STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		10/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/23/2017

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

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner, physician, and responsible party (RP) interviews the facility failed to discontinue a medication per the RP's request for 1 of 4 residents reviewed for accidents (Resident #4). Findings included: Resident #4 was readmitted to the facility on 06/16/2017 with diagnoses which included Alzheimer's disease, anxiety, depression, schizophrenia, and other psychotic disorder. Resident #4's most recent quarterly Minimum Data Set (MDS) dated 08/30/17 revealed Resident #4 was cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene and received antipsychotic, antidepressant, and antianxiety medication. A review of a physician's order dated 09/08/17 indicated Resident #4 was prescribed a central nervous system medication to treat repetitive behaviors. A review of a nurse practitioner's order dated 09/18/17 indicated the medication to treat repetitive behaviors was discontinued.	F 166	F 166 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The position of Lake Park Nursing and Rehabilitation center regarding the	

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F 166	Continued From page 3 On 09/25/17 at 1:26 PM an interview was conducted with Resident #4's Responsible Party (RP) who stated she had informed Nurse #1 that she wanted the physician to discontinue a medication that had been prescribed within the last two weeks to treat Resident #4's repetitive behaviors. The RP stated Resident #4 had fallen on 09/11/17 after receiving a few doses of the medication and was concerned that the medication had contributed to Resident #4's fall. The RP stated Resident #4 had acquired a urinary tract infection (UTI) after receiving the medication and was concerned that the medication contributed to Resident #4 acquiring a UTI. The RP stated Resident #4 had fallen again on 09/18/17 and felt the medication contributed to Resident #4's fall. The RP expressed concerns that Resident #4 continued to receive the medication for repetitive behaviors after she requested that the physician stop the medication. On 09/25/17 at 4:08 PM an interview was conducted with Nurse #1 who stated she had informed the RP that she could not discontinue the medication for Resident #4 without a physician's order. Nurse #1 stated she informed the RP that she would place a note in the physician's book for him to address. Nurse #1 stated the note indicated that the RP had requested the medication for repetitive behaviors be discontinued for Resident #4 related to adverse reaction. A review of the physician's book indicated on 09/12/17 a note was written for the physician that indicated the RP had requested the medication for repetitive behaviors for Resident #4 be discontinued related to concerns of adverse	F 166	process that lead to this deficiency was staff failed to follow established facility policy and protocol related to prompt follow up on resident concerns including both written and verbal. . What measures did the facility put in place for the resident affected: On 9/18/17 resident #4□s medication to treat repetitive behaviors was discontinued by the Nurse Practitioner (NP). Resident #4□s responsible party (RP) was notified of discontinuation of medication on 9/18/17 by NP and satisfied with resolution of request to discontinuation of medication. What measures were put in place for residents having the potential to be affected: On 10-17-2017 the administrator reviewed all resident concerns for the past thirty days to ensure residents and/or the resident RP are satisfied with the resolution and follow-up. Any areas of concern were addressed immediately. What systems were put in place to prevent the deficient practice from reoccurring: On 10-18-2017, the administrator initiated an in-service for the administrative staff on Follow Up to Resident Concerns which included: 1) When addressing resident concerns, you must include detailed	

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F 166	Continued From page 4 reaction related to a fall and UTI. A review of the documentation on the Medication Administration Record (MAR) indicated Resident #4 received the medication for repetitive behaviors each day from 09/09/17 to 09/18/17. On 09/26/17 an interview was conducted with the physician who stated on 09/12/17 during his scheduled visit to the facility he was aware that the RP wanted the medication for repetitive behaviors discontinued for Resident #4 due to adverse reaction concerns. The physician stated he explained to nursing his rationale for continuing the medication for repetitive behaviors for Resident #4. The physician stated he did not discontinue the medication as per the RP's request. The physician stated he had not called the RP to explain his rationale for not discontinuing the medication. The physician stated because he had explained his rationale for not discontinuing the medication to nursing he had believed that nursing would have informed the RP. On 09/27/17 at 9:49 AM an interview was conducted with the Nurse Practitioner (NP) who stated she was aware that Resident #4's RP wanted the medication to treat repetitive behaviors discontinued because of adverse reaction concerns. The RP stated she had spoken with the physician about the benefits of continuing the medication for Resident #4. The NP believed the nursing staff had communicated to the RP the rationale for continuing the medication for Resident #4. The NP stated she had not discussed the rationale for continuing the medication to treat repetitive behaviors with Resident #4's RP until 09/18/17 after Resident #4	F 166	information for resolution of concern to include a date and 2) Any needed audits or observations to support monitoring should be documented. 3)All verbal resident/family member concerns should be written on a concern form. This in-service was completed 10/26/17. All newly hired administrative staff will receive the Follow Up to Resident Concerns in-service during new employee orientation , annually and as needed. How the facility will monitor systems put in place: The Administrator and/or director of nursing (DON) will review resident concerns weekly for three months to ensure concern have been addressed and the resolution reviewed with the resident/RP in a timely manner to include a written response on the concern form to include details of the follow up that occurred with a date. The SW or acting SW will present all findings at the monthly QI committee meeting for three months. The QI committee will review the monthly for three 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 committee for further recommendations and oversight.	

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had fallen in the facility. The RP stated on 09/18/17 she discontinued the medication to treat repetitive behaviors for Resident #4 related to the RP's concern for adverse reaction.

On 09/28/17 at 8:55 AM an interview was conducted with the Director of Nursing (DON) who stated she was aware that Resident #4's RP wanted the medication to treat repetitive behaviors for Resident #4 discontinued because of adverse reaction concerns. The DON stated the physician had explained to her the rationale for continuing the medication to treat repetitive behaviors for Resident #4. The DON stated the physician had not specifically informed the DON that he wanted her to communicate his rationale to continue the medication with Resident #4's RP. The DON stated the physician had not written an order for the DON to communicate his rationale for continuing the medication to treat repetitive behaviors with Resident #4's RP. The DON stated she had not informed Resident #4's RP regarding the physician's rationale for not discontinuing the medication for Resident #4.

On 09/28/17 at 9:31 AM a telephone interview was conducted with Resident #4's RP who stated the physician should have discontinued the medication to treat repetitive behaviors for Resident #4's at her request. The RP stated the physician should have called her and explained his rationale for not discontinuing the medication after she had specifically requested that the medication be discontinued. The RP stated she was concerned that the physician or no one in the facility had contacted her to explain why Resident #4 remained on the medication to treat behaviors form 9/11/17 to 9/18/17 after she had requested the medication be discontinued.

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F 166	Continued From page 6 On 09/28/17 at 12:54 PM an interview was conducted with the Administrator who stated the DON was aware that Resident #4's RP wanted the medication to treat repetitive behaviors discontinued for Resident #4 because of adverse reaction concerns. The Administrator stated the DON was present when the physician had explained his rationale for continuing the medication for Resident #4. The Administrator stated it was her expectation that the DON would have followed through and contacted the RP regarding the physician's rationale for continuing the medication to treat repetitive behaviors for Resident #4.	F 166		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to schedule a psychiatric consultation appointment ordered by the Nurse Practitioner (NP) to address behavioral outbursts for 1 of 6 residents reviewed for unnecessary medications (Resident #103). Findings included: Resident #103 was admitted to the facility on 07/26/17 with diagnoses which included depression, dementia with behavioral disturbance, and diabetes mellitus.	F 250	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement	10/26/17

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F 250	Continued From page 7 Review of the admission Minimum Dates Set (MDS) dated 08/02/17 revealed Resident #103 was cognitively impaired and had a history of rejection of care. The MDS indicated Resident #103 had demonstrated physical and verbal behavioral symptoms directed toward others and received 7 days of antidepressant medications during the assessment. Review of care plan dated 08/03/17 indicated Resident #103 was at risk for adverse effects from antidepressant medications. Review of the nurse notes dated 08/01/17 revealed Resident #103 was resistive toward caregivers when they tried to provide care for him. Nurse notes dated 08/02/17 indicated the NP had ordered a psychiatric consultation for Resident #103. The nurse's note specified Nurse #3, who received the order, stated that she would forward the order to the Social Worker (SW) #1. Review of the physician orders dated 08/02/17 indicated that the NP had ordered a psychiatric consultation for Resident #103 due to his recent behavioral outbursts. Record reviews did not indicate that Resident #103 had received the psychiatric consultation ordered by the NP on 08/02/17. Further record reviews revealed Resident #103 had behavior outbursts on 08/03/17 and on 08/22/17. However, Resident's records did not reflect ongoing behavior issues after 08/22/17. During observations on 09/26/17 at 6:39 PM, Resident #103 was having dinner with other residents and he did not exhibit behaviors, including rejection of care.	F 250	with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through .Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to the provision of medically related social services to ensure all resident psychiatric consultations ordered are carried out timely. What measures did the facility put in place for the resident affected: On 8/2/17 the nurse practitioner wrote an order for resident consultation to psychiatric services related to behavioral outbursts. Resident #103 was referred to psychiatric services on 10-3-2017 by Administrator. On 10-03-2017 resident #103 was seen by psychiatric services related to behavioral outbursts. What measures were put in place for residents having the potential to be affected: On 10-20-2017 a 100% resident chart audit was completed by 10-26-2017 to	

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F 250	Continued From page 8 During an interview on 09/27/17 at 3:47 PM, Nurse Aide (NA) #1 stated Resident #103 had sporadic episodes of agitation in the past few months. In an interview conducted on 09/28/17 at 5:05 PM, Nurse #1 stated Resident #103 had been agitated with staff at times. However, Nurse #1 added she had never observed Resident #103 being agitated in person so far. During an interview on 09/28/17 at 6:20 PM, the Director of Nursing (DON) indicated that the facility had failed to arrange the psychiatric consultation appointment ordered by the NP on 08/02/17 for Resident #103. The DON expected all nursing staff to follow physician's orders and implement it in a timely manner. The DON stated that when a nurse received psychiatric consultation order from the physician, the nurse would copy the order and forward the hard copy to the SW in person to ensure this medically-related social services would be conducted. The SW would make the appointment and then inform the nurse the confirmed time and date of the psychiatric consultant's visit. According to the DON, Nurse #3 had failed to notify SW #1 to arrange for this psychiatric consultation appointment which resulted in the order not being carried out. The DON stated both Nurse #3 and SW #1 who were involved in this incident were no longer working at the facility. During an interview on 09/28/17 at 6:59 PM, the Administrator stated her expectations were for all consult orders to be arranged for Resident #103 and that he receive the recommended care ordered by the NP in a timely manner.	F 250	ensure all resident orders for psychiatric consultations had been carried out. What systems were put in place to prevent the deficient practice from reoccurring: On 10-20-2017 an in-service was initiated by SDC for 100% of RN□s and LPN□s to include contract staff related to notifying the social worker of all psychiatric referrals. The in-service will be 100% complete by10-26-2017.All newly hired employees will receive in-service during new employee orientation. How the facility will monitor systems put in place: On 10-20-2017, DON began auditing orders by reviewing copy of physician orders to ensure social work was notified of all referrals to psychiatric services using the referral audit tool. The audit will be completed weekly x 4 weeks, then monthly x 2 months. The Quality Improvement Committee will review the results of the audits monthly x 3 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	

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F 250	Continued From page 9 During a phone interview on 09/28/17 at 7:18 PM, the NP expected all her orders to be carried out by the nursing staff in a timely manner.	F 250		
F 258 SS=D	483.10(i)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS (i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain comfortable sound levels throughout third shift (11:00 PM to 7:00 AM) for 1 of 4 hallways (Hall 100) and 1 of 40 residents, who did not have a hearing impairment (Resident #13). The findings included: On 09/26/17 at 9:53 AM Resident #13 stated "the vacuuming at 6:00 AM is an annoyance, it wakes people up." On 09/26/17 at 5:34 PM Resident #13 stated the vacuuming occurs early in the morning around 6:00 AM and often wakes him up. Resident #13 also stated the noise was so loud he shut his bedroom door at night to cut down on the noise level in the morning. Resident #13 further stated if the people vacuuming were at home they would not be vacuuming at 6:00 AM, and asked why did they do it here at "my home." On 09/27/17 beginning at 6:09 AM, a housekeeper was observed cleaning throughout carpeted areas of the facility in halls 100, 200, 300 and 400 with a floor cleaning machine that	F 258	F 258 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The position of Lake Park Nursing and	10/26/17

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F 258	Continued From page 10 was noted to be very loud. The carpeted areas throughout the facility on halls 100, 200, 300 and 400 were observed being spot cleaned for up to 30 seconds at a time with a floor cleaning machine. The bedroom door for Resident #13, who resided on Hall 100, was noted to be closed while the floor cleaning was occurring. During an interview with the housekeeper on 09/27/17 at 6:57 AM, the housekeeper stated she was also considered a floor technician and came into work at 6 AM to start spot cleaning the floors, vacuuming and then would gather trash before she started her housekeeping duties around 7:00 AM. The housekeeper/floor technician also stated the floor cleaning machine was very noisy. During an interview with the Account Manager on 9/28/17 at 6:03 PM, the Account Manager indicated her job was over laundry, housekeeping and floor care. The Account Manger stated the floor technicians came in at 6:00 AM and gathered trash throughout the facility, vacuumed, spot cleaned carpet, and cleaned the front entrance. The Account Manager further stated that the floor technicians had to come in at 6:00 AM to get started so they could switch over to housekeeping duties between 7:00 AM and 7:30 AM. The Account Manager acknowledged that vacuuming and spot cleaning the carpet at 6:00 AM in the morning may be disturbing some of the residents and going forward they would look at changing the time for this to be done. During an interview with the Administrator on 09/28/17 at 8:32 PM, the Administrator acknowledged that vacuuming at 6:00 AM was not conducive to a homelike environment and plans were already being made to change the	F 258	Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to maintenance of comfortable sound levels. What measures did the facility put in place for the resident affected: On 10-20-2017 resident # 13 was interviewed by Dietary Manager and denied any further complaints of noise interrupting her sleep. What measures were put in place for residents having the potential to be affected: Spot cleaning and vacuuming of facility floors were changed by the housekeeping account manager. Spot cleaning and/or vacuuming will not occur before 9:00am or after 7:00pm. What systems were put in place to prevent the deficient practice from reoccurring: The account manager conducted an in-service with 100% of housekeeping staff on 10-17-2017 related to equipment operation hours. How the facility will monitor systems put in place: On 10-20-2017, Dietary Manager began completing alert and oriented resident interviews relate to level of noises causing sleep disturbances using the noise audit tool. 5 residents will be completed weekly x 4 weeks, then monthly x 2 months by DON.	

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	345502	A. BUILDING _____ B. WING _____	C 09/28/2017

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F 258	Continued From page 11 schedule for the floor technicians.	F 258	The Quality Improvement Committee will review the results of the audits monthly x 3 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to trim the toe nails of one of five sampled residents reviewed for activities of daily living. (Resident #103) The findings included: Resident #103 was admitted to the facility 07/26/17 with diagnoses which included dementia with behavioral disturbance, diabetes, muscle weakness and lack of coordination. The admission Minimum Data Set assessment dated 08/02/17 noted Resident #103 with severe cognitive impairment and totally dependent on staff for personal hygiene. The care plan dated 08/03/17 for Resident #103 included the following problem areas; -"Requires assistance/potential to restore or maintain maximum function of self-sufficiency for	F 312	Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute	10/26/17

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F 312	Continued From page 12 personal hygiene characterized by the following functions; shaving, makeup application, mouth care, daily maintaining of appearance related to: cognitive impairment, poor judgement." The goal for this problem area read, "Will be neat, clean and odor free." Approaches to this problem area included, "Provide total care to comb hair, shave, wash/dry face/hands and perineum." Review of the shower schedule noted Resident #103 was scheduled to have showers on second shift (3:00 PM-11:00 PM) on Wednesday and Friday. On 09/26/17 at 10:28 AM Resident #103 was observed lying in bed, on his back. Resident #103's feet extended out from the end of a sheet which was covering his upper body. All of the toe nails were observed and noted to be long; extending approximately 1/4" beyond the end of each toe. The left great toe nail and right second toe nail were also jagged. On 09/28/17 at 10:30 AM an observation was made of Resident #103's toe nails with the wound nurse. The toe nails were noted to be long; extending approximately 1/4" beyond the end of each toe. The left great toe nail and right second toe nail were not only long but jagged. The right fifth toe nail rested against the right fourth toe. The wound nurse separated the right fourth toe and fifth toe and noted the skin was intact. The wound nurse noted the nails were in need of attention but was not sure who was responsible for trimming toe nails, especially of residents who were diabetic. On 09/28/17 at 10:40 AM Nurse Aide (NA) # 1 stated when nursing assistants identified any	F 312	Resolution, formal appeal procedure and/or any other administrative or legal proceeding The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to activities of daily living (ADL) care to include the care of toenails What measures did the facility put in place for the resident affected: On 9-28-2017 resident # 103□s toenails were trimmed by DON. What measures were put in place for residents having the potential to be affected: On 10-20-2016 100% of residents toenails were audited to ensure they had received toenail care by 10-26-2017. Any areas of concern were immediately addressed either by a licensed nurse trimming toenails or a podiatry referral. What systems were put in place to prevent the deficient practice from reoccurring: On 10-20-2017 an in-service was initiated by the staff facilitator for 100% of nursing staff related to a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to include toenail care. The	

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F 312	Continued From page 13 issues with toe nails they recorded the concern on the shower sheet. NA # 1 obtained the shower sheet from the shower given on 09/27/17. Guidance on the shower sheet indicated "All abnormal skin conditions are to be reported to the charge nurse immediately. Document any identified issues." Also included on the shower sheet was "Nails cleaned/clipped" with a "yes" or "no refused" response as well as "Need for podiatry" with a "yes" or "no" response. The only box checked on the shower sheet for Resident #103 from 09/27/17 was a check next to "shower". NA #1 identified NA #2 as the nurse aide who gave the shower to Resident #103 on 09/27/17. NA #1 stated she was aware Resident #103 had long, jagged toe nails and had reported the concern in the past to Medication Tech #1. NA #1 stated Medication Tech #1 routinely worked on the unit where Resident #103 resided but was currently out on leave. On 09/28/17 at 10:55 AM the Director of Nursing (DON) stated nurses could trim the nails of residents who were diabetic but, if they were not comfortable providing nail care, the resident could be referred to a podiatrist. The DON indicated the Social Worker maintained the list of residents referred to the podiatrist. On 09/28/17 at 11:00 AM the Social Worker stated the podiatrist came to the facility every three months and the last visit was 08/30/17. The Social Worker provided the names of residents referred for the next visit by the podiatrist and Resident #103 was not included on the list. On 09/28/17 at 11:10 AM the Administrator stated nurses could file the toe nails of a diabetic resident but her expectation would be for the	F 312	in-service will be 100% complete by 10-26-2017. All newly hired employees will receive the in-service during new employee orientation. How the facility will monitor systems put in place: On 10-20-2017 resident toenails began being audited by the Treatment Nurse/DON to ensure all residents are receiving toenail care as needed. The ADL audit tool will be completed for 5 residents daily 5 x per week x 4 weeks, then 5 residents weekly x 4 weeks, then 5 residents monthly x 1months. The Quality Improvement Committee will review the results of the audits monthly x 3 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	

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F 312	Continued From page 14 resident to be referred to a podiatrist. On 09/28/17 at 11:24 AM the DON observed the toe nails of Resident #103 and agreed the nails were long and two were jagged and all were in need of attention. The DON stated she expected nursing assistants and medication techs to inform the nurse of any toe nail concerns for residents that were diabetic. The DON stated the nurse would then either trim the residents' nails or refer them to a podiatrist. The DON stated she would trim the nails of Resident #103. On 09/28/17 at 12:00 PM NA #2 confirmed she gave a shower to Resident #103 during second shift on 09/27/17. NA #2 stated she did not notice any concerns with the toe nails of Resident #103 when giving the shower but indicated she gave the shower quickly because Resident #103 didn't like having showers. NA #2 stated if she noticed an issue with toe nails she would report it to the nurse, especially if the resident was diabetic. On 09/28/17 at 7:51 PM the Administrator and Director of Nursing stated when staff provided daily care they should have recognized that the toe nails of Resident #103 needed to be trimmed and reported it to the nurse.	F 312		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 425		10/26/17

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F 425	Continued From page 15 employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff and the physician/nurse practitioner the facility failed to provide medication for five months as ordered by the physician for 1 of 6 residents with medications reviewed. (Resident #66) The findings included: Resident #66 was admitted 10/23/15 with diagnoses which included cerebral infarction, diabetes, depression, hemiplegia and hemiparesis, muscle weakness and pain. The current quarterly Minimum Data Set for Resident #66 dated 07/11/17 assessed him with severe cognitive impairment and totally dependent for personal hygiene. The current care plan dated 07/27/17 for Resident #66 included the following problem areas: -Requires assistance for personal hygiene for the following functions; shaving, mouth care, daily maintaining of appearance related to impaired mobility. The goal for this problem area read, "Will be neat, clean and odor free through next review." Approaches to this problem area included, "Provide total care to comb hair, shave, wash/dry face/hands and perineum." Review of physician orders for Resident #66	F 425	F 425 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to pharmaceutical services to ensure	

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F 425	Continued From page 16 noted the following: 01/17/17-Fluocinonide (a topical corticosteroid used to relieve pain, itching and swelling of skin) apply to scalp twice a day as needed for itching 09/09/17-Clarify Fluocinonide apply to scalp twice a day as needed for itching Review of the Medication Administration Records (MARs) for Resident #66 noted the Fluocinonide was not included on the MAR for the months of May 2017, June 2017, July 2017 and August 2017. The September 2017 MAR had the order for the Flucinonide handwritten and included on the MAR 09/09/17; the day of the clarification order. On 09/26/17 at 5:30 PM the Responsible Party (RP) of Resident #66 reported she had been asking for the Fluocinonide to apply to the scalp of Resident #66 since April 2017. The RP stated the Fluocinonide had been ordered in January by a dermatologist in conjunction with Ketoconazole (a prescription shampoo used to treat seborrheic dermatitis). The RP stated when requested, staff would say they ordered it and the Fluocinonide was still not available for use. The RP stated when available, she would apply the Fluocinonide to the scalp of Resident #66 due to ongoing issues with his scalp itching. The RP stated Resident #66 went back to the dermatologist recently and the RP discussed the Fluocinonide with the practitioner and was told there had been one refill available on the Fluocinonide which had yet to be refilled. On 09/27/17 at 10:40 AM the Nurse Practitioner indicated Fluocinonide would have been ordered for scalp itching for Resident #66 and stated it should be available for use regardless if ordered	F 425	medications ordered were received and available for resident to include PRN medications. . What measures did the facility put in place for the resident affected: On 09-28-2017 Flucocinonide was ordered from pharmacy for resident # 66 by DON. The medication was delivered to the facility on 09-28-2017 from Neil Medical Pharmacy and is available on the medication cart for resident #66. What measures were put in place for residents having the potential to be affected: On 10-20-2017 a 100% resident medication administration record (MAR) to medication cart audit was completed by10-26-2017 to ensure that 100% of medications ordered are available to include PRN medications. What systems were put in place to prevent the deficient practice from reoccurring: On 10-20-2017 and in-service was initiated by SDC for 100% of RN□s and LPN□s to include contract staff related to the ordering of medications and proper procedure if medication is not delivered by pharmacy to include the use of back up pharmacy. In-service will be 100% complete by 10-26-2017. All newly hired staff will receive in-service during new employee orientation.	

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F 425	Continued From page 17 routine or as needed. The Nurse Practitioner stated she assessed Resident #66 several times every week and noticed he often rubbed his head (back and forth) on the pillow when in bed. The Nurse Practitioner stated because of this, she had assessed the back of Resident #66's head and, other than occasional dry scalp, no issues were observed. During an interview on 09/27/17 at 4:22 PM the September 2017 Medication Administration Record (MAR) was observed with Nurse #2. Handwritten on the MAR for Resident #66 was the "Fluocinonide solution .05%. Apply to scalp twice a day as needed for itching." Nurse #2 produced the bottle of Fluocinonide solution which was stored in the medication cart and the bottle was empty. The label on the bottle indicated it had been dispensed from the pharmacy 01/17/17. Nurse #2 noted a reorder sticker had been removed from the bottle and stated that meant the medication had been reordered. Nurse #2 stated she had not pulled the reorder sticker from the bottle and wasn't aware of the status of the Flucinonide solution. On 09/27/17 at 4:30 PM the manager of the pharmacy that serviced the facility reported they had not received a reorder sticker for the Fluocinonide solution for Resident #66 and indicated the only time it had been dispensed was 01/17/17. On 09/27/17 at 5:17 PM Nurse #3 stated she was aware there were times the RP of Resident #66 had requested the Fluocinonide solution but wasn't aware of any issues with the availability of the medication.	F 425	How the facility will monitor systems put in place: On 10-20-2017, DON began completing MAR to medication cart audits for 10 residents to ensure medications are available as ordered using the medication audit tool. The audit will be completed weekly x 4 weeks then monthly 2 months. The Quality Improvement Committee will review the results of the audits monthly x 3 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	

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F 425	Continued From page 18	F 425		

On 09/27/17 at 6:15 PM Nurse #4 stated she was aware the RP of Resident #66 had been requesting the Fluocinonide solution the last couple months and was aware the bottle of Fluocinonide on the medication cart was empty. Nurse #4 stated she had requested the Fluocinonide several times from the pharmacy both via the reorder sticker (from the 01/17/17 bottle) as well as a reorder form. Nurse #4 stated when those attempts to reorder the Fluocinonide were unsuccessful she left a note for the physician/nurse practitioner which led to the clarification order on 09/09/17. Nurse #4 stated she called the pharmacy and they indicated the Fluocinonide was supposed to come.

On 09/28/17 at 1:45 PM the physician of Resident #66 stated he had noticed dry areas on the scalp of Resident #66 at times. The physician stated even though it was ordered "as needed" the Fluocinonide should have been available for use for Resident #66.

On 09/28/17 at 4:14 PM the Administrator and Director of Nursing (DON) stated they had not been aware the Fluocinonide had not been available for use for Resident #66. The DON stated she could not understand why the medication was not available for use if it had been reordered.

On 09/28/17 at 5:30 PM the RP of Resident #66 and Resident #66 were interviewed. The RP of Resident #66 stated the Fluocinonide, when used in conjunction with the Ketoconazole, was effective to treat the scalp of Resident #66. Resident #66 nodded his head up and down in response to what the RP reported. In addition, Resident #66 nodded his head up and down

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F 425	Continued From page 19 when asked if the Fluocinonide helped his scalp. On 09/28/17 at 6:00 PM in a follow-up interview the Administrator stated she expected all medications to be available for use with residents, including those ordered "as needed."	F 425		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the	F 520		10/26/17

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F 520	Continued From page 20 Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. The failure related to one recited deficiency which was originally cited during the March 2017 recertification and complaint survey and subsequently recited in May 2017 on the follow up and complaint survey and was recited during the facility's current recertification survey. The recited deficiency was in the area of activities of daily living care for dependent residents. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee during 2 consecutive federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F312: Based on record review, observations and interviews the facility failed to trim the toe nails of one of five sampled residents reviewed for	F 520	F 520 QAA Committee Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 21 activities of daily living. (Resident #103) During the recertification and complaint survey of 03/10/17, F312 was cited for failing to provide assistance with shaving, nail care, and dressing for 1 of 10 sampled residents (Resident #74). During the complaint survey of 03/30/17, F312 was cited for failure to provide incontinent care, showers, bed baths, and oral care as needed for 1 of 6 residents (Resident #9) reviewed for activities of daily living. During the follow-up survey of 05/03/17, F312 was cited for failure to check a resident for incontinence care on the day shift for 1 of 4 residents (Resident #72). On 09/28/17 at 9:10 PM the Administrator stated activities of daily living had continued to be part of the monitoring conducted by the facility Quality Assessment and Assurance Committee but the focus had been on the provision of showers and incontinence care, not necessarily all aspects of activities of daily living, including nail care.	F 520	The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was staff failed to follow established facility policy and protocol related to activities of daily living (ADL) care to include the care of toenails and the facility QI process. On 10-17-2017 the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 10-19-2017 the facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 312 (activities of daily living). As of 10-19-2017 , after the facility consultant in-service, the facility QI Committee will begin identifying other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 09/28/2017

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F 520	Continued From page 22	F 520	areas of quality concern through the QI review process, for example: review rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F312 activities of daily living. The Committee will continue to meet at a minimum of monthly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next	

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F 520	Continued From page 23	F 520	scheduled meeting.	