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	345502	A. BUILDING ______ B. WING ______	C 05/05/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/01/23 through 05/05/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6X5S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/01/23 through 05/05/23. Event ID# 6X5S11. The following intakes were investigated NC00188619, NC00189079, NC00190076, NC00193362, NC00195144, NC00197475, NC00198747, NC00199373, NC00199673, and NC00200593. Eleven of the thirty complaint allegations resulted in deficiency.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or	F 552		6/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/27/2023

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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F 552 Continued From page 1

option he or she prefers.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff interviews, Physician interview, and Family interviews the facility failed to communicate and provide information in a language the resident could understand for 1 of 1 resident whose primary language was Spanish (Resident #29).

The findings included:

Resident #29 was admitted to the facility on 7/20/21 with diagnoses that included pain in the right knee, arthritis, and infection related to an artificial joint.

A quarterly Minimum Data Set (MDS) for Resident #29 dated 4/23/23 revealed Resident #29 had moderate cognitive impairment with no behaviors.

The care plan for Resident #29 revealed Resident #29 had an inability to express emotion, listen and share information related to a hearing deficit and language barrier. The interventions included use the google app translator, Resident #29 was Spanish speaking only. Get the resident's attention before speaking and observe for and report any change in cognition.

An observation was made of Resident #29 on 5/1/23 at 5:20 PM. Resident #29 was sitting on the side of her bed looking through bags of clothing. Resident #29 spoke to me in Spanish while motioning her hands. Her roommate said she only spoke Spanish.

An interview was conducted on 5/1/23 at 5:25 PM

F 552

F552 483.10

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 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team observed Limited English Proficient (LEP) resident was not provided an acceptable means of communication.

1. Address how the facility will correct the deficiency as it relates to the individual.
Resident #29 continues to reside at the

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F 552	Continued From page 2 with Nurse Aide (NA) #5. NA #5 revealed Resident #29 spoke Spanish only. She had not used google translate with the resident. Resident #29 usually gestured her needs. During an interview on 5/1/23 at 5:30 PM Nurse #3 revealed it was difficult communicating with Resident #29 because she did not speak English, so she called the family if needed and they would help translate. Nurse #3 further revealed she has never used an interpreter for Resident #29. During an interview on 5/3/23 at 2:50 PM the Physician revealed that it was difficult to communicate with resident #29 because her primary language was Spanish, and she did not speak English. He indicated he had not used an interpreter with this resident, and he thought she understood some basic phrases. The Physician revealed the resident was sent to the hospital in February 2023 and he thought she understood the word "hospital" meant she was being transferred to the hospital. On 5/2/23 at 3:57 PM an interview was conducted with NA #4. She revealed Resident #29 only spoke Spanish and it was hard to communicate with her. She reported she was not usually assigned to care for Resident #29 but there was an NA that spoke that was usually assigned to Resident #29. She stated she had tried google translate with Resident #29 in the past, but the app could not capture what the resident said. She was unsure if the resident did not speak clearly or slowly enough for the app to work. NA #4 explained she could ask a question to the resident through the google translate app, but the app would not capture the resident's response. She tried to use yes or no questions with	F 552	facility and continues to be LEP. On 5/23/2023 a Spanish Communication Board was ordered and will be implemented upon arrival (5/26/23). On 5/25/2023 an Interpreter line was obtained and posted in Resident #28's room for use. 2. Address how the facility will act to protect residents in similar situations. On 5/23/2023 a 100% audit was completed by Department Heads of limited English proficiency (LEP). Any resident identified as a LEP resident was provided a communication board upon arrival from mail order (5/26/23) in his/her primary language. On 5/25/2023 a posting of the Interpreter line and direction was posted in the identified LEP resident's room. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. On 5/23/2023 the Facility Consultant educated facility department heads on the updated LEP communication boards and interpreter line per state & federal guidelines and facility protocol. This education included any newly admitted LEP resident to ensure acceptable communication is in place upon day of admission. On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and assigned department head began education to facility/agency staff on LEP	

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F 552	Continued From page 3 Resident #29. She further explained she relied on the resident's gesturing to identify her needs. During an interview on 5/4/23 at 8:41 AM the MDS Coordinator revealed when completing Resident #29's MDS assessments they utilized the NA that spoke Spanish to help translate so they could complete the assessment. She stated there had been times when they obtained assistance from the family, but they mostly used the NA who spoke Spanish. During a telephone interview on 5/4/23 at 10:17 AM Resident #29's family revealed there was a staff member that spoke Spanish at the facility that could communicate with Resident #29, but it was not on a consistent basis. They thought it was only a couple times a week. On the other days the family felt Resident #29 had trouble communicating her needs due to the language barrier. "She tells me sometimes they don't understand her when she needs to go to the bathroom." The Family stated Resident #29 called her last week and kept saying "COVID, COVID". The Family was told by Resident #29 that the staff put her in a different room and kept saying COVID, but she did not understand what was going on. The Family stated shortly after the call from Resident #29, a Nurse called and told them that the resident tested positive for Covid and had been moved to another room for isolation. A few days later the resident called the family again and told them she needed some clothes from her old room, but the staff did not understand what she was saying. The family revealed she went to the facility to gather things from Resident #29's old room and asked staff to give it to her. The Family stated they visit around 3 times a week, and they try to meet as many of	F 552	communication boards and interpreter line are in place per state & federal guidelines and facility protocol. This education will be completed on 05/31/2023. On 5/24/2023 the SDC added this education to the new hire packet and agency/contract staff packet. Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility staff and medication aide that has not completed education on LEP communication boards and interpreter line per state & federal guidelines and facility protocol. After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on LEP communication boards and interpreter line per state & federal guidelines and facility protocol. Beginning 6/2/2023 the DON, Treatment Nurse, UM, and/or assigned department head will complete monitoring of any LEP resident to ensure he/she has a communication board, and the interpreter line posting is visibly located in the resident room per state & federal guidelines and facility protocol. The DON, Treatment Nurse, UM, and/or assigned department head will review identified LEP residents twice weekly x3 months to ensure compliance of LEP communication boards and interpreter line are in place per state & federal guidelines and facility protocol.	

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the residents needs as possible while visiting. They did not think Resident #29 could effectively communicate with staff. Staff rarely called the family to translate for Resident #29, "they only called if there was a dire need." They further stated the resident had never used an interpreter to their knowledge.

During an interview on 5/4/23 at 11:34 AM Nurse #4 revealed she uses the google translate app to ask Resident #29 yes or no questions. She stated she could also ask the NA that spoke Spanish to translate Resident #29's needs and stated that NA work 3 days per week.

An interview was conducted with the Director of Rehab on 5/4/23 at 3:05 PM. The Director of Rehab revealed Resident #29 was Spanish speaking and was provided a communication board to express her needs. She stated that with the communication board Resident #29 could only express her basic needs such as eat, drink, pain, and bathroom. She further stated there was a Spanish speaking staff member that helped with translation.

During an interview on 5/4/23 at 3:37 PM Nurse #5 revealed it was difficult to communicate with Resident #29, she did a lot of pointing to express her needs. She stated she never used any type of interpreter services for Resident #29, and she has never seen her communication board.

An interview was conducted with the Unit Manager (UM) on 5/4/23 at 3:44 PM. The UM revealed she used gesturing to communicate with Resident #29. Staff could also use google translate, her communication board or call her family. The UM stated she had never used any

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Beginning 6/9/2023 the DON, and/or assigned department head will report the findings of the monitoring: LEP resident to ensure he/she has a communication board, and the interpreter line posting is visibly located in the resident room per state & federal guidelines and facility protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained.
Beginning the month of June 2023 and continuing for 3 months, 2023 the DON, and/or assigned department head will report the findings of the monitoring: LEP resident to ensure he/she has a communication board, and the interpreter line posting is visibly located in the resident room per state & federal guidelines and facility protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI)) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.

5. Date of completion 6/2/2023.

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F 552	Continued From page 5 interpreter services with Resident #29. An interview was conducted with the Director of Nursing (DON) and the Facility Consultant on 5/4/23 at 4:41 PM. The DON revealed Resident #29 used gesturing and her communication board to express her needs. They also utilized an NA that spoke Spanish. The DON stated she had not used an interpreter to communicate with the resident. The Facility Consultant explained she was not sure exactly when, but she implemented an interpreter line for Resident #29. She was not aware that it was not being used and did not know where the phone was. The Facility Consultant stated she was not sure if Resident #29 had ever used the interpreter line or if she had been care planned for it.	F 552		
F 565 SS=B	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		6/2/23

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F 565	Continued From page 6 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, the facility failed to resolve group grievances that were brought to resident council meetings for 5 consecutive months. Review of Resident Council Minutes from 12/7/22, 1/4/23, 2/22/23, 3/1/23, and 4/5/23 was completed. Each month's Resident Council meeting minutes had a section entitled "New Business," and cold foods was listed under this section for 12/7/22, 2/22/23, and 4/5/23. Resident council minutes for 1/4/23 and 3/1/23 did not identify a resolution to complaints of cold foods from previous resident council minutes (12/7/22, 2/22/23 and 4/5/23). During an interview on 5/2/23 at 4:22 PM the Activities Director indicated her standard practice	F 565	F565 483.10 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 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 through informal dispute	

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for submitting grievances voiced in resident council meetings was to document the grievances on the meeting minutes form and provide the Administrator the form. She further indicated the Administrator would assign the grievances to the appropriate department head, and she did not receive resolutions to bring back to the resident council meetings. Therefore, cold food concerns were brought up for several months during Resident Council meetings as new business or old business with no resolutions. She stated the facility was implementing a better follow-up process for resolving Resident Council issues.

During an interview on 5/3/23 at 11:30 AM Resident #51 revealed she was the Resident Council President, and that the facility did not act on grievances related to dietary although the Activities Director submitted them to the Administrator. She further revealed there had been at least three administrators in the past year. When dietary concerns were brought up in the Resident Council meeting and if the Dietary Manager was invited to the meeting and attended, nothing was done to resolve the issue.

During an interview on 5/4/23 at 9:03 AM, the Dietary Manager (CDM) indicated she had not received any dietary concerns through Resident Council meetings for the last few months.

During an interview on 5/4/23 at 5:31 PM, the Director of Nursing (DON) revealed she heard cold food concerns were mentioned during morning meetings but never heard about a resolution. She further revealed she would bring individual dietary concerns to dietary if residents brought it to her attention.

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resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team reviewed Resident Council minutes for 5 months (12/7/22, 1/4/23, 2/22/23, 3/1/23, and 4/5/23). This review identified no resolution for cold food for resident council member complaint of cold food (12/7/22, 2/22/23, and 4/5/23).

1. Address how the facility will correct the deficiency as it relates to the individual.
On 5/5/2023 an audit of Resident Council Meeting minutes for 6 months (11/2/23, 12/7/22, 1/4/23, 2/22/23, 3/1/23, and 4/5/23,) was reviewed by the Activities Director and Licensed Nursing Home Administrator (LNHA) to ensure any Resident Council concerns not previously resolved, were addressed with an acceptable resolution per state & federal guidelines and facility protocol pertaining to cold food.

2. Address how the facility will act to protect residents in similar situations.
On 5/5/2023 an audit of Resident Council Meeting minutes for 6 months (11/2/23, 12/7/22, 1/4/23, 2/22/23, 3/1/23, and 4/5/23,) was reviewed by the Activities Director and Licensed Nursing Home Administrator (LNHA) to ensure any Resident Council concerns not previously resolved, were addressed with an

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During a phone interview on 5/4/23 at 4:05 PM, the Social Worker revealed she worked full time for 2 years and currently worked PRN (as needed) for the facility. She further revealed she received cold food grievances in February or March 2023, that were voiced during Resident Council meetings and gave them to Dietary Department. She stated food carts left the kitchen hot and would sit on the hallways due to staffing shortage, which was a big issue.

During a phone interview on 5/4/23 at 12:35 PM, Administrator #1 indicated she was the Grievance Officer during the one month she worked at the facility 3/14/23-to 4/30/23. However, she was being trained on other duties and did not handle any grievances.

During a phone interview on 5/4/23 at 12:19 PM, Administrator #2 indicated she was the Grievance Officer during the time she worked at the facility (7/12/22 to 3/10/23) and she did not recall seeing any resident council meeting grievances about cold food.

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acceptable resolution per state & federal guidelines and facility protocol pertaining to cold food. Any Resident Council concerns pertaining to cold food will be reviewed with Resident Council members at the May 2023 Resident Council meeting to ensure any Resident Council concerns/grievances have been resolved with an acceptable resolution of improvement.

3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur.
On 5/23/2023 the Facility Consultant educated the Activity Director and Facility Administrator on state & federal guidelines and facility protocol on: Resident Council concern/grievance process and acceptable resolution. This education included reviewing the resolution in the following Resident Council meeting. In addition, the Facility Consultant and Facility Administrator educated the remaining Department Heads on: Resident Council concern/grievance process and acceptable resolution. This education will be completed on 05/31/2023.

On 5/23/2023 the Staff Development Coordinator (SDC) added this education to the new hire packet and agency/contract Department Head packet.

After 6/1/2023, no Contracted Agency/Facility Department Head will be allowed to work until he/she has completed education on state & federal

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F 565	Continued From page 9	F 565	guidelines and facility protocol on: Resident Council concern/grievance process and acceptable resolution. Beginning 6/2/2023 the Facility Administrator and Activity Director will review Resident Council Concerns/Grievances to ensure all Resident Council Concerns/Grievances have an acceptable resolution and have been reviewed in the Resident Council Meeting to ensure improvement. The Activity Director will monitor Resident Council Concerns/Grievances to ensure Resident Council Grievances/Concerns have an acceptable resolution within 1 week after Resident Council meeting for 3 months to ensure compliance of Resident Council concerns/grievances have been resolved with an acceptable resolution of improvement per state & federal guidelines and facility protocol. Beginning 6/9/2023 Activity Director will report the findings of this monitoring of Resident Council concerns/grievances have been resolved with an acceptable resolution of improvement per state & federal guidelines and facility protocol to the members of the Cardinal Intradisciplinary Team monthly for 3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained. Beginning the month of June 2023 and	

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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 565	Continued From page 10	F 565	continuing for 3 months Activity Director will report the findings of this monitoring of Resident Council concerns/grievances have been resolved with an acceptable resolution of improvement per state & federal guidelines and facility protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI)) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	
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 observations, record review, resident interviews and staff interviews the facility failed to provide nail care for 2 of 6 sampled residents (#5 and #48) reviewed for activities of daily living (ADL). 1. Resident #5 was admitted to the facility on 11/12/21 with diagnoses that included anemia, chronic kidney disease, dementia, and seizure disorder.	F 677	F677 483.24 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	6/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 11 A quarterly Minimum Data Set (MDS) assessment dated 2/10/23 indicated Resident #5 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; total dependence on locomotion and bathing; supervision with eating. A revised care plan dated 12/23/22 revealed Resident #5 required assistance with ADLs to maintain or achieve the highest level of functioning by providing total care for personal hygiene/ grooming (face, skin, hands, nails, and perineum). A continuous observation and interview on 5/1/23 at 10:23 AM to 10:30 AM revealed Resident #5's fingernails on both hands were long with jagged edges. The observation further revealed his left arm/ hand was contracted and fingernails were long. Resident #5 reported he recently asked staff to cut his fingernails and was told they did not have nail clippers to cut his nails. A follow-up observation on 5/2/23 at 10 AM revealed Resident #5's fingernails on both hands remained long, jagged, and untrimmed. A review of bathing sheets and progress notes in the electronic medical record indicated Resident #5 had no refusals of nail care. During an interview on 5/3/23 at 12:17 PM, Nurse Aide (NA) #1 indicated she normally provided bed baths during the 7:00 pm- 7:00 am shift and that nail care was usually performed by the shower team, if they weren't pulled to work on the floor. She further indicated that she had been assigned to Resident #5 and did not notice that his nails	F 677	written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this statement of deficiencies does not denote agreement with 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team observed 2 of 6 residents nail care was not provided. 1. Address how the facility will correct the deficiency as it relates to the individual. Resident #5 continues to reside at the facility. Resident #5’s nail care was corrected on 5/4/23. On 5/4/2023 Resident #5’s nails were cleaned trimmed and filed to his satisfaction by assigned Certified Nursing Assistant (CNA). Resident #480 no longer resides at the facility. 2. Address how the facility will act to protect residents in similar situations. On 5/3/2023 nursing staff were reminded by Director of Nursing (DON) and nurse unit manager (UM) to complete nail care	

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F 677 Continued From page 12
were overgrown or needed care.

During an interview on 5/2/23 at 4:03 PM, NA #2 revealed he started working at the facility on 4/28/23 and was assigned to Resident #5. He provided ADL care to Resident #5, noticed his nails needed to be trimmed and did not trim his nails because he did not have a nail clipper. He further revealed he asked a nurse (unable to recall the nurse's name) for clippers and was told they needed to check with the facility's corporate office.

2. Resident #48 was admitted to the facility on 2/7/22 with diagnoses that included coronary artery disease and respiratory failure.

A quarterly Minimum Data Set (MDS) assessment dated 3/27/23 indicated Resident #48 had moderate cognitive impairment and required extensive assistance with bed mobility, toileting, and personal hygiene: total assistance with transfers, dressing and bathing; supervision with eating.

A continuous observation and interview on 5/1/23 at 10:33 AM to 10:40 AM revealed Resident #48's fingernails on both hands were long, thick, and jagged with dark brown matter under his nails. Resident #48 further revealed he could not get staff to cut his fingernails, he wanted them cut and had not refused nail care especially since his left middle fingernail very thick, yellow in color and splitting.

A follow-up observation and interview with the Unit Manager on 5/2/23 at 4:13 PM revealed Resident #5 and #48's fingernails on both hands remained long with jagged edges as they were

F 677
for all residents to include cleaning, filing, and trimming.
On 5/15/2023 a 100% audit was completed by the special project Certified Nursing Assistant (CNA) of resident nail care to ensure nail care for all residents to include cleaning, filing, and trimming was completed as each resident allowed to his/her satisfaction.

3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur.
On 5/23/2023 the Facility Consultant educated facility department heads on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction.
On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), special assigned nurse, and assigned department head began education to facility/agency staff on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per

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observed on 5/1/23. The Unit Manager assessed the fingernails of both residents and determined their nails were overgrown and needed care. She further indicated she expected her staff to provide nail care during ADL care.

During an interview with the Director of Nursing (DON) on 5/4/23 at 5:25 PM revealed she was not aware nail care was not provided during ADL care and expected this task to be routinely assessed and performed weekly on shower days by nursing staff.

resident satisfaction.
This education will be completed on 05/31/2023.
On 5/24/2023 the SDC added this education to the new hire packet and agency/contract nursing staff packet.

Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility staff that has not completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines and facility expectation/protocol to include any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction.

After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines and facility expectation/protocol to include any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction.

Beginning 6/2/2023 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC),

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F 677	Continued From page 14	F 677	special assigned nurse, and assigned department head will complete monitoring of nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. The DON, Treatment Nurse, UM, treatment nurse, special assigned nurse, and/or assigned department head will review 6 random resident nails twice weekly x4 weeks, then 6 random resident nails weekly x8 weeks to ensure resident nail care is being as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. Beginning 6/9/2023 the DON, and/or assigned department head will report the findings of the monitoring nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON, and/or assigned department head will report the findings of the monitoring: nail care completed for residents on his/her	

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F 677	Continued From page 15	F 677	assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, resident interview, and Physician interview the facility failed to administer scheduled pain medication after it was requested for a resident that was experiencing ten out of ten pain. This occurred for one of four residents reviewed for pain. (Resident #310) This failure resulted in Resident #310 experiencing her pain being "off the charts" and crying related to her pain.	F 697	F697 483.25 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	6/2/23

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Continued From page 16
The findings included:

Resident #310 was admitted to the facility on 4/25/23 with diagnoses that included osteoarthritis of the right knee, right knee replacement, right knee pain, and rheumatoid arthritis.

A 5-day Minimum Data Set for Resident #310 dated 4/27/23 revealed she was cognitively intact with no behaviors. Resident #310 had a recent major joint surgery and required skilled nursing care. She was experiencing pain almost constantly and was on a pain regimen.

A baseline care plan for Resident #310 initiated on 4/25/23 revealed she had the potential for actual acute and/or chronic pain. The interventions included acknowledging the presence of pain and discomfort and listen to the residents' concerns. Administer pain medication as ordered by the physician. Anticipate the resident's need for pain relief and respond appropriately. Document/report complaints and non-verbal signs of pain. Notify the physician if pain management was not effective.

Review of a physician progress note dated 4/26/23 read in part: Resident #310 was being admitted to the skilled nursing facility after hospitalization for right total knee replacement per orthopedist and subsequently needing skilled care because she is unable to care for herself at home, unable to consistently bear weight and difficulty with persistent severe breakthrough pain. Reviewed for her ongoing treatment: We will change her analgesic regimen per her request to schedule her oxycodone at 20 mg every 4 hours as she does suffer from chronic

F 697 (Plan of Correction)

written allegation of compliance.
Lake Park Nursing and Rehabilitation Center response to this statement of deficiencies does not denote agreement with 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 � 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team reported that pain medication was not given as requested to a resident.

1. Address how the facility will correct the deficiency as it relates to the individual.
Resident #310 no longer resides at the facility.

2. Address how the facility will act to protect residents in similar situations.
On 5/25/2023 a 100% audit was completed by the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Nursing Unit Managers (UM), and assigned department heads through resident and/or staff interviews of resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place and is given timely.

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F 697	Continued From page 17 pain issues due to her rheumatoid arthritis and recent exacerbation with ongoing treatment. Review of Physician orders for Resident #310 revealed: oxycodone 10 milligrams(mg), give 2 tablets by mouth every four hours for chronic pain 4/26/23. Review of the April 2023 Medication Administration Record (MAR) for Resident #310 revealed she had oxycodone 20mg due to be given every 4 hours at 8 AM, 12 noon, 4 PM, 8 PM, 12 midnight and 4 AM. During an interview on 5/2/23 at 9:20 AM Resident #310 revealed she had been in the facility for about a week, she was in the facility for rehab after a knee surgery. Resident #310 stated sometimes the nurses did not bring her pain medication when she requested it. She reported this to the physician. She further stated after she reported the issue, the physician changed her pain medication from as needed to scheduled times through the day to ensure she received her medication timely. Resident #310 revealed on the weekend of 4/29/23, she could not recall if it was Saturday or Sunday, she requested her 8 PM pain medication. Resident #310 explained she asked an NA to tell the nurse she needed something for pain, her pain was an eight out of 10. She was told by the NA that the nurse was busy, but she would let her know. Resident #310 further explained that after about 30 minutes she activated her call light because the nurse had not come. She activated her call light another time before calling a friend to come to the nursing home. Resident #310 stated when her friend arrived at the facility her pain was ten out of ten, "my pain was off the charts" and she was in the	F 697	Any resident with reported/noted pain was corrected through pain management medication/intervention via present order or licensed provider new order to ensure resident has acceptable pain management medication/intervention. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. On 5/23/2023 the Facility Consultant educated facility department heads on resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol. On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency staff on ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain level and state & federal guidelines, and facility expectation/protocol. This education will be completed on	

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bed crying. She sent her friend to find a nurse and to ask for her pain medication. Resident #310 revealed the nurse brought her pain medication around 9:30 or 10 PM. She thought she waited more than two hours for her medication, this was not the first time her pain medication was late. Resident #310 stated she kept track of the time on her cell phone.

During an interview on 5/2/23 at 3:32 PM NA #4 revealed she worked on the hall where Resident #310 resided on Sunday 4/30/23. She further revealed it was very busy on that day and she could not recall if Resident #310 asked her to tell the nurse she needed pain medication. NA #4 stated that Resident #310 resided on the rehab unit. Residents on the rehab unit frequently requested pain medication. She further stated when a resident asked her to tell the nurse they needed something, she told the nurse.

An interview was conducted on 5/3/23 at 12:05 PM, Nurse #2 revealed she was the nurse on the hall where Resident #310 resided on Sunday 4/30/23 from 7 AM until 11 PM. She recalled that Resident #310 called for her pain medication around 7PM that evening, but she did not administer it because it was not due until 8 PM. It was also shift change and she was going to pass it on to the oncoming nurse. Nurse #2 explained it had been a challenging day, they were short staffed there was only an NA and herself working that hall with 20 something residents. She typically worked from 7PM until 7 AM, but she agreed to work 7 AM until 7PM on 4/30/23 because the facility was short staffed and there was not a nurse to cover that shift. Nurse #2 revealed she was allowed to give medications an hour before or an hour after and they would be

F 697

05/31/2023.
On 5/24/2023 the SDC added this education to the new hire packet and agency/contract nursing staff packet.

Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility nursing staff that has not completed education on ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol.

After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol.

Beginning 6/2/2023 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), special assigned nurse, and assigned department head will complete monitoring of ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol.
The DON, Treatment Nurse, UM, treatment nurse, special assigned nurse, and/or assigned department head will review 6 random residents twice weekly x4 weeks, then 6 random resident nails weekly x8 weeks to ensure ensuring each resident has adequate pain management

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considered on time. When Resident #310 requested pain medication it was around 7 PM and Nurse #2 expected to be relieved by another nurse at that time. She stated she was going to pass on Resident #310's pain medication request to the oncoming nurse but that nurse never came, "she was a no call no show". She covered the shift until 11 PM until the facility could find another nurse to relieve her. Nurse #2 revealed she did not plan to stay until 11 PM, by the time she notified the facility about the no call no show and got her night started she was behind and had forgotten about Resident #310's request for pain medication. She stated when she remembered the resident needed pain medication, there was a friend of Resident #310 running up to the cart telling her that Resident #310 was in her bed crying and needed her pain medication. Nurse #2 stated when she went to Resident #310's room to give the pain medication she was in her bed crying. She thought it was around 9:30 PM when she gave the medication. She said her medication being late was the result of the staffing situation that day. Nurse #2 stated the facility was frequently short staffed.

During an interview on 5/3/23 at 2:50 PM the Physician revealed Resident #310 mentioned to him that she was not receiving her pain medication when she requested it. Her pain medication was initially ordered as needed; he changed her medication to be given at scheduled times so she would not have to request it. The Physician further revealed he was not aware she was continuing to have trouble getting her medication as scheduled. The Physician stated he expected nurses to administer residents their pain medications as ordered.

F 697

in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This monitoring will be conducted through resident/staff interviews and/or reviewing resident Electronic Medication Administration Record (EMAR).

Beginning 6/9/2023 the DON, and/or assigned department head will report the findings of the monitoring: ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance.

4. Indicate how the facility will monitor its performance to make sure that solutions are sustained.
Beginning the month of June 2023 and continuing for 3 months, the DON will report the findings of the monitoring: ensuring each resident has adequate pain management in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued

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F 697	Continued From page 20 An interview was conducted with the Director of Nursing (DON) and the Facility Consultant on 5/4/23 at 4:41 PM. The DON revealed she expected the residents to receive their pain medications timely and as ordered. She further revealed she believed the issue with Resident #310 ' s pain medication was related to the staffing challenges the facility experienced on the weekend of 4/29/23. The DON stated there were multiple call outs on that weekend and this may have caused Resident #310's nurse to get behind.	F 697	Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		6/2/23

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§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, staff interviews, and resident interviews the facility failed to have sufficient nurse staffing to ensure residents received pain medication when needed. (Resident #310).

The findings included:

This citation is cross referenced to F697

B.) F697: Based on observations, record review, staff interviews, resident interview, and Physician interview the facility failed to administer scheduled pain medication after it was requested for a resident that was experiencing ten out of ten pain. This occurred for one of four residents reviewed for pain (Resident #310). This failure resulted in Resident #310 experiencing her pain being "off the charts" and crying related to her pain.

During an interview on 5/3/23 at 11:34 AM Nurse #4 revealed staffing was bad at the facility and on the days they had two or three NAs on the medical unit it was terrible. She stated on days when they had two to three NAs on the medical unit, she did a lot of "juggling", she would try to help the NAs pass and pick up meal trays, assist with feeding, and answer call lights. She further stated she knew all the baths and showers couldn't get done and residents didn't always get changed timely when they were short staffed. She explained she tried to help the best she could, but she had to be a nurse too. Nurse #4

F 725

F725 483.35

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 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team observed there was not adequate nursing staff in the facility to provide 1 of 1 resident pain medication was given timely resulting in reported pain level of 10 of 10.

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revealed because of the staffing issues she often helped the NAs provide care to the residents and at times her medication pass would be late.

An interview was conducted with Nurse #2 on 5/3/23 at 12:05 PM. Nurse #2 revealed staffing was "not so great" at the facility. She worked on the Rehabilitation Unit (Rehab unit) and there was one nurse on the Rehab unit for 23 residents. She stated she had to pass medications and there were a lot of residents on the unit that needed pain medications because they've had surgeries. She further stated it was a lot for one nurse. Nurse #2 revealed she worked the past weekend of 4/29/23 and the facility was very short staffed. She further revealed on Sunday 4/30/23 she worked from 7 AM until 7 PM and she was the only staff member on the Rehab unit until 9 AM. The NA was late and did not arrive until 9AM. Nurse #2 explained on that morning between 7 AM and 9 AM she answered call lights and passed breakfast trays. She could not start her medication pass until the NA came in, and because it was just the two of them, she helped turn and change residents. She stated because they were short staffed, she was behind on her medication passes and it was difficult to get caught up.

During an interview on 5/3/23 at 3:49 PM the Scheduler revealed the facility was cutting back a little on agency staff, so staffing was a little more of a struggle. They were currently hiring facility staff. She indicated hiring staff was not an issue, but retention was. The facility would hire a NA, they would work a few shifts and then not return. The Scheduler stated she was aware that the facility was short staffed the weekend of 4/29/23. The Medical Unit had a NA walk out and the two

F 725

1. Address how the facility will correct the deficiency as it relates to the individual.
A.) The facility continues to hire staff and renew contracts of agency licensed nursing staff to ensure adequate nursing staff is present in the facility to provide adequate care/administer pain medications to all residents.
B.) Resident #310 no longer resides at the facility.

2. Address how the facility will act to protect residents in similar situations.
A.) On 5/9/2023 the Lake Park Nursing and Rehabilitation Center employed a Work Force Facilitator (WFF) to manage licensed nursing staff to ensure adequate staff is in attendance on a 24-hour basis to provide nursing staff to meet all resident requests/needs/medication administration on a 24-hour basis as per state & federal guidelines and facility expectation/protocol.
Any reported staff shortage will be immediately corrected by calling other licensed staff to work to cover the licensed nursing staff shortage.
B.) On 5/25/2023 a 100% audit was completed by the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Nursing Unit Managers (UM), and assigned department heads through resident and/or staff interviews of resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place and is given timely. This audit included the facility

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Continued From page 23

remaining NAs had 30 something residents each. She further stated that was too many residents for the NAs to provide care for. Even when there were four NAs on the Medical Unit, they could have up to 20 residents and that was a lot for day shift. The Scheduler explained when the facility was short staffed, she would make phone calls to try to get staff to come in. She also used an app called schedule pop where staff can see vacancies, they offered bonuses for extra shifts, and she would call agencies to see if they had staff they could send. If they could not get enough staff, she, and the Director of Nursing (DON) would help on the unit. She stated the DON and Unit Manager came in on Sunday 4/30/23 to help when the facility was short staffed.

During an interview on 5/4/23 at 3:37 PM Nurse #5 revealed she was working on the rehab unit and there were about 25 residents. She stated with that number of residents they should have two nurses and two NAs. On that day she stated it was only herself and the NA. Nurse #5 explained she would help the NA with residents, trays and call lights and it slowed her down with her medication passes. "It makes me behind with meds".

A telephone interview was conducted with Administrator #1 on 5/4/23 at 12:44 PM. She revealed when she was at the facility, they were experiencing staffing challenges and it was getting worse. She stated the facility was cutting some of the agency staff as they hired facility staff. When they hired a facility staff member, they would cut an agency staff member. Administrator #1 revealed on the weekend of 4/29/23 the facility was very short staffed and on Sunday 4/30/23 she came in to help, but they

F 725

being staff adequately to ensure all resident requests/needs/medication administration are being met on a 24-hour basis as per state & federal guidelines and facility expectation/protocol.
Any resident with reported/noted pain was corrected through pain management medication/intervention via present order or licensed provider new order to ensure resident has acceptable pain management medication/intervention.

3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur.
A.) On 5/23/2023 the Facility Consultant completed education to facility department heads on WFF duties and licensed nursing staff requirements on a 24-hour basis as per state & federal guidelines and facility expectation/protocol.
On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency staff heads on WFF duties and licensed nursing staff requirements on a 24-hour basis as per state & federal guidelines and facility expectation/protocol.
This education will be completed on 05/31/2023.
On 5/24/2023 the SDC added this education to the new hire packet and agency/contract nursing staff packet.

B.) On 5/23/2023 the Facility Consultant educated facility department heads on resident pain, pain levels if reported/noted

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were still short.

During an interview with the DON and the Facility Consultant on 5/4/23 at 4:41 PM DON revealed staffing was an issue and the facility was trying to increase their staff. They had been using word of mouth, advertising, and offering bonuses. She stated they recently hired 11 but only had four shown up for orientation. Until the staffing was better, they continued to use agency. If the facility was short staffed, they called around, and offered hourly incentives for extra shifts. The DON stated she encouraged staff to make the best out of the staffing situation until it gets better.

F 725

pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol.
On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency staff on ensuring resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol.
This education will be completed on 05/31/2023.

On 5/24/2023 the SDC added this education to the new hire packet and

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F 725	Continued From page 25	F 725	agency/contract nursing staff packet. Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility nursing staff that has not completed education on ensuring resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol. After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on ensuring resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable	

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F 725	Continued From page 26	F 725	pain management medication/intervention and state & federal guidelines, and facility expectation/protocol. Beginning 5/24/2023 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), special assigned nurse, and WFF will complete monitoring of ensuring resident pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol. The Administrator, DON, UM, and/or WFF will review staffing grid daily to ensure adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol.	

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F 725	Continued From page 27	F 725	Beginning 5/24/2023 the Administrator, DON, and/or WFF will report the findings of the monitoring: ensuring adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol. to the members of the Cardinal Intradisciplinary Team daily (Monday – Friday {weekends will be reported on Friday}) x3 months to ensure compliance and review for further recommendations and/or follow up as needed for continued compliance. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON and/or WFF will report the findings of the monitoring: adequate nursing staff is present in the facility to meet all resident requests/needs/medication administration per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervention and state & federal guidelines, and facility expectation/protocol.	

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F 725	Continued From page 28	F 725	monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	

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	345502	A. BUILDING ______ B. WING ______	C 05/05/2023

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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The findings included:

This citation is cross referenced to F697

F697: Based on observations, record review, staff interviews, resident interview, and Physician interview the facility failed to administer scheduled pain medication after it was requested for a resident that was experiencing ten out of ten pain. This occurred for one of four residents reviewed for pain (Resident #310). This failure resulted in Resident #310 experiencing her pain being "off the charts" and crying related to her pain.

During an interview on 5/3/23 at 11:34 AM Nurse #4 revealed staffing was bad at the facility and on the days they had two or three Nurse Aides (NA) on the medical unit it was terrible. She stated on days when there were two to three NAs on the medical unit, she did a lot of "juggling", she would try to help the NAs pass and pick up meal trays, assist with feeding, and answer call lights. She further stated she knew all the baths and showers couldn't get done and residents didn't always get changed timely when they were short staffed. She explained she tried to help the best she could, but she had to be a nurse too. Nurse #4 revealed because of the staffing issues she often helped the NAs provide care to the residents and at times her medication pass would be late.

An interview was conducted with Nurse #2 on 5/3/23 at 12:05 PM. Nurse #2 revealed staffing was "not so great" at the facility. She worked on the Rehabilitation Unit (Rehab unit) and there was one nurse on the Rehab unit for 23 residents. She stated she had to pass medications and

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there were a lot of residents on the unit that needed pain medications because they've had surgeries. She further stated it was a lot for one nurse. Nurse #2 revealed she worked the past weekend of 4/29/23 and the facility was very short staffed. She further revealed on Sunday 4/30/23 she worked from 7 AM until 7 PM and she was the only staff member on the Rehab unit until 9 AM. The NA was late and did not arrive until 9AM. Nurse #2 explained on that morning between 7 AM and 9 AM she answered call lights and passed breakfast trays. She could not start her medication pass until the NA came in, and because it was just the two of them, she helped turn and change residents. She stated because they were short staffed, she was behind on her medication passes and it was difficult to get caught up.

During an interview on 5/3/23 at 3:49 PM the Scheduler revealed the facility was cutting back a little on agency staff, so staffing was a little more of a struggle. They were currently hiring facility staff. She indicated hiring staff was not an issue, but retention was. The facility would hire a NA, they would work a few shifts and then not return. The Scheduler stated she was aware that the facility was short staffed the weekend of 4/29/23. The Scheduler explained when the facility was short staffed, she would make phone calls to try to get staff to come in. She also used an app called schedule pop where staff can see vacancies, they offered bonuses for extra shifts, and she would call agencies to see if they had staff they could send. If they could not get enough staff, she, and the Director of Nursing (DON) would help on the unit. She stated the DON and Unit Manager came in on Sunday 4/30/23 to help when the facility was short staffed.

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During an interview on 5/4/23 at 3:37 PM Nurse #5 revealed she was working on the rehab unit and there were about 25 residents. She stated with that number of residents they should have two nurses and two NAs. On that day she stated it was only herself and the NA. Nurse #5 explained she would help the NA with residents, trays and call lights and it slowed her down with her medication passes. "It makes me behind with meds".

A telephone interview was conducted with Administrator #1 on 5/4/23 at 12:44 PM. She revealed when she was at the facility, they were experiencing staffing challenges and it was getting worse. She stated the facility was cutting some of the agency staff as they hired facility staff. When they hired a facility staff member, they would cut an agency staff member. Administrator #1 revealed on the weekend of 4/29/23 the facility was very short staffed and on Sunday 4/30/23 she came in to help, but they were still short.

During an interview with the DON and the Facility Consultant on 5/4/23 at 4:41 PM DON revealed staffing was an issue and the facility was trying to increase their staff. They had been using word of mouth, advertising, and offering bonuses. She stated they recently hired 11 but only four had shown up for orientation. Until the staffing was better, they continued to use agency. If the facility was short staffed, they called around, and offered hourly incentives for extra shifts. The DON stated she encouraged staff to make the best out of the staffing situation until it gets better.

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F 761 SS=E	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 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, staff interviews and record reviews, the facility failed to remove expired medications in accordance with manufacturer's guidelines and failed to date an opened eye medication for 4 of 6 medications carts observed during medication storage checks (200 hall, 400 hall, 600 hall, and 700 hall). The findings included:	F 761	F761 483.45 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	6/2/23

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1. Review of manufacturer's package insert for Latanoprost eye drops revealed unopened bottle should be stored under refrigeration between 36° to 46° F and protected from light. Once opened, Latanoprost could be stored at room temperature up to 77° F up to six weeks.

a. A medication storage audit was conducted on 05/02/23 at 3:18 PM for the 600-hall medication cart in the presence of Nurse #1. One bottle of Latanoprost 0.005% eye drop opened on 01/20/23 was found in the medication cart and ready to be used. The eye drop was dispensed from the pharmacy on 01/11/23.

During an interview conducted on 05/02/23 at 3:28 PM, Nurse #1 thought the eye drop would be expired a year from the dispensing date on 01/11/24. She did not know that opened Latanoprost eye drop stored in the room temperature would be expired in 6 weeks.

b. During a medication storage check conducted on 05/02/23 at 3:47 PM for 400-hall in the presence of Medication Aide (MA) #1, one bottle of Latanoprost 0.005% eye drop without opening date was found in the medication cart and ready to be used. The label indicated the eye drop would be expired 6 weeks after it was opened.

An interview was conducted on 05/02/23 at 3:54 PM. MA #1 explained she had not worked with 400-hall medication cart for long time. She acknowledged that the eye drop should be dated when it was opened and discarded after 6 weeks. She could not explain why the eye drop was not dated when it was opened.

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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 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 � 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team observed expired and undated opened medications remained on 4 of 6 medication carts.

1. Address how the facility will correct the deficiency as it relates to the individual.
On 5/2/2023 an audit of all medication carts was conducted by the Director of nursing (DON) and nurse Unit Manager (UM) . Any noted expired and/or opened undated medications were removed and replaced from these medication carts in accordance to manufacturer�s guidelines and facility protocol.

2. Address how the facility will act to protect residents in similar situations.
On 5/2/2023 an audit of all medication carts was conducted by DON and UM.

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2. Review of manufacturer's package insert for Novolog, Lantus, and Admelog indicated unopened vials should be stored in refrigerator at 36°F to 46°F until expiration and kept away from direct heat and light. Once these insulins were opened, it could be stored at room temperature (below 86°F) or refrigerated up to 28 days.

a. A subsequent medication storage audit was conducted on 05/02/23 at 4:59 PM for the 200-hall medication cart in the presence of Nurse #2. One vial of Lantus 100 unit/milliliter (ml) insulin opened on 03/27/23 and one vial of Novolog 100 unit/ml insulin opened on 03/01/23 were found in the medication cart under room temperature and ready to be used.

During an interview conducted on 05/02/23 at 5:08 PM, Nurse #2 explained one of the nurses worked before her might have opened another Novolog and forgotten to discard the expired one in the medication cart. She stated both insulins should be discarded after they were opened and stored under room temperature for 28 days.

b. A medication storage check was conducted on 05/02/23 at 5:25 PM for the 700-hall medication cart in the presence of Nurse #3. One vial of Admelog 100 unit/ml insulin opened on 03/31/23 was found in the medication cart under room temperature and ready to be used.

An interview was conducted on 05/02/23 at 5:28 PM. Nurse #3 stated she was not the only nurse who used this medication cart. It was hard for her to keep up with the expiration date of insulin if other nurses did not do their part. She acknowledged that the insulin should be discarded after it had been opened and stored in

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Any noted expired and/or open undated medications were removed and replaced from these medication carts in accordance with manufacturer□s guidelines and facility protocol.

3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur.
On 5/2/2023 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency nurses and medication aides on removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol. This education will be completed on 05/31/2023.
On 5/22/2023 the SDC added this education to the new hire packet and agency/contract nurse and medication aide packet.
Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility nurse and medication aide that has not completed education of removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol.
After 6/1/2023, no Contracted Agency/Facility Nursing Staff will be allowed to work until he/she has completed education on removing and

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F 761	Continued From page 56 room temperature for 28 days. An interview was conducted with the Director of Nursing (DON) on 05/02/23 at 5:54 PM. She stated nurses and MAs were instructed to check their respective medication cart for expired medications at least once every night. It was her expectation for the facility to remain free of expired medication and store all medications according to manufacturer's guidelines. During an interview with the Administrator on 05/04/23 at 4:38 PM, he expected all the nursing staff to follow facility's policy and procedure for medication storage and store all medications according to manufacturer's guideline.	F 761	replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol. Beginning 5/2/2023 the DON, Treatment Nurse, UM, and/or assigned special project nurse will complete monitoring of each medication cart to ensure compliance of removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol. The DON, Treatment Nurse, UC, and/or assigned special project nurse will review each facility medication cart once weekly x3 months to ensure compliance of removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol. Beginning 6/9/2023 the DON, Treatment Nurse, UM, and/or assigned special project nurse will report the findings of the monitoring: removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance	

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F 761	Continued From page 57	F 761	and review for further recommendations and/or follow up as needed for continued compliance. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON will report the findings of the monitoring: removing and replacing as indicated, expired and/or opened undated medications and dating medications when the medication is opened in accordance with manufacturer□s guidelines and facility protocol monthly to of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		6/2/23

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F 867	Continued From page 58 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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F 867	Continued From page 59 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility	F 867		

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F 867	Continued From page 60 assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions for Activities of Daily Living Care Provided for Dependent Residents, which were put into place during the complaint investigation survey of 2/21/22, and on the current recertification and complaint investigation survey of 5/5/23. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program.	F 867	F867 483.75 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	

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Continued From page 61

Findings included:

This tag is cross referenced to:

F 677: Based on observations, record review, resident interviews and staff interviews the facility failed to provide nail care for 2 of 6 sampled residents (#5 and #48) reviewed for Activities of Daily Living (ADL).

During the complaint investigation survey of 2/21/22 the facility failed to provide incontinence care to a resident causing the resident to soak through a brief, pad and onto bed linen for 1 of 3 residents reviewed for ADL care.

During a phone interview on 5/4/23 at 1:14 PM, Administrator #1 stated she was unaware that the facility received a deficiency related to ADL care on a complaint investigation survey in March 2022. Administrator #1 stated that during the time she was the Administrator, she facilitated QAPI meetings which included all the department managers, the Nurse Consultant and Physician. She stated during these meetings the agenda included a discussion related to agency nursing staff not providing patient care and that agency nursing staff received re-education. Monitoring included room rounds and a checklist that included concerns related to patient care. Any concerns identified during the room rounds were addressed. The Administrator stated that she attributed continued concerns related to ADL care to agency nursing staff not providing patient care.

An interview with the Nurse Consultant on 5/4/23 at 6:00 PM revealed she attributed continued concerns with ADL care to a lack of Director of Nursing (DON) oversight resulting from repeated

F 867

deficiencies does not denote agreement with 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 through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.

During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Park Nursing and Rehabilitation Center, the survey team observed facility's Quality Assurance and Performance Improvement (QAPI)committee failed to maintain implemented procedures and monitor the interventions for Activities of Daily Living Care Provided for Dependent Residents, which were put into place during the complaint investigation survey of2/21/22, and on the current recertification and complaint investigation survey of 5/5/23. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program.

1. Address how the facility will correct the deficiency as it relates to the individual.
Resident #5 continues to reside at the facility. Resident #5's nail care was corrected on 5/4/23.
On 5/4/2023 Resident #5's nails were cleaned trimmed and filed to his satisfaction by assigned Certified Nursing

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F 867	Continued From page 62 DON turnover in the last year. The Nurse Consultant stated the lack of DON oversight attributed to a lack of management of nursing care and implementation of policies and procedures.	F 867	Assistant (CNA). Resident #480 no longer resides at the facility. 2. Address how the facility will act to protect residents in similar situations. On 5/3/2023 nursing staff were reminded by Director of Nursing (DON) and nurse unit manager (UM) to complete nail care for all residents to include cleaning, filing, and trimming. On 5/15/2023 a 100% audit was completed by the special project Certified Nursing Assistant (CNA) of resident nail care to ensure nail care for all residents to include cleaning, filing, and trimming was completed as each resident allowed to his/her satisfaction. 3. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. On 5/23/2023 the Facility Consultant educated facility department heads on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction. On 5/24/23 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), special assigned nurse, and assigned department	

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F 867	Continued From page 63	F 867	head began education to facility/agency staff on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction. This education will be completed on 05/31/2023. On 5/24/2023 the SDC added this education to the new hire packet and agency/contract nursing staff packet. Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility staff that has not completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines and facility expectation/protocol to include any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction. After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal	

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F 867	Continued From page 64	F 867	guidelines and facility expectation/protocol to include any newly admitted resident requiring/requesting nail care is performed by assigned nursing staff within 24 hours of admission to the facility per resident satisfaction. Beginning 6/2/2023 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), special assigned nurse, and assigned department head will complete monitoring of nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. The DON, Treatment Nurse, UM, treatment nurse, special assigned nurse, and/or assigned department head will review 6 random resident nails twice weekly x4 weeks, then 6 random resident nails weekly x8 weeks to ensure resident nail care is being as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. Beginning 6/9/2023 the DON, and/or assigned department head will report the findings of the monitoring nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance and review for further recommendations and/or follow up as	

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F 867	Continued From page 65	F 867	needed for continued compliance. 4. Indicate how the facility will monitor its performance to make sure that solutions are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON, and/or assigned department head will report the findings of the monitoring: nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The Facility Consultant/Corporate Clinical Director and/or Regional Vice President of Operations will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings, to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes, and the Performance Improvement Plans once a month for 3 months. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	

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