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	345502	A. BUILDING _____ B. WING _____	C 02/21/2022

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 000	INITIAL COMMENTS A unannounced complaint investigation survey was conducted 2/14/22 through 2/17/22. Additional information was obtained through 2/21/22 A total of 21 allegations were investigated and 7 allegations were substantiated. Event ID# 54Y511.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2022

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F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a safe and sanitary environment in 2 of 3 shower rooms as evidenced by used, wet and dirty towels in the floor, dried feces on two shower chairs, and residents' personal belongings remaining in the shower room (100 hall shower room, 700 hall shower room). Findings included: a. An observation conducted on 2/14/22 at 12:08 PM revealed the shower room on the 100-hall had dried feces on a shower chair seat, used towels placed on the floor and tub, yellow stains and hair in the shower bath, an open men's razor and shaving cream placed on the towel bin lid, women's lotion and deodorant placed on the side of the shower tub, and a used luffa in a shower. An observation and interview conducted with the Director of Nursing (DON) on 12/14/22 at 12:15 PM of the shower room on the 100-hall revealed residents' belongings should not be left behind, the shower tub and chairs should be cleaned and sanitized after use and used towels should be	F 584	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 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 s 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 proceedings On 2/14/22 during a complaint survey at Lake Park Nursing, it was observed by the	

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F 584	Continued From page 2 placed in the towel bin. The DON stated the condition of the shower room was not acceptable. The DON further revealed the nursing staff who used the shower room were responsible for cleaning and sanitizing after each use. b. An observation and interview conducted with the DON on 2/14/22 at 11:05 AM revealed the shower room on the 700-hall had dried feces on a shower chair and a used band aid in the shower floor. The DON further revealed it is expected for staff to clean ad sanitize the shower room after each time used, and the condition of the 700-hall shower room was not acceptable. An interview conducted with Nurse Aide (NA) #1 on 2/15/22 at 9:45 AM revealed shower rooms were commonly nasty. NA #1 further revealed she usually had to clean the shower room before she used it because nursing staff would leave personal items, dirty towels, and wash cloths with feces in the floor. NA #1 stated it was expected for NAs to clean the shower room once a resident's shower was given. An interview conducted with Nurse #1 on 2/15/21 at 4:13 PM revealed the 100 and 700 shower rooms were consistently a mess. Nurse #1 further revealed on several occasions she had walked into the shower rooms and observed feces and urine on toilet and shower chairs, residents' personal items not being returned, and towels laying in the floor. Nurse #1 stated it was expected for staff to clean and sanitize thoroughly after each use. An interview conducted with Administrator on 2/15/22 at 6:04 PM revealed she was not aware 100-hall and 700-hall shower had not been	F 584	survey team, 2 of 3 shower rooms were in need of cleaning. On 2/14/22, the Director of Nursing (DON) immediately notified the Environmental Services Director (EVS Director) of findings of 100 & 700 hall shower rooms failed to ensure a safe, sanitary environment. The EVS Director removed the dirty towels from 100 hall shower floor and placed them in the dirty linen basket located in 100 hall shower room and discarded the band-aid from 700 hall shower room. All belongings in 100 hall shower room were discarded immediately by the EVS Supervisor including the women□s lotion, used luffa, shaving cream, deodorant, and used razor was placed in sharps container. The 100 and 700 hall shower chairs and bathtubs were immediately cleaned and disinfected with TB-Cide-Quad cleaning solution by the EVS Supervisor including sanitizing both floors of 100 and 700 hall shower rooms with Xcelent Multipurpose Cleaner by the Floor Tech. Root Cause: Nursing staff had not cleaned 2 of 3 shower rooms after resident showers. The Environmental Services staff had not yet completed the shower room daily cleaning. All residents have the potential to be affected by this alleged deficient practice. On 2/14/22 all shower rooms, shower chairs, bathtubs, were cleaned, sanitized, and disinfected by the EVS Director with	

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F 584	Continued From page 3 cleaned prior to observation. The Administrator further revealed she expected shower chairs to be cleaned and sanitized after use and used towels to not be left out. The Administrator stated it was expected for staff to clean shower rooms once the resident was taken back to their room.	F 584	TB-Cide-Quad and Xcelent Multipurpose Cleaner. On 2/22/22, the Administrator educated the (Interim) Director of Nursing and EVS Director on the requirements for a safe, clean, comfortable environment, including the observed deficient practices of unsanitary conditions in the shower rooms and shower room equipment. Beginning 2/22/22 the (Interim) Director of Nursing and/or EVS Director educated the nursing and environmental services staff on cleaning, sanitizing, and disinfecting the shower rooms and shower room equipment with the designated cleaning/sanitizing/disinfecting solutions. This education included removing resident personal items after each resident bath/shower. This education was completed on 3/16/22. After 3/18/22, no housekeepers or nursing staff will be allowed to work until education is completed on cleaning, sanitizing, and disinfecting the shower rooms and shower room equipment with the designated cleaning/sanitizing/disinfecting solutions. This education included removing resident personal items after each resident bath/shower. Beginning 3/18/22 the EVS Director or the Administrator will complete monitoring of facility shower rooms to ensure cleaning, sanitizing, and disinfecting the shower rooms and shower room equipment. This monitoring will be for compliance of 3	

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F 584	Continued From page 4	F 584	shower rooms 5xweekly x4 weeks, then 3 shower rooms 3xweekly x4 weeks, then 3 shower rooms weekly x4 Beginning the month of March 2022, the EVS Director or Administrator will report the findings of the environmental shower room audit tool at the monthly Quality Improvement (QI) Committee meeting. The EVS Director or Administrator will report the findings of Environmental Shower Room Audit Tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance of cleanliness & sanitation of shower rooms is maintained. Date of completion 03/21/2022.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide incontinence care prior to a resident (Resident #4) wetting through her brief, through her pad and onto her sheet for 1 of 3 residents reviewed for activities of daily living.	F 677	During a complaint survey at Lake Park Nursing and Rehab Center, the survey team observed a dependent resident brief was wet to include the dependent resident bed linen. On 2/15/22, during survey team	3/21/22

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F 677	Continued From page 5 The findings included: Resident #4 was admitted to the facility on 12/12/17 and readmitted on 08/08/18 with diagnoses which included intracranial hemorrhage, stroke, cognitive communication deficit and dementia. Resident #4's Care Area Assessment summary completed with her annual Minimum Data Set (MDS) assessment dated 08/27/21 revealed she was nonverbal, and staff anticipated her needs due to her inability to communicate with staff. She was dependent with all activities of daily living (ADL) due to her hemiplegia and hemiparesis on her left side secondary to hemorrhagic stroke. Resident #4 was incontinent, and staff provided incontinent care as needed. Resident #4's incontinence increased her risk for urinary tract infection and skin impairment. Resident #4's most recent quarterly Minimum Data Set (MDS) assessment dated 01/21/22 revealed she was severely impaired cognition and required total assistance of 1 to 2 staff with all activities of daily living and was totally dependent on 1 staff member for toileting. Resident #4's care plan dated 01/21/22 revealed a plan of care for her incontinence of bowel and bladder related to physical immobility and hemorrhagic stroke. The interventions included turning and repositioning every 2 hours and as needed, use of incontinent products, peri care after each episode of incontinence, obtain labs as ordered by physician, observe skin for impairment and observe for signs and symptoms of urinary tract infection.	F 677	incontinent care observation, surveyor noted resident #4 was wet through brief to include bed linen. Resident #4 was provided incontinence care and bed linen was changed and clean dry linen was put on resident #4 bed by NA#2 (agency CNA) with assistance of NA#3 (facility certified nursing assistant trainee). On 2/15/22 (Interim) Director of Nursing (DON) was notified by the surveyor of her incontinence care observation. The (Interim) DON immediately went to resident #4 room to ensure Resident #4 was clean & dry and bed linens were clean and dry. Root Cause: Agency CNA stated she did not change resident #4 because her strip (area in the peri-area of an adult brief that changes colors when resident is wet) was not dark indicating to NA#2 that resident was wet. NA#2 stated she thought the strip was not dark enough showing resident needed changing during her rounds. All residents have the potential to be affected by this alleged deficient practice. On 2/15/22 the (interim) DON, Nurse Manager, and scheduled Licensed Charge Nurses began & completed 100% audit of dependent residents requiring assistance with incontinent care to ensure that residents had incontinent care provided by nursing staff and had dry, clean linen.	

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F 677	Continued From page 6 Observation on 02/15/22 at 2:17 PM of Resident #4's incontinence care revealed the resident had wet her brief all the way up the back of the brief to all 4 corners of the plastic border around the brief. There appeared to be some dark substance smeared in the urine on the brief. Resident #4 had wet through her brief onto and through the pad under her and onto the bottom sheet of her bed. The resident required a complete bed change due to her wetting through her brief, pad, and sheet. Nurse Aide (NA) #2 provided her care with the assistance of NA #3. The resident's skin was intact with no signs of redness or breakdown. Interview on 02/15/22 at 2:35 PM with NA #2 who had taken care of Resident #4 on the 7:00 AM to 3:00 PM shift on 02/15/22 revealed she was with an agency but currently contracted at the facility. NA #2 stated she had last changed Resident #4 around 7:45 AM. NA #2 said she had checked the resident prior to lunch, and she was wet but not too wet, according to the strip on the front of her brief, so she decided not to change her at that time. NA #2 stated she had not been able to get back to the resident until around 2:15 PM to change her due to lunch trays and feeding residents and other duties. Interview on 02/15/22 at 6:15 PM with the Interim Director of Nursing (DON) revealed there were staffing challenges at the facility, and they were using a lot of agency staff. She stated they provided education to the agency staff upon hire and contract. The DON further stated it was her expectation that residents who were dependent on staff for incontinence care be checked every 2 hours and changed when wet. She indicated if Resident #4 was wet before lunch she should have been changed at that time and NA #2	F 677	The Staff Development/Infection Control Preventionist Nurse began education on 03/08/2022 of providing incontinent care to dependent residents at least every 3 hours and as needed when brief is soiled/wet no matter how dark the brief strip is, and resident bed linen is clean & dry. In addition, a perineal care educational video called CNA Waiver Training Video on Peri care was provided to Contracted Agency/Facility Nursing Staff. This education was completed on 03/18/2022. On 3/16/22 the Staff Development/Infection Control Preventionist Nurse mailed education to any Contracted Agency/Facility Nursing Staff that had not completed education of providing incontinent care to dependent residents at least every 3 hours and as needed when brief is soiled/wet no matter how dark the brief strip is, and resident bed linen is clean & dry. After 3/18/22, no Contracted Agency/Facility Nursing Staff will be allowed to work until education is completed. After 3/18/22, nursing staff including agency contracted staff will not be allowed to return to work until education and viewing the required video(s) has been completed. Certified letters were mailed to nursing staff including agency contracted nursing staff to complete a mandatory nursing in-service prior to returning to work.	

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F 677	Continued From page 7 should not have waited until she was soaked through her bedding to change the resident. Interview on 02/15/22 at 7:00 PM with the Administrator revealed she expected incontinence care to be done if a resident was wet regardless of the color of the front strip on the brief. She stated nurse aides were expected to check incontinent residents every 2 hours and change them as needed.	F 677	The (interim) Director of Nursing, the Unit Manager(s), and /or the assigned special project nurse will complete the Incontinent Rounding Monitoring to ensure compliance of incontinent care and bed linens are clean and dry. The (interim) Director of Nursing, the Unit Manager(s), and /or the assigned special project nurse will randomly observe 6 Contracted Agency/Facility Nursing Staff performing incontinence care on 1 resident daily at least 5x/week x 4 weeks, then 3x/week on 1 resident daily x 4 weeks, then weekly x4 weeks resident daily. The (interim) Director of Nursing, the Unit Manager(s), and /or the assigned special project department head will also monitor 6 random resident bed linens to ensure resident bed linen is clean and dry on 6 random residents 5x week x4 weeks, then 6 random residents 3xweeek x4 weeks, then 6 random residents weekly x4 weeks. The Director of Nursing or Unit Manager(s) will report the findings of the Incontinent Rounding Audit Tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Date of completion 03/21/2022.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/21/22

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F 880	Continued From page 8 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 9 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement their hand washing policy when 1 of 2 staff members (Nurse Aide (NA) # 2) failed to wash her hands and change her gloves when moving from a dirty body site to a clean body site for 1 of 3 residents (Resident #4) provided a partial bath during incontinence care. The findings included:	F 880	During a complaint survey at Lake Park Nursing and Rehab Center, the survey team observed a Contracted Agency Nursing Assistant (NA) performing a partial bed bath and incontinent care on a dependent incontinent resident (Resident #4). NA #2 failed to wash her hands and change her gloves when moving from a dirty body site to a clean body site. On 2/18/22 Facility Administrator, (interim) Director of Nursing, and Unit Manager	

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F 880	Continued From page 10 Review of a document entitled, "Handwashing Policy" last reviewed and revised on 03/10/20 read in part "Personnel are required to wash their hands after each direct or indirect contact for which handwashing is indicated by acceptable standards of practice. Personnel should wash their hands: · After contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them. · When otherwise indicated to avoid transfer of microorganisms to other residents and environment. · When indicated between tasks and procedures to prevent cross contamination of different body sites An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids." Observation on 02/15/22 at 2:17 PM of Resident #4's incontinence care revealed NA #2 drawing a basin of warm water to provide her care. NA #2 had several washcloths and with gloved hands obtained a washcloth and dipped it into the warm water and proceeded to clean the resident on her perineal area wiping front to back. NA #2 with the same gloves obtained a 2nd washcloth and dipped into the same water basin and cleaned the resident's buttocks of stool. NA #2 with a 3rd washcloth with the same gloves on dipped the washcloth in the same water basin and proceeded to wash the resident's face where she had drooled from the right side of her face. NA #2 cleaned the drool from her face and	F 880	conducted a telephone interview with Nursing Assistant (NA) #2 agency Certified Nursing Assistant which included education on Personal Protective Equipment (PPE) donning and doffing gloves, hand hygiene protocol, and cross contamination during care. During this interview the Contracted Agency NA #2 denied making these mistakes during surveyor observation. Contracted Agency NA #2 did not return to the facility after 2/19/22, nor did she renew her contract with the facility after 2/19/22. On 2/18/22 □ 3/15/22, 5 times weekly Infection Control observations were completed by Facility Administrator, (Interim) Director of Nursing, Unit Supervisors, and assigned special project department heads to ensure staff were performing proper PPE (donning & doffing of gloves), hand hygiene was being performed per CDC guidelines and facility protocol, as well as avoiding cross contamination during resident care. On 2/28/22 Resident #4 was assessed by the Facility Nurse Practitioner for infections or skin irritants. No infections or changes in condition were noted. Root Cause: Nursing Assistant (NA) #2 agency Certified Nursing Assistant made a mistake by not changing her gloves, washing her hands, and not changing the water in the bath basin. NA#2 stated to the surveyor that she was nervous as the surveyor was observing her during the care of this resident #4 which led to the deficient practice. All residents have the potential to be affected by this deficient practice.	

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	345502	A. BUILDING _____ B. WING _____	C 02/21/2022

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 880	Continued From page 11 proceeded to wash her entire face. After cleaning the resident's face with the same gloves on NA #2 proceeded to change the residents' linens putting clean linens on her bed and covering the resident with her blanket and spread. After completion of Resident #4's care and removal of the dirty linens, NA #2 removed her gloves and left the room with the dirty linens in a plastic bag. Interview on 02/15/22 at 2:35 PM was conducted with NA #2 after she had provided incontinence care and a partial bath to Resident #4. When asked about infection control and hand hygiene practices during care, NA #2 confirmed she had not removed her gloves, sanitized her hands and placed clean gloves before moving from a contaminated body site to a clean body site. NA #2 admitted that she should have removed her gloves, sanitized her hands and obtained clean water prior to washing the resident's face after providing incontinence care. She stated she usually worked from head to toe but had not noticed the resident had drool on her mouth until after she had turned her during incontinence care. NA #2 stated she should have removed her dirty gloves, washed her hands, applied clean gloves and obtained clean water prior to washing Resident #4's face. Interview on 02/15/22 at 6:15 PM with the interim Director of Nursing (DON) revealed NA #2 should have sanitized her hands and changed gloves before moving from a dirty body site to clean body site. The DON also stated NA #2 should have changed her water in the basin prior to washing her face. The DON further stated all NAs should be aware of the need to prevent cross contamination and prevent the spread of infection.	F 880	On 03/07/22 the Staff Development Coordinator/Infection Preventionist Nurse began training all Contracted Agency and Facility staff on requirements of Personal Protective Equipment (PPE) donning and doffing gloves, hand hygiene protocol, and avoiding cross contamination during care. Training will be completed for all Contracted Agency and Facility staff by 03/18/2022. All newly hired staff and/or newly contracted agency staff will receive this education during orientation prior to entering the resident care area. On 3/16/22 the Staff Development Coordinator/Infection Preventionist Nurse mailed education to all Contracted Agency and Facility staff on requirements of Personal Protective Equipment (PPE) donning and doffing gloves, hand hygiene protocol, and cross contamination during care, that had not completed education by end of day on 3/16/22. Agency and facility staff that have not received training on Personal Protective Equipment (PPE) donning and doffing gloves, hand hygiene protocol, and avoiding cross contamination during care by 03/18/2022 will not be allowed to work until this training is completed. On 3/16/2022, daily infection control and hand hygiene/cross-contamination observations were conducted by the facility Administrator, (Interim) Director of Nursing, Staff Development Nurse/Infection Preventionist Nurse, Unit Supervisors, and additional facility department heads on staff working to ensure PPE is being utilized (donning & doffing of gloves), hand hygiene is being	

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F 880	Continued From page 12 Interview on 02/15/22 at 7:00 PM with the Administrator revealed she would have expected NA #2 to discard her gloves after providing incontinence care, wash her hands and apply clean gloves prior to washing Resident #4's face. The Administrator stated all NAs should know to wash their hands and change their gloves when moving from a dirty to clean procedure or body part to prevent cross contamination and the potential spread of infection.	F 880	performed per CDC guidelines and facility protocol, as well as avoiding cross contamination during resident care. These observations will be performed randomly at least 5x/day at/least 5x/week and will be completed on 5/20/2022. Beginning 3/16/2022, Facility Leadership staff to include Facility Administrator, (Interim) Director of Nursing, Unit Supervisors, and/or assigned special project department heads will monitor 5 random agency/facility staff members by observing PPE is being utilized (donning & doffing of gloves), hand hygiene, and avoiding cross contamination during resident care areas per shift 5x/weekly x4 weeks, and then 5 random agency/facility staff members per shift 3x weekly x4 weeks, then 5 random agency/facility staff members per shift 2x weekly x4 weeks. This monitoring will be completed by 6/20/22 Beginning 4/1/2022 Corporate Clinical Consultant will conduct focused on-site visits twice monthly for 3 months to monitor ongoing compliance. The visit format will include random staff monitoring using proper hand hygiene, DONNING and DOFFING PPE (gloves) and any concerns for cross-contamination. The Corporate Clinical Consultant will observe random staff members to ensure competency and validation that the infection control program is being followed. Beginning 03/18/22 any concerns identified during this audit will be reported to the Facility Medical Director, Corporate	

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F 880	Continued From page 13	F 880	Clinical Consultant, and Assistant Regional Vice President of Operations for additional education and monitoring by the Facility Department Heads and Staff Development/Facility Infection Control Preventionist Nurse. Date of completion 3/21/22.	