NA #2 was terminated not providing safety for Resident 3) On 2/25/16, the administrator an in-service from the corporate President of Operations on F Taland 490.  The in-service included the following:  The facility must ensure the alleged violations involving mistred neglect, or abuse, including injurture unknown source and misappropersident property are reported immediately to the administrator facility and to other officials in accordance (including to the Staland certification agency).  The facility must have evided all alleged violations are thorough investigated, and must prevent for potential abuse while the investing progress.  The results of all investigation designated representative and the officials in accordance with State (including to the State survey and certification agency) within 5 words the incident, and if the alleged is verified appropriate corrective must be taken.  A 24 hour and 5 day report for each allegation, including allegidentified during an investigation	gation of olicy. ated for t#6.  received Vice gs 225 the at all reatment, ries of riation of the coordance ed te survey ence that ghly further gation is ons must or his/her o other e law and rking days d violation action is required egations		

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		345502	B. WING			R-C <b>03/14/2016</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00/14/2010	
				3315 FAITH CHURCH ROAD			
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 490}	Continued From pag	e 75	{F 49	0}			
		process of monitoring the		additional allegations occurring	a on the		
	implementation of the	·		same day and/or involving the	-		
	, , , , , , , , , , , , , , , , , , ,			employee/resident.			
	The findings included	l:		The facility must ensure s	taff		
	-			effectively and consistently co			
	Cross refer to F 223	- Based on staff interviews		through the chain of command	d, verbally		
		e facility failed to protect a		and in documentation, to attain			
		free from physical abuse		maintain resident⊡s well-being	•		
		rention when a resident		have been trained to effectivel	-		
		uring nursing care. A		consistently communicate thro	-		
		lly abused twice when a staff		chain of command, verbally ar			
	1	across the face and then on		documentation, to attain and n			
	reviewed for abuse.	f 1 sampled residents		residents□ safety from abuse.			
		Based on staff interviews		On 2/26/16, 2/29/16, 3/1/16 o	ır 3/2/16 all		
		e staff failed to immediately		staff and contract staff attende			
		staff of a witnessed incident		Directed □in-service presente			
	_	which a resident was slapped		Regional Ombudsman Area A	-		
		tified, the facility failed to		Aging Titled: Identification and			
	report the incident of	physical abuse to the Health		of Elder Abuse.			
	Care Personnel Regi	stry in 24 hours and the					
		in 5 working days for 1 of 1		4) The Corporate Staff, i.e. clir	-		
	sampled residents. (I			consultant and/or regional VP			
		- Based on staff interviews		continue to review all allegation			
	and record review, th			and interventions when report			
		sing care when a resident		administrator in accordance w			
		e combative to prevent an		Abuse Policy including notifica			
		buse, intervene when bbserved, and immediately		appropriate agencies for 6 mo	nuns.		
	' '	or from a combative resident		The monthly QI committee will	l review		
		e facility failed to report a		results of the Administrative A			
		physical abuse to the Health		abuse and continue to review			
		stry in 24 hours and the		allegations of abuse i.e. 24 ho	•		
		king days. The facility failed		report monthly for 6 months fo	-		
		policy and procedures in the		identification of trends, actions			
		protection, identification,		to determine the need for and			
		of physical abuse for 1 of 1		frequency of continued			
	abuse investigation r	eviewed.		interviews/monitoring and make	ке		
	During an interview v	vith the Administrator on		recommendations for monitori	na for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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	345502	B. WING		03/14/2016	
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010	
			3315 FAITH CHURCH ROAD		
LAKE PARK NURSING AND I	REHABILITATION CENTER		INDIAN TRAIL, NC 28079		
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informed by the 02/16/16 around in the facility on Administrator state she had begun to Administrator conducted by the had it all together later she realized thorough in her in "captain of the somewhere and get to the combative residence and get to the cornout staff could when Resident #Administrator state staff, then dependent to the cornout staff could when Resident #Administrator state staff to immediate combative residence a lack of training necessary tools combative residence combative residence and the staff could when Resident #Administrator state staff to immediate combative residence combative residence and the staff could when Resident #Administrator state staff to immediate combative residence combative residence and the staff could when Resident #Administrator state staff to immediate combative residence combative residence and the staff residenc	PM, she revealed she was Director of Nursing (DON) on Iunch time that abuse occurred 02/16/16 around 10:00 AM. The ated that the DON told her that he investigation, so the ntinued working in her office. The ated that around 4:00 PM, before ay, the DON came back to the office and told her that she had its and interviews, but the d not review the investigation e DON and assumed the DON or. The Administrator stated that d that the DON had not been investigation and that as the hip" it was her responsibility to orts of the investigation was Administrator stated that it was that staff ensure the safety of cents during nursing care and if uired the assistance of 2 nursing inding on whether or not the staff call bell would determine whether it call for additional assistance the became combative. The ated she attributed the failure of the treatment of the treatment of the treatment of the provided staff with the to know how to respond to a tent and what to do when a	{F 490	,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345502	B. WING		<del></del>	03/	14/2016
	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER		STREET ADDRE  3315 FAITH CH  INDIAN TRAIL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 514} SS=D	Resident #6 and knew combative, resistive to and try to hit at staff. he was involved in decorrection when abus January 2016. He stare-educated to report occurred or was withe to administrative staff he expected the facility protocol for reporting continued monitoring continued monitoring continued to occur.  The Administrator was jeopardy on 02/24/20  An extended survey was 483.75(I)(1) RES RECORDS-COMPLE LE  The facility must main resident in accordance standards and practic accurately documente systematically organis.  The clinical record me information to identify resident's assessment services provided; the	ke back. The Medical e was very familiar with w that at times she was quite o care and would strike out The Medical Director stated eveloping the plan of the occurred in the facility in the data staff were abuse immediately, if it the essed. If abuse was reported if, the Medical Director stated ty to follow the abuse to the proper authorities and to make sure abuse did not  s informed of immediate 16 at 5:27 PM.  was conducted on 02/25/16.  ETE/ACCURATE/ACCESSIB  Intain clinical records on each the with accepted professional these that are complete; the care in the resident; a record of the the test; the plan of care and	{F 4				3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	1011211 011 001 1 21211			3315 FAITH CHURCH ROAD			
LAKE PAF	RK NURSING AND REI	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
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{F 514}	Continued From pa	ige 78 NT is not met as evidenced	{F 514	1}			
	by: Based on an obse review of medical a	rvation, staff interviews and and facility records, the facility a physician order for 3 months		F 514 Resident Records			
	to the treatment red resident's indwellin days (Resident #11 time of administrati	cord regarding the change of a g urinary catheter every 30 2) and document the correct on of an enteral feeding \$436) for 2 of 31 medical		1) On 2/25/16, the staff nurse Resident #112'□s physician a an updated Foley catheter or On 2/25/16, Resident #112 catheter was changed accord Foley catheter order dated 2/	and obtained der. □'s Foley ding to the		
	10/23/15 with diagr disease, cerebrova hemiplegia. Review of the quar 01/22/16 revealed cognitively impaired catheter. Review of the care Resident #112 had elimination with an risk for infection. The	ras admitted to the facility on noses of peripheral vascular scular accident and terly Minimum Data Set dated Resident #112 was moderately d and had an indwelling Foley plan dated 01/28/16 revealed an altered pattern of urinary indwelling catheter and was at ne goal was for Resident #112 ary tract infection through the		On 2/25/16, the staff nurse Glucema 1.2 enteral feeding as ordered. On 2/25/16 the scontacted Resident #36□'s pregarding the resident not ge Glucema 1.2 as ordered, the not have 35 minutes of the tuproduct (29.05 cc). No new oreceived.  On 2/25/16, the Director of (DON)reviewed Resident #36 for the past 3 months with no findings.	at 50 cc/hour staff nurse hysician tting the resident did libe feeding orders were  Nursing 6□'s weights		
	next review. Interver care per facility pro catheter per physic protocol. Review of the treat Resident #112 reversible 10/23/15 throu care once every should be 11/01/15 throu catheter every 30 control of the second seco	entions included Foley catheter tocol and change Foley ian orders and/or facility  ment records (TAR) for ealed the following: gh 10/31/15 - urinary catheter ift. gh 11/30/15 - Change urinary lays. Documented on TAR as 15. No mention of urinary		<ul> <li>2) On 2/26/16, DON audited residents with a foley cathete residents receiving enteral fe accurate record documentation were no negative findings.</li> <li>3) On 2/26/16, DON initiated for 100% of nurses regarding documenting the correct time administration of enteral feed to include continuous feeding in-service was completed on</li> </ul>	er and edings for on. There  an in-service of e of ling products, gs. The		

CENTER	S FOR MEDICARE &	WEDICAID SERVICES				CIVID IVC	<u> </u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345502	B. WING _			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				33	315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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{F 514}	Continued From page	e 79	{F 5	143			
(*,		n 12/31/15 - No mention of	ر ا	177			
		every shift or change urinary			On 3/7/16, DON initiated an in-servic	Δ	
	catheter every 30 da				for 100% of nurses regarding the timely		
		n 01/31/16 - No mention of			and accurate transcription of physician		
	_	every shift or change urinary			orders to the Medication Administration		
	catheter every 30 day				Record (MAR) or the Treatment		
		n 02/25/16 - No mention of			Administration Record (TAR) to include	<b>!</b>	
		every shift or change urinary			orders to change a Foley catheter on the		
	catheter every 30 day				TAR. The in-service was completed o		
	Review of the nurse's	s notes from 10/23/15			3/14/16.		
	through 02/25/16 rev	ealed no note that Resident					
	#112's urinary cathet	er had been changed.			4) On 3/7/16, DON, QI nurse, staff		
	Review of the nurse's	s note dated 01/14/16 at 6:25			facilitator, and/or evening charge nurse		
		5 deflated the balloon of			will utilize the "Foley Catheter Audit Too	ol"	
		ary catheter and retracted			to validate Foley catheter orders are		
		e due to bleeding around the			transferred over from the current month	n to	
	external urethra.				the new month. The audit will be		
	An interview conduct				completed within 5 days of the		
		revealed she did not know			end-of-month MAR and TAR	41	
		s urinary catheter had last			reconciliation. This audit will be comple	tea	
	_	stated the last documented			for 6 months.		
		he TAR was 11/08/15 and on the TAR for 12/2015,			On 3/7/16,DON, QI nurse, staff		
		to change the urinary			facilitator, and/or evening charge nurse		
		ys. Nurse #5 stated the order			will utilize the "Enteral Feeding Audit To		
		catheter every 30 days did			to validate the enteral feeding is being		
		the TAR after 11/2015 so			administered according to physician		
	she wouldn't have kn				orders, to include nurses writing accura	ate.	
	changed.				start times on the enteral feeding bottle		
	An interview conduct	ed with Nurse #3 on					
		I revealed she normally			The audits will be completed 5 days a		
		to 11:00 PM shift with			week for 4 weeks, then 2 days a week	for	
	Resident #112. She r	reviewed the February 2016			4 weeks, then 1 time a week for 4		
	TAR for Resident #11	12 with the surveyor and			months.		
	confirmed there was	no order to change Resident					
	#112's urinary cathet	er every 30 days. She stated			The DON and/or the QI nurse, and/or t	he	
		aides provided catheter care			staff facilitator will monitor the "Foley		
		care but she did not know			Catheter Audit Tool" results to ensure		
	when the urinary cath	neter had last been changed			proper transcription of Foley catheter		

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	DF DEFICIENCIES CORRECTION	IDENTIFICATION NITIMBED:		JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 514}	for February 2016 an written on the TAR will what shift Resident # be changed. Nurse # on the floor was assigmonth to transcribe of month to the next mosure if anyone checked person that transcribe A phone call was attended by the facil Nurse #5 did not return During an interview of Director of Nursing (EPM she revealed the #112's urinary cathete been transcribed to the documentation in the urinary catheter being The Interim DON staft that all orders be transeach month. She staft	d stated it should have been that day of the month and 112's urinary catheter was to 5 further stated each nurse gned a couple of charts each orders from the previous onth to the TAR and was not ed the orders behind the ed them.  Empted on 02/25/16 at 2:45 e to her no longer being lity. A message was left but rn surveyors call.  CON) on 02/25/16 at 3:00 order to change Resident er every 30 days had not the TAR in 12/2015, 01/2016	{F 5	14}	orders onto the TAR. The DON and/or nurse, or staff facilitator will initial the bottom right corner of the audit tool wit the date to acknowledge completion at follow-up  The DON and/or the QI nurse, or staff facilitator will monitor the "Enteral Feed Audit Tool" results to ensure proper administration of enteral feedings.  The administrator and/or DON will prest the findings from the "Foley Catheter A and Enteral Feeding Audit" to the mon QI committee for recommendations as appropriate to maintain continued compliance and to the quarterly execu QA committee for further recommendations and oversight.	h nd ding sent audit thly		
	09/17/14. Diagnoses	admitted to the facility on included cognitive deficit, igestive tract, intestinal onitis.						
	Glucerna 1.2 (enteral 50 cc per hour, contir order included to prove	ated 02/12/16 was written for I feeding product) to infuse at nuously. The physician's vide Resident #36 with a every 4 hours at 2AM, 6AM,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245500	B. WING			R-C	
NAME OF D	ROVIDER OR SUPPLIER	345502	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD		03/14/2016	
NAME OF F	ROVIDER OR SUFFLIER			3315 FAITH CHURCH ROAD	'E		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 514}	10AM, 2PM, 6PM and order also indicated the medications (provided the percutaneous end tube.  On 02/24/16 at 05:35 her bed with the head approximately 30 deg AM, the enteral feeding was empty and the enteral feeding point of the enteral feeding point of the enteral feeding bood/24/16 at 06:01 AM record the date of 02 and rate of 50 cc on the Resident #36. On 02/46 administered med Resident #36 via the enteral feeding productions was intervied to the date of	d 10PM. The physician's hat staff could cocktail d all together) and give via doscopic gastrostomy (PEG)  AM Resident #36 was in d of the bed elevated to grees. On 02/24/16 at 05:48 mg bottle of Glucerna 1.2 mteral feeding pump was at #7 was observed to turn off tump per the request of was noted to gather supplies Resident #36 which included ttle of Glucerna 1.2. On 1, Nurse #6 was observed to 1/24/16, time of 05:30 AM, he enteral feeding bottle for 1/24/16 at 06:05 AM, Nurse ications and a water flush to PEG tube and started the cot.	{F 5	14}			
	feeding bottle as the he typically recorded medications and that medications for Resideralized that by record 05:30 AM, Resider TF product.  The Interim Director of interviewed on 02/25 interview she stated to should document the	25:30 AM on the enteral administration time because the time he prepared the was the time he prepared dent #36. Nurse #6 stated he ding an administration time at #36 missed 35 minutes of Property (DON) was 16 at 8:48 AM. During the hat for accuracy, staff actual time medications al feeding products infused					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) N A. BU			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R-C	
		345502	B. WING _			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I VKE DVE	RK NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
LANL FAI	IN NONSING AND INLINA	BEHATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG	REGULATORT ORT	100 IDENTIFY THE INTO ON MATION,	IAG		DEFICIENCY)	W.E.	
{F 514}	Continued From page	e 82	{F 5	14}			
	so that the medical re	ecord would document the					
	correct amount of ent						
		OON stated that based on					
		#6 documented for the					
		ct, Resident #36 missed 35					
(5.00)	minutes of enteral fee	eaing product.	( , ,	201			2/40/40
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMB	FRS/MEET	{F 5	20}			3/18/16
55=D	QUARTERLY/PLANS						
		•					
		in a quality assessment and					
		consisting of the director of					
		nysician designated by the other members of the					
	facility's staff.	other members of the					
	incomity of ortains						
	The quality assessme						
		east quarterly to identify					
		which quality assessment					
		ies are necessary; and					
		ents appropriate plans of tified quality deficiencies.					
		and quality denoterioles.					
	A State or the Secret	tary may not require					
	disclosure of the reco	ords of such committee					
		h disclosure is related to the					
	compliance of such control						
	requirements of this s	section.					
	Good faith attempts h	by the committee to identify					
		eficiencies will not be used as					
	a basis for sanctions.						
	This REALUDEMENT	is not met as evidenced					
	by:	וא ווטנ וווכנ מא פעועכוונכע					
		iews and review of facility			F 520 QAA Committee		
		-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	<b>345502</b> B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2016	
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
{F 520}	Continued From pag	e 83 Quality Assessment and	{F 520	)}		
	Assurance (QAA) co implemented proced interventions that the February 05, 2016. T deficiencies that were	mmittee failed to maintain ures and monitor these committee put into place on this was for 4 recited e originally cited during a		1) On 3/1/2016, the monthly QI Committee held a meeting. The administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator maintenance director, social workers,		
	and subsequently red Complaint and Follow conducted on Februa	-		medical records, dietary manager and housekeeping supervisor will attend monthly QI Committee meetings on ar ongoing basis and will assign addition	1	
	to be free from abuse implementation of ab administration and ac	the areas of a resident's right e, the facility's ruse policies and procedures, curacy of the clinical record. began on 02/16/16 when		team members as appropriate.  2) On 3/3/2016 the regional facility consultant in-serviced the facility administrator, DON, MDS nurse,		
	face and the witness did not immediately r for protection of Resi	slapped Resident #6 on the , NA #2 did not intervene and eport to administrative staff dent #6. A second incident of		treatment nurse, maintenance director dietary manager, social workers, medi records, dietary manager and housekeeping supervisor related to the	cal	
	slapped Resident #6 witness, NA #2 did no of Resident #6.	on the right thigh and the ot intervene for the protection is present and ongoing.		appropriate functioning of the QI Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and	5	
	Centers for Medicare	the State Agency and and Medicaid an acceptable nce (AOC) on 03/08/16.		developing and implementing appropriate plans of action for identified facility concerns to include F 223, F225, F226 F282, F490 and F520 all of which are immediate jeopardy level.		
	determine the status Jeopardy. The facility review of the followin Skin audits for all coo dated 02/16/16 Documentation of int	gnitively impaired residents erviews regarding abuse for		3) As of 3/3/2016, after the facility consultant in-service, the monthly QI Committee began identifying other are of quality concern through the QA revi process, for example: review of administrative rounds tools, resident	ew	
	Documentation of in-	esidents dated 02/16/16 services abuse, caring for residents		council minutes, and resident concern Corrective action has been taken for the	ne	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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		345502	B. WING _			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
I AKE DAI	DK NITIDGING VND DEI	HABILITATION CENTER		3315 FAITH CHURCH ROAD			
LAKE PAI	RK NOKSING AND REI	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
{F 520}	Continued From pa	ge 84	{F 5	20}			
	with dementia) for a completed by 03/07	all currently employed staff		deficiency.			
	Documentation of a which began on 02 24 hour/5 day repo on 03/03/16 and ar 02/27/16 A 24 hour/5 day repo on 03/03/16 and ar 02/27/16 A 24 hour/5 day repo on 03/03/16 and ar 02/27/16 A 24 hour/5 day repo on 03/03/16 and ar report of the HCPI Personnel Registry faxed the the HCPI Personnel files for a include criminal backecks, Nurse Aidechecks, Nurse Aidechecks, and abuse The facility's Abuse Observations of nucognitively intact reinterviews with all s 03/14/16, review of the AOC and interviews with all s 03/14/16, review of the AOC and interviews and record the immediate jeop jeopardy was remothe facility remains at a lower scope a actual harm with poharm that is not immifacility continues the implementation of the The findings including the continues and record the continues and recor	abuse monitoring on each shift /26/16 and remained ongoing rts for an allegation of abuse in allegation of neglect on port for Resident #6 for the fabuse which had not ported to the Health Care (HCPR). Both reports were R on 02/25/16 all staff hired since 02/16/16 to exterior checks, reference is Registry checks, license training is Policy.  Training are, interviews with family, staff present in the facility on all documentation to support iews with the facility's ctor of Nursing and the Nurse and sufficient evidence to faction by the facility to remove ardy at F-520. The immediate eved on 03/14/16 at 7:15 PM. The doubt of compliance at F-520 and severity of (D) isolated, no obtential for more than minimal mediate jeopardy, while the e process of monitoring the heir corrective action.		4) The Committee will of monthly with oversight President of Operations of Clinical Services or the Consultant. The QI Consultant. The QI Consultant. The QI Consultant and audit reviewed as a componerate each QI Committee Executive QI Committee Medical Director, will recompiled QI report infortends and review correst and the dates of complexecutive QI Committee facility's progress in the deficient practices or id The administrator will be ensuring Committee consultant administrator will be ensuring through furth other interventions. The DON will report back to Committee at the next squarterly meeting.	by the Vice s or Vice Preside the facility Clinical the facility will be sent of this overside meeting. The facility meeting the facility actions take the facility concerns the facility concerns are facility concerns are facility or facility concerns are facility or facility concerns are facility concerns are facility or facility concerns are facility concerns.	ent al g ns ight ee ken ne or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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		345502	B. WING _			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
I AKF PAI	RK NURSING AND RE	HABILITATION CENTER		3315 FAITH CHURCH ROAD		
LAKETA	AIT HOROITO AITO RE	INDICIATION SERVER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO  DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 520}	resident became of A resident was phystaff member slapp on the right thigh freviewed for abuse During a Complair 15, 2016, the facility protect a resident Recertification, Complaint survey 2016, the facility was resident from phystab. Cross refer to interviews and recimmediately stop of (Resident #6) becaresident and preveabuse, intervene wobserved, and imperpetrator from a secure unit. The fawitnessed incident Care Personnel Reinvestigation in 5 was to follow their abuse areas of preventio training and report abuse investigation During a Complair 15, 2016, the facility implement their abuse a policy that resident after abuse Complaint and Fol conducted on Feb cited for failure to policy/procedures.	iate intervention when a combative during nursing care. Assically abused twice when a ped her on the face and then or 1 of 1 sampled residents is e. (Resident #6). In the survey conducted on January the survey conducted on February 25, was cited for failure to protect a sical abuse.  For 226 - Based on staff or dreview, the facility failed to hursing care when a resident than an incident of physical when physical abuse was mediately remove the combative resident on a facility failed to report a the physical abuse to the Health degistry in 24 hours and the working days. The facility failed se policy and procedures in the notes of physical abuse for 1 of 1 or reviewed. The survey conducted on January the survey conducted on Ja	{F 5	20}		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	NG			-C
		345502	B. WING				14/2016
NAME OF P	ROVIDER OR SUPPLIER		- 1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		2010
				33	15 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REI	HABILITATION CENTER		IN	DIAN TRAIL, NC 28079		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 520}	Continued From pa	age 86	{F 5	203			
(,	_	ew of facility records, the	, ,	_0,			
		ew of facility records, the re staff failed to create and					
	-	at all residents would be					
		se and that staff would					
		ity's abuse policy and					
	procedures to inter	vene, protect and immediately					
	report abuse when	witnessed. A combative					
	resident experience	ed 2 episodes of physical					
	abuse without imme						
	protection and impl						
	and procedures for						
	reviewed for abuse						
		t conducted on January 15, is cited for failure of					
	,	npose the expectation for					
	implementation of t						
		During a Recertification,					
		ow up survey of February 25,					
		as cited for failure of					
	administration to cr	eate and impose a culture that					
	protected residents	from physical abuse.					
		514 - Based on an					
		nterviews and review of					
	_	records, the facility failed to					
		ian order for 3 months to the					
		garding the change of a					
		g Foley catheter every 30 days document the correct time of					
	,	n enteral feeding product					
		2 of 31 medical records					
	reviewed.	2 01 0 1 111041041 1000140					
		t survey conducted on January					
		was cited for failure to					
		ent of sexual abuse in the					
	medical record. Du	ring a Recertification,					
		ow up to Complaint survey of					
		the facility was cited for failure					
		sician's order to the treatment					
	record for 3 months	and document the correct					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345502	B. WING			03/	14/2016
NAME OF PI	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				3	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REI	HABILITATION CENTER		П	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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{F 520}	Continued From pa	nge 87	{F 5	วกเ			
(1 020)	-	-	्रा उ	20}			
		on of an enteral feeding					
	product.						
		with the Administrator on					
		M and a follow up interview on					
		M, she revealed that the					
		nonthly and quarterly. She hthly QAA meetings focused on					
		,					
	the same agenda each month, and the quarterly QAA meetings' agenda focused on unresolved or						
	new concerns. The Administrator stated that						
		ted in January 2016 during a					
	Federal Complaint survey, all department heads						
	were responsible for monitoring for abuse on all						
	•	trator stated that staff had no					
		use noted or brought for					
		orning staff meetings since					
		ederal Complaint survey. The					
	· ·	d that during these rounds,					
		able to communicate the					
	_	when quizzed regarding					
	implementation of t						
		The Administrator stated that					
		eat deficiency at F 223 to					
	some nursing staff	did not know how to respond					
	when a resident be	came combative during care					
	and that administra	tion needed to provide more					
	interactive in-service	es. The Administrator stated					
	she attributed a rep	eat deficiency at F226 to staff					
	not having the right	understanding of the abuse					
	policy/procedures of	or not getting enough					
		to implement the facility's					
	abuse policy and pr	rocedures regarding what to					
	report as abuse and	d when to report abuse. The					
	Administrator also	stated that she took					
	responsibility for im	plementing the facility's abuse					
	policy as it related t	to reporting abuse to the					
	Health Care Persor	nnel Registry (HCPR), as she					
	did not initially iden	tify the 2 incidents of abuse as					
	2 separate incident	s. The Administrator further					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	345502	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD	<b> </b>	03/14/2016
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 520}	stated that she attributed to a lack of staff training re-education on accumedical record.  The Medical Director 02/25/16 at 3:36 PM in developing the plan occurred in the facility that staff were re-education because was reported to the dical Director 02/25/16 at 3:36 PM in developing the plan occurred in the facility that staff were re-education on accumedical Director state follow the abuse protegore authorities and make sure abuse did  The Administrator wa jeopardy on 02/24/20	are ted a repeat deficiency at any safe to report abuse, it responsibility to reassure to report abuse and that anould have reported to the of abuse once a aware. The Administrator a repeat deficiency at F514 any and a need for are when documenting the awas interviewed on and stated he was involved and of correction when abuse and in January 2016. He stated cated to report abuse arred or was witnessed. If the administrative staff, the end he expected the facility to pool for reporting to the discontinued monitoring to not continue to occur.	{F 5:	20}		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345502	B. WING _			R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	CODE	00/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	00}		
	02/25/16. The facility immediate jeopardy F-226 (J), and F-490 01/06/16. An extend 02/25/16. Immediate	s conducted on 02/22/16 to was notified of ongoing on 02/24/16 at F-223 (J),				
	Nurse Aide (NA) #1: on the face and agai #6). Each incident of the secure unit and v #2 did not immediate administrative staff the abuse against Resid this Resident and off unit from further abu	began on 02/16/16 when slapped a combative resident n on the right thigh (Resident physical abuse occurred on was witnessed by NA #2. NA ely intervene or report to nat she witnessed physical ent #6 and failed to protect ner residents on the secure se. Resident #6 was ned discoloration to her right				
	Nurse Aide (NA) #1 face when the Resid during nursing care. abuse but did not im to administrative state protection to Resider which led to a secon toward Resident #6. Resident #6 on the face which which the state of the second toward Resident #6.	began on 02/16/16 when slapped Resident #6 on the ent became combative NA #2 witnessed the physical mediately intervene or report if. This resulted in a lack of the fand other residents d incident of physical abuse NA #2 witnessed NA #1 slap acc during morning care, but report the abuse. NA #1				
ABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE		(X6) DATE

Electronically Signed 03/21/2016

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345502	B. WING			R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ZIP CODE	03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)	DATE
{F 000}	#6 on the right thigh of The facility failed to re Health Care Personn and the investigation 5 working days.  483.75 (F 490) at J Immediate jeopardy to Nurse Aide (NA) #1 sface and the witness, did not immediately refor protection of Resi A second incident of 02/16/16 when NA #1 right thigh and the wi intervene for the protection of the facility provided to Centers for Medicare acceptable allegation A revisit survey was acceptable allegation of the facility provided to the compliance and to de ongoing Immediate J Jeopardy was removed the time of the exit remained out of complianced out of complianced, no actual hat than minimal harm the	ure unit, working veral hours later on essed NA #1 slap Resident during the provision of care. eport physical abuse to the el Registry within 24 hours of the physical abuse within began on 02/16/16 when slapped Resident #6 on the NA #2 did not intervene and eport to administrative staff dent #6 and other residents. physical abuse occurred on a slapped Resident #6 on the tness, NA #2 did not ection of Resident #6.  The State Agency and the and Medicaid with an of compliance on 03/08/16.  The conducted on 03/14/16 for element the status of the eopardy. Immediate ed on 03/14/16, the facility oliance at F-223, F-226, and pe and severity of (D) arm with potential for more	{F 0			
	of monitoring the imp corrective actions.	lementation of their				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	R-C / <b>14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRES	SS, CITY, STATE, ZIP CODE	03	/14/2016
				3315 FAITH CHU			
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
{F 223}	Continued From pag	je 2	{F 2	3}			
{F 223} SS=D	483.13(b), 483.13(c) ABUSE/INVOLUNTA		{F 2	-			3/18/16
	sexual, physical, and punishment, and inv  The facility must not	use verbal, mental, sexual, orporal punishment, or					
	by: Based on staff interfacility failed to prote from physical abuse when a resident beconursing care. A residuce when a staff marked face and then on the sampled residents reference with the sampled resident of the secure unit and with the sampled resident of the secure unit and with the sampled resident and out unit from further abuse against Resident and out unit from further abusessed with reddentification.	T is not met as evidenced views and record review, the ect a resident's right to be free with immediate intervention ame combative during dent was physically abused tember slapped her on the eright thigh for 1 of 1 eviewed for abuse. (Resident of began on 02/16/16 when slapped a combative resident in on the right thigh (Resident of physical abuse occurred on was witnessed by NA #2. NA ely intervene or report to that she witnessed physical lent #6 and failed to protect her residents on the secure se. Resident #6 was ened discoloration to her right arrdy is present and ongoing.		verbal, sex abuse, cor involuntary F 223  1) On 2/16 by the Mewere receives a sex a sex a head to revealed a thigh and sex afor physical terminated.  2) Becaus potential to physical a punishmer	lent has the right to be free xual, physical, and mental rporal punishment, and y seclusion  6/16, Resident #6 was ass dical Director. No new ord ived. On 2/16/16 Resident seed by Nurse #1 which in toe assessment. The findigated reddened area on upper small healing bruises. Resides in the facility. On 2/16 is suspended from employally abusing Resident #6 and on 2/22/16.  The all residents have the obe affected by verbal, see all mental abuse, corporal int, and involuntary seclusions aff nurses completed 100% in the facility of the complete the complete that the co	sessed ders t #6 acluded ings right sident 6/16 ment and	
	, ,	the State Agency and		body audit	t on all cognitively impaired in the facility for evidence	ed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
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NAME OF D	20//DED OD OLIDDLIED	345502	B. WING	OTDEET ADDRESS SITY STATE 7ID SODE	0	3/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
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{F 223}	Continued From pag	e 3	{F 223	3}		
		e and Medicaid an acceptable	,	abuse. No negative findings we	re	
		nce (AOC) on 03/08/16.		identified. On 2/16/16, the social		
	amogamen en eempma	( )		interviewed all alert and oriente		
	A revisit survey was	conducted on 03/14/16 to		related to abuse and resulted in		
		of the ongoing Immediate		negative responses. On 2/19/16	6 NA#2	
Jeopardy. The facility provided				was disciplined for failure to rep		
	review of the following	ng:		immediately allegation of abuse	according	
	Skin audits for all cog	gnitively impaired residents		to the Abuse policy and on 2/25		
	dated 02/16/16			was terminated for not providing	g safety for	
		terviews regarding abuse for		Resident #6.		
	, ,	residents dated 02/16/16		0) 0 0/40/40 11 6 111 4 15:		
	Documentation of in-			3) On 2/16//16 all facility staff in	•	
		abuse, caring for residents		Administrative and current cont		
	completed by 03/07/	l currently employed staff		present were re-educated eithe Administrator or Director of Nur	-	
		buse monitoring on each shift		(DON) on the Abuse Policy and	-	
		26/16 and remained ongoing		constitute abuse. Abuse will no		
	_	s for an allegation of abuse		tolerated, to ensure immediate		
		allegation of neglect on		all residents and removing the	-	
	02/27/16			from resident care area immedi		
	A 24 hour/5 day repo	ort for Resident #6 for the		2/18/16 staff facilitator started a	ı video	
	8:00 AM incident of a			in-service for all staff entitled Be	eing with a	
		orted to the Health Care		Person with Dementia: Actions		
	• • • •	HCPR). Both reports were		Reactions." On 2/26/16, 2/29/10		
	faxed the the HCPR			and/or 3/2/16 all staff and contr		
		I staff hired since 02/16/16 to		attended a Directed □in-service	•	
		kground checks, reference Registry checks, license		by the Regional Ombudsman A		
	checks, and abuse tr	•		Agency on Aging. Titled: Identif Prevention of Elder Abuse. On		
	The facility's Abuse F	_		Staff facilitator started an in-ser		
	145	,		nurses and nursing assistants of		
	Observations of nurs	sing care, interviews with		following resident care plans ar		
		idents, interviews with family,		guides. No staff will take an ass		
		aff present in the facility on		until these in-services has beer		
		all documentation to support		completed.		
	the AOC and intervie	ws with the facility's				
	Administrator, Direct	or of Nursing and the Nurse		On 3/4/16 an in-service was he	ld for all	
		sufficient evidence to		staff by The Geriatric and Adult		
	support corrective ac	ction by the facility to remove		Health Specialty Team titled "M	anaging	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C <b>03/14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/14/2010
				3315 FAITH CHURCH ROAD	
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	' '
PREFIX TAG		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
{F 223}	Continued From pag	ge 4	{F 223	3}	
	the immediate jeopardy at F-223. The immediate			Challenging Behaviors." Quarterly	
	jeopardy was removed on 03/14/16 at 7:15 PM.			in-services will be offered to all staff	by the
	The facility remained out of compliance at F-223			Specialty Team. All newly hired	
	at a lower scope and severity of (D) isolated, no			employees will continue to receive tr	-
	actual harm with potential for more than minimal			on the Abuse policy through written,	
	harm that is not immediate jeopardy, while the			and verbal education. New hires, pri	
		process of monitoring the		taking an assignment will watch the	
	implementation of th	eir corrective action.		series "Hand in Hand," a series prov	laing
				training on caring for residents with dementia and on preventing abuse.	
	The findings include	d:		dementia and on preventing abuse.	
	The infamige molade	u.		4) The DON, ADON, Department He	ads
	Resident #6 was adı	mitted to the facility on		and administrative staff on administr	
		s included dementia with		staff rounds will continue to monitor	
		ective disorder, cognitive		complete abuse observations on 10	
	communicative defic	cit, paranoid delusional beliefs		residents per shift to be completed s	even
	and psychosis. Resi	dent #6 was currently being		days a week three times a day to inc	lude
	treated and followed	by ongoing psychiatric		each shift per week x4 weeks, 10	
	services.			residents bi-weekly for 8 weeks and 10 residents monthly x3 months usir	
	Medical record revie	w revealed Resident #6 had		Abuse/Neglect audit tool called "Wat	ching
	physician orders dat	ed 08/31/15 for Ativan		For and Responding to an Incident."	The
		rams (mg) IM (intramuscular)		monthly QI committee will review res	
	_	for pain and 11/16/15 Ativan		of the Abuse/Neglect audit tool resul	
	1 mg every 8 hours	as needed for agitation.		monthly for 6 months for identificatio	
	A guartaris Minimos	Data Cat dated 40/00/45		trends, actions taken and to determine	
		Data Set dated 12/29/15		need for and/or frequency of continu	
		#6 with severely impaired extensive staff assistance of 2		monitoring, and make recommendat for monitoring for continued compliant	
		s of daily living (ADL) to		The administrator and/or DON will p	
		nsfers, dressing and toileting,		the findings and recommendations of	
		illy abusive and without		monthly QI committee to the quarter	
	impairments in range			executive QA committee for further	<b>,</b>
	1			recommendations and oversight.	
	A care plan dated 12	2/29/15 recorded that			
	Resident #6 had pro				
	-	ffective coping behaviors of			
	verbal and physical				
	treatment/care as ev	videnced by yelling, cursing,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING			1	-C <b>14/2016</b>
	ROVIDER OR SUPPLIER			3315	EET ADDRESS, CITY, STATE, ZIP CODE FAITH CHURCH ROAD AN TRAIL, NC 28079	1 03/	14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 223}	plan's goal specified resident's safety. The included the following slowly from the front, provide diversion acti ADL routine to accommodate accommodate is refused, leaved Review of the "Residus staff were encourage in a calm, reassuring refused, to approach A progress note dated practitioner (NP) revereferred by nursing for agitation and persever reported that Resider agitated primarily in the thickness of the NP to be very agitate Medications were adjusted to monitor.  A Skin Monitoring Re 02/15/16 did not recover with skin integrity.  Review of a nursing production of the cover of the technique to monitor accorded that Reside towards staff that day she administered Ative needed for agitation apositive effects and the second continue of the cover	elusional behavior. The care that staff were to ensure the care plan's interventions is approach calmly and respect personal space, vity, allow for flexibility in amodate mood, and when and return in 5-10 minutes. The care guide revealed to approach Resident #6 manner and if care was the Resident later.  If 02/05/16 by the nurse saled Resident #6 was revaluation of morning the morning. The progress esident #6 was noted by the did, angry, and confused. The usted and staff were to view for Resident #6 dated and staff were to view for Resident #6 dated written by Nurse #1 and the sation Administration Record in #6 was very combative of Nurse #1 documented that the sation 1 mg by mouth as	{F 2	23}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED
		345502	B. WING			R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ODE	03/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 223}	PM by Nurse #1 red (NA #1) verbalized a during care when the The Medical Director the Resident. Nurse assessment for Residened area to the A Skin Monitoring Residened area to the A Skin Monitoring Residened area to the A Skin Monitoring Residened area to the irregular reddened a long to the front of the An incident report of the completed by the Direcorded that NA #1 #6 on the leg and a noted with red mark A written statement recorded that NA #1 leg on 02/16/16 aro #6 become combati #1.  Review of a Health (HCPR) 24 Hour Inicompleted by the A 02/16/16 at 10:00 A Resident #6 on her pulling her hair. Resident #6 on her upper in Review of the facility written statement by 02/19/16, which red	corded that nursing assistant she slapped Resident #6 are Resident pulled her hair. For was notified and assessed with performed a full body sident #6 and noted a deep are Resident's right upper thigh.  Review dated 02/16/16, with the rinner thighs and an area, approximately 3 inches her upper right thigh.  Rated 02/16/16 at 5:03 PM irrector of Nursing (DON), at stated she struck Resident was as across the right thigh.  By NA #1 dated 02/16/16  If struck Resident #6 on her und 10:00 AM when Resident was and pulled the hair of NA  Care Personnel Registry tial Report dated 02/16/16 dministrator, recorded that on M, NA #1 stated she struck leg to stop the Resident from sident #6 was noted with a red	{F 2	23}		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345502	B. WING		R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER	IABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	03/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
{F 223}	witnessed NA #1 sla about 8:00 AM. The that the Administrator docur #2 on 02/17/16 and witnessed NA #1 sla 02/16/16 around 8: thigh above her kne Resident became of Written statements recorded that on 02 witnessed Resident morning care and Nathe left side of her fall leave the Resident's at the nurse's statio #6. Later in the mor 02/16/16, while in the witnessed Resident NA #1 slapped Re	as aware that NA #2 also ap Resident #6 on 02/16/16 e written statement recorded or was not aware. The mented that she spoke to NA was informed that NA #2 ap Resident #6 on the face on 00 AM and again on the right the at 10:00 AM, when the	{F 223}		

<u> </u>	O T OTT MEDIO, WE W	WILDIO/ WID OLIVIOLO				<del></del>	<del>7. 0000 000 1</del>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345502	B. WING			1	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	1-4/2010
					315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER			NDIAN TRAIL, NC 28079		
()(1) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 223}	Continued From page	e 8	{F 2	ววเ			
()			2 ال	.20,			
	•	nove the resident from harm, r and don't let the perpetrator					
		rooms. NA #2 stated that on					
	, •	O AM Resident #6 would not					
		and became combative					
	1	(kicking, yelling and hitting).					
		nessed Resident #6 hit NA					
	#1 twice, then witnes	sed NA #1 slap Resident #6					
		face and said "You are					
		A #2 stated the slap was					
		more than just a pat on the face, but it wasn't a					
		ed Resident #6 was already					
		upset. Both NAs continued					
		dressed, placed her in her					
		1 took Resident #6 to the tated that on the way to the					
	_	topped at the nurse's station					
	_	popped (Resident #6)" and					
		NA #2 stated that she found					
		11 did not hear NA #1's					
		ted she felt that when NA #1					
	slapped Resident #6	that the incident fit the					
		ut that she didn't know how					
	to separate NA #1 fro	om Resident #6. NA #2					
	further stated she did	I not think it would happen					
	0	urse #1 heard NA #1 report					
		ld take care of it. NA #2					
		er that morning around 10:00					
	AM, both NA #1 and						
	Resident #6 in the sh						
		mbative again. During care,					
		oull up the Resident's pants				ĺ	
		obed NA #1's hair. That's Resident #6 on her right					
	1	ne slap was loud enough to					
	_	now what to do. Resident				ſ	
		on NA #1 hair and they					
	finished pulling up the	<del>_</del>					
		wheelchair and NA #2 took				I	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING			1	-C
	ROVIDER OR SUPPLIER			3315	EET ADDRESS, CITY, STATE, ZIP CODE  FAITH CHURCH ROAD  AN TRAIL, NC 28079	1 03/	14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 223}	she observed NA #1 nurse's station and to that she "popped" Re #2 immediately left th DON returned to the talk to the DON and to the unit. NA #2 stated 02/16/16 what happed that NA #1 slapped Rher face about 8:00 At high about 10:00 AN informed the police of interviewed her that extended the Administrator on the her on the phone.  A telephone interviewed at 12:55 PM with NA worked on the facility permanent assignment abuse training. NA #1 how to identify abuse witnessed, she shoul from the resident, cal Administrator, and more resident were both wooz/16/16 Resident #6 and she responded by Resident's face and she responded by Resident #6 and told was a hand full, but sher face because she anything to it. NA #1 on the Resident's face	ning room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 stated that immediately go to the old Nurse #1 and Nurse #2 and the unit. NA #2 observed NA #1 hen NA #1 was escorted off of the DON asked her on ned and she told the DON desident #6 on the left side of the immediately was escorted off of the ned and she told the desident #6 on the left side of the immediately was to the immediately was conducted on 02/16/16 when he evening on the phone and 02/17/16 when she talked to was conducted on 02/24/16 #1. She stated that she is secure unit as her not and had recently received it stated she was trained on and if abuse was do remove the perpetrator and atched. NA #1 stated that on, is slapped her on the face by gently touching the said "Let's don't do that." NA and her face with my hand" ent. NA #1 stated she went to	{F 2	23}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345502	B. WING _			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
I AKE PAR	RK NURSING AND REHA	BII ITATION CENTER		3	3315 FAITH CHURCH ROAD		
				I	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	41E	5,112
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{F 223}	Continued From page	<u>•</u> 10	{F 2	ววเ			
(,		in the shower room and the	2 ۱۱	.20,			
		nbative, worse this time. NA					
	#1 stated that while s						
		Resident grabbed her hair,					
		up on my tip toes", so "I					
		ight knee to get her to stop,					
		opped." NA #1 stated she					
	struck her gently beca	ause it was not her nature to					
	hurt anyone. Residen	t #6 continued yelling and					
		essed and took her to the					
		ed afterwards, she reported					
	to Nurse #1 and Nurs						
		g, the DON came and took					
	a statement from her	and she was suspended.					
	A telephone interview	was conducted on 02/24/16					
	at 11:10 AM and a fol						
	conducted on 02/25/1	6 at 3:30 PM with Nurse #1.					
	During the interviews	, Nurse #1 stated that on					
		14 residents on the secure					
		10:15 AM, NA #1 informed					
		and NA #2 provided care to					
		ower room, the Resident					
		nd grabbed NA #1 by the					
		e "popped" Resident #6 to					
	get her to let go. Nurs						
		present and heard the					
	with Nurse #1, while I	stayed at the nurse's station					
		The DON came to the unit,					
	took a statement from	•					
		stated that NA #1 worked					
		he secure unit that day from				ſ	
		s suspended around 10:30				ſ	
		s not aware of any prior					
		garding NA #1. Nurse #1				ſ	
	-	en informed that NA #2				ſ	
	witnessed NA #1 slap	Resident #6 on the face				ſ	
		Nurse #1 stated Resident #6				I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
						R-C	
		345502	B. WING _		(	3/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LAKE DA	NA NUIDONIO AND DEU	A DII ITATION OFNITED		3315 FAITH CHURCH ROAD			
LAKE PAI	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 223}	to give her care. Nur trained that when re staff should give the try to redirect and co care. Nurse #1 state combative that day a needed) twice on he and later for pain. Not did not cooperate initiand Ativan was give Resident #6 was call assessment was corrund she was noted wright thigh about 3 in shape. Nurse #1 state changes noted to he The Administrator was 3:52 PM. She stated around lunch time of "popped" Resident #7 room and reported hadministrator that Nushe had started cominvestigation. The Administrator stated 9:00 PM, the police she knew about ano happened earlier that	nes, usually required 2 staff rese #1 stated that staff were sidents became combative, resident time to calm down, ome back later to provide and Resident #6 was very and received Ativan (as a shift that day for agitation curse #1 stated Resident #6 stially with a skin assessment, in to calm her down. Once im, a full body skin impleted, around 12:30 PM with a reddened area to her inches long and irregular in ted there were no other er skin or face.  That the DON informed her in 02/16/16 that NA #1 was suspended and that inpleting interviews for the diministrator called the police in A #1 was suspended and that inpleting interviews for the diministrator called the police in the police officer arrived. Since officer observed Resident is to either thigh. The later that evening, around officer caller her and asked if ther incident of abuse that at day, but the Administrator.	{F 22	<u>'</u>			
	at the DON's investigent stated she called NA	aware and she had not looked gation. The Administrator A #2 sometime the next S and obtained a statement					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C <b>03/14/2016</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
{F 223}	from her over the photo of physical abuse that on 02/16/16 and report Administrator asked in statements about what the statement and statement about what the statement asked in statement asked in the statement asked i	the regarding both incidents to were witnessed by NA #2 rted to the DON. The NA #2 to provide written at she saw.	{F 22	23}	
{F 226} SS=D	jeopardy on 02/24/16 An extended survey was 483.13(c) DEVELOP/ABUSE/NEGLECT, E The facility must developlicies and procedure	s notified of immediate at 5:27 PM.  vas conducted on 02/25/16.  IMPLMENT TC POLICIES  elop and implement written es that prohibit , and abuse of residents	{F 22	26}	3/18/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C <b>03/14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2010
				3315 FAITH CHURCH ROAD	
LAKE PAF	RK NURSING AND REH	IABILITATION CENTER		NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 226}	Continued From pa	ge 13	{F 226}		
	by: Based on staff interfacility failed to imm when a resident (Reto protect the reside physical abuse, interest was observed, and perpetrator from a consecure unit. The fact witnessed incident of Care Personnel Reginvestigation in 5 words to follow their abuse areas of prevention, training and reporting abuse investigation.	rviews and record review, the ediately stop nursing care esident #6) became combative ent and prevent an incident of ervene when physical abuse immediately remove the combative resident on a cility failed to report a por physical abuse to the Health epistry in 24 hours and the pricing days. The facility failed expolicy and procedures in the expression, identification, and of physical abuse for 1 of 1 reviewed.		F226 Development/Implementation Policies for Abuse/Neglect  1)On 2/16/16, Resident #6 was asses by the Medical Director. No new order were received. On 2/16/16 Resident # was assessed by Nurse #1 which inclea head to toe assessment. The finding revealed a reddened area on upper rightigh and small healing bruises. Resides the still resides in the facility. On 2/16/NA #1 was suspended from employment for physically abusing Resident #6 and terminated on 2/22/16. On 2/16/16 NA was re-educated on the Abuse Policy include immediately intervene and sto abuse, remove the perpetrator and	rs #6 uded gs ght dent 16 ent d A #2 to
	face when the Resid during nursing care. abuse but did not in to administrative sta protection to Reside which led to a secon toward Resident #6. Resident #6 on the did not immediately remained on the sec unsupervised and s 02/16/16, NA #2 wit #6 on the right thigh The facility failed to Health Care Person	dent became combative  NA #2 witnessed the physical amediately intervene or report of the first resulted in a lack of ent #6 and other residents and incident of physical abuse  NA #2 witnessed NA #1 slap face during morning care, but report the abuse. NA #1		immediately report.  2) Because all residents have the potential to be affected by verbal, sex physical and mental abuse, corporal punishment, and involuntary seclusior 2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social work interviewed all alert and oriented residented to abuse and resulted in no negative responses. On 2/19/16 NA#2 was disciplined for failure to report immediately allegation of abuse accort to the Abuse policy and on 2/25/16 NA	n on er dents 2

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		345502	B. WING _		03	/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				3315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN	OF CORRECTION	(X5)	
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{F 226}	Continued From pag	ge 14	{F 2	•		
	The immediate jeop	ardy is present and ongoing.		was terminated for not p Resident #6.	providing safety for	
	Centers for Medicar allegation of complia A revisit survey was determine the status Jeopardy. The facilit review of the following Skin audits for all codated 02/16/16 Documentation of in all cognitively intact Documentation of in (identifying/reporting with dementia) for a completed by 03/07/Documentation of all which began on 02/224 hour/5 day report	terviews regarding abuse for residents dated 02/16/16 -services g abuse, caring for residents ll currently employed staff		3) On 2/16//16 all facility Administrative and contriver re-educated either or DON on the Abuse Positive abuse. Abuse tolerated, to ensure immall residents and removing from resident care area 2/18/16 Staff facilitator sin-service for all staff entiperson with Dementia: A Reactions." On 2/26/16, 3/2/16 all staff and contria Direct □in-service president Ombudsman A Aging. Titled: Identification Elder Abuse.  On 3/1/16 Staff facilitato nurses and nursing assistance.	ract staff present by Administrator bolicy and what will not be nediate safety of ng the accused immediately. On started a video titled "Being with a Actions and 2/29/16, 3/1/16 or ract staff attended sented by the Area Agency on on and Prevention	
	8:00 AM incident of previously been represented the the HCPR Personnel files for a include criminal backnecks, Nurse Aidechecks, and abuse to The facility's Abuse  Observations of nurse cognitively intact resinterviews with all st	Il staff hired since 02/16/16 to kground checks, reference Registry checks, license raining		following resident care p guides.  On 3/4/16 an in-service staff by The Geriatric an Health Specialty Team ti Challenging Behaviors." in-services will be provid the Specialty Team.  Staff Facilitator will conti ongoing annual abuse a education through writte verbal education.	was offered for all d Adult Mental itled "Managing Quarterly ded to all staff by inue to provide and neglect en, video and	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	E SURVEY MPLETED
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LAKE DA	NAME OF THE PERSON	DU ITATION OFNITED		3315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 226}	Continued From page	e 15	{F 226	5}		
	Practitioner provided support corrective ac the immediate jeopar jeopardy was remove The facility remained at a lower scope and actual harm with pote harm that is not immediate.	or of Nursing and the Nurse sufficient evidence to tion by the facility to remove dy at F-226. The immediate ed on 03/14/16 at 7:15 PM. out of compliance at F-226 d severity of (D) isolated, no ential for more than minimal ediate jeopardy, while the process of monitoring the		receive training on the Abuse pol through written, video, and verba education. Prior to taking an assi new hires will watch the video se "Hand in Hand:" a series providir on caring for residents with deme on preventing abuse.  4) The DON, ADON, Department and administrative staff on admir staff rounds will continue to moni complete abuse observations on residents per shift to be complete days a week three times a day to	Il gnment ries on training entia and theads histrative tor and 10 ed seven	
	revised 11/01/06, inc do whatever is in its of mistreatment, neglect or misappropriation of employee who witness neglect, or misapproproccurred, will immedifincted to their supereport the incident to will be initiated to preadbuse while the invest Administrator is responsible to direct to ensure that appropriate agual indicated. Training	Abuse, Neglect, or Resident Property Policy", luded in part: The facility will control to prevent t, and abuse of our residents of their property. Any sees or suspects that abuse, oriation of property has ately report the alleged rivisor, who will immediately the Administrator. Measures event any further potential stigation is in progress. The consible to review the results and report the alleged incident encies in accordance with gulations. The Administrator ct the investigation process oriate agencies are notified, g: Training programs may		each shift. per week x4 weeks, 1 residents bi-weekly for 8 weeks a 10 residents monthly x3 months. Abuse/Neglect audit tool called "for and responding to an Incident monthly QI committee will review of the Abuse/Neglect audit tool remonthly for 6 months for identific trends, actions taken and to dete need for and/or frequency of commonitoring, and make recommenfor monitoring for continued components. The administrator and/or DON with findings and recommendation monthly QI committee to the qual executive QA committee for furth recommendations and oversight.	ond then using the Watching t." The results esults ation of remine the tinued adations pliance.	
	abuse and related int	resident vulnerability to erventions. Prevention: The pervision to staff to identify				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE	SURVEY
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	ROVIDER OR SUPPLIER			3315	ET ADDRESS, CITY, STATE, ZIP CODE  FAITH CHURCH ROAD  AN TRAIL, NC 28079	1 03/	14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	The facility will asses residents with needs lead to abuse, negle property. Protection: directly involved in a or misappropriation of immediately from emoutcome of the investigation of the investigation of the facility of	ors, such as rough handling. as, care plan, and monitor and behaviors that might ct, or misappropriation of Employees accused of being Illegations of abuse, neglect, of property will be suspended aployment pending the stigation.  I's Abuse, Neglect or Resident Property policy of physical abuse was not  mitted to the facility on a included dementia with ective disorder, cognitive it, paranoid delusional beliefs dent #6 was currently being by ongoing psychiatric  w revealed Resident #6 had ed 08/31/15 for Ativan rams (mg) IM (intramuscular) for pain and another ted 11/16/15 for Ativan 1 mg eded for agitation.  I Data Set dated 12/29/15 #6 with severely impaired extensive staff assistance of 2 for daily living (ADL) to sfers, dressing and toileting, Illy abusive and without	{F 2	26}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345502	B. WING			R-C 03/14/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	J3/14/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 226}	referred by nursing agitation and persever ported that Reside agitated primarily in note recorded that FNP to be very agitat Medications were accontinue to monitor.  A Skin Monitoring R 02/15/16 did not recovity with skin integrity.  Review of a nursing 02/16/16 at 4:49 PNF ebruary 2016 Med recorded that Reside towards staff that dashe administered At needed for agitation positive effects and needed for pain at 1 effects.  A nursing progress of PM by Nurse #1 recovered (NA #1) verbalized starting care when the The Medical Director the Resident. Nurse assessment for Resovered area to the A Skin Monitoring R completed by Nurse #6 had redness to here.	ealed Resident #6 was for evaluation of morning fering behaviors. Nursing ent #6 was noted increasingly the morning. The progress Resident #6 was noted by the ed, angry, and confused. It is a state of the ed and staff were to review for Resident #6 dated ord any changes or concerns progress note dated by Nurse #1 and the cation Administration Record ent #6 was very combative by. Nurse #1 documented that is an 1 mg by mouth as at 07:40 AM with some then Ativan 2 mg IM as 2:10 PM with slight positive rote dated 02/16/16 at 4:56 orded that nursing assistant the slapped Resident #6 are Resident pulled her hair. It was notified and assessed #1 performed a full body ident #6 and noted a deep are Resident's right upper thigh.	{F 22	6}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		345502	B. WING _			R-C 03/14/2016
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	· · · · · · · · · · · · · · · · · · ·	5071472010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 226}	completed by the D recorded that NA # #6 on the leg and a noted with red mark.  A written statement recorded that NA # leg on 02/16/16 are #6 become combat #1. A Disciplinary W completed by the D recorded that NA # inappropriate way obehavior.  A Consultation Rep by the DON, record not report abuse im employee from an a another supervisor advised of abuse, b.  Review of a Health (HCPR) 24 Hour Incompleted by the A 02/16/16 at 10:00 A Resident #6 on her	lated 02/16/16 at 5:03 PM irector of Nursing (DON), 1 stated she struck Resident fterwards the Resident was as on the right thigh.  by NA #1 dated 02/16/16 1 struck Resident #6 on her und 10:00 AM when Resident ive and pulled the hair of NA Varning Notice dated 02/16/16, ON and signed by NA #1, 1 was suspended for an of dealing with a resident ort dated 02/16/16, completed ed a concern that NA #2 did mediately, remove the abuse situation and report to when the charge nurse was	{F 2:	26}		
	immediately susper include the incident occurred on 02/16/- Review of the facilit written statement b 02/19/16, which red	right thigh. NA #1 was nded. The report did not of physical abuse that 16 at 8:00 AM.  y's investigation revealed a y the Administrator, dated corded that she spoke to the 102/16/16 around 9:00 PM				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079		3/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 226}	witnessed NA #1 sla about 8:00 AM. The that the Administrator Administrator docum #2 on 02/17/16 and witnessed NA #1 sla 02/16/16 around 8:0 thigh above her knee Resident became co Written statements be recorded that on 02/ witnessed Resident morning care and Na the left side of her fal leave the Resident's at the nurse's station #6. NA #2 did not re abuse against Reside the nursing staff head in the morning arour in the shower room, #6 grab the hair of Na Resident #6 on the I #1 leave the shower to Nurse #1 and Nur Written statements be and the Administrator recorded that Nurse aware that NA #2 wi #6 on the left side of AM. NA #1 did self-ral Resident #6 on the ral 10:00 AM.	e was aware that NA #2 also p Resident #6 on 02/16/16 written statement recorded or was not aware. The nented that she spoke to NA was informed that NA #2 p Resident #6 on the face on 00 AM and again on the right e at 10:00 AM, when the ombative.  by NA #2, dated 02/17/16, 16/16 at 7:30 AM, NA #2 #6 become combative during A #1 slapped Resident #6 on ince. NA #2 witnessed NA #1 incom and make a statement on that she "popped" Resident port the witnessed physical lent #6 because she thought and 9:45 AM on 02/16/16, while NA #2 witnessed Resident IA #1 and NA #1 slapped leg. NA #2 then witnessed NA room and report the incident	{F 22	6}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONS	STRUCTION	(X3) DATE COMP	SURVEY LETED
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		345502	B. WING _		<del></del>	03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET	FADDRESS, CITY, STATE, ZIP CODE		
LAVEDAD	DE NUIDONO AND DEUA	DII ITATION CENTED		3315 FA	AITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIA	N TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	Continued From page recorded on 02/16/16 immediately reported combative resident or care and immediately wrong. The physical a was immediately sus was called at 6:00 PN was substantiated an The report did not incabuse that occurred of An interview with NA 02/24/16 at 10:30 AM received a lot of abust that if she witnessed nurse/supervisor, remwatch the perpetrator go into any resident ro 02/16/16 around 7:30 cooperate with staff a during morning care (NA #2 stated she witr #1 twice, then witness on the left side of her going to stop that." No more than just a pat of hard slap. NA #2 stated she with that slap.	e 20 at 10:00 AM, NA #1 that she slapped a the leg during resident knew what she did was abuse was witnessed, NA #1 pended, law enforcement d, the allegation of abuse d NA #1 was terminated. lude the witnessed physical on 02/16/16 at 8:00 AM.	{F 2	26}		ME	DAIL
	getting Resident #6 d wheelchair and NA # dining room. NA #1 st dining room, NA #1 st and told Nurse #1 "I p Nurse #1 said "Ok." N out later that Nurse # statement. NA #2 stat	ressed, placed her in her I took Resident #6 to the tated that on the way to the topped at the nurse's station topped (Resident #6)" and NA #2 stated that she found I did not hear NA #1's ted she felt that when NA #1 that the incident fit the					
	definition of abuse, bu	ut that she didn't know how m Resident #6. NA #2					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY MPLETED
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		345502	B. WING _		o:	3/14/2016
	PROVIDER OR SUPPLIER  ARK NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ΣE		
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{F 226}	further stated she di again and thought N the incident and wor further stated that la AM, both NA #1 and Resident #6 in the s Resident became on NA #1 bent down to and Resident #6 grawhen NA #1 slapped thigh. NA #2 stated hear, but she didn't #6 released her grip finished pulling up the transferred her to the Resident #6 to the of she observed NA #1 nurse's station and that she "popped" R #2 immediately left tunit with the DON. Not to NA #1 and NA #1 #2 stated the DON a happened and she that slapped Resident #6 about 8:00 AM and 10:00 AM. NA #2 stated the DON and that evening on Administrator on 02/2 her that e	d not think it would happen lurse #1 heard NA #1 report all take care of it. NA #2 ter that morning around 10:00 I NA #2 were toileting hower room when the embative again. During care, pull up the Resident's pants abbed NA #1's hair. That's id Resident #6 on her right the slap was loud enough to know what to do. Resident on NA #1 hair and they he Resident's pants, ie wheelchair and NA #2 took lining room. NA #2 stated that immediately go to the cold Nurse #1 and Nurse #2 resident #6 on the leg. Nurse he unit and returned to the IA #2 observed the DON talk was escorted off the unit. NA resked her on 02/16/16 what root he left side of her face then on her right thigh about ated she also informed law 16/16 when he interviewed the phone and the 17/16 when she talked to her was conducted on 02/24/16 A #1. She stated that she y's secure unit as her ent and had recently received #1 stated she was trained on	{F 22	(6)		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
LAVEDA	RK NURSING AND REHA	ADII ITATION CENTED		3315 I	FAITH CHURCH ROAD		
LAKE PAI	KK NUKSING AND KENA	ABILITATION CENTER		INDIA	AN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	Administrator, and m resident were both w 02/16/16 Resident #4 and she responded to Resident's face and #1 stated "I just touc and NA #2 was present the nurse's station at Resident #6 and told was a hand full, but sher face because she anything to it. NA #1 on the Resident's face morning around 10:00 toileting Resident #6 Resident became co #1 stated that while she Resident's brief, the pulling so hard "I was smacked her on the I said stop and she should she s	Il law enforcement or the nake sure the perpetrator and vatched. NA #1 stated that on, 6 slapped her on the face by gently touching the said "Let's don't do that." NA hed her face with my hand ent. NA #1 stated she went to	{F 2	26}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		X3) DATE SURVEY COMPLETED
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<b>345502</b> B. WING		03/14/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, C	CITY, STATE, ZIP CODE	
LAKE PARK NURSING AND REHABILITATION CENTER  3315 FAITH CHURCI		
INDIAN TRAIL, NO	28079	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 226  Continued From page 23   hair. NA #1 stated she "popped" Resident #6 to get her to let go. Nurse #1 stated Nurse #2 (supervisor) was also present and heard the conversation. NA #1 stayed at the nurse's station with Nurse #1, while Nurse #2 reported the incident to the DON. The DON came to the unit, took a statement from NA #1 and she was suspended. Nurse #1 stated that NA #1 worked with all residents on the secure unit that day from 7:00 AM until she was suspended around 10:30 AM, but Nurse #1 was not aware of any prior incidents of abuse regarding NA #1. Nurse #1 stated she had not been informed that NA #2 witnessed NA #1 slap Resident #6 on the face earlier that morning. Nurse #1 stated Resident #6 was combative at times, usually required 2 staff to give her care. Nurse #1 stated that staff were trained that when residents became combative, staff should give the resident time to calm down, try to redirect and come back later to provide care. Nurse #1 stated Resident #6 was very combative that day and received Ativan (as needed) twice on her shift that day for agitation and later for pain. Nurse #1 stated Resident #6 did not cooperate initially with a skin assessment, and Ativan was given to calm her down. Once Resident #6 was calm, a full body skin assessment was completed, around 12:30 PM and she was noted with a reddened area to her right thigh about 3 inches long and irregular in shape. Nurse #1 stated there were no other changes noted to her skin or face.  The Administrator was interviewed on 02/24/16 at 3:52 PM. She stated that the DON informed her around lunch time on 02/16/16 that NA #1 "popped" Resident #6 on the knee in the shower room and reported herself. The DON told the Administrator that NA #1 was suspended and that		

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345502	B. WING _			03/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEDA	DE NUIDEING AND DEUA	DILITATION CENTED		3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	investigation. The Adworking in her office a PM she obtained the the DON to complete Report. The DON left but informed the Admishe had obtained all tinterviews. The Adminivestigation before the thought the DON had Administrator called lapt. The Administrator called lapt. The Administrator called lapt. The Administrator called lapt. The Administrator called law enforcement obsequence and the phone regarding labout another incider earlier that day, but the was not aware and shoon's investigation. Called NA #2 sometim 02/17/16 and obtaine the phone regarding labuse that were witned to the DON. The Administrator state HCPR 24 Hour Initial 5 Day Working Report not complete a separation physical abuse that of 8:00 AM because it winvestigation. The Adnow she realized that	pleting interviews for the ministrator continued and sometime before 4:00 necessary information from the HCPR 24 Hour Initial for the day around 4:00 PM, sinistrator before she left that the written statements and inistrator did not review the he DON left because she done everything. The law enforcement around 6:00 or stated she went to see that the written that day around 7:00 ement arrived. Both she and erved Resident #6 without high. The Administrator ing, around 9:00 PM, law let and asked if she knew and of abuse that happened the Administrator stated she he had not looked at the The Administrator stated she he the next morning on do a statement from her over both incidents of physical lessed by NA #2 and reported hinistrator asked NA #2 to ments about what she saw. It the step of the incident of courred on 02/17/16 and the ret on 02/22/16, but she did late report for the incident of courred on 02/16/16 around was included in her ministrator further said that it both incidents of physical	{F 2	26}			
	I .	both incidents of physical een reported to the HCPR.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245502	B. WING		R-C
	ROVIDER OR SUPPLIER	345502 BILITATION CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  3315 FAITH CHURCH ROAD  INDIAN TRAIL, NC 28079	03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
, ,	AM. Nurse #2 stated Supervisor on the 7Al Nurse #2 and Nurse #3 station on the secure 10:00 AM when NA # to know that I just pop #1 proceeded to say #6 because the Resid #2 stated she asked I station. Nurse #2 wer what occurred. The D obtained a statement suspended. Nurse #2 of any previous incide #1 and Resident #6.  Attempts to interview unsuccessful.  The administrator was jeopardy on 02/24/16  An extended survey w 483.75 EFFECTIVE ADMINISTRATION/R  A facility must be adm enables it to use its re efficiently to attain or practicable physical, if	ewed on 02/25/16 at 10:28 she was the Nurse M - 3PM shift on 02/16/16. #1 were both at the nurse's unit on 02/16/16 around 1 said "I just want everybody oped (named Resident)." NA that she "popped" Resident dent pulled her hair. Nurse NA #1 to stay at the nurse's at to find the DON and report iON came to the secure unit, from NA #1 and she was a stated she was not aware ents of abuse between NA  the DON were  Is notified of immediate at 5:27 PM  was conducted on 02/25/16.  ESIDENT WELL-BEING  ministered in a manner that resources effectively and maintain the highest mental, and psychosocial	{F 226		3/18/16
	by: Based on staff interv	is not met as evidenced iews and review of facility dministrative staff failed to		A facility must be administered in a manner that enables it to use its	

NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE				7 5012511				) <sub>-</sub> C
NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    FURTHER   PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    Continued From page 26   Create and impose a culture that all residents would be protected from abuse and that staff would implement the facility's abuse policy and procedures to intervene, protect and immediately report abuse when witnessed. A combative resident experienced 2 episodes of physical abuse without immediate facility intervention, protection and implementation of abuse policies and procedures for 1 of 1 sampled residents reviewed for abuse (Resident #6).   Immediate jeopardy began on 02/16/16 when NA #2 did not intervene and did not immediately report to administrative staff for protection of Resident #6 on the right thigh and the witness, NA #2 did not intervene for the protection of Resident #6.   Immediate jeopardy is present and ongoing. The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable   Centers for Medica			345502	B. WING			1	_
CASE   DEFICIENCY	NAME OF DE	DOVIDED OD SLIDDLIED	0.0002		eti.	DEET ADDRESS CITY STATE 7ID CODE	1 03	/14/2016
INDIAN TRAIL, NC 28079   (C4) ID PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   FREGUED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)   CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY   DEFICIENCY	NAME OF F	NOVIDER OR SUFFLIER						
SUMMARY STATEMENT OF DEFICIENCIES   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PREFIX TAG   CROSS-REFERENCE TO THE APPROPRIATE   DEFICIENCY)      F 490	LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER					
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intervene for the protection of Resident #6.  Immediate jeopardy is present and ongoing.  The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable  intervene for the protection of Resident #6.  2) On 2/16/16, staff nurses completed 100% body audit on all cognitively impaired residents in the facility for		02/16/16 when NA#	1 slapped Resident #6 on the			On 2/16/16 NA #1 was suspended from	n	
Immediate jeopardy is present and ongoing.  The facility provided the State Agency and Centers for Medicare and Medicaid an acceptable  2) On 2/16/16, staff nurses completed 100% body audit on all cognitively impaired residents in the facility for						employment and terminated on 2/22/16	<b>3</b> .	
Centers for Medicare and Medicaid an acceptable impaired residents in the facility for		Immediate jeopardy i	is present and ongoing.			2) On 2/16/16, staff nurses completed		
		The facility provided	the State Agency and			100% body audit on all cognitively		
						impaired residents in the facility for		
allegation of compliance (AOC) on 03/08/16.  evidence of abuse. No negative findings were identified.		allegation of complia	nce (AOC) on 03/08/16.			evidence of abuse. No negative finding were identified.	S	
A revisit survey was conducted on 03/14/16 to  On 2/16/16, the social worker interviewed		A revisit survey was	conducted on 03/14/16 to			On 2/16/16, the social worker interview	ved	
determine the status of the ongoing Immediate all alert and oriented residents related to		determine the status	of the ongoing Immediate			all alert and oriented residents related	iO	
Jeopardy. The facility provided documentation for abuse and resulting in no negative		Jeopardy. The facility	provided documentation for			abuse and resulting in no negative		
review of the following: responses.			•			·		
Skin audits for all cognitively impaired residents  On 2/19/16 NA#2 was disciplined for		_	gnitively impaired residents					
dated 02/16/16 failure to report immediately allegation of							of	
Documentation of interviews regarding abuse for abuse according to the Abuse Policy.								
all cognitively intact residents dated 02/16/16  On 2/25/16 NA #2 was terminated for not							not	
Documentation of in-services providing safety for Resident#6.						providing safety for Resident#6.		
(identifying/reporting abuse, caring for residents			<del>-</del>			2) On 2/25/46, the administrator	ad	
with dementia) for all currently employed staff  3) On 2/25/16, the administrator received  an in convice from the corporate Vice						•	<b>zu</b>	
completed by 03/07/16 an in-service from the corporate Vice						•		
Documentation of abuse monitoring on each shift  which began on 02/26/16 and remained ongoing  President of Operations on F Tags 225  and 490.								
24 hour/5 day reports for an allegation of abuse  The in-service included the following:								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	1, ,	E SURVEY IPLETED
			A. BOILDIN	<u> </u>	-   ,	R-C
		345502	B. WING		ı	3/14/2016
NAME OF P	ROVIDER OR SUPPLIER	1 0.0002		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	0/14/2010
TO UNE OF TH	TO VIDER OR OUT FEILING			3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
				· .		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE
{F 490}	Continued From page	e 27	{F 49	90}		
,		allegation of neglect on	(, ,,	The facility must ensure that	all	
	02/27/16	anegation of neglect on		alleged violations involving mistre		
		ort for Resident #6 for the		neglect, or abuse, including injurie		
	8:00 AM incident of a			unknown source and misappropria		
		orted to the Health Care		resident property are reported		
		HCPR). Both reports were		immediately to the administrator o	f the	
	faxed the the HCPR	on 02/25/16		facility and to other officials in acc	ordance	
	Personnel files for all	staff hired since 02/16/16 to		with State law through established	I	
		ground checks, reference		procedures (including to the State	survey	
		Registry checks, license		and certification agency).		
	checks, and abuse tr			The facility must have eviden		
	The facility's Abuse F	Policy		all alleged violations are thorough	-	
				investigated, and must prevent fur		
		ing care, interviews with		potential abuse while the investiga	ition is	
		dents, interviews with family,		in progress.		
		aff present in the facility on all documentation to support		The results of all investigation be reported to the administrator or		
	the AOC and intervie			designated representative and to		
		or of Nursing and the Nurse		officials in accordance with State I		
		sufficient evidence to		(including to the State survey and	200	
		tion by the facility to remove		certification agency) within 5 work	ng days	
		rdy at F-490. The immediate		of the incident, and if the alleged		
		ed on 03/14/16 at 7:15 PM.		is verified appropriate corrective a		
		out of compliance at F-490		must be taken.		
	-	d severity of (D) isolated, no		A 24 hour and 5 day report is	required	
	· ·	ential for more than minimal		for each allegation, including alleg	ations	
	harm that is not imme	ediate jeopardy, while the		identified during an investigation a	nd/or	
		process of monitoring the		additional allegations occurring or		
	implementation of the	eir corrective action.		same day and/or involving the sar	те	
				employee/resident.		
	The findings included	<b>i</b> :		The facility must ensure staff		
		D		effectively and consistently comm		
		- Based on staff interviews		through the chain of command, ve	-	
		ne facility failed to protect a		and in documentation, to attain an		
	_	free from physical abuse		maintain resident □s well-being. S		
		vention when a resident uring nursing care. A		been trained to effectively and cor	•	
		illy abused twice when a staff		communicate through the chain of command, verbally and in docume		
		across the face and then on		to attain and maintain residents		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			R-C <b>03/14/2016</b>	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	'	STREET ADDRESS, CITY, STATE, ZIP 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	, CODE	33.1.1120.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIAT		NC
{F 490}	reviewed for abuse. Cross refer to F225 and record review, to notify administrative of physical abuse in on the face. Once personnel Reginvestigative finding sampled residents. Cross refer to F 226 and record review, to immediately stop not (Resident #6) becard incident of physical abuse was remove the perpetration of a secure unit. The witnessed incident of Care Personnel Reginvestigation in 5 words to follow their abuse areas of prevention, training and reporting abuse investigation. During an interview 02/24/16 at 3:52 PM informed by the Direct O2/16/16 around luming the facility on 02/24. Administrator stated she had begun the investing for the day, and the Administrator stated leaving for the day, and the statements are statements as the statements are statements and the statements are statements.	of 1 sampled residents (Resident #6).  - Based on staff interviews he staff failed to immediately staff of a witnessed incident which a resident was slapped otified, the facility failed to f physical abuse to the Health gistry in 24 hours and the s in 5 working days for 1 of 1 (Resident #6).  - Based on staff interviews he facility failed to rsing care when a resident ne combative to prevent an abuse, intervene when observed, and immediately ator from a combative resident e facility failed to report a of physical abuse to the Health gistry in 24 hours and the orking days. The facility failed e policy and procedures in the protection, identification, g of physical abuse for 1 of 1 reviewed. with the Administrator on I, she revealed she was ector of Nursing (DON) on ch time that abuse occurred 16/16 around 10:00 AM. The I that the DON told her that	{F 4	from abuse.  On 2/26/16, 2/29/16, 3/1/staff and contract staff att Directed □in-service press Regional Ombudsman Ar Aging Titled: Identification of Elder Abuse.  4) The Corporate Staff, i.e. consultant and/or regional continue to review all alle and interventions when readministrator in accordan Abuse Policy including not appropriate agencies for the Administrati abuse and continue to revallegations of abuse i.e. 2 report monthly for 6 mont identification of trends, act to determine the need for frequency of continued interviews/monitoring and recommendations for more continued compliance.  The administrator and/or the findings and recommendations and over executive QA committee of executive QA committee of executive QA committee of recommendations and over the findings and over the findings and over the executive QA committee of the commendations and over the findings and over the finding	tended a sented by the rea Agency on and Prevention of an and Prevention of a second of a	on ing se or d	

		TE SURVEY MPLETED				
		345502	B. WING _			R-C <b>3/14/2016</b>
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	0/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 490}	had it all together. T later she realized that thorough in her inve "captain of the ship" make sure all parts of completed. The Adn her expectation that combative residents Resident #6 requires staff, then depending could get to the call or not staff could call when Resident #6 b Administrator stated staff to immediately combative resident of a lack of training that necessary tools to k combative resident of combative resident of the Was in the facility informed that Resided day, struck a staff me was witnessed to staff Director stated that of Resident #6 and known combative, resistive and try to hit at staff he was involved in of correction when abut January 2016. He si re-educated to report occurred or was with to administrative staff	DN and assumed the DON he Administrator stated that at the DON had not been stigation and that as the it was her responsibility to of the investigation was hinistrator stated that it was staff ensure the safety of during nursing care and if d the assistance of 2 nursing g on whether or not the staff bell would determine whether I for additional assistance ecame combative. The she attributed the failure of report abuse and protect a from further abuse was due to t provided staff with the now how to respond to a and what to do when a was abused.  If was interviewed on I. The Medical Director stated on 02/16/16 and was ent #6 was combative that ember and the staff member rike back. The Medical ne was very familiar with ew that at times she was quite to care and would strike out. The Medical Director stated eveloping the plan of ise occurred in the facility in	{F 49	90}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345502	B. WING				-C
	ROVIDER OR SUPPLIER			S1 33	TREET ADDRESS, CITY, STATE, ZIP CODE  315 FAITH CHURCH ROAD  IDIAN TRAIL, NC 28079	1 03/	14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 490} {F 514} SS=D	continued monitoring continue to occur.  The Administrator wa jeopardy on 02/24/20  An extended survey was 483.75(I)(1) RES RECORDS-COMPLE LE  The facility must main resident in accordance standards and practic accurately documents systematically organis.  The clinical record mainformation to identify resident's assessment services provided; the preadmission screeniand progress notes.  This REQUIREMENT by:  Based on an observative of medical and failed to transcribe and to the treatment record resident's indwelling I (Resident #112) and administration of an ed (Resident #36) for 2 decrees the continuation of the contin	to the proper authorities and to make sure abuse did not sinformed of immediate 16 at 5:27 PM.  It was conducted on 02/25/16.  ITE/ACCURATE/ACCESSIB  Intain clinical records on each we with accepted professional est that are complete; ed; readily accessible; and zed.  Just contain sufficient the resident; a record of the late; the plan of care and exercise results of any ang conducted by the State;  The is not met as evidenced ation, staff interviews and diffacility records, the facility physician order for 3 months are regarding the change of a foley catheter every 30 days document the correct time of enteral feeding product	{F 4		F 514 Resident Records  1) On 2/25/16, the staff nurse contacte Resident #112'□s physician and obtain an updated Foley catheter order. On 2/25/16, Resident #12□'s Foley catheter was changed according to the Extense that can be accor	ed	3/18/16
	reviewed.				Foley catheter order dated 2/25/16.		
	i .		1				l .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			5 14//10			R	R-C
		345502	B. WING _			03/	/14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IAKEDAI	DK NITIDGING AND DEL	IABILITATION CENTER		3	315 FAITH CHURCH ROAD		
LANE PAI	RK NURSING AND REF	IABILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 514}	Continued From pa	_	{F 5	14}			
	The findings include	ed:			On 2/25/16, the staff nurse started the		
	Dasidant #110aa	admitted to the facility on			Glucema 1.2 enteral feeding at 50 cc/h		
		admitted to the facility on oses of peripheral vascular			as ordered. On 2/25/16 the staff nurse		
	disease, cerebrovas				contacted Resident #36□'s physician regarding the resident not getting the		
	hemiplegia.	soular accident and			Glucema 1.2 as ordered, the resident	hit	
		erly Minimum Data Set dated			not have 35 minutes of the tube feedin		
	01/22/16 revealed Resident #112 was moderately				product (29.05 cc). No new orders wer	e	
	cognitively impaired and had an indwelling Foley				received.		
	catheter.				On 2/25/16, the Director of Nursing		
		plan dated 01/28/16 revealed			(DON)reviewed Resident #36□'s weigl		
		an altered pattern of urinary			for the past 3 months with no negative		
		ndwelling catheter and was at e goal was for Resident #112			findings.		
		ary tract infection through the					
		ntions included Foley catheter			2) On 2/26/16, DON audited all other		
		cocol and change Foley			residents with a foley catheter and		
		an orders and/or facility			residents receiving enteral feedings for	-	
	protocol.	·			accurate record documentation. There		
	Review of the treatr	ment records (TAR) for			were no negative findings.		
	Resident #112 reve						
		gh 10/31/15 - Foley catheter			3) On 2/26/16, DON initiated an in-serv	/ice	
	care once every shi				for 100% of nurses regarding		
	1	gh 11/30/15 - Change Foley			documenting the correct time of	-4-	
		ays. Documented on TAR as			administration of enteral feeding produ	Cts,	
	catheter care every	5. No mention of Foley			to include continuous feedings. The		
		gh 12/31/15 - No mention of			in-service was completed on 3/7/16.		
		every shift or change Foley			On 3/7/16, DON initiated an in-service	·e	
	catheter every 30 d				for 100% of nurses regarding the timel		
	_	gh 01/31/16 - No mention of			and accurate transcription of physician	-	
		every shift or change Foley			orders to the Medication Administration		
	catheter every 30 d				Record (MAR) or the Treatment		
		gh 02/25/16 - No mention of			Administration Record (TAR) to include		
		every shift or change Foley			orders to change a Foley catheter on t		
	catheter every 30 da	-			TAR. The in-service was completed on	ı	
		e's notes from 10/23/15			3/14/16.		
	_	vealed no note that Resident					
	#112's Foley cathet	er had been changed. Review			4) On 3/7/16, DON, QI nurse, staff		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			55.25	-			R-C
		345502	B. WING				/14/2016
NAME OF PI	ROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	11712010
					315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER			NDIAN TRAIL, NC 28079		
040.15	CHMMADVCT	TATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 514}	Continued From page	e 32	{F 5	141			
( )		ated 01/14/16 at 6:25 AM	ر ا	177	facilitator, and/or evening charge nurse		
	revealed Nurse #5 de			facilitator, and/or evening charge nurse will utilize the "Foley Catheter Audit To			
		y catheter and retracted the			to validate Foley catheter orders are	Oi	
		me due to bleeding around			transferred over from the current month	h to	
	the external urethra.	•			the new month. The audit will be		
	An interview conduct			completed within 5 days of the			
	02/24/16 at 9:40 AM			end-of-month MAR and TAR			
	when Resident #112'			reconciliation. This audit will be comple	eted		
	been changed. She s			for 6 months.			
	Foley catheter chang						
	and there were no or			On 3/7/16,DON, QI nurse, staff			
	01/2016 and 02/2016				facilitator, and/or evening charge nurse		
		ys. Nurse #5 stated the order			will utilize the "Enteral Feeding Audit To	ool"	
		catheter every 30 days did			to validate the enteral feeding is being		
		the TAR after 11/2015 so			administered according to physician	at a	
	she wouldn't have kn changed.	own it needed to be			orders, to include nurses writing accurate start times on the enteral feeding bottle		
	An interview conduct	ed with Nurse #3 on			Start times on the enteral reeding bottle		
		I revealed she normally			The audits will be completed 5 days a		
		to 11:00 PM shift with			week for 4 weeks, then 2 days a week	for	
		eviewed the February 2016			4 weeks, then 1 time a week for 4		
		12 with the surveyor and			months.		
		no order to change Resident					
		r every 30 days. She stated			The DON and/or the QI nurse, and/or t	he	
	she knew the nurse a	aides provided Foley catheter			staff facilitator will monitor the "Foley		
	_	nce care but she did not			Catheter Audit Tool" results to ensure		
	·	catheter had last been			proper transcription of Foley catheter		
	_	nad not been documented on			orders onto the TAR. The DON and/ or	· QI	
		2016 and stated it should			nurse, or staff facilitator will initial the		
		the TAR what day of the			bottom right corner of the audit tool wit		
		Resident #112's Foley			the date to acknowledge completion ar	าต	
		nanged. Nurse #5 further			follow-up		
		the floor was assigned a			The DON and/or the Ol pures or stoff		
	· ·	n month to transcribe orders onth to the			The DON and/or the QI nurse,or staff facilitator will monitor the "Enteral Feed	dina	
		e if anyone checked the			Audit Tool" results to ensure proper	anig	
		rson that transcribed them.			administration of enteral feedings.		
	1	empted on 02/25/16 at 2:45			asiminor attori or criteral recullings.		
		e to her no longer being			The administrator and/or DON will pres	sent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					F	R-C	
		345502	B. WING _		03	/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
I AKE DAI	DK NIIDGING AND DE	HABILITATION CENTER		3315 FAITH CHURCH ROAD			
LANE PAI	KK NUKSING AND KE	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 514}	Continued From page 33 employed by the facility. A message was left but Nurse #5 did not return surveyors call. During an interview conducted with the Interim Director of Nursing (DON) on 02/25/16 at 3:00 PM she revealed the order to change Resident #112's Foley catheter every 30 days had not been transcribed to the TAR in 12/2015, 01/2016 and 02/2016 and she could not find any documentation in the medical record of the Foley catheter being changed since 11/08/15. The Interim DON stated it was her expectation that all orders be transcribed correctly to the TAR each month. She stated the nurse's should have been checking behind each other for transcription mistakes.  2. Resident #36 was admitted to the facility on 09/17/14. Diagnoses included cognitive deficit, artificial opening of digestive tract, intestinal obstruction, and peritonitis.  A physician's order dated 02/12/16 was written for Glucerna 1.2 (enteral feeding product) to infuse at		{F 5	the findings from the "Foley Catheter Audit and Enteral Feeding Audit" to the monthly QI committee for recommendations as appropriate to maintain continued compliance and to the quarterly executive QA committee for further recommendations and oversight.			
	50 cc per hour, co order included to p water flush of 500 10AM, 2PM, 6PM order also indicate medications (provi the percutaneous tube.  On 02/24/16 at 05 her bed with the heapproximately 30 c AM, the enteral fee was empty and the noted beeping. Nu	ntinuously. The physician's provide Resident #36 with a cc every 4 hours at 2AM, 6AM, and 10PM. The physician's d that staff could cocktail ded all together) and give via endoscopic gastrostomy (PEG)  235 AM Resident #36 was in ead of the bed elevated to degrees. On 02/24/16 at 05:48 eding bottle of Glucerna 1.2 e enteral feeding pump was rse #7 was observed to turn off pump per the request of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED  R-C 03/14/2016	
		<b>345502</b> B. WING				
NAME OF PROVIDER OR SUPPLIER  LAKE PARK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP O 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
{F 514}	and medications for an enteral feeding be 02/24/16 at 06:01 Al record the date of 02 and rate of 50 cc on Resident #36. On 02 #6 administered med Resident #36 via the enteral feeding prod Nurse #6 was interviand stated he wrote feeding bottle as the he typically recorded medications and than medications for Resirealized that by record of 05:30 AM, Reside TF product.  The Interim Director interviewed on 02/25 interview she stated should document the were given and enterso that the medical recorrect amount of erinfused. The Interim the hang time Nurse	was noted to gather supplies Resident #36 which included offile of Glucerna 1.2. On M, Nurse #6 was observed to 2/24/16, time of 05:30 AM, the enteral feeding bottle for 2/24/16 at 06:05 AM, Nurse dications and a water flush to 2/24/16 at office and started the dications and a water flush to 2/24/16 at 6:10 AM 05:30 AM on the enteral administration time because I the time he prepared the t was the time he prepared dent #36. Nurse #6 stated he rding an administration time and the rding an administration time office Nursing (DON) was 6/16 at 8:48 AM. During the that for accuracy, staff actual time medications ral feeding products infused ecord would document the otheral feeding product DON stated that based on #6 documented for the fuct, Resident #36 missed 35	{F 5	14}		