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 09/13/2018

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# 2JUH11.	F 000		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide splint application for 1 of 1 resident (Resident #70) reviewed for position/mobility. The findings included: Resident #70 was admitted to the facility on 03/29/18 and diagnoses included abnormal posture and compression fracture of thoracic (chest) vertebra (bone).	F 688	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	10/11/18

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

Electronically Signed | 10/02/2018

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F 688	Continued From page 1 The quarterly Minimum Data Set (MDS) dated 06/28/18 indicated Resident #70 had severe cognitive impairment and required extensive assistance with mobility, transfers, dressing, toileting, and personal hygiene. A review of the medical record indicated Resident #70 had a diagnosis of left hand contracture dated 07/24/18. A review of the current care plan revealed an identified problem that Resident #70 required assistance/potential to restore or maintain function of self-sufficiency for mobility characterized by the following functions; positioning related to: at risk for worsening of present contracture and at risk for development of further contracture. The goal was that contracture of left hand would not worsen. Interventions to address problem were as follows: staff were to refer Resident #70 to therapist for evaluation/recommendations and administer treatments as ordered. A review of a Rehabilitation Communication to Nursing form indicated therapy was discontinued on 08/07/18 and restorative nursing services were to begin on 08/08/18 for Resident #70. Occupational therapy recommended restorative nursing for a splinting program and Resident #70 was to receive left palm guard splint for 4-6 hours 6 times a week for 12 weeks for contracture management to prevent further contractures for quality of life purposes. The form indicated per restorative aide (RA) signature on 07/31/18 that the RA was trained on palm guard splint application for Resident #70. A review of the Restorative Nursing	F 688	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 the facility had failed to provide splint application recommended for position/ mobility on one resident. F688 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #70 was screened by Licensed Occupational Therapy Assistant(LOTA) on 9/12/2018 with no further contractures noted on the Left Hand. Contracture assessment was completed on 9/20/2018 by Occupational Therapist (OT) and no further contracture was noted as well. Evaluation and treatment was complete on 9/20/2018 by OT for Occupational therapy. Treatment began on 9/20/2018 by OT for contracture management and re-establishing restorative program. Recommendation to initiate restorative for Range of Motion (ROM) and splinting	

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F 688	Continued From page 2 documentation from 08/08/18 to 09/11/18 for splint application revealed an absence of documentation by the RA to indicate the left palm guard splint had been applied to Resident #70 as per restorative nursing requirements. Resident #70 was observed without a left palm guard splint to left hand contracture on the following dates and times: · 09/10/18 at 10:24 AM · 09/10/18 at 12:35 PM · 09/11/18 at 1:34 PM On 09/11/18 at 5:15 PM Resident #70 was observed sitting in a wheelchair in her room. Left hand noted to have left middle, ring, and little finger contracted towards palm of left hand. On 09/11/18 at 3:10 PM a telephone interview was conducted with the Interim Rehabilitation Director (IRD) who stated Resident #70 was discharged from therapy services on 08/07/18 and was placed on a restorative nursing program for splinting of a contracture to the left hand. The IRD stated therapy staff trained the RA to apply a left palm guard splint for 4-6 hours a day for 6 days a week times 12 weeks for contracture management and prevention of further contractures for quality of life purposes for Resident #70. The IRD stated Resident #70 should have been wearing the palm guard splint from 08/08/18 to 11/08/18 for 4-6 hours a day. The IRD stated it was her expectation that the restorative nursing program would have been followed for Resident #70 as recommended to prevent further decline in Resident #70's left hand contracture management. The IRD stated it was her expectation that the RA would have informed the therapist if Resident #70 did not want to have	F 688	program will be begin once therapy is completed. Re-training & re-education of Restorative Aide (RA) was completed on 9/14/2018 by Director of Nursing (DON). Care Plan updated accordingly by MDS Nurse on 9/11/2018 and 9/20/2018. Re-training and re-education of DON by Administrator on restorative program was completed on 9/13/2018 and 9/27/2018. 2. Address how the corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice. A 100% audit of all resident with current contracture management splints was completed on 9/17/2018 by DON. A 100 % contracture assessment of all resident will be completed by October 1, 2018 by Therapy department. Therapy will evaluate and treat as needed. This will be completed prior October 11, 2018. Any therapy recommendation for Restorative Program will be initiated by Therapy. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur Restorative Program will be coordinated and monitored by the Quality Improvement (QI) Nurse as of October 1, 2018. The RA will document Restorative treatments as ordered. Quality	

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F 688	Continued From page 3 the left palm guard splint applied or if the palm guard splint caused pain so that a further evaluation could have been conducted. The IRD stated it was her expectation that Resident #70 would be evaluated by therapy to determine any decline in contracture management since the left palm guard splint had not been applied 4-6 hours a day for 6 days a week as recommended by therapy. On 09/11/18 at 3:20 PM an interview was conducted with the RA who stated she had been trained by therapy to place the left palm guard splint on Resident #70 for left hand contracture. The RA stated Resident #70 did not want to wear the left palm guard splint and she did not inform the therapist or the Director of Nursing (DON) who was over the restorative nursing program. The RA stated she did not realize that she needed to communicate to the DON or therapist that Resident #70 did not want to wear the palm guard splint. The RA stated it was her responsibility to apply the left the left palm guard splint during her day shift work schedule. The RA stated she had time to apply the left palm guard splint during her day shift work schedule but Resident #70 did not want it applied related to pain. The RA stated she had not documented in the restorative nursing notes form 08/08/18 to 09/11/18 under splint application any attempts to apply the left palm guard splint on Resident #70. On 09/11/18 at 3:43 PM an interview was conducted with the DON who stated she was responsible for the restorative nursing program and was unaware that the RA had not been placing the left palm guard splint on Resident #70 during her day shift working schedule as per therapy recommendations since 8/8/18 to current.	F 688	Improvement (QI) Nurse will evaluate effectiveness or lack of effectiveness of the program at least weekly or as needed. Restorative program meeting will be conducted at least weekly by QI Nurse and RA. Any refusals or change in condition will be reported to the Interdisciplinary Team (IDT) by QI Nurse for any further intervention & referral as needed. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. All residents with Restorative contracture Management Program will be documented, monitored and a monthly report will be submitted to QAPI Committee by QI Nurse for compliance x 3 months. Contracture or any change in mobility will be reported as needed to IDT team for immediate and appropriate intervention thereafter.	

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F 688	Continued From page 4	F 688		

The DON stated it was her expectation that the RA would have notified her or the therapist that Resident #70 was refusing to wear the palm guard splint so that appropriate interventions could have been initiated. The DON stated it was her expectation that the RA would have documented the refusal or the application of the left palm guard splint. The DON stated her expectation was that therapy would evaluate Resident #70's left hand contracture to determine if any decline in function had occurred because of not wearing the palm guard splint as recommended by therapy.

On 09/11/18 at 3:48 PM an interview was conducted with the Occupational Therapist Assistant (OTA) who stated on 07/18/18 she provided training to the RA regarding the application of a left palm guard splint for Resident #70 for left hand contracture. The OTA stated the RA performed an actual return demonstration of the application of the left palm guard splint on Resident #70. The OTA stated Resident #70 did not present any resistance to wearing the left palm guard splint. The OTA stated it was the responsibility of the RA to apply the left palm guard splint to Resident #70 ' s left hand contracture during her day shift work schedule. The OTA stated she instructed the RA to notify her if Resident #70 experienced any problems or concerns with wearing the left palm guard splint. The OTA stated the RA never informed her since 08/08/18 that Resident #70 had refused to wear the left palm guard splint or experienced any pain with the splint. The OTA stated her expectation was that the RA would have notified her that Resident #70 was resistant to wearing the left palm guard splint so that she could have performed an observation of the RA applying the

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F 688	Continued From page 5 left hand guard splint to determine any issues with the application process or implement other interventions. The OTA stated Resident #70 would require an evaluation to determine if any further decline occurred because of not wearing the left palm guard splint since 08/08/18 as recommended by therapy. On 09/11/18 at 05:15 PM an interview was conducted with the Administrator who stated it was her expectation that the RA would have applied Resident #70's left palm guard splint for left hand contracture as recommended by therapy. The Administrator stated it was her expectation that the RA would have notified the DON and therapy if Resident #70 refused to wear the palm guard splint or if the splint did not fit. The administrator stated her expectation was that the RA would have documented per facility policy in the restorative aide notes that Resident #70 refused to wear the palm guard splint. The administrator stated her expectation was that Resident #70 would be evaluated by therapy to determine any decline in contracture management. A review of a Rehabilitation Screening form dated 09/12/18 indicated Resident #70 had not had a decline in her left hand contracture since discontinued from skilled occupational therapy services on 08/07/18.	F 688		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		10/11/18

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F 761	Continued From page 6 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard 1of 1 multi-dose tuberculin derivative vial that was opened and expired for 85 days and was available for use in 1 of 2 medication refrigerators. Findings included: A review of the manufacturer's recommendation for multi-dose tuberculin derivative indicated that once opened the product was to be discarded after 30 days. A review of the facility policy entitled Medication Expiration Dates (revised 11/01/17) indicated	F 761	F761 The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility failed to discard an expired multi-dose tuberculin derivative stored in the medication refrigerator. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice The expired multi-dose vial tuberculin purified protein derivative (PPD) in the medication refrigerator at the Memory	

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F 761	Continued From page 7 tuberculin derivative could be kept for up to 30 days after opening per manufacturer. On 09/11/18 at 8:26 AM 1 of 1 multi-dose vial of tuberculin purified protein derivative was observed opened and dated 05/18/18 in the memory care unit medication storage refrigerator. Nurse #1 verified the tuberculin vial was dated 5/18/18 when opened and remained in the medication refrigerator ready for resident use after being expired for over 2 months. Nurse #1 immediately removed the tuberculin vial dated 5/18/18 from the medication refrigerator. On 09/11/18 at 8:37 AM an interview was conducted with the Nursing Supervisor who verified the tuberculin purified protein derivative was dated 5/18/18 when opened and should have been discarded in 30 days. The Nursing Supervisor stated it was the responsibility of all nursing staff to check the medication refrigerator for expired medication and remove from resident use. On 09/11/18 at 8:44 AM an interview was conducted with the Director of Nursing (DON) who verified the tuberculin multi-dose vial was dated 5/18/18 when opened and was in the memory care unit medication refrigerator ready for resident use. The DON stated the tuberculin vial was good for 30 days once opened and was expired and should have been discarded on 06/18/18. On 09/11/18 at 8:52 AM an interview was conducted with the Administrator who stated her expectation was that the expired tuberculin vial dated 05/18/18 would have been discarded 30 days after opening and returned to pharmacy.	F 761	Care Unit Medication Storage Room was immediately removed and returned to the pharmacy on 9/11/2018. A 100% audit of all medication refrigerators in all Medication Storage rooms was conducted by DON on 9/11/2018 and 9/13/2018 and no other negative findings were noted. 2. Address how the corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice. A 100 % audit of all medication storage rooms to include all medication and treatment carts, medication refrigerators and medication back –up kits were conducted by the Director of Nursing (DON) on 9/13/2018. A 100 % in-service of all licensed nursing staff was completed on 09/28/2018 by Staff Facilitator related to Labeling and Storage of Drugs. The Staff Facilitator will provide in-service for all new employees and agency license staff upon orientation, yearly and as needed thereafter. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur An auditing tool to check expired medications on all medication refrigerators to include all medication storage rooms and carts was initiated on 9/13/2018 by DON. This tool will be completed daily by the nurse-in- charge of unit and submitted to the DON for review	

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F 761	Continued From page 8	F 761	weekly. Any negative findings will be reported to the DON and expired meds will be returned to pharmacy per policy. Pharmacy consultant will conduct checks quarterly and report compliance or any negative findings for immediate correction. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. DON will perform weekly checks using the audit tool x 1 month, then bi-monthly x 1 month, then monthly x 1 month and randomly thereafter. The Nurse- in-charge will check compliance daily for each shift and submit audit tool weekly to the DON. The DON will report compliance and submit written report of compliance to QAPI committee monthly x 3 months and will report compliance at least 5x/ week to Administrator during Stand-up meeting thereafter.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		10/11/18

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F 812	Continued From page 9 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to have a clean ice machine, attached cabinets doors (2 lower cabinets), secured cover to ice machine and clean cabinet shelves (2 lower cabinets) in 1 of 3 nourishment rooms (600 hall nourishment room). Findings included: Observation on 09/11/2018 at 09:37 AM of the 600 hall nourishment room revealed the following: a. The ledge above the ice bin inside the ice maker had black dust and a dead insect on it b. Cover for the ice machine compression not secured c. Two lower cabinet doors of sink cabinet not properly secured for opening and closing d. Large brown stain on shelf in left lower shelf of cabinet and white substance on the right lower cabinet shelf Interview on 09/11/2018 at 09:48 AM with the Dietary Manager (DM) revealed housekeeping was responsible for cleaning the ice maker. Interview on 09/11/2018 at 09:55 AM with the Maintenance Director (MD) revealed no one had	F 812	F812 The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility had failed to clean ice machine and failed to clean shelves in one out of three nourishment room. 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice The Memory Care Nourishment was immediately put out of order on 9/11/2018. The nourishment room was put under detailed cleaning and repair by Housekeeping and Maintenance to include the cleaning of ice bin and the counter shelves. This was completed on 9/12/2018. 2. Address how the corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice.	

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F 812	Continued From page 10 told him about the doors on the lower sink cabinets that were not secured in good operating condition. He stated he didn't know how the large brown stain got on the left lower cabinet shelf. He stated it could be a spill. Interview on 09/11/2018 at 09:57 AM with the Housekeeping District Manager (HDM) revealed housekeeping was responsible for the ice machine and stated there was "a little dust" on the inner ledge after he ran his finger along the edge. Interview on 09/11/at 10:01 AM with the MD revealed he was responsible for cleaning the inside of the ice machine bin and ice shoot. Interview on 09/11/2018 at 10:03 AM Housekeeper #1 stated she cleaned the sink and emptied the trash in the 600 hall nourishment room. She stated she didn't know where the large brown stain came from in the left lower cabinet and would have cleaned it up if someone had told her about it. Interview on 09/11/2018 at 10:15 AM with the Administrator which included observations in the 600 all nourishment room revealed housekeeping was responsible for cleaning the outside of the ice machine including the outside ledge above the ice bin when the ice machine lid was up. She confirmed there was debris and a large dead fly on the ledge. She stated housekeeping was responsible for cleaning the cabinets in the nourishment rooms and maintenance was responsible for maintenance of the cabinet doors including having them properly secured and in good working order.	F 812	A 100% audit of all nourishment rooms in the facility was completed on 9/12/2018. A 100 % of all cabinet doors was completed on 9/27/2018 to ensure that it is properly secured for opening and closing. A 100% in-service of Dietary, Maintenance and Housekeeping staff was completed on 9/17/2018 by Certified Dietary Manager (CDM), Housekeeping Supervisor and the Administrator. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur An audit and monitoring log will be completed by Housekeeping department and Maintenance Supervisor to ensure cleanliness & good repair of ice bins and cabinet/ shelves in all Nourishment Rooms. The Housekeeping Supervisor and Maintenance Supervisor will perform & log at least 5x/week QA Rounds to each Nourishment room x 1 month , then 3x/ week x 1 month, then weekly x 1 month and will report to Administrator during Stand-Up meeting compliance or any concerns noted for immediate actions or corrections. The completed audit will be submitted to the Quality Improvement (QI) Nurse for compliance check. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance	

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 09/13/2018

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

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F 812	Continued From page 11 Interview on 09/12/2018 at 3:57 PM with the Administrator revealed it was a team effort to clean the ice machine and nourishment rooms. The combined effort included maintenance, housekeeping dietary services and nursing to maintain the nourishments. The Administrator further stated it was her expectation that the cabinets were in good repair and the ice machine and cabinets were clean.	F 812	system of the facility. The QI Nurse will report compliance to Quality Assurance Process Improvement (QAPI) Committee monthly x 3 months. The Housekeeping Supervisor and Maintenance Supervisor will continue to report compliance or concerns as needed to Administrator during Stand-up Meeting thereafter.	