DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILD	ING	i		
		345502	B. WING				R-C
	ROVIDER OR SUPPLIER	040002			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/14/2016
					3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
1/10		,			DEFICIENCY)		
{F 000}	INITIAL COMMENTS		{F (	000	}		
	A recertification, com						
		s conducted on 02/22/16 to was notified of immediate					
		at F-223 (J), F-225 (J),					
		F-490 (J), and F-520 (J)					
	-	6/16. An extended survey					
		/25/16. Immediate jeopardy					
	was present and rem						
	completion of the surv	vey.					
	483.13 (F 223) at J						
		began on 02/16/16 when					
		lapped a combative resident					
	-	on the right thigh (Resident physical abuse occurred on					
		as witnessed by NA #2. NA					
		ly intervene or report to					
		at she witnessed physical					
	•	ent #6 and failed to protect					
	unit from further abus	er residents on the secure					
		ned discoloration to her right					
	thigh.						
	483.13 (F 225) at J						
	· · ·	began on 02/16/16 when					
		ailed to immediately report					
	that she witnessed ph	nysical abuse to a combative					
	, , , , , , , , , , , , , , , , , , ,	) on the secure unit which					
	resulted in further phy						
		e Resident #6 on the face, Ity report the abuse or					
		from further abuse. NA #1					
	remained on the secu						
	unsupervised and wa	s witnessed again on					
	02/16/16, by NA #2, t	o slap Resident #6 on the					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Electronically Signed

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.

03/21/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/24/2016 // APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ISTRUCTION	(X3) DATE SURVEY COMPLETED R-C		SURVEY LETED
		345502	B. WING					-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER		•	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER			AITH CHURCH ROAD N TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	ĸ	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 000}	abuse to the Health C within 24 hours and the physical abuse within 483.13 (F 226) at J Immediate Jeopardy Nurse Aide (NA) #1 s face when the Resided during nursing care. If abuse but did not immediate protection to Resident which led to a second toward Resident #6. Resident #6 on the fac did not immediately re- remained on the secu- unsupervised and secu- 02/16/16, NA #2 with #6 on the right thigh of The facility failed to re- Health Care Personn and the investigation 5 working days. 483.20 (F 282) at J Immediate Jeopardy Nurse Aide (NA) #1 s on the face and again #6). Each incident of the secure unit and w #2 did not immediate Resident #6 and other unit from physical abu	y failed to report physical Care Personnel Registry ne investigation of the 5 working days. began on 02/16/16 when lapped Resident #6 on the ent became combative NA #2 witnessed the physical nediately intervene or report 7. This resulted in a lack of t #6 and other residents 1 incident of physical abuse NA #2 witnessed NA #1 slap the during morning care, but eport the abuse. NA #1 ure unit, working veral hours later on essed NA #1 slap Resident during the provision of care. eport physical abuse to the el Registry within 24 hours of the physical abuse within began on 02/16/16 when lapped a combative resident non the right thigh (Resident physical abuse occurred on ras witnessed by NA #2. NA by intervene to protect or residents on the secure	{F 0	00}				

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/24/2016 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			0	R-C )3/14/2016
NAME OF P	ROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
{F 000}	Continued From page	2	{F 0	)00}	}		
	Nurse Aide (NA) #1 s face and the witness, did not immediately re- for protection of Resid A second incident of 02/16/16 when NA #1 right thigh and the wit- intervene for the prote 483.75 (F 520) at J Immediate jeopardy to Nurse Aide (NA) #1 s face and the witness, did not immediately re- for protection of Resid physical abuse occur slapped Resident #6 witness, NA #2 did no of Resident #6. The facility provided to Centers for Medicare acceptable allegation A revisit survey was of verification of the faci compliance and to de ongoing Immediate J Jeopardy was remove At the time of the exit remained out of comp F-226, F-282, F-490, and severity of (D) iso potential for more that	ection of Resident #6. began on 02/16/16 when lapped Resident #6 on the NA #2 did not intervene and eport to administrative staff dent #6. A second incident of red on 02/16/16 when NA #1 on the right thigh and the ot intervene for the protection the State Agency and the and Medicaid with an of compliance on 03/08/16.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/201 FORM APPROVEI OMB NO. 0938-039		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING		R-C 03/14/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00,14,2010		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
{F 000}	Continued From page		{F 000]	}			
	the process of monito their corrective action	ring the implementation of					
{F 164} SS=D	483.10(e), 483.75(l)(4		{F 164	}	3/18/16		
		right to personal privacy and r her personal and clinical					
	Personal privacy includes accommodation medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, bu does not require the facility to provide a pri room for each resident.						
	section, the resident r	paragraph (e)(3) of this may approve or refuse the nd clinical records to any facility.					
	and clinical records d resident is transferred	o refuse release of personal oes not apply when the I to another health care elease is required by law.					
	contained in the resid the form or storage m release is required by	r transfer to another law; third party payment					
	by: Based on an observa	is not met as evidenced ation, staff interviews and w, the facility failed to provide		A resident has the right to personal privacy and confidentiality of his or he	er		

Facility ID: 970828

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		MEDICAID SERVICES				<u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	LE CONSTRUCTION	CO	TE SURVEY MPLETED
		345502	B. WING			R-C <b>3/14/2016</b>
NAME OF PF	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CO	•	5/14/2010
				3315 FAITH CHURCH ROAD		
LAKE PAR	K NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETION DATE
{F 164}	Continued From page	a 4	{F 164	n		
[1 101]			1 10-	•		
		resident, by closing the y curtain during medication		personal and clinical records Personal privacy includes	5.	
		hen an enteral feeding		accommodations, medical ti	eatment	
		tered for 1 of 3 sample		written and telephone comm		
		or enteral feeding products		personal care, visits and me		
	(Resident #36)			family and resident groups,	-	
	(			not require the facility to pro		
	The findings included	1:		room for each resident.		
	Resident #36 was ad	mitted to the facility on				
		included cognitive deficit,		F 164		
		igestive tract, intestinal				
	obstruction, and perif	onitis.		1) Since 2/24/16 resident#3 provided privacy by closing		
	On 02/24/16 at 05:35	6 AM Resident #36 was in		the privacy curtain during m	edication	
	her bed with the head	d of the bed elevated to		administration and when ete	rnal feeding	
		grees. On 02/24/16 at 05:48		product is administered.		
		ng bottle of Glucerna 1.2				
		nteral feeding pump was		2) On 2/26/16 Nurse#6 and		
		e #7 was observed to turn off		were in-serviced by staff fac		
		ump per the request of		to providing privacy during r		
		vas noted to gather supplies		administration and when en	•	
		Resident #36 which included		administration to tube fed re		
	•	ottle of Glucerna 1.2. On		include closing blinds and p	•	
		<ol> <li>Nurse #7 lifted the shirt of exposed her brief, torso, and</li> </ol>		privacy curtain. Privacy is be to all tube fed residents by c		
		ath her breast area. Nurse		blinds and the privacy curtai	•	
	-	lications to Resident #36 via		medication administration a	-	
		arted the enteral feeding		eternal feeding product is a		
		curtain was open, the				
		ent in the room, the room				
	door was open and th			3) On 2/26/16 the staff facili	tator initiated	
		the first bed next to the room		in-servicing with all nursing		
		in the room faced the		providing privacy (pulling cu		
	facility's parking lot. 7	There was car activity noted		blinds etc.) during care inclu		
	and people observed	in the parking lot.		medication administration a	nd enteral	
				feeding administration to the		
		ewed on 02/24/16 at 6:10 AM		resident. All new hires will c		
	and stated he was tr	ained to provide privacy	1	receive in-service during or	ontation	1

CENTER STATEMENT ( AND PLAN OF NAME OF P	DEPARTMENT OF HEALTH AND HUMAN SERVICES         DEPARTMENT OF HEALTH AND HUMAN SERVICES         STATEMENT OF DEFICIENCIES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         AND PLAN OF CORRECTION         AND PLAN OF CORRECTION         AME OF PROVIDER OR SUPPLIER         LAKE PARK NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES		A. BUILDING B. WING S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED R-C 03/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
{F 164}	privacy curtain betwee sure the blinds were of providing privacy to R administered her med The Interim Director of interviewed on 02/25/ interview she stated to incident of sexual abu- to leave room doors of provided unless the re- their door closed. The expected staff to prov	I medications by closing the en residents and to make closed; he apologized for not esident #36 when he lications. If Nursing (DON) was 16 at 8:48 AM. During the hat due to the recent use, staff were encouraged upen when care was esident requested to have a Interim DON stated she ide privacy to a resident by rtain between residents and	{F 164}	<ul> <li>process.</li> <li>4) The provision of resident privacy wi monitored by the administrative staff (DON, ADON, nursing supervisor, staff facilitator, MDS, social worker, activitied director, maintenance director, admissions director, medical records, dietary manager, housekeeping supervisor). Administrative staff is monitoring staff performance for pulling privacy curtains and closing window bit to ensure resident privacy is being provided during care. Tube fed reside will be included in the monitoring to ensure privacy is provided during medication /tube feeding administration using the Privacy/Choices/ADLs/Wheelchair aud tool. To make sure that the solutions a sustained, the audit tool will be complet on 10 residents per working week to include all 3 shifts x 4 weeks, then 10 residents bi-weekly for 8 weeks, then 10 residents bi-weekly for 8 weeks, then 10 residents monthly x 3 months. The DO and/or administrator will review the au- results on a weekly basis to make sure any area of concern regarding privacy corrected at time of identification and solutions are sustained.</li> <li>The monthly QI committee will review results of the "Privacy/Choices/ADL's/Wheelchair aud tool monthly for 6 months for identification of trends, actions taken and to determ the need for and/or frequency of continued monitoring, and make recommendations for monitoring for</li> </ul>	ff ess g of linds ents n dit re eted 10 DN dit estis is the udit tion

Facility ID: 970828

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. DOILDING		R-C
		345502	B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
LAKE PA	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD	
				INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
{F 164}	Continued From page	e 6	{F 164	} continued compliance.	
				The administrator and/or DON will p the findings and recommendations of monthly QI committee to the quarter executive QA committee for further recommendations and oversight.	of the
{F 166} SS=D	483.10(f)(2) RIGHT T RESOLVE GRIEVAN	TO PROMPT EFFORTS TO ICES	{F 166	}	3/18/16
	facility to resolve grie	t to prompt efforts by the vances the resident may with respect to the behavior			
	by: Based on record rev interviews the facility regarding bed baths for grievances. (Resi The findings included	l: admitted to the facility on		A resident has the right to prompt ef by the facility to resolve grievances t resident may have, including those v respect to the behavior of other resid F 166	the vith
	hypertension, anxiety and weakness. Revie quarterly Minimum D 01/25/16 indicated th cognitively intact and assistance with activi MDS further indicated identified.	<ul> <li>/, depression, dysphagia,</li> <li>ew of the most recent</li> <li>ata Set (MDS) dated</li> <li>at Resident #24 was</li> <li>required extensive</li> <li>ities of daily living (ADL). The</li> </ul>		1) On 2/25/16 resident #24 was interviewed by the DON to discuss concern related to bathing schedule. Resident #24 is satisfied with receive three bed baths per week. Resident bathing schedule was adjusted by th DON to ensure resident would receive three baths per week.	ing #24 ne
	through 02/24/16 for Resident #24 had red	Resident #24 revealed that ceived no type of bathing or or 21 of the last 30 days.		2) On 2/29/16 resident concerns were reviewed for the past thirty days to e residents and/or the resident RP are satisfied with the resolution and follo	ensure

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
	CONNECTION	IDENTIFICATION NOWDER.	A. BUILDI	IG		
						R-C
		345502	B. WING			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
{F 166}	Continued From page	e 7	{F 1	563		
. ,		esident #24's friend and		Any areas of concern	were addressed	
	responsible party (RF	<ul> <li>P) filed a grievance on</li> <li>f that read in part Resident</li> </ul>		immediately.		
		baths this is not including bed		3) On 3/1/16 the adm	inistrator initiated an	
	baths given by hospic	-		in-service for the adm		
		cted outcome stated that		Follow Up to Residen	nt Concerns which	
		eceive an extra bath weekly.		included:		
	The resolution to the	grievance stated that				
	Resident #24 would r	eceive an extra bath a week		1) When addressing	resident concerns,	
	for a total of 3 baths	per week and Resident # 24		you must include deta	ailed information for	
	was satisfied with the			resolution of concern		
		ent Concern" form was		<ol><li>Any needed audit</li></ol>		
	Administrator.	or of Nursing (DON) and the		support monitoring sh documented.	nould be	
		ent #24 on 02/23/16 at 3:02				
		was waiting to get his bath		4) The administrator		
		#24 stated that he had not		review resident conce		
		Il and was waiting on the		"Resident Concern" r	0	
	nursing assistant to	ated that he did not take		ensure concern have the resolution reviewe		
		nic pain, so he took bed nd Thursdays when the		resident/RP in a time a written response or	-	
		nd assisted him. Resident		and details of the follo		
		e days that hospice is not		with a date.		
		f is "supposed to wash me				
	-	Resident #24 further stated		The administrator and	d/or DON will present	
		py with 3 bed baths per		all findings at the mor	-	
		stated the he remembered		meeting. The QI com	-	
		his friend and RP on his		minutes of the reside		
		tion was fine if he was			nt Concern" audit tool	
	actually receiving the	3 bed baths per week but		for 6 months for ident		
	he was not.			actions taken, and to	determine the need	
	Interview with Social	Worker Assistant (SWA) on		for and/or frequency	of continued	
		stated the resident concern		monitoring, and make		
		side her office and on		for monitoring for con	tinued compliance.	
		and families are notified				
	-	ed. When a resident or family			d/or DON will present	
	-	aced on the "Resident		the findings and reco		
	Concern" form and th	en she routed it to the		monthly QI committee	e to the quarterly	

Facility ID: 970828

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2010 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		R-C 03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
{F 166}	Continued From page		{F 16	•		
{F 223} SS=D	recalled the grievance stated that he was in resolution of adding t no other follow up wa Resident #24 was rec would be up the man concern was routed to Interview with the inter (DON) on 02/24/16 at had received the grie had spoken with the side bath was scheduled as receive 3 bath per we agreement with this. no further follow up h Resident #24 had rec further stated that she week or 2 later to see satisfied with the reso 483.13(b), 483.13(c)( ABUSE/INVOLUNTA The resident has the sexual, physical, and punishment, and invo The facility must not to or physical abuse, co involuntary seclusion This REQUIREMENT by: Based on staff interv facility failed to proteo from physical abuse of	he 3 bath per week but that is done to determine if ceiving the bath or not, that ager for the department that oo. erim Director of Nursing t 5:51 PM revealed that she vance from the DON and shower team and an extra so that Resident #24 would eek and he was in The interim DON stated that ad been done to determine if ceived 3 baths per week, she e should have went back a e if Resident #24 was olution at that point. 1)(i) FREE FROM RY SECLUSION right to be free from verbal, mental abuse, corporal oluntary seclusion. use verbal, mental, sexual, rporal punishment, or	{F 22:	<ul> <li>executive QA committee for further recommendations and oversight.</li> <li>The resident has the right to be free verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion</li> </ul>	from	

Event ID: NYX812

Facility ID: 970828

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		ND HUMAN SERVICES				FORM	): 03/24/201 /I APPROVE ). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		33	15 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
{F 223}	Continued From page	- <b>0</b>	(F 02	101			
{i 220}	nursing care. A reside	e 9 ent was physically abused ember slapped her on the	{F 22	23}	F 223		
	face and then on the sampled residents re #6). Immediate Jeopardy Nurse Aide (NA) #1 s on the face and again #6). Each incident of the secure unit and w #2 did not immediate administrative staff th abuse against Reside this Resident and oth unit from further abus assessed with redden thigh.	right thigh for 1 of 1 viewed for abuse. (Resident began on 02/16/16 when slapped a combative resident n on the right thigh (Resident physical abuse occurred on vas witnessed by NA #2. NA ly intervene or report to nat she witnessed physical ent #6 and failed to protect ner residents on the secure			<ol> <li>1) On 2/16/16, Resident #6 was asset by the Medical Director. No new order were received. On 2/16/16 Resident # was assessed by Nurse #1 which incl a head to toe assessment. The finding revealed a reddened area on upper ri thigh and small healing bruises. Resi #6 still resides in the facility. On 2/16/ NA #1 was suspended from employm for physically abusing Resident #6 an terminated on 2/22/16.</li> <li>2) Because all residents have the potential to be affected by verbal, sex physical and mental abuse, corporal punishment, and involuntary seclusion 2/16/16 staff nurses completed 100%</li> </ol>	rs #6 uded gs ght dent 16 ent d	
	Centers for Medicare allegation of complian	the State Agency and and Medicaid an acceptable nce (AOC) on 03/08/16.			body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findings were identified. On 2/16/16, the social work interviewed all alert and oriented resid	ker	
	determine the status Jeopardy. The facility review of the followin Skin audits for all coo dated 02/16/16 Documentation of inte	conducted on 03/14/16 to of the ongoing Immediate r provided documentation for g: gnitively impaired residents erviews regarding abuse for esidents dated 02/16/16			related to abuse and resulted in no negative responses. On 2/19/16 NA#, was disciplined for failure to report immediately allegation of abuse accor to the Abuse policy and on 2/25/16 N, was terminated for not providing safet Resident #6.	rding A #2	
	Documentation of in- (identifying/reporting with dementia) for all completed by 03/07/ <sup>7</sup> Documentation of ab which began on 02/2	services abuse, caring for residents currently employed staff			3) On 2/16//16 all facility staff includin Administrative and current contract st present were re-educated either by Administrator or Director of Nursing (DON) on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety	aff	

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		ND HUMAN SERVICES				FOR	D: 03/24/201 M APPROVEI
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	• •			COMPLETED	
		345502	B. WING				R-C 8/ <b>14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				33	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 223}	Continued From page	e 10	JE 3	223}			
(,	1.0	allegation of neglect on	ι <sup>2</sup>	-205	all residents and removing the accus	ed	
	02/27/16				from resident care area immediately.		
		ort for Resident #6 for the			2/18/16 staff facilitator started a vide		
	8:00 AM incident of a	abuse which had not			in-service for all staff entitled Being	with a	
		rted to the Health Care			Person with Dementia: Actions and		
	•••	HCPR). Both reports were			Reactions." On 2/26/16, 2/29/16, 3/1		
	faxed the the HCPR	on 02/25/16 staff hired since 02/16/16 to			and/or 3/2/16 all staff and contract st		
		ground checks, reference			attended a Directed □in-service pres by the Regional Ombudsman Area	enteu	
		Registry checks, license			Agency on Aging. Titled: Identificatio	n and	
	checks, and abuse tr				Prevention of Elder Abuse. On 3/1/10		
	The facility's Abuse F	Policy			Staff facilitator started an in-service f	or all	
					nurses and nursing assistants on		
		ing care, interviews with			following resident care plans and car		
		dents, interviews with family,			guides. No staff will take an assignm	ent	
		aff present in the facility on Il documentation to support			until these in-services has been completed.		
	the AOC and intervie				completed.		
		or of Nursing and the Nurse			On 3/4/16 an in-service was held for	all	
		sufficient evidence to			staff by The Geriatric and Adult Ment	al	
		tion by the facility to remove			Health Specialty Team titled "Managi	ng	
		dy at F-223. The immediate			Challenging Behaviors." Quarterly		
		ed on 03/14/16 at 7:15 PM.			in-services will be offered to all staff I	by the	
	-	out of compliance at F-223			Specialty Team. All newly hired employees will continue to receive tra	ainina	
	-	d severity of (D) isolated, no ential for more than minimal			on the Abuse policy through written,	•	
		ediate jeopardy, while the			and verbal education. New hires, prio		
		process of monitoring the			taking an assignment will watch the		
	implementation of the				series "Hand in Hand," a series prov	riding	
					training on caring for residents with		
					dementia and on preventing abuse.		
	The findings included	1:				e de	
	Posidont #6 was ada	nitted to the facility on			4) The DON, ADON, Department He		
		nitted to the facility on included dementia with			and administrative staff on administra staff rounds will continue to monitor a		
	-	ective disorder, cognitive			complete abuse observations on 10		
		it, paranoid delusional beliefs			residents per shift to be completed se	even	
		lent #6 was currently being			days a week three times a day to inc		
		by ongoing psychiatric			each shift per week x4 weeks, 10		

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING				R-C 3/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA			33	315 FAITH CHURCH ROAD		
	IN NORSING AND REHA	BEHATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 223}	physician orders date (antianxiety) 2 milligra injection as needed for 1 mg every 8 hours a A quarterly Minimum assessed Resident # cognition, required ex- persons for activities include mobility, trans physically and verbal impairments in range A care plan dated 12/ Resident #6 had protocharacterized by ineff verbal and physical at treatment/care as evi swinging arms and do plan's goal specified resident's safety. The included the following slowly from the front, provide diversion actif ADL routine to accorr care is refused, leave Review of the "Residu staff were encourage	v revealed Resident #6 had d 08/31/15 for Ativan ams (mg) IM (intramuscular) or pain and 11/16/15 Ativan s needed for agitation. Data Set dated 12/29/15 6 with severely impaired dtensive staff assistance of 2 of daily living (ADL) to offers, dressing and toileting, ly abusive and without of motion. (29/15 recorded that blematic behavior fective coping behaviors of buse, resistive to denced by yelling, cursing, elusional behavior. The care that staff were to ensure the e care plan's interventions g: approach calmly and respect personal space, vity, allow for flexibility in modate mood, and when e and return in 5-10 minutes. ent care guide" revealed d to approach Resident #6 manner and if care was	{F 2	223}	residents bi-weekly for 8 weeks and th 10 residents monthly x3 months using Abuse/Neglect audit tool called "Wato For and Responding to an Incident." monthly QI committee will review resu of the Abuse/Neglect audit tool results monthly for 6 months for identification trends, actions taken and to determine need for and/or frequency of continue monitoring, and make recommendation for monitoring for continued compliand The administrator and/or DON will pre- the findings and recommendations of monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	the hing The ilts of the dons ce. esent the	
	practitioner (NP) rever referred by nursing for agitation and persever	d 02/05/16 by the nurse aled Resident #6 was r evaluation of morning ering behaviors. Nursing at #6 was noted increasingly					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA				3315 FAITH CHURCH ROAD		
	IN NORSING AND REITA				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 223}	agitated primarily in the note recorded that Review of a nursing progress not positive effects and the needed for pain at 12 effects. A nursing progress not positive effects and the needed for pain at 12 effects. A nursing progress not positive effects and the needed for pain at 12 effects.	he morning. The progress esident #6 was noted by the d, angry, and confused. usted and staff were to view for Resident #6 dated rd any changes or concern orogress note dated written by Nurse #1 and the ation Administration Record ht #6 was very combative . Nurse #1 documented that an 1 mg by mouth as at 7:40 AM with some hen Ativan 2 mg IM as :10 PM with slight positive the dated 02/16/16 at 4:56 rded that nursing assistant he slapped Resident #6 Resident pulled her hair. was notified and assessed #1 performed a full body lent #6 and noted a deep Resident's right upper thigh.	{F 2	223			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345502	B. WING				R-C 3/14/2016
	ROVIDER OR SUPPLIER	BILITATION CENTER		331	REET ADDRESS, CITY, STATE, ZIP CODE 5 FAITH CHURCH ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		DIAN TRAIL, NC 28079 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 223}	noted with red marks A written statement b recorded that NA #1 s leg on 02/16/16 arour #6 become combative #1. Review of a Health C (HCPR) 24 Hour Initia completed by the Adr 02/16/16 at 10:00 AW Resident #6 on her le pulling her hair. Reside mark on her upper rig Review of the facility! written statement by to 02/19/16, which record Deputy Sheriff on 02/ was asked if she was witnessed NA #1 slap about 8:00 AM. The w that the Administrator Administrator docume #2 on 02/17/16 and w witnessed NA #1 slap 02/16/16 around 8:00 thigh above her knee Resident became cord Written statements by recorded that on 02/1 witnessed Resident # morning care and NA the left side of her face leave the Resident's to	erwards the Resident was across the right thigh. y NA #1 dated 02/16/16 struck Resident #6 on her and 10:00 AM when Resident e and pulled the hair of NA are Personnel Registry al Report dated 02/16/16 ministrator, recorded that on 1, NA #1 stated she struck eg to stop the Resident from dent #6 was noted with a red ght thigh. s investigation revealed a the Administrator, dated rded that she spoke to the 16/16 around 9:00 PM and a aware that NA #2 also 0 Resident #6 on 02/16/16 written statement recorded r was not aware. The ented that she spoke to NA vas informed that NA #2 0 Resident #6 on the face on 0 AM and again on the right at 10:00 AM, when the	{F 2	23}			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		O. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
			5.14/11/0			R-C
		345502	B. WING		03	/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
{F 223}	Continued From page	a 14	{F 223			
(i 220)			{F 223	3		
	#6. Later in the morning around 9:45 AM on 02/16/16, while in the shower room, NA #2					
		6 grab the hair of NA #1 and				
	NA #1 slapped Resident #6 on the leg. NA #2					
		1 leave the shower room and				
	report the incident to	Nurse #1 and Nurse #2.				
	Review of a HCPR 5	Working Day Report dated				
	02/19/16, completed					
	recorded on 02/16/16					
	immediately reported					
		n the leg during resident ouse was witnessed, NA #1				
		pended, the police was				
		e allegation of abuse was				
	substantiated and NA	#1 was terminated.				
		#2 was conducted on				
		1. NA #2 stated that she				
		e training recently and knew abuse she should tell the				
		nove the resident from harm,				
		and don't let the perpetrator				
	, <b>Q</b>	ooms. NA #2 stated that on				
		AM Resident #6 would not				
	•	Ind became combative (kicking, yelling and hitting).				
		nessed Resident #6 hit NA				
		sed NA #1 slap Resident #6				
	on the left side of her	face and said "You are				
		A #2 stated the slap was				
		on the face, but it wasn't a				
		ed Resident #6 was already upset. Both NAs continued				
		lressed, placed her in her				
		1 took Resident #6 to the				
	-	tated that on the way to the				
		topped at the nurse's station				
	and told Nurse #1 "I p	popped (Resident #6)" and				1

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TATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY PLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			R-C
		345502	B. WING		03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 223}	Nurse #1 said "Ok." Nout later that Nurse # statement. NA #2 stat slapped Resident #6 definition of abuse, but to separate NA #1 fro further stated she did again and thought Nut the incident and woul further stated that late AM, both NA #1 and I Resident #6 in the sh Resident became cor NA #1 bent down to p and Resident #6 grab when NA #1 slapped thigh. NA #2 stated th hear, but she didn't ku #6 released her grip of finished pulling up the transferred her to the	NA #2 stated that she found 1 did not hear NA #1's ted she felt that when NA #1 that the incident fit the ut that she didn't know how im Resident #6. NA #2 not think it would happen urse #1 heard NA #1 report d take care of it. NA #2 er that morning around 10:00 NA #2 were toileting ower room when the nbative again. During care, bull up the Resident's pants obed NA #1's hair. That's Resident #6 on her right ne slap was loud enough to now what to do. Resident on NA #1 hair and they	{F 223}			
	she observed NA #1 i nurse's station and to that she "popped" Re #2 immediately left th DON returned to the talk to the DON and ti the unit. NA #2 stated 02/16/16 what happed that NA #1 slapped R her face about 8:00 A thigh about 10:00 AM informed the police of interviewed her that e					

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	TED: 03/24/2016 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		345502	B. WING				R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				3315 F	AITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		INDIA	N TRAIL, NC 28079		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION)           TAG         CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 223}	at 12:55 PM with NA worked on the facility permanent assignme abuse training. NA #1 how to identify abuse witnessed, she should from the resident, cal Administrator, and ma resident were both wa 02/16/16 Resident #6 and she responded b Resident's face and s #1 stated "I just touch and NA #2 was prese the nurse's station aff Resident #6 and told was a hand full, but s her face because she anything to it. NA #1 on the Resident's fac morning around 10:00 toileting Resident #6 Resident became cor #1 stated that while s Resident's brief, the F pulling so hard "I was smacked her on the r I said stop and she st struck her gently beca hurt anyone. Resident hitting, we got her dre day room. NA #1 state to Nurse #1 and Nurs Resident #6 on the le a statement from her A telephone interview at 11:10 AM and a fol	#1. She stated that she 's secure unit as her nt and had recently received I stated she was trained on and if abuse was d remove the perpetrator I law enforcement or the ake sure the perpetrator and atched. NA #1 stated that on, b slapped her on the face y gently touching the said "Let's don't do that." NA hed her face with my hand" ent. NA #1 stated she went to the providing care to Nurse #1 that the Resident he did not report touching e did not think there was stated there was no mark left e. NA #1 stated later that 0 AM, she and NA #2 were in the shower room and the mbative, worse this time. NA he was pulling up the Resident grabbed her hair, a up on my tip toes", so "I ight knee to get her to stop, topped." NA #1 stated she ause it was not her nature to at #6 continued yelling and essed and took her to the ed afterwards, she reported se #2 that she struck eg, the DON came and took and she was suspended.	{F 2	23}			

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	S FOR MEDICARE &					O. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	E SURVEY		
	CONTRECTION		A. BUILDING					
						R-C		
		345502		B. WING 03/14/2016				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD				
		BILITATION CENTER		INDIAN TRAIL, NC 28079				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE		
{F 223}	Continued From page	e 17	{F 223	}				
		, Nurse #1 stated that on						
		14 residents on the secure						
		10:15 AM, NA #1 informed						
		and NA #2 provided care to						
		lower room, the Resident						
		nd grabbed NA #1 by the						
		e "popped" Resident #6 to						
		se #1 stated Nurse #2						
		present and heard the						
		stayed at the nurse's station						
		Nurse #2 reported the						
		The DON came to the unit,						
		n NA #1 and she was						
		I stated that NA #1 worked						
		the secure unit that day from						
		s suspended around 10:30						
		is not aware of any prior						
		garding NA #1. Nurse #1						
		een informed that NA #2						
		Resident #6 on the face						
		Nurse #1 stated Resident #6						
	-	es, usually required 2 staff						
		se #1 stated that staff were						
		idents became combative,						
	staff should give the	resident time to calm down,						
	try to redirect and co	me back later to provide						
		d Resident #6 was very						
	combative that day a	nd received Ativan (as						
	needed) twice on her	shift that day for agitation						
	and later for pain. Nu	rse #1 stated Resident #6						
		ially with a skin assessment,						
	and Ativan was given	to calm her down. Once						
	Resident #6 was calr	n, a full body skin						
		npleted, around 12:30 PM						
	and she was noted w	ith a reddened area to her						
	right thigh about 3 inc	ches long and irregular in						
	shape. Nurse #1 stat	ed there were no other						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 MAPPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345502	B. WING				₹-C 8/ <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 223}	3:52 PM. She stated around lunch time on "popped" Resident ## room and reported he Administrator that NA she had started comp investigation. The Ad around 6:00 PM. The went to see Resident around 7:00 PM whe Both she and the poli #6 without any marks Administrator stated I 9:00 PM, the police of she knew about anot happened earlier that stated she was not an at the DON's investig stated she called NA morning on 02/17/16 from her over the pho of physical abuse that on 02/16/16 and report Administrator asked I statements about whe Nurse #2 was intervie AM. Nurse #2 stated Supervisor on the 7A Nurse #2 and Nurse # station on the secure 10:00 AM when NA # to know that I just pop #1 proceeded to say #6 because the Resid #2 stated she asked station. Nurse #2 wer	s interviewed on 02/24/16 at that the DON informed her 02/16/16 that NA #1 5 on the knee in the shower erself. The DON told the 4 #1 was suspended and that oleting interviews for the ministrator called the police Administrator stated she #6 for the first time that day in the police officer arrived. ice officer observed Resident to either thigh. The later that evening, around fficer caller her and asked if her incident of abuse that t day, but the Administrator ware and she had not looked ation. The Administrator #2 sometime the next and obtained a statement one regarding both incidents t were witnessed by NA #2 orted to the DON. The NA #2 to provide written at she saw.	{F 2	223}			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2010 FORM APPROVED OMB NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
	ROVIDER OR SUPPLIER	BILITATION CENTER	331	EET ADDRESS, CITY, STATE, ZIP CO 5 FAITH CHURCH ROAD DIAN TRAIL, NC 28079	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
{F 223} {F 225} SS=D	suspended. Nurse #2 of any previous incide #1 and Resident #6. Attempts to interview unsuccessful. The administrator was jeopardy on 02/24/16 An extended survey w 483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPC	from NA #1 and she was estated she was not aware ents of abuse between NA the DON were s notified of immediate at 5:27 PM. was conducted on 02/25/16. c)(2) - (4) DRT	{F 223} {F 225}		3/18/16
	been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misap and report any knowle court of law against a indicate unfitness for other facility staff to th or licensing authoritie The facility must ensu- involving mistreatment including injuries of un misappropriation of re-	employ individuals who have ibusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s. ure that all alleged violations nt, neglect, or abuse,			
	to other officials in ac through established p State survey and cert	cordance with State law procedures (including to the			

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CENTER STATEMENT (	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA		3:	315 FAITH CHURCH ROAD	
	KK NUKSING AND KEHA	BILITATION CENTER	11	NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACT           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 225}	prevent further potent investigation is in pro- The results of all inve- to the administrator o representative and to with State law (includ certification agency) v incident, and if the all	hly investigated, and must tial abuse while the gress. stigations must be reported	{F 225}		
	by: Based on staff interv staff failed to immedia staff of a witnessed in which a resident was notified, the facility fai physical abuse to the Registry in 24 hours a in 5 working days for (Resident #6). Immediate Jeopardy I Nurse Aide (NA) #2 fa that she witnessed ph resident (Resident #6 resulted in further phy witnessed NA #1 slap but did not immediate protect the Resident f remained on the secu unsupervised and wa 02/16/16, by NA #2, tr right thigh. The facility	PResident #6 on the face, Ity report the abuse or from further abuse. NA #1 Ire unit, working		<ul> <li>F225 Investigation/Report allegations/individuals</li> <li>The facility must have evidence that a alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation in progress and the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with Stat law( including to State Survey and certification agency) within 5 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</li> <li>1) On 2/16/16, Resident #6 was asses by the Medical Director. No new or were received. On 2/16/16, Resident #6 was asses by Nurse #1 which included a head to assessment. The findings revealed a</li> </ul>	the be essed ders sed

Facility ID: 970828

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/20 FORM APPROVE OMB NO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER		- <b>1</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/14/2010
				3315 FAITH CHURCH ROAD	
LAKE PAF	K NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 225}	Continued From page	o 21	{F 225]		
<b>ξι 220</b> β			{F 225		4 - : - · I-
		he investigation of the		reddened area on the upper right t	•
	physical abuse within	i o working days.		and small healing bruises. Resider still resides in the facility. On 2/16/	
	The immediate ieopa	irdy is present and ongoing.		#1 was suspended from employment	
				terminated on 2/22/16.	
	The facility provided f	the State Agency and		On 2/16/16, staff nurses comple	ted
	Centers for Medicare	and Medicaid an acceptable		100% body audit on all cognitively	,
	allegation of complian	nce (AOC) on 03/08/16.		impaired residents in the facility fo	
	• • •			evidence of abuse. No negative fir	-
	-	conducted on 03/14/16 to		were identified. On 2/16/16, the so	
		of the ongoing Immediate / provided documentation for		worker interviewed all alert and or residents related to abuse and res	
	review of the followin	-		no negative responses.	
		gnitively impaired residents		On 2/19/16 NA#2 was discipline	d for
	dated 02/16/16			failure to report immediately allega	
	Documentation of inte	erviews regarding abuse for		abuse according to the Abuse poli	
	all cognitively intact re	esidents dated 02/16/16		on 2/25/16 NA #2 was terminated	for not
	Documentation of in-			providing safety for Resident #6.	
		abuse, caring for residents			
	-	currently employed staff		2) On 2/16/16 administrator submi	
	completed by 03/07/1	use monitoring on each shift		24 hour report to DHSR Health Ca Registry. On 2/22/16 administrator	
		6/16 and remained ongoing		submitted the 5 day report to DHS	
		s for an allegation of abuse		Health Care Registry for initial abu	
		allegation of neglect on		investigation of NA#1 striking Res	
	02/27/16			on the thigh.	
		rt for Resident #6 for the		On 2/25/16 administrator submitt	
	8:00 AM incident of a			hour report to DHSR Health Care	0,
		rted to the Health Care		for NA#1 alleging slapping Reside	
		HCPR). Both reports were		the face. On 2/25/16 administrator	
	faxed the the HCPR of	on 02/25/16 staff hired since 02/16/16 to		submitted 5 day report to DHSR H Care Registry for allegation identif	
		ground checks, reference		during investigation of initial abuse	
		Registry checks, license		involving NA#1 and NA#2 not repo	
	checks, and abuse tra			immediately 8:00 AM physical abu	-
	The facility's Abuse F	-		slapping incident.	
		ing care, interviews with		3) On 2/18/16 "The Hand in Hand:	A
		dents, interviews with family,		Training Series for Nursing Homes	

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/ FORM APPRO OMB NO. 0938-0	OVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		R-C 03/14/2016	5
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLET E APPROPRIATE DATE	TION
{F 225}	03/14/16, review of a the AOC and interview Administrator, Director Practitioner provided support corrective act the immediate jeopar jeopardy was remove The facility remained at a lower scope and actual harm with pote harm that is not imme facility continues the implementation of the The findings included Resident #6 was adm 04/10/14. Diagnoses behaviors, mood affe communicative defici and psychosis. Resid followed and treated services. A quarterly Minimum assessed Resident # cognition, required ex persons for activities include mobility, trans physically and verbal impairments in range A nursing progress no PM written by Nurse assistant (NA #1) ver	ff present in the facility on Il documentation to support ws with the facility's or of Nursing and the Nurse sufficient evidence to tion by the facility to remove dy at F-225. The immediate ed on 03/14/16 at 7:15 PM. out of compliance at F-225 d severity of (D) isolated, no ential for more than minimal ediate jeopardy, while the process of monitoring the eir corrective action. hitted to the facility on included dementia with ctive disorder, cognitive t, paranoid delusional beliefs lent #6 was currently being by ongoing psychiatric Data Set dated 12/29/15 6 with severely impaired stensive staff assistance of 2 of daily living (ADL) to sfers, dressing and toileting, ly abusive and without of motion. Dete dated 02/16/16 at 4:56 #1 recorded that nursing	{F 22	<ul> <li>5)</li> <li>Person-Centered Care of Pere Dementia and Prevention of Module Four- Being with a Prevention of Module Four- Being with a Preventia: Actions and React viewed by all staff.</li> <li>On 2/26/16, 2/29/16, 2/1/16 of staff and contract staff attend Directed-in-service presented Regional Ombudsman Area Aging Title: Identification and of Elder Abuse.</li> <li>On 2/25/16 administrator rectin-service from the corporate President of Operations. The included the following: The facility must ensure alleged violations involving meglect, or abuse, including i unknown source and misapp resident property are reporter immediately to the administration facility and to other officials in with State law through establic procedures (including to the and certification agency) The facility must have evail alleged violations are thor investigated, and must prever potential abuse while the investigated representative ar officials in accordance with S (including to the State survey certification agency) within 5 of the incident, and if the alleged violation for the administration agency in the state survey certification agency within 5 of the incident, and if the alleged violation for the state survey certification agency within 5 of the incident, and if the alleged violation for the state survey certification agency within 5 of the incident, and if the alleged violation for the state survey certification agency within 5 of the incident, and if the alleged violation for the state survey certification agency within 5 of the incident agency within</li></ul>	Abuse, erson with tions was or 3/2/16 all led a d by the Agency on d Prevention eived an Vice in-service that all histreatment, njuries of ropriation of d ator of the n accordance ished State survey vidence that oughly int further estigation is gations must tor or his/her id to other itate law v and working days	

Facility ID: 970828

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345502	B. WING				R-C / <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	RK NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	Continued From page	e 23	{F 22	25}			
	dated 02/16/16 comp Nursing (DON) record redness to her inner for reddened area, appro- the front of her upper A written statement bor recorded that NA #1 solid leg on 02/16/16 aroun #6 become combative #1. A Consultation Report by the DON, recorded not report abuse immer employee from an abor another supervisor wor advised of abuse, but Review of a Health C (HCPR) 24 Hour Initia completed by the Adr 02/16/16 at 10:00 AW Resident #6 on her lee pulling her hair. NA # suspended. The repor physical abuse that of AM. Review of the facility' written statement by for 02/19/16, which record Deputy Sheriff on 02/ was asked if she was witnessed NA #1 slap	<ul> <li>#1, and an incident report leted by the Director of ded that Resident #6 had thighs and an irregular oximately 3 inches long to right thigh.</li> <li>y NA #1 dated 02/16/16 struck Resident #6 on her nd 10:00 AM when Resident e and pulled the hair of NA</li> <li>rt dated 02/16/16, completed d a concern that NA #2 did nediately, remove the buse situation and report to hen the charge nurse was t did not respond.</li> <li>care Personnel Registry al Report dated 02/16/16 ministrator, recorded that on 1, NA #1 stated she struck eg to stop the Resident from 1 was immediately</li> </ul>			<ul> <li>must be taken.</li> <li>A 24 hour and 5 day report is reaction of the each allegation, including allegation and additional allegations occurring on the same day and/or involving the same employee/resident.</li> <li>4) The Corporate staff, i.e. corporate nursing consultant and/or regional via president will continue to review all allegations of abuse and intervention when reported to the administrator in accordance with the abuse policy and Elder Justice Act including appropriat agencies notifications. The monthly committee will review results of any allegations of the need for and /or freque of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings recommendations and oversight.</li> </ul>	ons for e ce s s d e QI y and ency	

Facility ID: 970828

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/24/2016 M APPROVEE D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345502	B. WING				R-C / <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	ABILITATION CENTER			15 FAITH CHURCH ROAD		
				IN	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 225}	Continued From page	e 24	{F 2	251			
(*)		ministrator was not aware.	رب <u>د</u>	201			
		cumented that she spoke to					
	NA #2 on 02/17/16 a	nd was informed that NA #2					
	-	o Resident #6 on the face on					
		0 AM and again on the right					
	Resident became co	e at 10:00 AM, when the mbative.					
	Written statements b	y NA #2, dated 02/17/16,					
		16/16 at 7:30 AM, NA #2					
		#6 become combative during					
	-	#1 slapped Resident #6 on					
		ce. NA #2 witnessed NA #1 room and make a statement					
		that she "popped" Resident					
		t she did not report the					
		buse against Resident #6					
		the nursing staff heard NA					
		in the morning around 9:45					
		le in the shower room, NA #2 #6 grab the hair of NA #1 and					
		lent #6 on the leg. NA #2					
		1 leave the shower room and					
		Nurse #1 and Nurse #2. NA					
		report the witnessed					
	incident of staff to res time.	sident physical abuse at this					
		y Nurse #1 dated 02/16/16 r dated 02/19/16 both					
		#1 stated she was not made					
		nessed NA #1 slap Resident					
		her face on 02/16/16 at 8:00					
		eport that she "popped"					
	Resident #6 on the ri 10:00 AM.	ght thigh on 02/16/16 around					
		Working Day Report dated					
	I COLOR OF A LICER 5	working Day Report dated					1

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				FOF	ED: 03/24/2016 RM APPROVED O. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	e Survey IPLETED
	345502	B. WING			R-C 3/14/2016
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		, 14,2010
			3315 FAITH CHURCH ROAD		
KK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
02/19/16, completed recorded on 02/16/16 immediately reported combative resident o care. The physical at was immediately sus called at 6:00 PM, the substantiated and NA report did not include abuse that occurred of An interview with NA 02/24/16 at 10:30 AM received a lot of abus that if she witnessed nurse/supervisor, rem watch the perpetrator go into any resident r 02/16/16 around 7:30 cooperate with staff a during morning care NA #2 stated she with #1 twice, then witness on the left side of her going to stop that." N more than just a pat of hard slap. NA #2 stat upset and remained of getting Resident #6 of wheelchair and NA #1 dining room, NA #1 s and told Nurse #1 "I Nurse #1 said "Ok." I	by the Administrator, b at 10:00 AM, NA #1 that she slapped a n the leg during resident ouse was witnessed, NA #1 pended, the police was a allegation of abuse was A #1 was terminated. The the witnessed physical on 02/16/16 around 8:00 AM. #2 was conducted on A. NA #2 stated that she se training recently and knew abuse she should tell the nove the resident from harm, r and don't let the perpetrator rooms. NA #2 stated that on D AM Resident #6 would not and became combative (kicking, yelling and hitting). nessed Resident #6 hit NA sed NA #1 slap Resident #6 r face and said "You are IA #2 stated the slap was on the face, but it wasn't a ted Resident #6 was already upset. Both NAs continued fressed, placed her in her 1 took Resident #6 to the tated that on the way to the topped at the nurse's station popped (Resident #6)" and NA #2 stated that she found e1 did not hear NA #1's	{F 22			
	S FOR MEDICARE &     OF DEFICIENCIES     CORRECTION      ROVIDER OR SUPPLIER     RK NURSING AND REHA     SUMMARY ST     (EACH DEFICIENCI     REGULATORY OR      Continued From page     02/19/16, completed     recorded on 02/16/16     immediately reported     combative resident o     care. The physical at     was immediately sus     called at 6:00 PM, th     substantiated and NA     report did not include     abuse that occurred     An interview with NA     02/24/16 at 10:30 AM     received a lot of abus     that if she witnessed     nurse/supervisor, ren     watch the perpetrator     go into any resident r     02/16/16 around 7:30     cooperate with staff a     during morning care     NA #2 stated she witt     #1 twice, then witnes     on the left side of her     going to stop that." N     more than just a pate     hard slap. NA #2 state     upset and remained     getting Resident #6 c     wheelchair and NA #1 s     dining room. NA #1 s     dining room. NA #1 s     and told Nurse #1 said "Ok." I     out later that Nurse #	F CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345502         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25 02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative resident on the leg during resident care. The physical abuse was witnessed, NA #1 was immediately suspended, the police was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 around 8:00 AM.         An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 hit NA #1 twice, then witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6 was already upset and remained upset. Both NAs continued getting room, NA #1 stated that on the way to the dining room, NA #1 stated that on the way to the dining room, NA #1 st	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES         CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         ABUILDING         345502         ROVIDER OR SUPPLIER         REX NURSING AND REHABILITATION CENTER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25         02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA#11 immediately reported that she slapped a combative resident on the leg during resident care. The physical abuse was witnessed, NA #11 was immediately suspended, the police was called at 6:00 PM, the allegation of abuse was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 around 8:00 AM.         An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed abuse she should tell the nurse/supervisor, remove the resident from harm, watch the perpetrator and don't let the perpetrator go into any resident rooms. NA #2 stated that on 02/16/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed NA #1 slap Resident #6 on the left side of her face and said "You are going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 was already upset and remained upset. Both NAs continued getting Resident #6 dressed, placed her in her wheelchair and NA #1 took Resident #6)" and Nurse #1 said "O	IS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (x1) PROVIDERSUPPLERCLIA JDENTFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A. BUILDING         ROVIDER OR SUPPLER       345502       B. WING         RK NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP OC 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079         SUMMARY STATEMENT OF DEFICIENCIES (RACH CORRECTIVE ACTIVE REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREVIDERS PLAN OF C (EACH CORRECTIVE ACTIVE REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREVIDERS PLAN OF C (EACH CORRECTIVE ACTIVE TAG         Continued From page 25 02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1 immediately reported that she slapped a combative regident on the leg during resident care. The physical abuse was witnessed, NA #1 was immediately suspended, the police was substantiated and NA #1 was terminated. The report did not include the witnessed physical abuse that occurred on 02/16/16 around 8:00 AM.         An interview with NA #2 was conducted on 02/24/16 at 10:30 AM. NA #2 stated that she received a lot of abuse training recently and knew that if she witnessed Abuse is should tell the nurse/supervisor, remove the resident ffom harm, watch the perpetrator and don't let the perpetrator go into any resident comes. NA #2 stated that on 02/12/16 around 7:30 AM Resident #6 would not cooperate with staff and became combative during morning care (kicking, yelling and hitting). NA #2 stated she witnessed Resident #6 to the dining room. NA #1 stopped at the nurse's station ant lot Nurse #1 stafe OK NA #2 stated that on the dining room. NA #1 stopped at the nurse's station and told Nurse #1 staid "OK." NA #2 stated fmat form and Nurse #1 staid "OK." NA #2 stat	MENT OF HEALTH AND HUMAN SERVICES     FOO       SFOR MEDICARE & MEDICALD SERVICES     OMB N       OF DEFICIENCIES     (X) PROVIDERUNUPLIENCLIA. IDENTIFICATION NUMBER:     DC2 MULTIPLE CONSTRUCTION       346502     B. WING     00       RK NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, 2P 000E     3315 FATH CHURCH ROAD INDIAN TRAIL, NC 28079       ILEAD OFFICIENCY WIST DE PRECORDED BY FULL REQUILINGY OR USC DENTIFYING INFORMATION)     D     PRECIN       Continued From page 25     02/19/14     D     READ OFFICIENCY)       Continued From page 25     (F 225)     (F 225)       Continued From page 25     (F 225)       02/19/16, completed by the Administrator, recorded on 02/16/16 at 10:00 AM, NA #1     FOO ORESCIVE ADDRESS       Immediately reported that she slapped a     Combative resident on the leg duation of abuse was substantiated and NA #1 (was terminated. The received a lot 00 AM, NA #2 stated that on 02/24/16 at 10:30 AM. NA #2 stated that on 02/24/16 at no troom AM. PS 41 stated that on 02/24/16 at 10:30 AM. NA #2 stated that on 02/24/16 at no troom AM. NA #2 stated that on 02/24/16 at no troom AM. PS 41 state ADDRESS, remove the resident for marm, watch the perpetrator and don't let the perpetrator going to stop that." NA #2 stated the slap was more than just a pat on the face, but it wasn't a hard slap. NA #2 stated Resident #6 to the dining room. NA #1 stated Resident #6 to the dining room. NA #1 stated Resident #6 to the dini

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			COMF	E SURVEY PLETED
		345502	B. WING			R-C 03/14/2016	
NAME OF PF	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				3	315 FAITH CHURCH ROAD		
	K NURSING AND REHA	BILITATION CENTER		11	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 225}	again and thought Nu the incident and woul further stated that late AM, both NA #1 and Resident #6 in the sh Resident became cor NA #1 bent down to p and Resident #6 grad when NA #1 slapped thigh. NA #2 stated th hear, but she didn't k #6 released her grip of finished pulling up the transferred her to the Resident #6 to the dir she observed NA #1 nurse's station and to that she "popped" Re #2 immediately left th unit with the DON. N/ the DON and then N/ unit. NA #2 stated the 02/16/16 what happe that NA #1 slapped R her face about 8:00 A thigh about 10:00 AM informed the police of interviewed her that et the Administrator on 0 her on the phone. A telephone interview at 12:55 PM with NA worked on the facility permanent assignme	not think it would happen urse #1 heard NA #1 report d take care of it. NA #2 er that morning around 10:00 NA #2 were toileting ower room when the mbative again. During care, pull up the Resident's pants obed NA #1's hair. That's Resident #6 on her right he slap was loud enough to now what to do. Resident on NA #1 hair and they e Resident's pants, wheelchair and NA #2 took hing room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 sident #6 on the leg. Nurse is unit and returned to the A#2 observed NA #1 talk to A#1 was escorted off the e DON asked her on ned and she told the DON lesident #6 on the left side of M and then on her right I. NA #2 stated she also fficer on 02/16/16 when he evening on the phone and 02/17/16 when she talked to was conducted on 02/24/16 #1. She stated that she 's secure unit as her nt and had recently received	{F 2	225}			
	how to identify abuse	I stated she was trained on and if abuse was d remove the perpetrator					

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/24/2016 1 APPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				3) DATE COMP	SURVEY LETED
		345502	B. WING			R-C 03/14/2016		
NAME OF PRO	VIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	NURSING AND REHA			3315 FAITH CHURCH ROAD				
	NORSING AND REHA	BILITATION CENTER			INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	<u>:</u>	(X5) COMPLETION DATE
	Administrator, and ma resident were both wa 02/16/16 Resident #6 she responded by ger face and said "Let's d ust touched her face was present. NA #1 s nurse's station after p and told Nurse #1 tha full, but she did not re because she did not re because she did not re resident's face. NA # around 10:00 AM, she Resident #6 in the she became combative, w hat while she was pu he Resident grabbed was up on my tip toes right knee to get her t stopped." NA #1 state because it was not he Resident #6 continuener dressed and took stated afterwards, she Nurse #2 that she stru- he DON came and to and she was suspend A telephone interviews at 11:10 AM and a foll conducted on 02/25/1 During the interviews, 02/16/16 there were 1 unit. Around 10:00 or her that while NA #1 a Resident #6 in the she	law enforcement or the ake sure the perpetrator and atched. NA #1 stated that on, slapped her in the face and htly touching the Resident's on't do that." NA #1 stated "I with my hand" and NA #2 tated she went to the roviding care to Resident #6 t the Resident was a hand port touching her face hink there was anything to was no mark left on the e1 stated later that morning e and NA #2 were toileting ower room and the Resident vorse this time. NA #1 stated Illing up the Resident's brief, her hair, pulling so hard "I s", so "I smacked her on the o stop, I said stop and she ed she struck her gently er nature to hurt anyone. d yelling and hitting, we got her to the day room. NA #1 e reported to Nurse #1 and uck Resident #6 on the leg, bok a statement from her led.	{F 2	225				

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	R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULT				
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	PLETED
	345502	B. WING			R-C 03/14/2016	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			3	315 FAITH CHURCH ROAD		
LAKE PARK NURSING AND REHABILITATION C	ENTER		11	NDIAN TRAIL, NC 28079		
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
<ul> <li>{F 225} Continued From page 28 hair. NA #1 stated she "popped" F get her to let go. Nurse #1 stated (supervisor) was also present and conversation. NA #1 stayed at the with Nurse #1, while Nurse #2 rep incident to the DON. The DON ca took a statement from NA #1 and suspended. Nurse #1 stated that I with all residents on the secure un 7:00 AM until she was suspended AM, but Nurse #1 was not aware of incidents of abuse regarding NA # stated she had not been informed witnessed NA #1 slap Resident #6 earlier that morning.</li> <li>The Administrator was interviewed 3:52 PM. She stated that the DON around lunch time on 02/16/16 tha "popped" Resident #6 on the kneet room and reported herself. The DO Administrator that NA #1 was sus she had started completing intervi investigation. The Administrator co working in her office and sometim PM she obtained the necessary in the DON to complete the HCPR 2 Report. The DON left for the day a but informed the Administrator bell she had obtained all the written st interviews. The Administrator did investigation before the DON left I thought the DON had done every Administrator called law enforcem PM. The Administrator stated she Resident #6 for the first time that of PM when law enforcement arrived the law enforcement observed Re without any marks to either thigh.</li> </ul>	Nurse #2 I heard the e nurse's station forted the me to the unit, she was NA #1 worked hit that day from around 10:30 of any prior #1. Nurse #1 that NA #2 5 on the face d on 02/24/16 at I informed her at NA #1 e in the shower ON told the pended and that ews for the ontinued e before 4:00 formation from 4 Hour Initial around 4:00 PM, fore she left that atements and not review the because she hing. The tent around 6:00 went to see day around 7:00 8. Both she and sident #6	{F 2	225}			

Facility ID: 970828

If continuation sheet Page 29 of 89

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					F	NTED: 03/24/2016 ORM APPROVED 3 NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTR		(X3)	DATE SURVEY COMPLETED
	345502	B. WING			R-C 03/14/2016	
NAME OF PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP COD	E	
			3315 FAIT	TH CHURCH ROAD		
LAKE PARK NURSING AND REHAE	SILITATION CENTER		INDIAN T	TRAIL, NC 28079		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
<ul> <li>9:00 PM, law enforcem she knew about anothe happened earlier that of stated she was not aw at the DON's investigal stated she called NA # morning on 02/17/16 a from her over the phor of physical abuse that on 02/16/16 and report Administrator asked NJ statements about what Administrator stated she HCPR 24 Hour Initial F 5 Day Working Report not report the incident occurred on 02/16/16 awas included in her inv Administrator further si that both incidents of p been reported to the H</li> <li>Nurse #2 was interview AM. Nurse #2 stated she Supervisor on the 7AM Nurse #2 and Nurse # station on the secure u 10:00 AM when NA #1 to know that I just popp #1 proceeded to say tf #6 because the Reside #2 stated she asked N station. Nurse #2 went what occurred. The DC obtained a statement f suspended. Nurse #2 statement f</li> </ul>	ter that evening, around nent called her and asked if er incident of abuse that day, but the Administrator are and she had not looked tion. The Administrator 2 sometime the next and obtained a statement he regarding both incidents were witnessed by NA #2 ted to the DON. The A #2 to provide written t she saw. The he completed/faxed the Report on 02/17/16 and the on 02/22/16, but she did of physical abuse that around 8:00 AM because it vestigation. The aid that now she realized ohysical abuse should have ICPR.	{F 2	25}			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	0011-12010
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER	-	315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
{F 225}	Continued From page	e 30	{F 225}		
	Attempts to interview unsuccessful.	the DON were			
	The administrator wa jeopardy on 02/24/16	s notified of immediate at 5:27 PM.			
{F 226} SS=D	An extended survey v 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		{F 226}		3/18/16
	policies and procedur	t, and abuse of residents			
	by: Based on staff interv facility failed to immer when a resident (Res to protect the residen physical abuse, interv was observed, and in perpetrator from a co secure unit. The facili witnessed incident of Care Personnel Regis investigation in 5 wor to follow their abuse p areas of prevention, p training and reporting abuse investigation re	physical abuse to the Health stry in 24 hours and the king days. The facility failed policy and procedures in the protection, identification, of physical abuse for 1 of 1		F226 Development/Implementation Policies for Abuse/Neglect 1)On 2/16/16, Resident #6 was assess by the Medical Director. No new orders were received. On 2/16/16 Resident #6 was assessed by Nurse #1 which inclu- a head to toe assessment. The findings revealed a reddened area on upper right thigh and small healing bruises. Resid #6 still resides in the facility. On 2/16/10 NA #1 was suspended from employme for physically abusing Resident #6 and terminated on 2/22/16. On 2/16/16 NA was re-educated on the Abuse Policy to include immediately intervene and stop abuse, remove the perpetrator and	6 5 ded 5 ht ent 6 nt #2 5

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2 FORM APPRO OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO	•
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD	
			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETI E APPROPRIATE DATE
{F 226}	Continued From page	s 31	{F 226	a)	
()		ent became combative	1 220	immediately report.	
		NA #2 witnessed the physical			
	abuse but did not imm to administrative staff protection to Residen which led to a second toward Resident #6.	nediately intervene or report This resulted in a lack of t #6 and other residents incident of physical abuse NA #2 witnessed NA #1 slap		<ol> <li>Because all residents had potential to be affected by very physical and mental abuse, or punishment, and involuntary 2/16/16 staff nurses complet</li> </ol>	erbal, sexual, corporal seclusion on ed 100%
	did not immediately re remained on the secu unsupervised and sec	veral hours later on		body audit on all cognitively residents in the facility for ev abuse. No negative findings identified. On 2/16/16, the sc	idence of were ocial worker
	#6 on the right thigh of The facility failed to re Health Care Personn	essed NA #1 slap Resident during the provision of care. eport physical abuse to the el Registry within 24 hours		interviewed all alert and orien related to abuse and resulted negative responses. On 2/19 was disciplined for failure to	d in no 0/16 NA#2 report
	5 working days.	of the physical abuse within rdy is present and ongoing.		immediately allegation of about to the Abuse policy and on 2 was terminated for not provid Resident #6.	/25/16 NA #2
		he State Agency and and Medicaid an acceptable nce (AOC) on 03/08/16.		3) On 2/16//16 all facility sta Administrative and contract s were re-educated either by A or DON on the Abuse Policy	staff present
d	determine the status	conducted on 03/14/16 to of the ongoing Immediate provided documentation for		constitute abuse. Abuse will tolerated, to ensure immedia all residents and removing th	te safety of
	dated 02/16/16	nitively impaired residents		from resident care area imm 2/18/16 Staff facilitator starte in-service for all staff entitled	ed a video d "Being with
	all cognitively intact re Documentation of in-s			a Person with Dementia: Act Reactions." On 2/26/16, 2/29 3/2/16 all staff and contract s	9/16, 3/1/16 or staff attended
	with dementia) for all completed by 03/07/1	abuse, caring for residents currently employed staff 6 use monitoring on each shift		a Direct □in-service presente Regional Ombudsman Area Aging. Titled: Identification a of Elder Abuse.	Agency on
	which began on 02/20	6/16 and remained ongoing for an allegation of abuse		On 3/1/16 Staff facilitator in-	serviced all

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVE	8-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					R-C	
		345502	B. WING		03/14/20	16
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD		
	KK NUKSING AND KEHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	(X5) PLETION DATE
{F 226}	Continued From page	a 32	{F 226	n		
(1 220)	1 0	llegation of neglect on	{  220	-	on	
	02/27/16	megation of neglect on		nurses and nursing assistants following resident care plans a		
		rt for Resident #6 for the		guides.		
	8:00 AM incident of a					
	previously been repor	rted to the Health Care		On 3/4/16 an in-service was of	fered for all	
	Personnel Registry (H	HCPR). Both reports were		staff by The Geriatric and Adult	t Mental	
	faxed the the HCPR of			Health Specialty Team titled "M		
		staff hired since 02/16/16 to		Challenging Behaviors." Quarte		
		ground checks, reference		in-services will be provided to a	all staff by	
		Registry checks, license		the Specialty Team.		
	checks, and abuse tra The facility's Abuse P	•		Staff Facilitator will continue to	nrovide	
		Uncy		ongoing annual abuse and neg	-	
	Observations of nursi	ing care, interviews with		education through written, vide		
		dents, interviews with family,		verbal education.		
	interviews with all sta	ff present in the facility on				
		Il documentation to support		All newly hired employees will		
	the AOC and interview	-		receive training on the Abuse p		
		or of Nursing and the Nurse		through written, video, and ver		
	Practitioner provided			education. Prior to taking an as	•	
		tion by the facility to remove dy at F-226. The immediate		new hires will watch the video		
		ed on 03/14/16 at 7:15 PM.		"Hand in Hand:" a series provid on caring for residents with der		
		out of compliance at F-226		on preventing abuse.		
		I severity of (D) isolated, no				
	-	ential for more than minimal		4) The DON, ADON, Departm	ent Heads	
		ediate jeopardy, while the		and administrative staff on adn		
		process of monitoring the		staff rounds will continue to mo		
	implementation of the	er corrective action.		complete abuse observations of		
				residents per shift to be comple		
	The findings included	l:		days a week three times a day each shift. per week x4 weeks,		
				residents bi-weekly for 8 weeks		
	The facility's policy "A	Abuse, Neglect, or		10 residents monthly x3 month		
		Resident Property Policy",		Abuse/Neglect audit tool called		
		uded in part: The facility will		for and responding to an Incide		
	do whatever is in its c	control to prevent		monthly QI committee will revie	ew results	
		t, and abuse of our residents		of the Abuse/Neglect audit tool		
	or misappropriation of	f their property Any		monthly for 6 months for identi	fication of	

Facility ID: 970828

	S FOR MEDICARE &			E CONSTRUCTION		O. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED		
			A. DOILDING			R-C		
		345502	B. WING			3/14/2016		
NAME OF P	ROVIDER OR SUPPLIER	•	- <b>·</b>	STREET ADDRESS, CITY, STATE, ZIP COD				
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD	TH CHURCH ROAD			
		BIENANON GENTER		INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE		
{F 226}	Continued From page	<b>-</b> 33	{F 226					
(1 220)		sses or suspects that abuse,		trends, actions taken and to c	determine the			
		priation of property has		need for and/or frequency of				
		ately report the alleged		monitoring, and make recom				
		rvisor, who will immediately		for monitoring for continued of				
	-	the Administrator. Measures						
		vent any further potential		The administrator and/or DOI	•			
		stigation is in progress. The onsible to review the results		the findings and recommendate monthly QI committee to the				
		nd report the alleged incident		executive QA committee for f	• •			
	-	encies in accordance with		recommendations and oversi				
		gulations. The Administrator			•			
	· ·	ct the investigation process						
		priate agencies are notified,						
	-	g: Training programs may resident vulnerability to						
		erventions. Prevention: The						
		pervision to staff to identify						
		ors, such as rough handling.						
		s, care plan, and monitor						
		and behaviors that might						
	-	t, or misappropriation of						
		Employees accused of being legations of abuse, neglect,						
		of property will be suspended						
		ployment pending the						
	outcome of the invest	tigation.						
	Review of the facility'	s Abuse, Neglect or						
		Resident Property policy						
	revealed a definition	of physical abuse was not						
	included.							
	Resident #6 was adm	nitted to the facility on						
		included dementia with						
	behaviors, mood affe	ctive disorder, cognitive						
		t, paranoid delusional beliefs						
	and psychosis. Resid treated and followed	lent #6 was currently being						

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			PLETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2010
	RK NURSING AND REHA	BILITATION CENTER		:	3315 FAITH CHURCH ROAD		
					INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	Continued From page	e 34	{F 2	226]	}		
	Medical record review physician orders date (antianxiety) 2 milligra injection as needed for physician's order date every 8 hours as need A quarterly Minimum assessed Resident #6 cognition, required ex persons for activities include mobility, trans physically and verball impairments in range A progress note dated practitioner (NP) reve referred by nursing for agitation and perseve reported that Residen agitated primarily in th note recorded that Res NP to be very agitated Medications were adj continue to monitor. A Skin Monitoring Ret 02/15/16 did not recon with skin integrity. Review of a nursing p 02/16/16 at 4:49 PM H February 2016 Medic recorded that Residen towards staff that day she administered Ativ needed for agitation a	v revealed Resident #6 had d 08/31/15 for Ativan ams (mg) IM (intramuscular) or pain and another ed 11/16/15 for Ativan 1 mg ded for agitation. Data Set dated 12/29/15 6 with severely impaired stensive staff assistance of 2 of daily living (ADL) to sfers, dressing and toileting, ly abusive and without of motion. d 02/05/16 by the nurse ealed Resident #6 was or evaluation of morning ering behaviors. Nursing ht #6 was noted increasingly he morning. The progress esident #6 was noted by the d, angry, and confused. usted and staff were to view for Resident #6 dated rd any changes or concerns progress note dated by Nurse #1 and the iation Administration Record in #6 was very combative v. Nurse #1 documented that					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE	
		345502	B. WING				-C 14/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA			:	3315 FAITH CHURCH ROAD		
		BIEITATION CENTER	INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	Continued From page needed for pain at 12 effects. A nursing progress no PM by Nurse #1 reco (NA #1) verbalized sh during care when the The Medical Director the Resident. Nurse # assessment for Resid reddened area to the A Skin Monitoring Ret completed by Nurse # #6 had redness to he irregular reddened are long to the front of he An incident report dat completed by the Direc recorded that NA #1 s #6 on the leg and after noted with red marks A written statement by recorded that NA #1 s leg on 02/16/16 arour #6 become combative #1. A Disciplinary Wa completed by the DO recorded that NA #1 s leg on 02/16/16 arour #6 become combative #1. A Disciplinary Wa completed by the DO recorded that NA #1 s	e 35 :10 PM with slight positive bite dated 02/16/16 at 4:56 rded that nursing assistant e slapped Resident #6 Resident pulled her hair. was notified and assessed #1 performed a full body lent #6 and noted a deep Resident's right upper thigh. view dated 02/16/16, #1, recorded that Resident r inner thighs and an ea, approximately 3 inches r upper right thigh. ed 02/16/16 at 5:03 PM ector of Nursing (DON), stated she struck Resident erwards the Resident was on the right thigh. y NA #1 dated 02/16/16 struck Resident #6 on her hd 10:00 AM when Resident e and pulled the hair of NA rning Notice dated 02/16/16, N and signed by NA #1, was suspended for an dealing with a resident	{F 2		DEFICIENCY)		
		ediately, remove the use situation and report to nen the charge nurse was					

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			:	3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA		1	NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
{F 226}	Continued From page	e 36	{F 226}		
. ,	advised of abuse, but		()		
	(HCPR) 24 Hour Initia completed by the Adr 02/16/16 at 10:00 AW Resident #6 on her le pulling her hair. Resid mark on her upper rig immediately suspend include the incident of occurred on 02/16/16 Review of the facility' written statement by to 02/19/16, which record law enforcement on 0 and was asked if she witnessed NA #1 slap about 8:00 AM. The w that the Administrator Administrator docume #2 on 02/17/16 and w witnessed NA #1 slap 02/16/16 around 8:00 thigh above her knee Resident became cor	ed. The report did not f physical abuse that a t 8:00 AM. s investigation revealed a the Administrator, dated rded that she spoke to the 02/16/16 around 9:00 PM was aware that NA #2 also b Resident #6 on 02/16/16 written statement recorded was not aware. The ented that she spoke to NA vas informed that NA #2 b Resident #6 on the face on 0 AM and again on the right at 10:00 AM, when the mbative.			
	recorded that on 02/1 witnessed Resident # morning care and NA the left side of her fac	y NA #2, dated 02/17/16, 6/16 at 7:30 AM, NA #2 6 become combative during #1 slapped Resident #6 on ce. NA #2 witnessed NA #1			
	at the nurse's station #6. NA #2 did not rep abuse against Reside	room and make a statement that she "popped" Resident ort the witnessed physical ent #6 because she thought d NA #1's statement. Later			
	•	d 9:45 AM on 02/16/16, while			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345502	B. WING			R-C 03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			5 FAITH CHURCH ROAD IAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	#6 grab the hair of N/ Resident #6 on the lef #1 leave the shower in to Nurse #1 and Nurse Written statements by and the Administrator recorded that Nurse # aware that NA #2 with #6 on the left side of AM. NA #1 did self-re Resident #6 on the right 10:00 AM. Review of a HCPR 5 02/19/16, completed recorded on 02/16/16 immediately reported combative resident of care and immediately wrong. The physical at was immediately sust was called at 6:00 PM was substantiated an The report did not inc abuse that occurred of An interview with NA 02/24/16 at 10:30 AM received a lot of abust that if she witnessed nurse/supervisor, rem watch the perpetrator go into any resident r 02/16/16 around 7:30 cooperate with staff at during morning care (	NA #2 witnessed Resident A #1 and NA #1 slapped g. NA #2 then witnessed NA room and report the incident se #2. / Nurse #1 dated 02/16/16 dated 02/19/16 both #1 stated she was not made nessed NA #1 slap Resident ther face on 02/16/16 at 8:00 port that she "popped" ght thigh on 02/16/16 around Working Day Report dated by the Administrator, at 10:00 AM, NA #1	{F 2:	26}			

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/24/2016 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345502	B. WING _				R-C 3/14/2016
NAME OF PROVIDER OR S	UPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				331	15 FAITH CHURCH ROAD		
LAKE PARK NURSING	AND REHA	BILITATION CENTER		IND	DIAN TRAIL, NC 28079		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
#1 twice, f on the left going to s more than hard slap. upset and getting Re wheelchai dining roo and told N Nurse #1 out later th statement slapped R definition to separat further sta again and the incide further sta again and the incide further sta AM, both Resident # Resident # NA #1 ber and Resid when NA thigh. NA hear, but s #6 release finished p transferred Resident # she obser nurse's sta that she "p #2 immed unit with th	side of her op that." N just a pat of NA #2 stat remained u sident #6 of r and NA # m. NA #1 s urse #1 "I p said "Ok." I hat Nurse # NA #2 stat of abuse, b e NA #1 s thought Nu ted she did thought Nu ted she did thought Nu ted she did thought Nu ted she did thought Nu ted that late NA #1 and would ted that late NA #1 and f6 in the sh became cou t down to p ent #6 grat #1 slapped #2 stated the she didn't k ed her grip of ulling up the d her to the f6 to the dif ved NA #1 ation and to popped" Re fately left the DON. No	e 38 sed NA #1 slap Resident #6 face and said "You are A #2 stated the slap was on the face, but it wasn't a ed Resident #6 was already upset. Both NAs continued lressed, placed her in her 1 took Resident #6 to the tated that on the way to the topped at the nurse's station popped (Resident #6)" and NA #2 stated that she found 1 did not hear NA #1's ted she felt that when NA #1 that the incident fit the ut that she didn't know how om Resident #6. NA #2 not think it would happen urse #1 heard NA #1 report 1d take care of it. NA #2 er that morning around 10:00 NA #2 were toileting ower room when the mbative again. During care, pull up the Resident's pants obed NA #1's hair. That's Resident #6 on her right he slap was loud enough to now what to do. Resident on NA #1 hair and they e Resident's pants, wheelchair and NA #2 took ning room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 esident #6 on the leg. Nurse he unit and returned to the A#2 observed the DON talk was escorted off the unit. NA	{F 2:	26}			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	-
				3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
{F 226}	happened and she to slapped Resident #6 about 8:00 AM and th 10:00 AM. NA #2 state enforcement on 02/10 her that evening on th Administrator on 02/10 on the phone. A telephone interview at 12:55 PM with NA worked on the facility permanent assignme abuse training. NA #1 how to identify abuse witnessed, she should from the resident, cal Administrator, and ma resident were both wa 02/16/16 Resident #6 and she responded b Resident's face and s #1 stated "I just touch and NA #2 was present the nurse's station aff Resident #6 and told was a hand full, but s her face because she anything to it. NA #1 on the Resident #6 Resident became cor #1 stated that while s Resident's brief, the F pulling so hard "I was smacked her on the r	sked her on 02/16/16 what Id the DON that NA #1 on the left side of her face hen on her right thigh about ted she also informed law 6/16 when he interviewed he phone and the 7/16 when she talked to her 7/16 when she talked that she 7/16 when she talked that she 7/16 when she talked that on 7/16 when she talked that on 8 slapped her on the face 7/17 y gently touching the 7/17 stated she went to	{F 2:	26}	

Facility ID: 970828

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	IPLETED
			A. BOILDING			R-C
		345502	B. WING			3/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/14/2010
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER	INDIAN TRAIL, NC 28079			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	STENET OF DELIVITOR OF DELIVITOR	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETIO DATE
{F 226}	Continued From page	e 40	{F 226	A1		
		ause it was not her nature to	1 220	01		
		ause it was not her hature to it #6 continued yelling and				
h d tc R a A	-	essed and took her to the				
		ed afterwards, she reported				
	to Nurse #1 and Nurs	•				
	Resident #6 on the le	eg, the DON came and took				
	a statement from her	and she was suspended.				
	A telephone interview	v was conducted on 02/24/16				
	at 11:10 AM and a fol					
		16 at 3:30 PM with Nurse #1.				
		, Nurse #1 stated that on				
	-	14 residents on the secure				
	unit. Around 10:00 or	10:15 AM, NA #1 informed				
	her that while NA #1	and NA #2 provided care to				
		ower room, the Resident				
		nd grabbed NA #1 by the				
		e "popped" Resident #6 to				
		se #1 stated Nurse #2				
		present and heard the				
		stayed at the nurse's station Nurse #2 reported the				
		The DON came to the unit,				
		n NA #1 and she was				
		stated that NA #1 worked				
		he secure unit that day from				
		s suspended around 10:30				
	AM, but Nurse #1 wa	s not aware of any prior				
		garding NA #1. Nurse #1				
		een informed that NA #2				
		Resident #6 on the face				
		Nurse #1 stated Resident #6				
		es, usually required 2 staff				
		se #1 stated that staff were idents became combative.				
		resident time to calm down,				
	÷	me back later to provide				
	-	Resident #6 was very				
			1	1		1

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING _		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIF	•
				3315 FAITH CHURCH ROAD	
LAKE PA	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
{F 226}	needed) twice on her and later for pain. Nu did not cooperate init and Ativan was given Resident #6 was caln assessment was corr and she was noted w right thigh about 3 ind shape. Nurse #1 state changes noted to her The Administrator wa 3:52 PM. She stated around lunch time on "popped" Resident #6 room and reported he Administrator that NA she had started comp investigation. The Ad working in her office a PM she obtained the the DON to complete Report. The DON left but informed the Admi she had obtained all f interviews. The Administrator called her the Administrator called II PM. The Administrator Resident #6 for the fil PM when law enforce law enforcement obse any marks to either th stated later that even enforcement called her about another incider earlier that day, but the	shift that day for agitation rse #1 stated Resident #6 ially with a skin assessment, to calm her down. Once n, a full body skin apleted, around 12:30 PM ith a reddened area to her ches long and irregular in ed there were no other skin or face. s interviewed on 02/24/16 at that the DON informed her 02/16/16 that NA #1 6 on the knee in the shower erself. The DON told the A #1 was suspended and that oleting interviews for the	{F 22		

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D SERVICES			FORM APPROVEI OMB NO. 0938-039
DER/SUPPLIER/CLIA FICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
345502	B. WING _		03/14/2016
		STREET ADDRESS, CITY, STATE, Z	•
		3315 FAITH CHURCH ROAD	
		INDIAN TRAIL, NC 28079	
DEFICIENCIES RECEDED BY FULL (ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
histrator stated she t morning on hent from her over ents of physical VA #2 and reported asked NA #2 to ut what she saw. Impleted/faxed the 02/17/16 and the 02/16/16 around for the incident of n 02/16/16 around ed in her further said that lents of physical ed to the HCPR. 2/25/16 at 10:28 he Nurse hift on 02/16/16. Dth at the nurse's /16/16 around ust want everybody ed Resident)." NA popped" Resident I her hair. Nurse tay at the nurse's he DON and report to the secure unit, f1 and she was e was not aware use between NA were	{F 2:	26}	
	ed Resident)." NA popped" Resident I her hair. Nurse tay at the nurse's ne DON and report to the secure unit, #1 and she was e was not aware use between NA were	ed Resident)." NA popped" Resident I her hair. Nurse tay at the nurse's ne DON and report to the secure unit, #1 and she was e was not aware use between NA were	ed Resident)." NA popped" Resident I her hair. Nurse tay at the nurse's ne DON and report to the secure unit, #1 and she was e was not aware ise between NA were

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		ND HUMAN SERVICES MEDICAID SERVICES			OMB	RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 03/14/2016	
		345502	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 226}	Continued From page	e 43	{F 226	5}		
{F 242} SS=D	-	was conducted on 02/25/16. ERMINATION - RIGHT TO	{F 242	2}		3/18/16
	schedules, and health her interests, assess interact with member inside and outside the	right to choose activities, h care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that resident.				
	by: Based record review interviews the facility the choice of bathing residents sampled for The findings included Resident #24 was rea 12/18/15 with diagnos hypertension, anxiety and weakness. Revie comprehensive signif set (MDS) dated 11/0 very important to Res between a tub bath, s bath. This MDS also required total assistan bathing. The MDS fu were identified. Review of Resident # 12/2015 that was kep not identify his bathin Review of a care plan	failed to assess and honor frequency for 1 of 3 r choices. (Resident #24) l: admitted to the facility on ses that included y, depression, dysphagia, ew of the most recent ficant change minimum data 06/15 indicated that it was sident #24 to choose shower, bed bath, or sponge indicated Resident #24		<ul> <li>The resident has the right to che activities, schedules, and health consistent with his or her interest assessments, and plans of care, with members of the community inside and outside the facilt5iy, a choices about aspects of this or the facility that are significant to resident.</li> <li>F 242 Self-Determination-Right to Choices</li> <li>1) On 2/25/16, the Director of Ne (DON) spoke with resident # 24 and confirm his choice of bathing frequency in order to honor his r make a choice. The DON then a resident # 24 so bathing preferent schedule to include Saturday a f bath in addition to being provide bed bath by Hospice services or</li> </ul>	care ts, interact both and make her life in the to Make ursing to assess g ight to updated nce ull bed d a full	

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/24/201 DRM APPROVE NO. 0938-039
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 03/14/2016	
		345502	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	I	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				33	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 242}	Continued From page	- 44	{F 2	0401			
(1 2 12)			<u>الم</u>	-423	Tuesdays and Thursdays		
	related to impaired m	self-sufficiency for bathing			Tuesdays and Thursdays.		
		of said care plan stated that			2) On 2/26/16, the social worker		
		be neat, clean, and odor free			completed a 100% audit of all		
	through the next revie	ew period. Interventions			interviewable residents to assess the	eir	
		to provide some physical			choice of bathing frequency. The re-		
		ng and encourage Resident			of the 100% audit was given to the D		
		self-care as ability permitted.			to update the bathing preference sch	nedule	
	· · ·	s master shower schedule			on 2/26/16.		
	revealed Resident #2				2) On 2/26/16 the administrator in		
	second shift.	sdays and Saturdays on			<ol> <li>On 2/26/16 the administrator in- serviced the admissions coordinator</li> </ol>		
		s bathing log dated 01/28/16			regarding asking the resident and/or		
		Resident #24 revealed that			resident 's family about the resident		
		ceived no type of bathing or			bathing preference as part of the		
	bathing assistance fo	r 21 of the last 30 days.			admission □s process by utilizing a		
		ent #24 on 02/23/16 at 3:02			"Bathing Preference" questionnaire.		
		was waiting to get his bath			admission coordinator will then give	а	
	-	#24 stated that he had not			copy of the Bathing Preference	4	
	-	Il and was waiting on the			questionnaire to the nursing department so the shower team can schedule the		
		<ul> <li>A) to come and wash him.</li> <li>ated that he did not take</li> </ul>			resident' s bathing preference in or		
		nic pain, so he took bed			honor his/her choice.		
		nd Thursdays when the					
		nd assisted him. Resident			On 3/14/16, the Staff facilitator and s	social	
		e days that hospice is not			worker in-serviced regarding		
	· · ·	f is "supposed to wash me			Self-Determination for all licensed nu		
		Resident #24 further stated			and certified nursing assistants. The		
		py with 3 bed baths per			Self-Determination in-service include		
	week.	on 02/24/16 of 9:40 AM			Residents have the right to make ch		
		on 02/24/16 at 8:49 AM			about aspects of his or her life in the		
		ing care of Resident #24 f completed his bed baths on			facility that are significant to the resident facility that are significant to the resident has the right to ma		
		s she believed but was not			choices about his or her bathing		
	sure. NA #4 stated th				preference. All future employees wil	l be	
		a bed bath today but she			in-serviced during their orientation		
		ould get one because he was			process.		
	on hospice services.	NA #4 was not aware of					
	Resident #24's bathir	ng preference in regards to			4) On 3/10/16, the DON and/or Soc	ial	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION	OMB NO. 0938-0	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
			/		R-C	
		345502	B. WING		03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/14/2010	
				3315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE	
{F 242}	Continued From page	e 45	{F 242	2}		
		t knew that hospice provided		Service utilized a Bathing Preferen	nce	
	bed baths twice a we	• •		Audit Tool to ensure residents are		
	In a follow up intervie	w with Resident #24 on		receiving their choice of bathing		
		he stated that he had finally		preference. The "Bathing Prefere		
		n yesterday at 4:00 PM when		Audit Tool" will be completed weel		
		ie to do it. Resident #24 also		twelve weeks, then monthly x thre		
		d shaved him yesterday		months. Any negative findings will	be	
	while doing his bed b			addressed immediately.		
		s. Resident #24 stated that			·	
		e received were the ones that		The monthly QI committee will rev results of the "Bathing Preference		
		d for him on Tuesdays and eally bothered him because		Tool" monthly for 6 months for	Audit	
		took a shower once a day.		identification of trends, actions tak	ren and	
		on 02/24/16 at 9:48 AM		to determine the need for and/or		
		s a part of the shower team		frequency of continued monitoring	i, and	
		4 was showered once a		make recommendations for monitor		
	week on Saturday an	d that hospice staff came on		continued compliance.		
	Tuesdays and Thurso	days but was not aware of				
	whether Resident #24	4 received a bed bath or a		The administrator and/or DON will		
	shower. NA #5 was n			the findings and recommendations		
	Resident #24 was ac	-		monthly QI committee to the quart		
		aware that was his scheduled		executive QA committee for furthe	r	
	•	as not aware of Resident		recommendations and oversight		
		nces in regards to frequency				
		bath due to severe pain.				
		erim Director of Nursing t 5:51 PM revealed that on				
	. ,	ed baths are assigned by				
	room number and if t					
		ney needed to let the staff				
	-	rearrange their shower				
		DON stated she thought				
	the Admissions Direc	tor asked choices for				
	laundry and hair serv					
		obtained to her knowledge.				
		e resident could request a				
	-	r/bathing schedule but if they				
		nge then the resident would				
	stay on the schedule	that was assigned by room	1			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		R-C 03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	·	
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
{F 242} {F 253} SS=E	and was not aware the and care needed to be resident. Interview with the Adu at 10:46 AM revealed obtained every quarte 10% of the residents practices. Admission provide any record of survey being complete would have included 483.15(h)(2) HOUSE MAINTENANCE SEF The facility must provi	DON was new to this role nat preferences on activities be obtained from each mission Director on 02/25/16 I bathing preferences were er when they interviewed for satisfaction on facility Director was unable to F Resident #24's satisfaction ted in the last year which bathing preferences. KEEPING & RVICES ride housekeeping and s necessary to maintain a	{F 242} {F 253}		3/18/16	
	by: Based on observation facility failed to maint of 11 wheelschairs or of 6 halls (Rooms 20) 204 B, 300 and 305 E The findings included On 2/22/2016 at 10:2 9:55 AM, tour of the f was conducted. The in rooms 201 B, 202 and 305 B were obset food particles, food co spots. On 2/22/2016 at 10:2 wheelchair, which be	-		The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. F 253 Housekeeping & Maintenance Services 1) On 2/25/16,the housekeeping staff cleaned the wheelchairs for Rooms 20 202A, 202B, 203A, 204B, 300, and 305 2) On 2/26/16,the housekeeping supervisor completed a 100% audit of resident wheelchairs for cleanliness. A	о 1В, 5В. аll	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG	· · ·	IPLETED
						R-C
		345502	B. WING		0	3/14/2016
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				3315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	deliation center		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 253}	Continued From page	e 47	{F 2	53}		
		lirty with food particles and		wheelchairs that were iden	tified as not	
		of dirt and food observed on		being clean were immediat		
	the wheelchair were	5		for cleaning by the houseke	•	
		7 AM, an observation of the				
		longed to the resident who		3) On 2/26/16, a system wa	· ·	
		A revealed the wheelchair's		by the housekeeping super		
		lirty with food particles, dirt t and food observed on the		cleaning wheelchairs. All re wheelchairs are to be clear		
	wheelchair were dried			as needed during first and	•	
		7 AM, an observation of the		the housekeeping staff. A V		
		longed to the resident who		Log will be completed by th		
	resided in room 202 E	3 revealed the wheelchair's		housekeeping staff after wh		
		lirty with food particles, dirt		cleaned. The completed W		
	-	t and food observed on the		will then be given to the fac	-	
	wheelchair were dried	a and dusty. 32 AM, an observation of the		administrator and the regio	nai	
		longed to the resident who		housekeeping director. On 2/26/16, the housekee	enina	
		evealed the wheelchair's		supervisor in-serviced the h		
		lirty with food particles, dirt		staff on cleaning wheelchai		
		t and food observed on the				
	wheelchair were dried	-		4) On 3/1/16, the Maintena		
		0 AM, an observation of the		began auditing the Wheel (		
		longed to the resident who		weekly basis and ongoing.		
		A revealed dried hard dirt		Maintenance director will m proper completion and follo		
	the seat of the wheel	s frame and food particles in		Wheel Chair Log tool by ini		
		3 AM, an observation of the		bottom right hand corner of	•	
		onged to the resident who				
		B revealed the wheelchair's		The Environmental Superv	isor will present	
		lirty with food particles, dirt		findings of the Wheel Chair	Log at the	
		t and food observed on the		monthly QI committee mee	•	
	wheelchair were dried	-		monthly QI committee will r		
		AM, an observation of the		results of the monitoring for	rcontinued	
		onged to the resident who B revealed the wheelchair's		compliance.		
		on was dirty with dried dirt,		The monthly QI committee	will review the	
		es along the edges of the		results monthly for 6 month		
	seat cushion.			identification of trends, acti		
	0.0000000000000	6 AM, an observation of the		to determine the need for a	. 17	

Facility ID: 970828

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	S FOR MEDICARE &					<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING			२-C
		345502	B. WING			k-0 k/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		14/2010
				315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER	1	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
{F 253}	Continued From pag	e 18	{F 253}			
ί 200 <u>β</u>			{F 253}		toring and	
		onged to the resident who A revealed the wheelchair's		frequency of continued moni make recommendations for		
		dirty with food particles, dirt		continued compliance.		
		rt and food observed on the				
	wheelchair were drie			The administrator and/or DC	N will present	
		AM, an observation of the		the findings and recommend	•	
	wheelchair which bel	onged to the resident who		monthly QI committee to the	quarterly	
		revealed the wheelchair's		executive QA committee for		
		dirty with food particles, dirt		recommendations and overs	ight.	
	-	rt and food observed on the				
	wheelchair were drie					
		B AM, an observation of the				
		onged to the resident who B revealed the wheelchair's				
		dirty with food particles, dirt				
		rt and food observed on the				
	wheelchair were drie					
		AM, environmental rounds				
	were conducted with	the maintenance director				
		g supervisor on the 200 and				
		the wheelchairs for rooms				
		203 A, 204 B, 300 and 305				
		g supervisor stated that				
		esponsible for cleaning ed that wheel chairs were to				
		ine schedule every Tuesday.				
		neelchairs were to be brought				
		building by the nursing staff				
		eeping staff would high				
	•	d sanitize them and return				
		s room. The housekeeping				
		t he had no specific cleaning				
		c halls or rooms and no				
	specific notification o	f a wheelchair cleaning				
	-	U.				
{F 282}	183 JU(F)(J)(!) CED	/ICES BY QUALIFIED	{F 282}			3/18/16

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 282}	must be provided by a accordance with each care. This REQUIREMENT by: Based on staff interv facility failed to follow resident became com Staff failed to immedia the resident became of resident at a later time incidents of physical a residents reviewed wi addressed problemat Immediate Jeopardy I Nurse Aide (NA) #1 s on the face and again #6). Each incident of the secure unit and w #2 did not immediate Resident #6 and othe unit from physical abu assessed with redden thigh.	d or arranged by the facility qualified persons in a resident's written plan of is not met as evidenced iews and record review, the the plan of care when a abative during nursing care. ately stop nursing care when combative and approach the e. This resulted in 2 abuse for 1 of 3 sampled ith care plans which ic behaviors (Resident #6). began on 02/16/16 when lapped a combative resident physical abuse occurred on ras witnessed by NA #2. NA ly intervene to protect or residents on the secure	{F 282}		the
		he State Agency and and Medicaid an acceptable nce (AOC) on 03/08/16.		diversional activity, allow for flexibility Activity of Daily Living (ADL) routine to accommodate mood, and when care i refused, leave and return in 5-10 minu	o is
	determine the status	conducted on 03/14/16 to of the ongoing Immediate provided documentation for g:		2) On 3/4/16, the MDS nurse reviewer 100% of the care plans and care guid for all residents identified through the MDS process with behaviors to ensur	es

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /		COMPLETED
					R-C
		345502	B. WING		03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
				3315 FAITH CHURCH ROAD	
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLE
{F 282}	Continued From page	e 50	{F 282	3	
(*)		nitively impaired residents	1 202	those behaviors were addressed	I on the
	dated 02/16/16			care plan and care guide to inclu	
		erviews regarding abuse for		interventions needed during staf	
		esidents dated 02/16/16		interaction with the resident. On	
	Documentation of in-			MDS nurse will continue to ident	
		abuse, caring for residents		resident with behaviors through	•
		currently employed staff		process. Care plans and care g	
	completed by 03/07/1			updated with each resident MDS	
		use monitoring on each shift		assessment or a resident chang	
		6/16 and remained ongoing		status.	
	-	s for an allegation of abuse			
		Illegation of neglect on		3) On 3/1/16, the staff facilitator	
	02/27/16			in-serviced at 100% all nurses a	nd
	A 24 hour/5 day repo	rt for Resident #6 for the		nursing assistants related to follo	owing
	8:00 AM incident of a	buse which had not		resident care guides and care pl	ans to
	previously been repo	rted to the Health Care		ensure each resident is provided	l quality
	Personnel Registry (H	HCPR). Both reports were		care and safety is maintained. D	
	faxed the the HCPR of			orientation of new employees nu	
		staff hired since 02/16/16 to		nursing assistants will continue t	
		ground checks, reference		educated on the importance of fe	-
		Registry checks, license		residents care plans and care gu	lides and
	checks, and abuse tra			locations of each form.	
	The facility's Abuse P	'olicy			
	Obeen stars f	ing and interview 19		4) The administrative nurses, DC	
		ing care, interviews with		facilitator, and or MDS nurse beg	
		dents, interviews with family,		utilizing on 3/4/16 the audit tool	
		If present in the facility on		Care Guide" to ensure care guid	
		Il documentation to support		being followed to include interve required to assist with managem	
	the AOC and interview	or of Nursing and the Nurse		residents identified with behavio	
	Practitioner provided				· · · ·
		tion by the facility to remove		Random audit of 20% of residen	ts with
		dy at F-282. The immediate		identified behaviors will be review	
		ed on 03/14/16 at 7:15 PM.		weekly x 4 weeks, biweekly x8 w	
		out of compliance at F-282		then monthly x 3 months.	
	-	severity of (D) isolated, no			
		ential for more than minimal		The monthly QI committee will re	eview
		ediate jeopardy, while the		results of the "Following Care G	
		salato jooparay, mino tilo	1		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		PLETED
		345502	B. WING _				-C / <b>14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		33	15 FAITH CHURCH ROAD		
				IN	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From page	e 51	/F 2	821			
		mentation of their corrective action. the need for and /or frequency of continued monitoring and make recommendations for monitoring for					
	The findings included	l:	continued compliance.				
	04/10/14. Diagnoses behaviors, mood affe communicative defici and psychosis. Resid	hitted to the facility on included dementia with ctive disorder, cognitive t, paranoid delusional beliefs lent #6 was currently being by ongoing psychiatric			The administrator and/or DON will pre the findings and recommendation to the quarterly executive QA committee for further recommendations and oversig	ne	
	physician orders date (antianxiety) 2 milligr injection as needed for	w revealed Resident #6 had ed 08/31/15 for Ativan ams (mg) IM (intramuscular) or pain. The resident had order dated 11/16/15 for nours as needed for					
	assessed Resident # cognition, required ex persons for activities include mobility, trans	Data Set dated 12/29/15 6 with severely impaired ktensive staff assistance of 2 of daily living (ADL) to sfers, dressing and toileting, ly abusive and without of motion.					
	verbal and physical a treatment/care as evi swinging arms and d plan's goal specified resident's safety. The included the following	plematic behavior fective coping behaviors of					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	ADL routine to accom care is refused, leave Review of the "Reside staff were encouraged in a calm, reassuring refused, to approach A progress note dated practitioner (NP) rever referred by nursing fo agitation and persever reported that Resider agitated primarily in the note recorded that Resider Medications were adj continue to monitor. Review of a nursing po 02/16/16 at 4:49 PM February 2016 Medic revealed that Resider towards staff that day she administered Ativ needed for agitation a positive effects and the needed for pain at 12 effects. A nursing progress no PM written by Nurse a assistant (NA #1) vert Resident #6 during ca her hair. The Medical assessed the Resider body assessment for	vity, allow for flexibility in modate mood, and when and return in 5-10 minutes. ent care guide" revealed d to approach Resident #6 manner and if care was the Resident later. d 02/05/16 by the nurse aled Resident #6 was r evaluation of morning ring behaviors. Nursing it #6 was noted increasingly he morning. The progress esident #6 was noted by the d, angry, and confused. usted and staff were to progress note dated written by Nurse #1 and the ation Administration Record at #6 was very combative . Nurse #1 documented that an 1 mg by mouth as at 7:40 AM with some hen Ativan 2 mg IM as :10 PM with slight positive	{F 2	282			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
	CONTRECTION		A. BUILD	ING			-C
		345502	B. WING				-O 14/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD		
					INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	Continued From page	\$ 53	{F 2	282	}		
	completed by the Dire recorded that NA #1 s #6 on the leg and afte noted with red marks A written statement by recorded that NA #1 s leg on 02/16/16 arour #6 become combative Review of a written st Administrator, dated 0 she became aware of that NA #2 also withe #6 on the face on 02/ written statement reco was not previously av documented that she and was informed that slap Resident #6 on t	y NA #1 dated 02/16/16 struck Resident #6 on her nd 10:00 AM when Resident e and pulled her hair.					
	recorded that on 02/1 witnessed Resident # morning care and stru- care continued and R combative. During the Resident #6 on the le the morning around 9 the shower room, Res combative and struck continued and NA #2	v NA #2, dated 02/17/16, 6/16 at 7:30 AM, NA #2 6 become combative during uck NA #1 twice. Nursing esident #6 continued to be e care, NA #1 slapped ft side of her face. Later in :45 AM on 02/16/16, while in sident #6 again became NA #1. Nursing care witnessed Resident #6 grab NA #1 slapped Resident #6					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282}	Continued From page	2 54	{F 2	282}			
	02/16/16 around 7:30 cooperate with staff a during morning care, NA #2 stated she witr #1 twice, then witness on the left side of her going to stop that." Na already upset and ren continued getting Res her in her wheelchair to the dining room. Na when NA #1 slapped fit the definition of abu how to separate NA # further stated she did again. NA #2 further st around 10:00 AM, bot toileting Resident #6 if the Resident became NA #1. During care, N the Resident's pants a NA #1's hair. That's w Resident's pants, tran wheelchair and NA #2 dining room. A telephone interview at 12:55 PM with NA s worked on the facility' permanent assignmen 02/16/16 Resident #6 and she responded by	1. NA #2 stated that on AM Resident #6 would not nd became combative kicking, yelling and hitting. hessed Resident #6 hit NA sed NA #1 slap Resident #6 face and said "You are A #2 stated Resident #6 was nained upset. Both NAs sident #6 dressed, placed and NA #1 took Resident #6 A #2 stated she felt that Resident #6 that the incident use, but that she didn't know #1 from Resident #6. NA #2 not think it would happen stated that later that morning th NA #1 and NA #2 were in the shower room when combative again and struck IA #1 bent down to pull up and Resident #6 grabbed when NA #1 slapped ght thigh. NA #2 stated she bo. Resident #6 released her d they finished pulling up the asferred her to the 2 took Resident #6 to the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345502	B. WING				/14/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE PA	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD		
	1				INDIAN TRAIL, NC 28079		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	and NA #2 was preset the nurse's station aff Resident #6 and told was a hand full. NA # around 10:00 AM, shi Resident #6 in the shi became combative, wi that while she was put the Resident grabbed was up on my tip toes right knee to get her to stopped." NA #1 state because it was not he Resident #6 continue her dressed and took stated she was traine resident time to calm but Resident #6 usua #1 stated that Reside and this often worked offering her chocolate 02/16/16. NA #1 conf providing nursing card Resident became agi trained, but rather con Resident care. NA #1 Resident #6 was not #2 was not much helg #6, when she became at 11:10 AM and a fol conducted on 02/25/1 During the interviews 02/16/16 around 10:0 informed her that whi	hed her face with my hand" ent. NA #1 stated she went to the providing care to Nurse #1 that the Resident #1 stated later that morning e and NA #2 were toileting ower room and the Resident vorse this time. NA #1 stated alling up the Resident's brief, d her hair, pulling so hard "I s", so "I smacked her on the to stop, I said stop and she ed she struck her gently er nature to hurt anyone. d yelling and hitting, we got her to the day room. NA #1 ed to allow a combative down and come back later, ally worked well with her. NA int #6 liked chocolate milk to calm her down, but e milk did not work on irmed that she did not stop e to Resident #6 when the tated, as she had been intinued and completed the stated she knew striking the right thing to do, but NA o and so striking Resident e combative, was just a e was conducted on 02/24/16 low up interview was 16 at 3:30 PM with Nurse #1. , Nurse #1 stated that on 10 or 10:15 AM, NA #1	{F 2	282			

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 03/24/2016 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		ISTRUCTION	(X3) DA	ATE SURVEY MPLETED
		345502	B. WING _			C	R-C )3/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
				3315 F	AITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		INDIA	N TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	κ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 282}	#1 by the hair. NA #1 Resident #6 to get he that NA #1 worked wi secure unit that day f suspended around 10 not aware of any prio regarding NA #1. Nur been informed that N Resident #6 on the fa Nurse #1 stated Resi times, usually require Nurse #1 stated that residents became con the resident time to c come back later to pr Resident #6 was very Nurse #1 heard Resid care both around 8:00 #1 stated Resident #6 needed) twice on her and later for pain. Nu assist the NAs with n reported to her that R and thought the prn A for agitation was effect The Administrator wa 3:52 PM. The Admini expectation that staff combative residents of Resident #6 required staff, then depending could get to the call b or not staff could call when Resident #6 be	e combative and grabbed NA stated she "popped" er to let go. Nurse #1 stated ith all residents on the rom 7:00 AM until she was 0:30 AM, but Nurse #1 was r incidents of abuse rse #1 stated she had not A #2 witnessed NA #1 slap ace earlier that morning. dent #6 was combative at ed 2 staff to give her care. staff were trained that when mbative, staff should give alm down, try to redirect and ovide care. Nurse #1 stated / combative that day and dent #6 yelling at staff during 0 AM and 10:00 AM. Nurse 6 received Ativan (as shift that day for agitation rse #1 stated she did not ursing care as it was only the sident #6 was a hand full tivan Resident #6 received ctive. s interviewed on 02/24/16 at strator stated that it was her ensure the safety of during nursing care and if the assistance of 2 nursing on whether or not the staff well would determine whether for additional assistance crame combative. was interviewed on	{F 2	82}			
	needed) twice on her and later for pain. Nu assist the NAs with n reported to her that R and thought the prn A for agitation was effec The Administrator wa 3:52 PM. The Admini expectation that staff combative residents of Resident #6 required staff, then depending could get to the call b or not staff could call when Resident #6 be	shift that day for agitation rse #1 stated she did not ursing care as it was only tesident #6 was a hand full tivan Resident #6 received ctive. s interviewed on 02/24/16 at strator stated that it was her ensure the safety of during nursing care and if the assistance of 2 nursing on whether or not the staff well would determine whether for additional assistance came combative.					

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CENTER	S FOR MEDICARE &				OMB NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R-C	
		345502	B. WING		03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2010	
			3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE	
{F 282}	Continued From page	9 57	{F 282}			
		nt #6 was combative that mber and the staff member				
	Director stated that h Resident #6 and knew combative, resistive t	e was very familiar with w that at times she was quite o care and would strike out				
	he expected nursing nursing care if a resident time allow the resident time	The Medical Director stated staff to immediately stop lent became combative, e to calm down, to notify the nce, to continue to monitor				
	and approach later. Attempts to interview unsuccessful.	the DON were				
	The administrator wa jeopardy on 02/24/16	s notified of immediate at 5:27 PM.				
{F 309} SS=D			{F 309}		3/18/16	
	provide the necessar or maintain the highe mental, and psychose	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment				
	by:	<ul> <li>is not met as evidenced</li> <li>ns, staff interviews and</li> </ul>		Each resident must receive and the		
	medical record review			facility must provide the necessary car and services to attain or maintain the	e	

Facility ID: 970828

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		MEDICAID SERVICES				<u>/B NO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3	3) DATE SURVEY COMPLETED
			A. BUILDIN	3	—	R-C
		345502	B. WING			03/14/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE	03/14/2016
0.002				3315 FAITH CHURCH		
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROV	/IDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
{F 309}	Continued From pag	e 58	{F 30	9}		
	support to prevent a	decline in range of motion for		-	cable physical, mental and	
		ents reviewed for well-being			well-being in accordance	
	(Resident #80).			with the comp	pressive assessment and	
				plan of care.		
	The findings included	d:		5000		
	Posidont #80 was as	mitted to the facility on		F309		
		Imitted to the facility on included rhabdomyolysis,		1) On 2/25/16	, the administrator directed	
	•	neral muscle weakness,			ssistant to place foot rests or	n
		nd mobility, history of falling,		-	'□s wheelchair so the	
	and dementia without	t behavioral disturbances,		resident⊡s leg	gs were no longer dangling	
	among others.			and her feet v	vere not pointing towards the	•
				floor.		
		Data Set, dated 12/10/15		0 0/05/40	the MDO survey and issued	
		80 with severely impaired			the MDS nurse reviewed	
	cognition, delirium, d extensive staff assist				□'s care plan. The care plan led having Resident #80'□s	
		aff assistance of 2 persons		-	. The MDS nurse on $3/3/16$	
		pmotion, not steady, only		-	care plan on and care guide	
		staff assistance when			sts on wheelchair with feet	
	moving from seated	to standing and surface to		placed on peo	dals. The MDS nurse placed	1
	surface, and a wheelchair for mobility.			the updated c closet.	are guide in Resident #80⊡s	6
		/01/16 and Resident Care ident #80 with chronic		2) On 2/20/46	, the Director of Nursing	
		n intellectual function, at risk			eted a 100% audit of all	
		and falls characterized by			ng a resident roster, to	
		d judgement due to her			esident in need of leg rests	
		a. Interventions included to			als added to their wheelchair	
	-	mobility, use of a low			in need of leg rests and/or	
		front wedge cushion, dycem		foot pedals we	ere addressed.	
		nder top cushion, personal			1000/ 6	
		nti-roll back brakes, and to			100% of nursing staff were	
	elevate legs when in	wheelchair.			follow the resident care	
	Resident #80 was of	oserved without her legs			e guides. On 3/14/16, staff erviced all nurses and	
		wheel chair on the following			tants regarding positioning o	f
	dates/times:	wheel of an of the following			et while in a wheelchair.	•

Facility ID: 970828

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		MEDICAID SERVICES				10.0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	3		
		345502	B. WING			R-C
		343302		STREET ADDRESS, CITY, STATE, ZIP COD		3/14/2016
NAME OF P	ROVIDER OR SUPPLIER				)E	
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD		
	1			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
{F 309}	Continued From page	e 59	{F 309	10		
[	10	Resident #80 was in her	1 00.	4) The audit tool for Privacy/		
		n a thick cushion, in her		Choices/ADL s/Wheelchairs	will be	
		water from a staff member,		monitored by administrative s		
		wheelchair positioned		staff during rounds to ensure	-	
	-	oth feet crossed at the ankle,		legs are not dangling, feet res		
	-	ely 4 inches off the floor.		place if needed and feet are		
		relaxed, both feet pointed		down while sitting in their who		
	downward towards th			audit will be completed daily		
				weeks, 1x a week x8 weeks a		
	02/23/16 4:36 PM Re	esident #80 was in her		month x3 months.		
	wheelchair, seated o	n a thick cushion, in her				
		vision, wheelchair positioned		The Administrator, DON and	d/or ADON	
	-	oth feet hung approximately		will review each		
	4 inches off the floor.			Privacy/Choices/ADL s/Whe	elchair Audit	
	relaxed, both feet po	inted downward towards the		tool weekly to verify completion		
	floor.			correct any identified concern	IS.	
	02/24/16 6:39 AM Resident #80 was in her			The monthly QI committee w		
		n a thick cushion, at the		results of the Privacy/Choices		
		feet crossed at the ankles,		Wheelchair audit tool results	-	
		ely 4 inches off the floor.		months for identification of tre		
		relaxed, both feet pointed		taken and to determine the n		
		downward towards the floor.		and/or frequency of continued and make recommendations	•	
	On 02/24/16 at 06.20	AM, Nurse #6 stated he		monitoring for continued com		
		Resident #80 on the 11PM -			קומווטב.	
		stated that Resident #80		The administrator and/or DOI	N will present	
		ause she kicked her feet all		the findings and recommendation		
		wheelchair. Nurse #6 stated		monthly QI committee to the		
		Resident #80 with foot/leg		executive QA	4-3-10-19	
		air as long as he had worked				
		nes staff placed a chair in				
		e her legs, so she did not				
	kick her feet. Nurse #					
		vould kick her feet so hard				
	that she might overtu	ırn in her wheelchair. Nurse				
	-	80 to relax her feet and				
	noted that both feet p	pointed in a downward				
	-	Her feet are starting to				

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If continuation sheet Page 60 of 89

	S FOR MEDICARE &					IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED	
			A. BUILDING	;		ВC	
		345502	B. WING			R-C	
	ROVIDER OR SUPPLIER	040002		STREET ADDRESS, CITY, STATE, ZIP COD		3/14/2016	
NAME OF P	ROVIDER OR SUPPLIER				E		
LAKE PAF	K NURSING AND REH	ABILITATION CENTER	3315 FAITH CHURCH ROAD				
			INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
{F 309}	Continued From pag	e 60	{F 309	16			
(,	1 0	had not noticed that before	1.000	·)			
1	• •	her to therapy due to a lack of					
		n she was in her wheelchair.					
	An interview on 02/24/16 at 06:41 AM with Nurse						
	Aide (NA) #6 reveale	ed she worked with Resident					
	#80 routinely on the						
	occasionally on othe						
		wheelchair that morning. NA					
		ot aware that Resident #6					
	•	elevated while in the					
	wheelchair. NA #6 fu						
	-	either hung while she was hair or she kicked her feet.					
		ver saw Resident #80 use					
	foot/leg rests in her v						
	An interview on 02/2	4/16 at 11:53 AM with the					
		vealed she was aware that					
		low seated wheel chair					
	without foot/leg rests	and had observed Resident					
	in her wheel chair wi	th her feet hanging above the					
		lanager stated that Resident					
	-	eet up on a chair, on foot/leg					
		The Therapy Manager stated					
		uld elevate her legs herself					
		ition her to allow her to Therapy Manager stated					
		ould have a chair, leg/foot					
		d such that she could prop					
	-	in a low position while					
	-	hair to prevent a decline in					
		e Therapy Manager stated					
	•	sident #80 declined therapy					
		sion and Resident #80 was					
	-	residents that could not					
	receive therapy serv	ices due the family's request.					
		er stated that Resident #80					

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345502	B. WING		R-C 03/14/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
{F 309} {F 312} SS=E	thinner cushion to set to reach the floor. An interview on 02/25 Interim Director of Nu Resident #80 kicked her wheel chair, but li Interim DON stated th #80 to be positioned her feet reached the elevated when in her prevent a decline in re 483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives th	but staff had not tried a e if that would allow her feet 5/16 at 08:48 AM with the ursing (DON) revealed her feet routinely when in iked to prop her feet up. The nat she expected Resident in her wheel chair such that floor or to have her feet wheel chair for safety and to ange of motion. RE PROVIDED FOR	{F 309}		3/18/16	
	by: Based on observatio and staff interviews th bed baths and failed 2 of 5 residents samp living (ADL) (Residen The findings included 1. Resident #24 was 12/18/15 with diagnos hypertension, anxiety and weakness. Revie quarterly Minimum Da 01/25/16 indicated the	l: readmitted to the facility on sis that included: , depression, dysphagia, w of the most recent ata Set (MDS) dated		<ul> <li>F 312 ADL Care Provided for Depender Residents</li> <li>1) On 2/25/16, Resident #24 was provide a bed bath, shave, clothing change. On 2/25/16, Resident #112 was provided assistance with nail care.</li> <li>2) On 2/26/16 a 100% audit of all residents shower reviews for the past three days were completed by the Direct of Nursing.</li> </ul>	ded	

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If continuation sheet Page 62 of 89

		MEDICAID SERVICES				938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. DOILDIN		R-C	
		345502	B. WING		03/14	2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2010
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
{F 312}	Continued From page	e 62	{F 31	2}		
	one person for bathir			On 2/26/16 a 100% aud	lit of all	
	indicated no behavio	-		residents□ fingernails was		
		n dated 12/18/15 read in part		the Director of Nursing an		
		quired assistance to restore		Any resident requiring as		
		self-sufficiency for bathing		bath, shower, shaving, fin		
	related to impaired m	obility and physical		activity of daily living (ADI	_)care was	
	limitations. The goal	of said care plan stated that		provided at time of audit.		
	Resident #24 would I	be neat, clean, and odor free				
	through the next revi	ew period. Interventions		3) On 3/10/16 the staff fac	cilitator	
	included: one person	to provide some physical		in-serviced nurses and nu	irsing assistants	
	assistance with bathi	ng and encourage Resident		regarding assistance with	ADL care.	
		self-care as ability permitted.				
		s master shower schedule		4) The "Privacy/Choice/Al		
	revealed Resident #2			Audit Tool" will be monitor	•	
		esdays and Saturdays on		administrative staff team.		
	second shift.			staff team (administrator,		
		s bathing log dated 01/28/16		staff facilitator, MDS, adm	-	
		Resident #24 revealed that		worker, activity director, d		
		ceived no type of bathing or		housekeeping supervisor,		
		or 21 of the last 30 days.		director) will notify assign	-	
		lent #24 on 02/23/16 at 3:02		of any ADL care needed.	-	
		nt #24 was lying in the bed		provide ADL care at the ti		
		ad not been shaved with		care is identified. To make		
		ely a quarter inch long and earing the same red t-shirt		solutions are sustained, n done 5x a week x4 weeks	<b>u</b>	
		mbroidered on the lower left		weeks and 1x per month		
		at he was wearing the			x 5 monuns.	
	previous day.	at the was wearing the		The administrator, DON,	ADON and/or	
		ent #24 on 02/23/16 at 3:02		staff facilitator will review		
		was waiting to get his bath		tools at least once weekly		
		#24 stated that he had not		completion, ensure reside	-	
		Il and was waiting on the		receiving bathing, shaving		
		A) to come and wash him.		clothing change and solut		
		ated that he does not take		sustained.		
	showers due to chror	nic pain, so he took bed				
	baths on Tuesdays a	nd Thursdays when the		The monthly QI committee	e will review	
	hospice staff came a	nd assisted him. Resident		results of the audit tools re	esults monthly	
		e days that hospice is not		for 6 months for identifica	tion of trends,	
		f is "supposed to wash me	1	actions taken and to deter		

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	OMB NO. 09 (X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETE	
			A. DOILDING		R-C	
		345502	B. WING		03/14/2	2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CC	(X5) DMPLETIO DATE
(E 212)	Continued From non	- 62	(5.040			
{F 312}	1.0	e 63	{F 312	-		
	up and they do not."	on 02/24/16 at 8:49 AM		for and/or frequency of continu		
		ing care of Resident #24		for monitoring, and make recommendation for monitoring for continued co		
		f completed his bed baths on				
		s she believed but was not		The administrator and/or DON	will present	
	sure. NA #4 stated th			the findings and recommendation	-	
	scheduled to receive	a bed bath today but she		monthly QI committee to the qu	uarterly	
		uld get one because he was		executive QA committee for fur		
	on hospice services.			recommendations and oversig	ht.	
	-	w with Resident #24 on				
		he stated that he had finally				
		n yesterday at 4:00 PM when ne to do it. Resident #24 also				
		d shaved him yesterday				
	while doing his bed b					
	-	s. Resident #24 stated that				
		e received were the ones that				
		d for him on Tuesdays and				
		eally bothered him because				
		took a shower once a day.				
		on 02/24/16 at 9:48 AM				
		s a part of the shower team				
		4 was showered once a				
	-	d that hospice staff came on days but was not aware of				
	-	4 received a bed bath or a				
	shower.					
		erim Director of Nursing				
	(Interim DON) on 02/	24/16 at 5:51 PM revealed				
	that on admission she					
		mber and if the resident				
		fferent they needed to let				
		ey would rearrange their				
		e Interim DON stated that it that if hospice performed				
		ys and Thursdays the staff is				
		I bed baths on the other				
	days of the week and					
	Udvo ULILIE WEEK AU	record them on the pathing				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345502	B. WING			R-C 03/14/2016	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	14/2010
	K NURSING AND REHA			33	15 FAITH CHURCH ROAD		
	IN NORSING AND REITA			IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 312}	<ul> <li>staff was not perform expected.</li> <li>2. Resident #112 was 10/23/15 with diagnost disease, Cerebrovaschemiplegia.</li> <li>Review of the quarter 01/22/16 revealed Recognitively impaired a assistance with personal dependent for bathing Review of the care pl Resident #112 require maintain maximum furpersonal hygiene char functions; shaving, mof appearance related goal was for Residen odor free through the interventions included supervision with physio Observations of Resirevealed the following 02/22/16 at 12:15 hands were approxim debris under all finge 02/23/16 at 3:45</li> </ul>	e was not aware that the ing the bed baths like she a admitted to the facility on ses of peripheral vascular cular Accident and "Iy Minimum Data Set dated esident #112 was moderately and required extensive onal hygiene and was g. an dated 01/28/16 revealed ed assistance to restore or unction of self-sufficiency for uracterized by the following outh care, daily maintaining d to impaired mobility. The t #112 to be neat, clean and next review. The d providing constant sical assistance. dent #112's fingernails g: 5 PM Fingernails on both nately ¼ inch long with brown	{F 3	112}	DEFICIENCY)		
	debris under all finge 02/24/16 at 2:56 hands were approxim debris under all finge 02/25/16 at 10:12	rnails. PM Fingernails on both nately ¼ inch long with brown rnails. 2 AM Fingernails on both nately ¼ inch long with brown rnails.					

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 03/24/20 MAPPROVE <u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED R-C 03/14/2016	
		345502	B. WING			
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COD		
	K NURSING AND REHA	BILITATION CENTER	331	5 FAITH CHURCH ROAD		
			INE	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 312}	Continued From page	a 65	(= 312)			
{i 012}			{F 312}			
		P) on 02/22/16 at 12:45 she for the facility to keep				
		ernails cleaned and trimmed.				
		not recall staff cleaning or				
	trimming Resident #1	•				
		ed with nurse aide (NA) #3				
		AM revealed nail care was				
		sident showers and as d she gave Resident #112				
		ed under his fingernails with				
		ated she could not trim his				
		he was a diabetic and the				
	-	d to trim nails on a resident				
	with diabetes. She st	ated the nurses did nail care				
	on residents with dial					
	An interview conduct					
		I revealed nail care was to As during showers and as				
		sident had diabetes and				
	then the nurse should					
		d NA#3 were accompanied				
		om on 02/25/16 at 10:30 AM				
		fingernails and confirmed				
		ris underneath each nail and				
	trimmed.	have been cleaned and				
		onducted on 02/25/16 at				
	÷	Director of Nursing stated it				
	was her expectation	for nail care to be performed				
		needed by NAs and as				
	-	residents with diabetes.				
{F 315} SS=G	483.25(d) NO CATHE RESTORE BLADDE	ETER, PREVENT UTI, R	{F 315}			3/18/16
	Based on the resider	-				
		ity must ensure that a				
	resident who enters t					
	indwelling catheter is	not catheterized unless the				

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CENTER	S FOR MEDICARE &	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 315}	catheterization was newho is incontinent of litreatment and services infections and to restor function as possible. This REQUIREMENT by: Based on record revision interviews the facility indwelling urinary Follor order for 1 of 1 reside care (Resident #112). The findings included Resident #112 was and 10/23/15 with diagnoss disease, cerebrovasc and neurogenic bladd Review of the quarter 01/22/16 revealed Recognitively impaired a catheter. Review of the care pla Resident #112 had ar elimination with an indwas at risk for infection Resident #112 to be finfection through the and/or facility protocometers.	dition demonstrates that ecessary; and a resident oladder receives appropriate is to prevent urinary tract ore as much normal bladder is not met as evidenced ew and Physician and staff failed to change an ey catheter per physician nt reviewed for catheter is dmitted to the facility on ses of peripheral vascular ular accident, hemiplegia ler. ly Minimum Data Set dated sident #112 was moderately ind had an indwelling urinary an dated 01/28/16 revealed naltered pattern of urinary dwelling Foley catheter and in. The goal was for ree from urinary tract next review. Interventions e per facility protocol and r per physician orders	{F 315}	<ul> <li>F 315 No Catheter, Prevent UTI, Res Bladder</li> <li>1) On 2/25/16, the staff nurse contacter Resident #112' s physician and obtai an updated Foley catheter order. On 2/25/16, Resident #112' s Foley catheter was changed according to th Foley catheter order dated 2/25/16.</li> <li>2) On 3/7/16, the Director of Nursing (DON) audited all residents with a fole catheter to ensure they were being changed as ordered. No negative findings.</li> <li>3) On 3/7/16 the DON initiated an in-service for 100% of nurses regarding the timely and accurate transcription of physician orders to the medication administration records(MAR) or the treatment administration records(TAR include orders to change a Foley catheter 4) On 3/7/16, the DON, QI nurse, staff facilitator, and/or evening charge nurse</li> </ul>	ed ned / e ?y ?y of of ),to eter. f
		12's indwelling urinary Foley anged every 30 days. ent records (TAR) for		will utilize the "Foley Catheter Audit To to validate Foley catheter orders are transferred over from the current mon	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		<u>3 NO. 0938-03</u> DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		COMPLETED
						R-C
		345502	B. WING			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
				3315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE
{F 315}	Continued From page	e 67	{F 3	5}		
. ,	Resident #112 revea			the new months. Th	ne audit will be	
		n 11/30/15 - change the Foley		completed within 5 c		
	•	ys. Documented on TAR as			and TAR reconciliation	
	changed on 11/08/15			and continue month	ly for 6 months.	
	<ul> <li>12/01/15 through</li> </ul>	h 12/31/15 - no order to				
		theter every 30 days on TAR.				
	•	h 01/31/16 - no order to		The DON/ADON, nu	÷ .	
		theter every 30 days on TAR.		and/or staff facilitato		
		h 02/25/16 - no order to theter every 30 days on TAR.			atheter Audit Tool" to	
		s notes from 10/23/15		ensure proper transe catheter orders are		
		ealed no note that Resident			nursing supervisor will	
	-	catheter had been changed.			ht corner of the "Foley	
		s note dated 01/14/16 at 6:25		Catheter Audit Tool"	•	
	AM revealed Nurse #	t5 deflated the balloon of		period of six months	6.	
	Resident #112's urina	ary Foley catheter and				
	-	atheter out some due to		The DON/ADON, nu	÷ .	
		external urethra. Review of		and/or staff facilitato		
		1/15/16 at 11:36 PM revealed		TARs using the "Fol		
		n episode of vomiting and an		Tool" to ensure cath	•	
		on was administered. Vital		-	ordered. The audit will y x 4 weeks, biweekly	
		s: blood pressure - 140/78, ns - 18, temperature - 103		times 8 weeks,then		
		a dated 01/16/16 at 12:20 AM				
	revealed Resident #			The DON will preser	nt all findings from the	
		emergency management		"Foley Catheter Aud	-	
	system.			monthly QI committe		
	Review of the hospita	al discharge summary		recommendations a	s appropriate to	
		112 was admitted to the		maintain continued	compliance.	
		epsis most likely due to				
		urinary tract infection from			nd/or DON will present	
		catheter. Resident #112 was		-	ommendations of the	
	-	nsive care unit with sepsis ved at discharge back to the		monthly QI committe executive QA comm		
	facility on 01/21/16.	New at discharge back to the		recommendations a		
		e on 02/22/16 at 11:30 AM				
		112 had an indwelling				
		draining clear, yellow urine.				
		ted with Nurse #4 on				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345502	B. WING			— R-C — 03/14/201	
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				33	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 315}	02/24/16 at 9:40 AM when Resident #112's last been changed. S documented urinary for TAR was 11/08/15 and the TAR for 12/2015, change the urinary For Nurse #5 stated the of Foley catheter every transcribed to the TAR wouldn't have known An interview conducter 02/25/16 at 10:15 AW worked the 3:00 PM fr Resident #112. She re TAR for Resident #11 confirmed there was #112's urinary Foley catheter because it had not be for February 2016 an written on the TAR will what shift Resident # was to be changed. No nurse on the floor was charts each month to previous month to the was not sure if anyon the person that transf An interview conducto on 02/25/16 at 1:41 Fr aware the urinary Fole been placed on the TAR and 02/2016. He state catheters to be changed ordered. The physicia always the risk of infe	revealed she did not know s urinary Foley catheter had he stated the last foley catheter change on the d there were no orders on 01/2016 and 02/2016 to obley catheter every 30 days. Forder to change the urinary 30 days did not get R after 11/2015 so she it needed to be changed. ed with Nurse #3 on I revealed she normally to 11:00 PM shift with eviewed the February 2016 2 with the surveyor and no order to change Resident catheter every 30 days. She bow when Resident #112's r had last been changed een documented on the TAR d stated it should have been hat day of the month and 112's urinary Foley catheter Jurse #5 further stated each s assigned a couple of transcribe orders from the e next month to the TAR and e checked the orders behind cribed them. ed with the facility Physician PM revealed he was not ey catheter order had not AR for 12/2015, 01/2016 ed he expected the urinary	{F 3	315}			

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345502	B. WING			R-C <b>3/14/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
		-		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 315}	Continued From page	e 69	{F 315	3		
{F 441} SS=D	infection leading to R hospitalization on 01/ A phone call was atter PM with Nurse #5 duremployed by the facil Nurse #5 did not reture During an interview of Director of Nursing (ID PM she revealed the #112's urinary cathete been transcribed to the and 02/2016 and she documentation in the urinary Foley cathete 11/08/15. The Interime interviewed nurses the #112 and none of the Resident #112's urinars stated Resident #112 should have been char order to change the of documented on the T 483.65 INFECTION Of SPREAD, LINENS The facility must estate Infection Control Prog- safe, sanitary and con to help prevent the de of disease and infection (a) Infection Control F The facility must estate Program under which (1) Investigates, cont in the facility;	16/16. mpted on 02/25/16 at 2:45 e to her no longer being ity. A message was left but rn surveyors call. onducted with the Interim DON) on 02/25/16 at 3:00 order to change Resident er every 30 days had not he TAR in 12/2015, 01/2016 could not find any medical record of the r being changed since DON further stated she had iat provided care to Resident m recalled changing ary Foley catheter. The DON 's urinary Foley catheter anged every 30 days and the eatheter should have been AR. CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control	{F 441	}		3/18/16

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
{F 441}	Continued From pag	e 70	{F 44	41}	
		an individual resident; and d of incidents and corrective actions.			
	prevent the spread o isolate the resident. (2) The facility must p communicable disea from direct contact w direct contact will tran (3) The facility must p hands after each direct hand washing is indice professional practice (c) Linens Personnel must hand	n Control Program sident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if nsmit the disease. require staff to wash their ect resident contact for which cated by accepted			
	by: Based on observation interviews the facility precautions while set resident on contact is contact isolation obset hall (Resident #137). The findings included Resident #137 was a 01/20/16 with diagno diff), bacteria that can life-threatening inflam	l: Idmitted to the facility on ses of clostridium difficile (c n cause severe diarrhea to		F 441 Infection Control 1) On 2/26/2016 the Director (DON) reviewed resident # and physician s order to er isolation precautions were in correct signage for contact was on the resident s door the door storage bin for per- protective equipment (PPE) with needed supplies to incl and gloves.	137 □'s chart nsure correct mplemented, precautions , and the over sonal ) was stocked

Facility ID: 970828

		MEDICAID SERVICES				OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE S COMPL	
						R-C	
		345502	B. WING			03/1	4/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		33	15 FAITH CHURCH ROAD		
				IN	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
{F 441}	Continued From page	o 71	{F 4	1411			
[ ]	dated 09/2014 reveal		<b>۲</b> Γ 4	• • • • •			
		be followed by all staff.			2) On 2/26/16 the DON reviewed all		
	•	e on 02/22/16 at 12:30 PM			residents with isolation precautions		
		37's room had a red Contact			including contact precautions to ensure		
		door that read in part: wear			the correct isolation precautions were	,	
		g room. Wear a gown if			implemented with the appropriate signa	aae	
	expected to be soiled				and over the door storage bin for PPE	.5-	
		e of Nurse #4 setting up the			were in place for each identified resider	nt.	
	lunch tray for Reside	nt #137 on 02/22/16 at 12:40			No negative findings were identified.		
	PM revealed Nurse #	4 taking the lunch tray from					
	the cart, knock on Re	esident #137's door and			3) On 3/2/16 the DON and Staff facilitat	tor	
		ner lunch tray. Nurse #4 did			in-serviced all facility staff on Infection		
	-	entering Resident #137's			Control. The Infection Control		
		ed the meal tray on Resident			in-service included the following:		
		and positioned the over					
		nt #137 to reach her tray.			1. The facility must establish an infect		
		off of the plate, removed			control program under which itDecid what procedures, such as isolation sho		
		acket and opened the straw urse #4 then exited Resident			be applied to an individual resident.	uia	
		washing her hands. Nurse			Contact precautions help prevent		
		er from her pocket when she			transmission of infectious agents		
		I and proceeded to take			2. All employees must follow the signa	ade	
		lunch cart to give to another			for precautions to include contact	.90	
	resident.	<b>3</b> • • • • •			precaution when entering a resident s		
	An interview conduct	ed with Nurse #4 on			room.		
	12/22/16 at 12:55 PM	I revealed she did not wear			3. This includes wearing gloves when		
	gloves during the set	-up of Resident #137's lunch			entering a resident s room who is on		
		not touch anything but the			contact precautions to set up a resident	t⊡s	
	-	the room. Nurse #4 stated			meal tray.		
		zer between passing meal			4. Each employee must wash their		
		washing because it took less			hands after glove use to include when		
	time.				exiting a resident⊡s room who is on		
	-	conducted with the Interim			contact precautions to prevent the spre		
	- ·	DON) on 02/23/16 at 11:30			of infection to another resident s room	-	
		xpected staff to wear gloves			For example, when you are exiting a resident⊡s room who is on contact		
		I trays for residents on autions and staff had been			precautions, you must remove your glo	VAS	
		hands before leaving the			and wash your hands before delivering		
		isolation precautions. The			meal tray to another resident s room. I		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/201 FORM APPROVE OMB NO. 0938-039
TATEMENT (	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         LAKE PARK NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)         {F 441}       Continued From page 72 Interim DON further stated hand sanitizer did not kill c diff and that was why it was important to use soap and water for handwashing before leaving the residents room.       {F 441}       employee will work until in-service continue to be in-serviced during orientation process.         4) On 2/26/16 the DON and/or st facilitator utilized a "Resident Ca Tool" to ensure staff follows isola precautions for residents who are contact precautions. The "Reside Audit Tool" will be completed five weeks, a weeks, twice weeks/ y weeks, any negative findings addressed immediately by the D and/or staff facilitator by providin retraining.         The DON will present all findings monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly QI committee will review results of the "Resident Care Au monthly to f months	STREET ADDRESS, CITY, STATE, ZIP CODE				
	345502       ME OF PROVIDER OR SUPPLIER       XKE PARK NURSING AND REHABILITATION CENTER       X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 441}     Continued From page 72 Interim DON further stated hand sanitizer did not kill c diff and that was why it was important to use soap and water for handwashing before leaving		3315 FAITH CHURCH ROAD		
LAKE PAF	K NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 441}	Interim DON further kill c diff and that was soap and water for h	stated hand sanitizer did not s why it was important to use	{F 441	<ul> <li>employee will work until in-service is completed. All future employees will continue to be in-serviced during their orientation process.</li> <li>4) On 2/26/16 the DON and/or staff facilitator utilized a "Resident Care Au Tool" to ensure staff follows isolation precautions for residents who are on contact precautions. The "Resident C Audit Tool" will be completed five time weekly x 4 weeks, twice weekly x 4 weeks, and month 12 weeks. Any negative findings will addressed immediately by the DON and/or staff facilitator by providing</li> </ul>	udit are es ly x be
				results of the "Resident Care Audit To monthly for 6 months for identification trends, actions taken, and to determin the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.	i of ie
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/F	RESIDENT WELL-BEING	{F 490	the findings and recommendations of monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	the

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
{F 490}	A facility must be adn enables it to use its re efficiently to attain or practicable physical, well-being of each res	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial	{F 490	}	
	by: Based on staff interv records, the facility ac create and impose a would be protected fr would implement the procedures to interve report abuse when wi resident experienced abuse without immed protection and implem and procedures for 1 reviewed for abuse (F Immediate jeopardy b Nurse Aide (NA) #1 s face and the witness, did not immediately re for protection of Resid A second incident of p 02/16/16 when NA #1 right thigh and the witi intervene for the prote Immediate jeopardy is The facility provided t Centers for Medicare allegation of complian	iews and review of facility dministrative staff failed to culture that all residents om abuse and that staff facility's abuse policy and ne, protect and immediately itnessed. A combative 2 episodes of physical liate facility intervention, nentation of abuse policies of 1 sampled residents Resident #6). Degan on 02/16/16 when lapped Resident #6 on the NA #2 did not intervene and eport to administrative staff dent #6 and other residents. physical abuse occurred on I slapped Resident #6 on the tness, NA #2 did not ection of Resident #6. s present and ongoing.		A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. F490 1) On 2/16/16, Resident#6 was assee by the Medical Director. No new ord were received. On 2/16/16, Resident#6 was assees by Nurse #1 which included a head to assessment. The findings revealed a reddened area on the upper right this and small healing bruises. Resident still resides in the facility. On 2/16/16, staff nurses complete 100% body audit on all cognitively impaired residents in the facility for evidence of abuse. No negative findi were identified. On 2/16/16, the social worker interviewed all alert and oriented residents resident and residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evidence of all alert and oriented residents in the facility for evide	able ssed ers ssed o toe gh t #6 from (16. d

Facility ID: 970828

	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TI	PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	OMPLETED
			A. DOILDIN	<u> </u>		R-C
		345502	B. WING			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	00/14/2010
				3315 FAITH CHURCH ROAD	)	
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	9	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S	PLAN OF CORRECTION	(X5)
PRÉFIX TAG	· ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	COMPLETIO DATE
{F 490}	Continued From pag	e 74	{F 49	0}		
. ,	review of the followin			•	was disciplined for	
		gnitively impaired residents			nediately allegation of	
	dated 02/16/16	5 · 5  · 2 ·		abuse according to		
		erviews regarding abuse for			was terminated for	
		residents dated 02/16/16		not providing safety	for Resident#6.	
	Documentation of in-	services				
	(identifying/reporting	abuse, caring for residents		3) On 2/25/16, the a	administrator received	
		l currently employed staff		an in-service from the	-	
	completed by 03/07/			President of Operat	ions on F Tags 225	
		use monitoring on each shift		and 490.		
		6/16 and remained ongoing			ce included the	
		s for an allegation of abuse		following:		
		allegation of neglect on			st ensure that all	
	02/27/16	ort for Dooidopt #6 for the		-	volving mistreatment,	
	8:00 AM incident of a	ort for Resident #6 for the		neglect, or abuse, ir	d misappropriation of	
		orted to the Health Care		resident property an		
		HCPR). Both reports were		immediately to the a	-	
	faxed the the HCPR				officials in accordance	
		I staff hired since 02/16/16 to		with State law throu		
	include criminal back	ground checks, reference			ng to the State survey	
		Registry checks, license		and certification age		
	checks, and abuse tr	aining		The facility mus	st have evidence that	
	The facility's Abuse F	Policy		all alleged violations	s are thoroughly	
				investigated, and m		
		ing care, interviews with			le the investigation is	
		idents, interviews with family,		in progress.		
		aff present in the facility on			all investigations must	
		Ill documentation to support		-	dministrator or his/her	
	the AOC and intervie	-		designated represer		
		or of Nursing and the Nurse		officials in accordan		
		sufficient evidence to		(including to the Sta	-	
		tion by the facility to remove rdy at F-490. The immediate			) within 5 working days if the alleged violation	
		ed on 03/14/16 at 7:15 PM.		is verified appropria	-	
		out of compliance at F-490		must be taken.		
		d severity of (D) isolated, no			5 day report is required	
		ential for more than minimal			including allegations	
		ediate jeopardy, while the			investigation and/or	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/14/2010
			:	3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
{F 490}	Continued From page	o 75	(F 490		
[]			1 430		the
	implementation of the	process of monitoring the		additional allegations occurring on same day and/or involving the same	
				employee/resident.	
	The findings included	i:		The facility must ensure staff	
				effectively and consistently comm	
		- Based on staff interviews		through the chain of command, ve	-
		e facility failed to protect a		and in documentation, to attain an	
		free from physical abuse rention when a resident		maintain resident⊡s well-being. S have been trained to effectively an	
	became combative d			consistently communicate through	
		lly abused twice when a staff		chain of command, verbally and in	
		across the face and then on		documentation, to attain and main	
		f 1 sampled residents		residents□ safety from abuse.	
	reviewed for abuse. (	· · · · · · · · · · · · · · · · · · ·			
		Based on staff interviews		On 2/26/16, 2/29/16, 3/1/16 or 3/2	2/16 all
		e staff failed to immediately staff of a witnessed incident		staff and contract staff attended a Directed □in-service presented by	the
		which a resident was slapped		Regional Ombudsman Area Agend	
		tified, the facility failed to		Aging Titled: Identification and Pre	
		physical abuse to the Health		of Elder Abuse.	
		stry in 24 hours and the			
	• •	in 5 working days for 1 of 1		4) The Corporate Staff, i.e. clinical	-
	sampled residents. (F			consultant and/or regional VP will	
		- Based on staff interviews		continue to review all allegations of	
	and record review, th	le facility failed to sing care when a resident		and interventions when reported to administrator in accordance with the	
	, , , , , , , , , , , , , , , , , , ,	e combative to prevent an		Abuse Policy including notification	
	. ,	buse, intervene when		appropriate agencies for 6 months	
		observed, and immediately			
		or from a combative resident		The monthly QI committee will rev	
		facility failed to report a		results of the Administrative Audit	Tool for
		physical abuse to the Health		abuse and continue to review any	
		stry in 24 hours and the		allegations of abuse i.e. 24 hour/5	o/day
	-	king days. The facility failed policy and procedures in the		report monthly for 6 months for identification of trends, actions tak	en and
		protection, identification,		to determine the need for and/or	
		of physical abuse for 1 of 1		frequency of continued	
	abuse investigation r			interviews/monitoring and make	
	-	vith the Administrator on		recommendations for monitoring for	or

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING _				-C 14/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				33	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 490}	Continued From page	e 76	{F 4	90}			
	02/24/16 at 3:52 PM,	she revealed she was tor of Nursing (DON) on		,	continued compliance.		
	02/16/16 around lunc in the facility on 02/16 Administrator stated to she had begun the im Administrator continu Administrator continu Administrator stated to leaving for the day, the Administrator's office written statements an Administrator did not conducted by the DO had it all together. The later she realized that thorough in her invess "captain of the ship" if make sure all parts of completed. The Admin her expectation that so completed. The Admin her expectation that so combative residents of Resident #6 required staff, then depending could get to the call bo or not staff could call when Resident #6 be Administrator stated so staff to immediately re combative resident for a lack of training that necessary tools to kn combative resident an combative resident an combative resident an combative resident w The Medical Director 02/25/16 at 3:36 PM. he was in the facility of	h time that abuse occurred 3/16 around 10:00 AM. The that the DON told her that vestigation, so the ed working in her office. The that around 4:00 PM, before he DON came back to the and told her that she had nd interviews, but the review the investigation N and assumed the DON e Administrator stated that t the DON had not been tigation and that as the t was her responsibility to f the investigation was nistrator stated that it was staff ensure the safety of during nursing care and if the assistance of 2 nursing on whether or not the staff well would determine whether for additional assistance came combative. The she attributed the failure of eport abuse and protect a om further abuse was due to provided staff with the ow how to respond to a nd what to do when a as abused. was interviewed on The Medical Director stated			The administrator and/or DON will pre the findings and recommendations of monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	the	

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		(X3) DATE	E SURVEY PLETED
		345502	B. WING			R-C / <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 514} SS=D	was witnessed to strik Director stated that he Resident #6 and knew combative, resistive to and try to hit at staff. he was involved in de correction when abus January 2016. He sta re-educated to report occurred or was withe to administrative staff he expected the facilir protocol for reporting continued monitoring continue to occur. The Administrator was jeopardy on 02/24/20 An extended survey w 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice accurately documente systematically organiz The clinical record mu information to identify resident's assessments services provided; the	ke back. The Medical e was very familiar with w that at times she was quite o care and would strike out The Medical Director stated eveloping the plan of e occurred in the facility in ted that staff were abuse immediately, if it essed. If abuse was reported to the Medical Director stated ty to follow the abuse to the proper authorities and to make sure abuse did not s informed of immediate 16 at 5:27 PM. vas conducted on 02/25/16. ETE/ACCURATE/ACCESSIB that in clinical records on each te with accepted professional tes that are complete; ed; readily accessible; and zed. ust contain sufficient the resident; a record of the tts; the plan of care and	{F 4			3/18/16

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
			:	3315 FAITH CHURCH ROAD	
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
{F 514}		e 78 Γ is not met as evidenced	(F 514)		
	Based on an observa review of medical and failed to transcribe a to the treatment reco resident's indwelling days (Resident #112) time of administration	ation, staff interviews and d facility records, the facility physician order for 3 months rd regarding the change of a urinary catheter every 30 and document the correct of an enteral feeding 6) for 2 of 31 medical		F 514 Resident Records 1) On 2/25/16, the staff nurse conta Resident #112'□s physician and ob an updated Foley catheter order. On 2/25/16, Resident #112□'s Fo catheter was changed according to Foley catheter order dated 2/25/16	btained bley blee
	10/23/15 with diagnost disease, cerebrovaso hemiplegia. Review of the quarter 01/22/16 revealed Re cognitively impaired a catheter. Review of the care pl Resident #112 had an elimination with an in risk for infection. The	s admitted to the facility on ses of peripheral vascular		On 2/25/16, the staff nurse started Glucema 1.2 enteral feeding at 50 as ordered. On 2/25/16 the staff nurse contacted Resident #36 's physici regarding the resident not getting the Glucema 1.2 as ordered, the resided not have 35 minutes of the tube feed product (29.05 cc). No new orders received. On 2/25/16, the Director of Nursin (DON)reviewed Resident #36 's w for the past 3 months with no negatifindings.	cc/hour urse an he ent did eding were ng reights
	next review. Intervent care per facility proto catheter per physicial protocol. Review of the treatmon Resident #112 reveal 10/23/15 through care once every shift 11/01/15 through catheter every 30 day	tions included Foley catheter col and change Foley n orders and/or facility ent records (TAR) for led the following: n 10/31/15 - urinary catheter n 11/30/15 - Change urinary ys. Documented on TAR as . No mention of urinary		<ul> <li>2) On 2/26/16, DON audited all oth residents with a foley catheter and residents receiving enteral feedings accurate record documentation. The were no negative findings.</li> <li>3) On 2/26/16, DON initiated an infor 100% of nurses regarding documenting the correct time of administration of enteral feeding pr to include continuous feedings. The in-service was completed on 3/7/16</li> </ul>	s for here service roducts,

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						NO. 0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	ATE SURVEY
			A. BUILDII	NG		R-C
		345502	B. WING			03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		JJ/14/2010
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX		ON SHOULD BE HE APPROPRIATE	COMPLETION
{F 514}	Continued From pag	e 79	{F 5	14}		
	12/01/15 throug	h 12/31/15 - No mention of				
		every shift or change urinary		On 3/7/16, DON initiated a	an in-service	
	catheter every 30 da			for 100% of nurses regardin		
		h 01/31/16 - No mention of		and accurate transcription of		
	•	every shift or change urinary		orders to the Medication Ad		
	catheter every 30 da			Record (MAR) or the Treatn		
	-	h 02/25/16 - No mention of		Administration Record (TAR		
		every shift or change urinary		orders to change a Foley ca		
	catheter every 30 da	-		TAR. The in-service was c	ompleted on	
		s notes from 10/23/15		3/14/16.		
	-	realed no note that Resident		4) On 3/7/16 DON OLDUR	so staff	
	-	er had been changed. s note dated 01/14/16 at 6:25		4) On 3/7/16, DON, QI nurs facilitator, and/or evening ch		
		#5 deflated the balloon of		will utilize the "Foley Cathet		
		ary catheter and retracted		to validate Foley catheter or		
		e due to bleeding around the		transferred over from the cu		
	external urethra.			the new month. The audit v		
	An interview conduct	ted with Nurse #4 on		completed within 5 days of		
	02/24/16 at 9:40 AM	revealed she did not know		end-of-month MAR and TAF		
	when Resident #112	's urinary catheter had last		reconciliation. This audit wil	I be completed	
	been changed. She	stated the last documented		for 6 months.		
	catheter change on t	he TAR was 11/08/15 and				
		on the TAR for 12/2015,		On 3/7/16,DON, QI nurse		
		6 to change the urinary		facilitator, and/or evening ch	•	
		ys. Nurse #5 stated the order		will utilize the "Enteral Feed	-	
		/ catheter every 30 days did		to validate the enteral feedin		
		the TAR after 11/2015 so		administered according to p	•	
	she wouldn't have kr			orders, to include nurses wr start times on the enteral fe		
	changed. An interview conduct	ted with Nurse #3 on			curry bollies.	
		I revealed she normally		The audits will be completed	d 5 days a	
		to 11:00 PM shift with		week for 4 weeks, then 2 da	•	
		reviewed the February 2016		4 weeks, then 1 time a week		
		12 with the surveyor and		months.		
		no order to change Resident				
		er every 30 days. She stated		The DON and/or the QI nurs	se, and/or the	
		aides provided catheter care		staff facilitator will monitor th		
		care but she did not know		Catheter Audit Tool" results	-	
	I	heter had last been changed		proper transcription of Foley		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345502	B. WING				R-C / <b>14/2016</b>
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
				IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 514}	for February 2016 and written on the TAR with what shift Resident # be changed. Nurse # on the floor was assig month to transcribe of month to the next mo sure if anyone checked person that transcribed A phone call was atter PM with Nurse #5 due employed by the facial Nurse #5 did not retu During an interview of Director of Nursing (D PM she revealed the #112's urinary cathete been transcribed to the and 02/2016 and she documentation in the urinary catheter being The Interim DON statt that all orders be tran each month. She statt been checking behind mistakes. 2. Resident #36 was 09/17/14. Diagnoses artificial opening of di obstruction, and peritt A physician's order da Glucerna 1.2 (enteral 50 cc per hour, contir order included to prov	ten documented on the TAR d stated it should have been hat day of the month and 112's urinary catheter was to 5 further stated each nurse gned a couple of charts each rders from the previous nth to the TAR and was not ed the orders behind the ed them. mpted on 02/25/16 at 2:45 e to her no longer being ity. A message was left but rn surveyors call. onducted with the Interim DON) on 02/25/16 at 3:00 order to change Resident er every 30 days had not he TAR in 12/2015, 01/2016 could not find any medical record of the g changed since 11/08/15. ed it was her expectation scribed correctly to the TAR ed the nurse's should have d each other for transcription	{F 5	514}	orders onto the TAR. The DON and/ nurse, or staff facilitator will initial the bottom right corner of the audit tool wit the date to acknowledge completion a follow-up The DON and/or the QI nurse, or staff facilitator will monitor the "Enteral Fee Audit Tool" results to ensure proper administration of enteral feedings. The administrator and/or DON will pre- the findings from the "Foley Catheter," and Enteral Feeding Audit" to the mor QI committee for recommendations as appropriate to maintain continued compliance and to the quarterly exect QA committee for further recommendations and oversight.	th ind eding sent Audit athly s	

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	-					FORM	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		SURVEY PLETED
		345502	B. WING				-0 14/2016
	D PLAN OF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345502         AME OF PROVIDER OR SUPPLIER         AKE PARK NURSING AND REHABILITATION CENTER         (X4) ID         PREFIX       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)		3	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 514}	10AM, 2PM, 6PM and order also indicated th medications (provided the percutaneous end tube. On 02/24/16 at 05:35 her bed with the head approximately 30 deg AM, the enteral feeding by noted beeping. Nurse the enteral feeding pu Nurse #6. Nurse #6 w and medications for F an enteral feeding bo 02/24/16 at 06:01 AW record the date of 02/ and rate of 50 cc on t Resident #36. On 02/ #6 administered med Resident #36 via the enteral feeding produ Nurse #6 was intervie and stated he wrote 0 feeding bottle as the a he typically recorded medications and that medications for Resid realized that by record of 05:30 AM, Resider TF product. The Interim Director of interviewed on 02/25/ interview she stated to should document the	d 10PM. The physician's hat staff could cocktail d all together) and give via doscopic gastrostomy (PEG) AM Resident #36 was in d of the bed elevated to grees. On 02/24/16 at 05:48 ng bottle of Glucerna 1.2 nteral feeding pump was e #7 was observed to turn off ump per the request of vas noted to gather supplies Resident #36 which included ttle of Glucerna 1.2. On I, Nurse #6 was observed to /24/16, time of 05:30 AM, he enteral feeding bottle for /24/16 at 06:05 AM, Nurse ications and a water flush to PEG tube and started the loct. ewed on 02/24/16 at 6:10 AM 05:30 AM on the enteral administration time because the time he prepared the time he prepared dent #36. Nurse #6 stated he ding an administration time	{F 5	514}			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/20 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345502	B. WING		03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
{F 514}	correct amount of ent infused. The Interim I the hang time Nurse #	cord would document the eral feeding product DON stated that based on #6 documented for the ct, Resident #36 missed 35	{F 514}			
{F 520} SS=D	483.75(0)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS		{F 520}		3/18/16	
	assurance committee	in a quality assessment and consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies.				
		rds of such committee h disclosure is related to the ommittee with the				
		y the committee to identify ficiencies will not be used as				
	by:	is not met as evidenced		F 520 QAA Committee		

Event ID: NYX812

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24 FORM APPR OMB NO. 0938	OVE
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		345502	B. WING		R-C 03/14/201	6
NAME OF P	ROVIDER OR SUPPLIER	L	s	TREET ADDRESS, CITY, STATE, ZIP CODE		-
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	ETIO
{F 520}	Assurance (QAA) cor implemented procedu interventions that the February 05, 2016. T deficiencies that were Complaint survey cor and subsequently rec Complaint and Follow conducted on Februa deficiencies were in t to be free from abuse implementation of ab administration and ac Immediate jeopardy b Nurse Aide (NA) #1 s face and the witness, did not immediately re for protection of Resi physical abuse occur slapped Resident #6 witness, NA #2 did not	Quality Assessment and mmittee failed to maintain ures and monitor these committee put into place on his was for 4 recited e originally cited during a nducted on January 15, 2016 cited during a Recertification, w up Complaint survey any 25, 2016. The he areas of a resident's right	{F 520}	<ol> <li>On 3/1/2016, the monthly QI Committee held a meeting. The administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator maintenance director, social workers, medical records, dietary manager and housekeeping supervisor will attend monthly QI Committee meetings on an ongoing basis and will assign addition team members as appropriate.</li> <li>On 3/3/2016 the regional facility consultant in-serviced the facility administrator, DON, MDS nurse, treatment nurse, maintenance director dietary manager, social workers, med records, dietary manager and housekeeping supervisor related to th appropriate functioning of the QI Committee and the purpose of the committee to include identifying issues related to quality assessment and assurance activities as needed and developing and implementing approprint</li> </ol>	n al r, ical e	
	allegation of complian A revisit survey was of determine the status	and Medicaid an acceptable nce (AOC) on 03/08/16. conducted on 03/14/16 to of the ongoing Immediate		plans of action for identified facility concerns to include F 223, F225, F220 F282, F490 and F520 all of which are immediate jeopardy level. 3) As of 3/3/2016, after the facility		
	review of the followin Skin audits for all cog dated 02/16/16 Documentation of inte all cognitively intact re Documentation of in-	nitively impaired residents erviews regarding abuse for esidents dated 02/16/16		consultant in-service, the monthly QI Committee began identifying other are of quality concern through the QA revi process, for example: review of administrative rounds tools, resident council minutes, and resident concern Corrective action has been taken for t identified concerns related to the repe	ew Iog. he	

Facility ID: 970828

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					ED: 03/24/2016 RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _				R-C 3/14/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				33	15 FAITH CHURCH ROAD		
	RK NURSING AND REHA	ABILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 520}	Continued From page	<u>- 84</u>	{F 52	201			
(*;		currently employed staff	1 02	_0}	deficiency.		
	Documentation of ab which began on 02/2/ 24 hour/5 day reports on 03/03/16 and an a 02/27/16 A 24 hour/5 day repo 8:00 AM incident of a previously been repo Personnel Registry (H faxed the the HCPR of Personnel files for all include criminal back checks, Nurse Aide F checks, and abuse the The facility's Abuse F Observations of nurse cognitively intact resist interviews with all sta 03/14/16, review of a the AOC and interview Administrator, Director Practitioner provided support corrective ac the immediate jeopar jeopardy was remove The facility remained at a lower scope and actual harm with pote harm that is not imme facility continues the implementation of the The findings included 1a. Cross refer to F 2 interviews and record	use monitoring on each shift 6/16 and remained ongoing a for an allegation of abuse allegation of neglect on rt for Resident #6 for the abuse which had not rted to the Health Care HCPR). Both reports were on 02/25/16 staff hired since 02/16/16 to ground checks, reference Registry checks, license aining Policy ing care, interviews with dents, interviews with family, off present in the facility on II documentation to support ws with the facility's or of Nursing and the Nurse sufficient evidence to tion by the facility to remove dy at F-520. The immediate ed on 03/14/16 at 7:15 PM. out of compliance at F-520 d severity of (D) isolated, no ential for more than minimal ediate jeopardy, while the process of monitoring the eir corrective action.			4) The Committee will continue to me monthly with oversight by the Vice President of Operations or Vice Presi of Clinical Services or the facility Clini Consultant. The QI Committee meetin agenda and minutes with resulting pla of correction and audit results will be reviewed as a component of this over after each QI Committee meeting. The Executive QI Committee, including th Medical Director, will review monthly compiled QI report information, review trends and review corrective actions to and the dates of completion. The Executive QI Committee will validate facility's progress in the correction of deficient practices or identify concern The administrator will be responsible ensuring Committee concerns are addressed through further training or other interventions. The administrato DON will report back to the Executive Committee at the next scheduled quarterly meeting.	dent ical ng ans sight e e the v aken the s. for r or	

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/24/2016 FORM APPROVED MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION		3) DATE SURVEY COMPLETED
		345502	B. WING _				R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREE	TADDRESS, CITY, STATE, ZIP CODE		
				3315 F	AITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		INDIA	N TRAIL, NC 28079		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 520}	abuse with immediate resident became com A resident was physic staff member slapped on the right thigh for reviewed for abuse. ( During a Complaint s 15, 2016, the facility was protect a resident from Recertification, Comp Complaint survey cor 2016, the facility was resident from physica 1b. Cross refer to F 2 interviews and record immediately stop nurs (Resident #6) becam resident and prevent abuse, intervene whe observed, and immed perpetrator from a co secure unit. The facility witnessed incident of Care Personnel Regi investigation in 5 wor to follow their abuse p areas of prevention, p training and reporting abuse investigation re During a Complaint s 15, 2016, the facility v implement their abuse. Complaint and Follow	e intervention when a bative during nursing care. cally abused twice when a d her on the face and then 1 of 1 sampled residents Resident #6). urvey conducted on January was cited for failure to m sexual abuse. During a blaint and Follow up to nducted on February 25, cited for failure to protect a d abuse. 26 - Based on staff review, the facility failed to sing care when a resident e combative to protect the an incident of physical en physical abuse was diately remove the mbative resident on a ty failed to report a physical abuse to the Health stry in 24 hours and the king days. The facility failed policy and procedures in the protection, identification, of physical abuse for 1 of 1 eviewed. urvey conducted on January was cited for failure to e policy/procedures and luded assessment of a During a Recertification, of up to Complaint survey ry 25, 2016, the facility was blement their abuse	{F 5:	20}			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 03/24/2016 RM APPROVED IO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C 03/14/2016		
		345502	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		15 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 520}	facility administrative impose a culture that protected from abuse implement the facility procedures to interve report abuse when w resident experienced abuse without immed protection and impler and procedures for 1 reviewed for abuse (F During a Complaint c 2016 the facility was administration to imple implementation of the policy/procedures. Du Complaint and Follow 2016, the facility was administration to creat protected residents fr 1d. Cross refer to F 5 observation, staff inter medical and facility re transcribe a physiciar treatment record rega resident's indwelling I (Resident #112) and administration of an e (Resident #36) for 2 of reviewed. During a Complaint s 15, 2016 the facility w document an incident medical record. Durin Complaint and Follow February 25, 2016, th to transcribe a physic	v of facility records, the staff failed to create and all residents would be and that staff would 's abuse policy and ne, protect and immediately itnessed. A combative 2 episodes of physical liate facility intervention, nentation of abuse policies of 1 sampled residents Resident #6). onducted on January 15, cited for failure of ose the expectation for e facility's abuse uring a Recertification, v up survey of February 25, cited for failure of ate and impose a culture that om physical abuse. att - Based on an erviews and review of ecords, the facility failed to n order for 3 months to the arding the change of a Foley catheter every 30 days document the correct time of enteral feeding product of 31 medical records urvey conducted on January vas cited for failure to t of sexual abuse in the	{F 520}				

Facility ID: 970828

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	СОМ	E SURVEY PLETED	
		345502	B. WING _				R-C <b>3/14/2016</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				33	315 FAITH CHURCH ROAD			
	RK NURSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 520}	Continued From page	e 87	F 5	201				
(*)	time of administration	n of an enteral feeding	10	205				
	product.							
	02/25/16 at 4:29 PM	vith the Administrator on and a follow up interview on she revealed that the						
	facility's QAA met mo	onthly and quarterly. She ly QAA meetings focused on						
		ch month, and the quarterly						
		da focused on unresolved or						
		dministrator stated that						
		d in January 2016 during a						
	-	urvey, all department heads						
		monitoring for abuse on all atom stated that staff had no						
		e noted or brought for						
		rning staff meetings since						
		deral Complaint survey. The						
		that during these rounds,						
		le to communicate the						
		nen quizzed regarding						
	implementation of the							
		he Administrator stated that at deficiency at F 223 to						
	-	d not know how to respond						
		ame combative during care						
		on needed to provide more						
	interactive in-services	s. The Administrator stated						
		at deficiency at F226 to staff						
		inderstanding of the abuse						
	policy/procedures or							
		o implement the facility's cedures regarding what to						
		when to report abuse. The						
	Administrator also sta	-						
		lementing the facility's abuse						
	policy as it related to	reporting abuse to the						
		el Registry (HCPR), as she						
		y the 2 incidents of abuse as						
	2 separate incidents.	The Administrator further						

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED				
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED				
		345502	B. WING _				-C 14/2016				
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE						
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE				
{F 520}	F490 to staff not feelin was administration's r staff that it was okay t administrative staff sh HCPR both incidents administration becam stated she attributed a to a lack of staff traini re-education on accur medical record. The Medical Director 02/25/16 at 3:36 PM a in developing the plar occurred in the facility that staff were re-edu immediately, if it occu abuse was reported to Medical Director state follow the abuse proto proper authorities and make sure abuse did The Administrator was jeopardy on 02/24/20	ted a repeat deficiency at ng safe to report abuse, it responsibility to reassure to report abuse and that nould have reported to the of abuse once e aware. The Administrator a repeat deficiency at F514 ng and a need for racy when documenting the was interviewed on and stated he was involved n of correction when abuse r in January 2016. He stated cated to report abuse rred or was witnessed. If o administrative staff, the ed he expected the facility to ocol for reporting to the d continued monitoring to not continue to occur.	{F 5	20}							

Facility ID: 970828

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DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(	OMB NO. 0938-0391			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		345502	B. WING _			R-C 03/14/2016			
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE	E, ZIP CODE				
				3315 FAITH CHURCH ROAD					
	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	DATE			
{F 000}	0} INITIAL COMMENTS {F 000}								
	02/25/16. The facility immediate jeopardy of F-226 (J), and F-490 01/06/16. An extende 02/25/16. Immediate remained ongoing at survey. 483.13 (F 223) at J Immediate Jeopardy Nurse Aide (NA) #1 s on the face and again #6). Each incident of the secure unit and w #2 did not immediate administrative staff th abuse against Reside this Resident and oth unit from further abus	s conducted on 02/22/16 to was notified of ongoing on 02/24/16 at F-223 (J), (J), which began on ed survey was conducted on jeopardy was present and the completion of the began on 02/16/16 when lapped a combative resident on the right thigh (Resident physical abuse occurred on vas witnessed by NA #2. NA ly intervene or report to at she witnessed physical ent #6 and failed to protect er residents on the secure							
	Nurse Aide (NA) #1 s face when the Reside during nursing care. If abuse but did not imm to administrative staff protection to Residen which led to a second toward Resident #6. Resident #6 on the factor	began on 02/16/16 when lapped Resident #6 on the ent became combative NA #2 witnessed the physical nediately intervene or report f. This resulted in a lack of t #6 and other residents d incident of physical abuse NA #2 witnessed NA #1 slap nee during morning care, but eport the abuse. NA #1							
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE .	TITLE		(X6) DATE			

Electronically Signed

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.

03/21/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	
		345502	B. WING				-0 14/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	remained on the seculursupervised and secularsupervised and the investigation of the facility failed to reflect the investigation of the secular and the investigation of the secular and the witness, did not immediately reflect the secular and the witness, did not immediately reflect the secular and the witness, did not immediately reflect the secular and the witness, did not immediately reflect the secular and the with intervene for the protect of the secular and the with intervene for the protect of the secular acceptable allegation of the facility provided the secular and to de ongoing Immediate Jecularsupervised and the exit remained out of compliance and to de ongoing Immediate Jecular allower scolisolated, no actual hat than minimal harm the secular acceptable and the secular and the secular and the secular and the secular allower scolisolated, no actual hat than minimal harm the secular and	are unit, working veral hours later on essed NA #1 slap Resident during the provision of care. eport physical abuse to the el Registry within 24 hours of the physical abuse within began on 02/16/16 when lapped Resident #6 on the NA #2 did not intervene and eport to administrative staff dent #6 and other residents. ohysical abuse occurred on slapped Resident #6 on the mess, NA #2 did not ection of Resident #6 on the ness, NA #2 did not ection of Resident #6. the State Agency and the and Medicaid with an of compliance on 03/08/16. conducted on 03/14/16 for lity's allegation of termine the status of the eopardy. Immediate ed on 03/14/16 at 7:15 PM. on 03/14/16, the facility oliance at F-223, F-226, and pe and severity of (D) rm with potential for more at is not immediate cility continues the process	{F 0	000}			

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED O. 0938-0391	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		345502	B. WING				k-0 8/14/2016	
NAME OF PF	ROVIDER OR SUPPLIER		<b>I</b>	S	IREET ADDRESS, CITY, STATE, ZIP CODE	1		
	K NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 223} {F 223} SS=D	Continued From page 483.13(b), 483.13(c)( ABUSE/INVOLUNTA	1)(i) FREE FROM	{F 2 {F 2	-			3/18/16	
	sexual, physical, and punishment, and invo	right to be free from verbal, mental abuse, corporal oluntary seclusion. use verbal, mental, sexual,						
	or physical abuse, co involuntary seclusion	rporal punishment, or						
	facility failed to protect from physical abuse when a resident becan nursing care. A reside	iews and record review, the ct a resident's right to be free with immediate intervention ame combative during ent was physically abused ember slapped her on the			The resident has the right to be free fr verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion F 223	rom		
	<ul><li>#6).</li><li>Immediate Jeopardy</li><li>Nurse Aide (NA) #1 s</li><li>on the face and agair</li><li>#6). Each incident of</li></ul>	viewed for abuse. (Resident began on 02/16/16 when lapped a combative resident n on the right thigh (Resident physical abuse occurred on			1) On 2/16/16, Resident #6 was assess by the Medical Director. No new orders were received. On 2/16/16 Resident # was assessed by Nurse #1 which inclu a head to toe assessment. The finding revealed a reddened area on upper rig thigh and small healing bruises. Resid	s 6 uded is jht ent		
	#2 did not immediate administrative staff th abuse against Reside	vas witnessed by NA #2. NA ly intervene or report to lat she witnessed physical ent #6 and failed to protect er residents on the secure			<ul> <li>#6 still resides in the facility. On 2/16/1 NA #1 was suspended from employme for physically abusing Resident #6 and terminated on 2/22/16.</li> <li>2) Because all residents have the</li> </ul>	ent		
	assessed with redder thigh.	ned discoloration to her right			potential to be affected by verbal, sexu physical and mental abuse, corporal punishment, and involuntary seclusion			
	The immediate jeopa The facility provided t	rdy is present and ongoing. the State Agency and			2/16/16 staff nurses completed 100% body audit on all cognitively impaired residents in the facility for evidence of			

Facility ID: 970828

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					OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DOILDING		R-C
		345502	B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				3315 FAITH CHURCH ROAD	
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
{F 223}	Continued From page	e 3	{F 223	3}	
. ,		and Medicaid an acceptable	(	abuse. No negative findings were	
		nce (AOC) on 03/08/16.		identified. On 2/16/16, the social w	vorker
				interviewed all alert and oriented r	esidents
		conducted on 03/14/16 to		related to abuse and resulted in no	-
		of the ongoing Immediate		negative responses. On 2/19/16 N	
		/ provided documentation for		was disciplined for failure to report immediately allegation of abuse ac	
	review of the followin	g. gnitively impaired residents		to the Abuse policy and on 2/25/16	<b>e</b>
	dated 02/16/16			was terminated for not providing s	
		erviews regarding abuse for		Resident #6.	
		esidents dated 02/16/16			
	Documentation of in-			3) On 2/16//16 all facility staff inclu	uding
		abuse, caring for residents		Administrative and current contract	
		currently employed staff		present were re-educated either b	•
	completed by 03/07/	use monitoring on each shift		Administrator or Director of Nursin (DON) on the Abuse Policy and wi	-
		6/16 and remained ongoing		constitute abuse. Abuse will not be	
		s for an allegation of abuse		tolerated, to ensure immediate saf	
		allegation of neglect on		all residents and removing the acc	2
	02/27/16			from resident care area immediate	
		rt for Resident #6 for the		2/18/16 staff facilitator started a vi	
	8:00 AM incident of a			in-service for all staff entitled Bein	
		rted to the Health Care HCPR). Both reports were		Person with Dementia: Actions an Reactions." On 2/26/16, 2/29/16, 3	
	faxed the the HCPR			and/or 3/2/16 all staff and contract	
		staff hired since 02/16/16 to		attended a Directed Din-service pr	
		ground checks, reference		by the Regional Ombudsman Area	
		Registry checks, license		Agency on Aging. Titled: Identifica	
	checks, and abuse tr	5		Prevention of Elder Abuse. On 3/1	
	The facility's Abuse F	Policy		Staff facilitator started an in-servic	e for all
	Observations of a	ing core interviewe with		nurses and nursing assistants on	
		ing care, interviews with dents, interviews with family,		following resident care plans and o guides. No staff will take an assigr	
		aff present in the facility on		until these in-services has been	
		Il documentation to support		completed.	
	the AOC and intervie				
	Administrator, Directo	or of Nursing and the Nurse		On 3/4/16 an in-service was held f	
		sufficient evidence to		staff by The Geriatric and Adult Me	
	support corrective ac	tion by the facility to remove		Health Specialty Team titled "Man	aging

Facility ID: 970828

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF		TRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· · ·	PLETED
							२-C
		345502	B. WING				8/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
				3315 FAI	ITH CHURCH ROAD		
	RK NURSING AND REH	ABILITATION CENTER		INDIAN	TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 223}	Continued From pag	le 4	{F 22:	31			
(. 220)	1 0	rdy at F-223. The immediate	1 22.	-	allenging Behaviors." Quarterly		
		ed on 03/14/16 at 7:15 PM.			ervices will be offered to all staf	f by the	
		l out of compliance at F-223			cialty Team. All newly hired		
	at a lower scope and	d severity of (D) isolated, no			ployees will continue to receive	training	
	actual harm with pote	ential for more than minimal		on t	he Abuse policy through written	, video,	
		ediate jeopardy, while the			verbal education. New hires, p		
		process of monitoring the			ng an assignment will watch the		
	implementation of the	eir corrective action.			es "Hand in Hand," a series pro	•	
					ning on caring for residents with nentia and on preventing abuse		
	The findings included	d.			lentia and on preventing abuse	•	
	The infange moldae.	<b>.</b>		4) T	he DON, ADON, Department H	eads	
	Resident #6 was adr	nitted to the facility on			administrative staff on adminis		
		s included dementia with		staf	f rounds will continue to monitor	and	
	behaviors, mood affe	ective disorder, cognitive		com	plete abuse observations on 10	)	
		it, paranoid delusional beliefs		resi	dents per shift to be completed	seven	
		dent #6 was currently being		-	s a week three times a day to ir	Iclude	
		by ongoing psychiatric			h shift per week x4 weeks, 10		
	services.				dents bi-weekly for 8 weeks and		
	Modical record ravia	w revealed Resident #6 had			residents monthly x3 months us ise/Neglect audit tool called "Wa	-	
		ed 08/31/15 for Ativan			and Responding to an Incident		
		rams (mg) IM (intramuscular)			nthly QI committee will review re		
		for pain and 11/16/15 Ativan			ne Abuse/Neglect audit tool resi		
		as needed for agitation.			nthly for 6 months for identificati		
				tren	ds, actions taken and to determ	ine the	
		Data Set dated 12/29/15			d for and/or frequency of contin		
		#6 with severely impaired			nitoring, and make recommendation		
	-	extensive staff assistance of 2			monitoring for continued compliant and a compliant and a complexity of the complexit		
		s of daily living (ADL) to sfers, dressing and toileting,			administrator and/or DON will findings and recommendations		
		lly abusive and without			nthly QI committee to the quarte		
	impairments in range	-			cutive QA committee for further		
					ommendations and oversight.		
	A care plan dated 12	2/29/15 recorded that			5.4		
	Resident #6 had pro	blematic behavior					
	-	ffective coping behaviors of					
	verbal and physical a						
	treatment/care as ev	videnced by yelling, cursing,					

Facility ID: 970828

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 223}	swinging arms and de plan's goal specified t resident's safety. The included the following slowly from the front, provide diversion acti ADL routine to accom care is refused, leave Review of the "Reside staff were encouraged in a calm, reassuring refused, to approach A progress note dated practitioner (NP) reve referred by nursing fo agitation and perseve reported that Residen agitated primarily in th note recorded that Res NP to be very agitated Medications were adj continue to monitor. A Skin Monitoring Ret 02/15/16 did not recon with skin integrity. Review of a nursing p 02/16/16 at 4:49 PM of February 2016 Medic recorded that Residen towards staff that day she administered Ativ needed for agitation a positive effects and th	elusional behavior. The care hat staff were to ensure the care plan's interventions : approach calmly and respect personal space, vity, allow for flexibility in modate mood, and when and return in 5-10 minutes. ent care guide" revealed d to approach Resident #6 manner and if care was the Resident later. d 02/05/16 by the nurse aled Resident #6 was r evaluation of morning ring behaviors. Nursing it #6 was noted increasingly he morning. The progress esident #6 was noted by the d, angry, and confused. usted and staff were to view for Resident #6 dated rd any changes or concern progress note dated written by Nurse #1 and the ation Administration Record ht #6 was very combative . Nurse #1 documented that an 1 mg by mouth as at 7:40 AM with some	{F 2	223}			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 223}	A nursing progress no PM by Nurse #1 reco (NA #1) verbalized sh during care when the The Medical Director the Resident. Nurse # assessment for Resid reddened area to the A Skin Monitoring Re- completed by Nurse # #6 had redness to he irregular reddened are long to the front of he An incident report dat completed by the Dire recorded that NA #1 s #6 on the leg and afte noted with red marks A written statement by recorded that NA #1 s leg on 02/16/16 arour #6 become combative #1. Review of a Health C (HCPR) 24 Hour Initia completed by the Adm 02/16/16 at 10:00 AM Resident #6 on her le pulling her hair. Resid mark on her upper rig Review of the facility's written statement by t 02/19/16, which recor	be dated 02/16/16 at 4:56 rded that nursing assistant e slapped Resident #6 Resident pulled her hair. was notified and assessed #1 performed a full body lent #6 and noted a deep Resident's right upper thigh. view dated 02/16/16, #1, recorded that Resident r inner thighs and an ea, approximately 3 inches r upper right thigh. ed 02/16/16 at 5:03 PM ector of Nursing (DON), stated she struck Resident erwards the Resident was across the right thigh. y NA #1 dated 02/16/16 struck Resident #6 on her nd 10:00 AM when Resident e and pulled the hair of NA are Personnel Registry al Report dated 02/16/16 ninistrator, recorded that on , NA #1 stated she struck g to stop the Resident from lent #6 was noted with a red	{F 2	223}			

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			R-C <b>3/14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 223}	witnessed NA #1 slap about 8:00 AM. The v that the Administrator Administrator docume #2 on 02/17/16 and w witnessed NA #1 slap 02/16/16 around 8:00 thigh above her knee Resident became cor Written statements by recorded that on 02/1 witnessed Resident # morning care and NA the left side of her fac leave the Resident's fa at the nurse's station #6. Later in the morni 02/16/16, while in the witnessed Resident # NA #1 slapped Resid then witnessed NA #' report the incident to Review of a HCPR 5 02/19/16, completed recorded on 02/16/16 immediately reported combative resident on care. The physical ab was immediately susp called at 6:00 PM, the substantiated and NA An interview with NA 02/24/16 at 10:30 AM received a lot of abus	a aware that NA #2 also o Resident #6 on 02/16/16 written statement recorded was not aware. The ented that she spoke to NA vas informed that NA #2 o Resident #6 on the face on 0 AM and again on the right at 10:00 AM, when the mbative. y NA #2, dated 02/17/16, 6/16 at 7:30 AM, NA #2 the become combative during a #1 slapped Resident #6 on ce. NA #2 witnessed NA #1 room and make a statement that she "popped" Resident ing around 9:45 AM on e shower room, NA #2 the grab the hair of NA #1 and ent #6 on the leg. NA #2 1 leave the shower room and Nurse #1 and Nurse #2. Working Day Report dated by the Administrator, a at 10:00 AM, NA #1 that she slapped a in the leg during resident ouse was witnessed, NA #1 pended, the police was e allegation of abuse was	{F 223	3}		

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · ·	E SURVEY IPLETED
		DENTIFICATION NOMBER.	A. BUILDING			
						R-C
		345502	B. WING			3/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD		
		BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE
{F 223}	Continued From page	e 8	{F 223	3		
		nove the resident from harm,	(	1		
	• •	r and don't let the perpetrator				
		rooms. NA #2 stated that on				
	0 1	AM Resident #6 would not				
		and became combative				
		(kicking, yelling and hitting).				
		nessed Resident #6 hit NA				
		sed NA #1 slap Resident #6				
		face and said "You are				
	going to stop that." N	A #2 stated the slap was				
		on the face, but it wasn't a				
		ed Resident #6 was already				
	upset and remained	upset. Both NAs continued				
		dressed, placed her in her				
		1 took Resident #6 to the				
	dining room. NA #1 s	tated that on the way to the				
	dining room, NA #1 s	topped at the nurse's station				
	and told Nurse #1 "I	popped (Resident #6)" and				
	Nurse #1 said "Ok." I	NA #2 stated that she found				
	out later that Nurse #	1 did not hear NA #1's				
	statement. NA #2 sta	ited she felt that when NA #1				
	slapped Resident #6	that the incident fit the				
		ut that she didn't know how				
	-	om Resident #6. NA #2				
		I not think it would happen				
		urse #1 heard NA #1 report				
		Id take care of it. NA #2				
		er that morning around 10:00				
	AM, both NA #1 and					
	Resident #6 in the sh					
		mbative again. During care,				
	-	oull up the Resident's pants				
		bbed NA #1's hair. That's				
		Resident #6 on her right				
	-	ne slap was loud enough to				
		now what to do. Resident				
	#6 released her grip	on NA #1 hair and they				1
	finished pulling up the	-				

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345502	B. WING				R-C 3/14/2016	
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				331	5 FAITH CHURCH ROAD			
	RK NURSING AND REHA	BILITATION CENTER		IND	IAN TRAIL, NC 28079			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
{F 223}	Resident #6 to the dir she observed NA #1 nurse's station and to that she "popped" Re #2 immediately left th DON returned to the talk to the DON and t the unit. NA #2 stated 02/16/16 what happe that NA #1 slapped R her face about 8:00 A thigh about 10:00 AM informed the police of interviewed her that e the Administrator on 0 her on the phone. A telephone interview at 12:55 PM with NA worked on the facility permanent assignme abuse training. NA #1 how to identify abuse witnessed, she should from the resident, cal Administrator, and ma resident were both wa 02/16/16 Resident #6 and she responded b Resident's face and s #1 stated "I just touch and NA #2 was prese the nurse's station aff Resident #6 and told was a hand full, but s her face because she anything to it. NA #1 on the Resident's face	hing room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 sident #6 on the leg. Nurse is unit and Nurse #2 and the unit. NA #2 observed NA #1 hen NA #1 was escorted off d the DON asked her on ned and she told the DON desident #6 on the left side of M and then on her right i. NA #2 stated she also fficer on 02/16/16 when he evening on the phone and 02/17/16 when she talked to was conducted on 02/24/16 #1. She stated that she 's secure unit as her nt and had recently received I stated she was trained on and if abuse was d remove the perpetrator I law enforcement or the ake sure the perpetrator and atched. NA #1 stated that on, is slapped her on the face y gently touching the said "Let's don't do that." NA hed her face with my hand" ent. NA #1 stated she went to	{F 2	223}				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•
				3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
{F 223}	Resident became cor #1 stated that while s Resident's brief, the F pulling so hard "I was smacked her on the r I said stop and she st struck her gently beca hurt anyone. Residen hitting, we got her dre day room. NA #1 stat to Nurse #1 and Nurs Resident #6 on the le a statement from her A telephone interview at 11:10 AM and a fol conducted on 02/25/1 During the interviews 02/16/16 there were unit. Around 10:00 or her that while NA #1 Resident #6 in the sh became combative at hair. NA #1 stated sh get her to let go. Nurs (supervisor) was also conversation. NA #1 with Nurse #1, while I incident to the DON. took a statement from suspended. Nurse #1 with all residents on t 7:00 AM until she wat AM, but Nurse #1 wa incidents of abuse registated she had not be witnessed NA #1 slap	in the shower room and the mbative, worse this time. NA he was pulling up the Resident grabbed her hair, a up on my tip toes", so "I right knee to get her to stop, topped." NA #1 stated she ause it was not her nature to at #6 continued yelling and essed and took her to the red afterwards, she reported afterwards, she reported at #2 that she struck eg, the DON came and took and she was suspended. Was conducted on 02/24/16 How up interview was 16 at 3:30 PM with Nurse #1. , Nurse #1 stated that on 14 residents on the secure 10:15 AM, NA #1 informed and NA #2 provided care to ower room, the Resident and NA #2 provided care to ower room, the Resident and NA #1 stated Nurse #2 o present and heard the stayed at the nurse's station Nurse #2 reported the The DON came to the unit,	{F 2:	23}	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24 FORM APPR( OMB NO. 0938-	OVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _		R-C 03/14/2016	6
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
				3315 FAITH CHURCH ROAD		
	K NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION (X5 E ACTION SHOULD BE COMPLE D TO THE APPROPRIATE DAT CIENCY)	ETION
{F 223}	to give her care. Nurs trained that when res staff should give the r try to redirect and cor care. Nurse #1 stated combative that day an needed) twice on her and later for pain. Nu did not cooperate initia and Ativan was given Resident #6 was caln assessment was corr and she was noted w right thigh about 3 ind shape. Nurse #1 state changes noted to her The Administrator wa 3:52 PM. She stated around lunch time on "popped" Resident #6 room and reported her Administrator that NA she had started comp investigation. The Ad around 6:00 PM. The went to see Resident around 7:00 PM when Both she and the poli #6 without any marks Administrator stated I 9:00 PM, the police o	es, usually required 2 staff se #1 stated that staff were idents became combative, resident time to calm down, me back later to provide I Resident #6 was very nd received Ativan (as shift that day for agitation rse #1 stated Resident #6 ially with a skin assessment, to calm her down. Once n, a full body skin npleted, around 12:30 PM ith a reddened area to her ches long and irregular in ed there were no other skin or face. s interviewed on 02/24/16 at that the DON informed her 02/16/16 that NA #1 5 on the knee in the shower erself. The DON told the s #1 was suspended and that oleting interviews for the ministrator called the police Administrator stated she #6 for the first time that day n the police officer arrived. ce officer observed Resident	{F 22			
	stated she was not av at the DON's investig stated she called NA	a day, but the Administrator ware and she had not looked ation. The Administrator #2 sometime the next and obtained a statement				

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		MEDICAID SERVICES			OMB NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED R-C
		345502	B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DDE
LAKE PAF	K NURSING AND REHA	BILITATION CENTER		5 FAITH CHURCH ROAD DIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC TE APPROPRIATE DATE
{F 223}	Continued From page	2 12	{F 223}		
(*,	from her over the pho of physical abuse tha on 02/16/16 and repo	ne regarding both incidents t were witnessed by NA #2 rted to the DON. The NA #2 to provide written	(1 220)		
	AM. Nurse #2 stated Supervisor on the 7A Nurse #2 and Nurse # station on the secure 10:00 AM when NA # to know that I just pop #1 proceeded to say #6 because the Resid #2 stated she asked I station. Nurse #2 wer what occurred. The D obtained a statement suspended. Nurse #2	ewed on 02/25/16 at 10:28 she was the Nurse M - 3 PM shift on 02/16/16. #1 were both at the nurse's unit on 02/16/16 around 1 said "I just want everybody oped (named Resident)." NA that she "popped" Resident dent pulled her hair. Nurse NA #1 to stay at the nurse's at to find the DON and report ON came to the secure unit, from NA #1 and she was stated she was not aware ents of abuse between NA			
	Attempts to interview unsuccessful. The administrator wa jeopardy on 02/24/16	s notified of immediate			
{F 226} SS=D	An extended survey v 483.13(c) DEVELOP/ ABUSE/NEGLECT, E		{F 226}		3/18/16
	policies and procedur	, and abuse of residents			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/201 FORM APPROVE OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345502		· ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
			B. WING		03/14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•
LAKE PA	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE ICIENCY)
{F 226}	Continued From page	e 13	{F 2	26}	
	by: Based on staff interv facility failed to immer when a resident (Res to protect the residen physical abuse, interv was observed, and in perpetrator from a co secure unit. The facili witnessed incident of Care Personnel Regis investigation in 5 wor to follow their abuse p areas of prevention, p training and reporting abuse investigation re Immediate Jeopardy Nurse Aide (NA) #1 s face when the Reside during nursing care. I abuse but did not imm to administrative staff protection to Residen which led to a second toward Resident #6. Resident #6 on the fa did not immediately re remained on the secu unsupervised and sec 02/16/16, NA #2 with #6 on the right thigh of The facility failed to re Health Care Personn	physical abuse to the Health stry in 24 hours and the king days. The facility failed policy and procedures in the protection, identification, of physical abuse for 1 of 1 eviewed. began on 02/16/16 when lapped Resident #6 on the ent became combative NA #2 witnessed the physical nediately intervene or report This resulted in a lack of t #6 and other residents I incident of physical abuse NA #2 witnessed NA #1 slap ice during morning care, but eport the abuse. NA #1 ure unit, working		<ul> <li>F226 Development/In Policies for Abuse/Neg</li> <li>1)On 2/16/16, Resider by the Medical Directo were received. On 2/1 was assessed by Nurs a head to toe assessm revealed a reddened a thigh and small healin #6 still resides in the fr NA #1 was suspended for physically abusing terminated on 2/22/16 was re-educated on th include immediately in abuse, remove the pe immediately report.</li> <li>2) Because all resider potential to be affected physical and mental a punishment, and invol 2/16/16 staff nurses co body audit on all cogn residents in the facility abuse. No negative fir identified. On 2/16/16, interviewed all alert ar related to abuse and r negative responses. O was disciplined for fail immediately allegation to the Abuse policy an</li> </ul>	glect ht #6 was assessed for. No new orders 6/16 Resident #6 se #1 which included nent. The findings area on upper right g bruises. Resident acility. On 2/16/16 d from employment Resident #6 and 0. On 2/16/16 NA #2 he Abuse Policy to htervene and stop rpetrator and hts have the d by verbal, sexual, buse, corporal luntary seclusion on ompleted 100% itively impaired v for evidence of hdings were the social worker hd oriented residents resulted in no On 2/19/16 NA#2 lure to report n of abuse according

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING				R-C / <b>14/2016</b>	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
				33	15 FAITH CHURCH ROAD			
LAKE PARK NURSING AND REHABILITATION CENTER			IN	DIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 226}	Continued From page	e 14	{F 22	26}		r		
	The immediate jeopa	rdy is present and ongoing.			was terminated for not providing safet Resident #6.	y for		
	allegation of complian A revisit survey was of determine the status Jeopardy. The facility review of the following	and Medicaid an acceptable nce (AOC) on 03/08/16. conducted on 03/14/16 to of the ongoing Immediate provided documentation for			3) On 2/16//16 all facility staff includin Administrative and contract staff press were re-educated either by Administra or DON on the Abuse Policy and what constitute abuse. Abuse will not be tolerated, to ensure immediate safety all residents and removing the accuse from resident care area immediately. 2/18/16 Staff facilitator started a video in-service for all staff entitled "Being v	of On		
	Documentation of inte all cognitively intact re Documentation of in-s (identifying/reporting) with dementia) for all completed by 03/07/1 Documentation of abo which began on 02/20 24 hour/5 day reports	tion of interviews regarding abuse for ly intact residents dated 02/16/16 tion of in-services reporting abuse, caring for residents tia) for all currently employed staff			Person with Dementia: Actions and Reactions." On 2/26/16, 2/29/16, 3/1/ 3/2/16 all staff and contract staff atten a Direct □in-service presented by the Regional Ombudsman Area Agency of Aging. Titled: Identification and Preve of Elder Abuse. On 3/1/16 Staff facilitator in-serviced a	16 or ded n ntion		
	02/27/16 A 24 hour/5 day report 8:00 AM incident of a previously been report Personnel Registry (H faxed the the HCPR of Personnel files for all include criminal back checks, Nurse Aide R checks, and abuse tra The facility's Abuse P Observations of nursi cognitively intact resid	rted to the Health Care HCPR). Both reports were on 02/25/16 staff hired since 02/16/16 to ground checks, reference Registry checks, license aining			nurses and nursing assistants on following resident care plans and care guides. On 3/4/16 an in-service was offered for staff by The Geriatric and Adult Menta Health Specialty Team titled "Managir Challenging Behaviors." Quarterly in-services will be provided to all staff the Specialty Team. Staff Facilitator will continue to provide ongoing annual abuse and neglect education through written, video and verbal education.	or all I Ig by		
		Il documentation to support			All newly hired employees will continu	e to		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING	B. WING			R-C 8/ <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG			BE	(X5) COMPLETION DATE			
{F 226}	the AOC and interview Administrator, Director Practitioner provided support corrective act the immediate jeopar jeopardy was remove The facility remained at a lower scope and actual harm with pote harm that is not immediate facility continues the implementation of the The findings included The facility's policy "A Misappropriation of R revised 11/01/06, incl do whatever is in its of mistreatment, neglect or misappropriation o employee who witnes neglect, or misapprop occurred, will immedii incident to their super report the incident to will be initiated to pre abuse while the invest Administrator is respon of the investigation and to the appropriate age State and Federal reg- is responsible to direct to ensure that approp- as indicated. Training include: Indicators of abuse and related int	ws with the facility's or of Nursing and the Nurse sufficient evidence to tion by the facility to remove dy at F-226. The immediate ed on 03/14/16 at 7:15 PM. out of compliance at F-226 d severity of (D) isolated, no ential for more than minimal ediate jeopardy, while the process of monitoring the eir corrective action. t: Abuse, Neglect, or tesident Property Policy", uded in part: The facility will control to prevent t, and abuse of our residents	{F 2	226}	receive training on the Abuse policy through written, video, and verbal education. Prior to taking an assignm new hires will watch the video series "Hand in Hand:" a series providing tra on caring for residents with dementia on preventing abuse. 4) The DON, ADON, Department Hea and administrative staff on administra staff rounds will continue to monitor a complete abuse observations on 10 residents per shift to be completed set days a week three times a day to incl each shift. per week x4 weeks, 10 residents bi-weekly for 8 weeks and t 10 residents monthly x3 months using Abuse/Neglect audit tool called "Watc for and responding to an Incident." Th monthly QI committee will review resu of the Abuse/Neglect audit tool results monthly for 6 months for identification trends, actions taken and to determin need for and/or frequency of continue monitoring, and make recommendation for monitoring for continued complian The administrator and/or DON will pre- the findings and recommendations of monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	aining and ads tive nd ven ude hen g the ching he ults s of e the ed cons ce. esent the	

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345502	B. WING				R-C / <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	-		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAI	LAKE PARK NURSING AND REHABILITATION CENTER				3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 226}	inappropriate behavior The facility will assess residents with needs lead to abuse, neglect property. Protection: If directly involved in all or misappropriation of immediately from emp outcome of the invest Review of the facility's Misappropriation of R revealed a definition of included. Resident #6 was adm 04/10/14. Diagnoses behaviors, mood affec communicative deficit and psychosis. Resid treated and followed B services. Medical record review physician orders date (antianxiety) 2 milligra injection as needed for physician's order date every 8 hours as need A quarterly Minimum assessed Resident #6 cognition, required ex persons for activities of include mobility, trans physically and verball impairments in range	ors, such as rough handling. s, care plan, and monitor and behaviors that might t, or misappropriation of Employees accused of being egations of abuse, neglect, f property will be suspended oloyment pending the igation. s Abuse, Neglect or esident Property policy of physical abuse was not hitted to the facility on included dementia with ctive disorder, cognitive t, paranoid delusional beliefs ent #6 was currently being by ongoing psychiatric v revealed Resident #6 had d 08/31/15 for Ativan ams (mg) IM (intramuscular) or pain and another ed 11/16/15 for Ativan 1 mg ded for agitation. Data Set dated 12/29/15 6 with severely impaired ttensive staff assistance of 2 of daily living (ADL) to ofers, dressing and toileting, y abusive and without	{F 2	226}			

Facility ID: 970828

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		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/201 FORM APPROVE OMB NO. 0938-039		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345502		B. WING		R-C 03/14/2016		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/14/2010		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
{F 226}	practitioner (NP) reveres referred by nursing for agitation and perseveres reported that Resider agitated primarily in the note recorded that Resider Addications were adj continue to monitor. A Skin Monitoring Ref 02/15/16 did not recorded that Resider 202/15/16 did not recorded that Resider towards staff that day she administered Ativn needed for agitation apositive effects and the needed for pain at 12 effects. A nursing progress not PM by Nurse #1 recorded the Resident. Nurse # assessment for Resident towards recorded the A Skin Monitoring Ref 202/16/16 at 202/16/16/16 at 202/16/16 at 202/16/16 at 202/16/16 at 202/16/1	aled Resident #6 was r evaluation of morning ring behaviors. Nursing t #6 was noted increasingly he morning. The progress asident #6 was noted by the d, angry, and confused. usted and staff were to view for Resident #6 dated rd any changes or concerns rogress note dated by Nurse #1 and the ation Administration Record ht #6 was very combative . Nurse #1 documented that an 1 mg by mouth as it 07:40 AM with some hen Ativan 2 mg IM as :10 PM with slight positive the dated 02/16/16 at 4:56 rded that nursing assistant e slapped Resident #6 Resident pulled her hair. was notified and assessed e1 performed a full body lent #6 and noted a deep Resident's right upper thigh.	{F 226}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			
		345502	B. WING				-C 14/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079			247
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 226}	Continued From page	9 18	{F 2	26}			
	An incident report dat completed by the Dire recorded that NA #1 s #6 on the leg and aften noted with red marks A written statement by recorded that NA #1 s leg on 02/16/16 arour #6 become combative #1. A Disciplinary Wa completed by the DO recorded that NA #1 v inappropriate way of o behavior. A Consultation Report by the DON, recorded not report abuse imm employee from an ab another supervisor wh advised of abuse, but Review of a Health C (HCPR) 24 Hour Initia completed by the Adm 02/16/16 at 10:00 AM Resident #6 on her le pulling her hair. Reside mark on her upper rig	ted 02/16/16 at 5:03 PM ector of Nursing (DON), stated she struck Resident erwards the Resident was on the right thigh. y NA #1 dated 02/16/16 struck Resident #6 on her nd 10:00 AM when Resident e and pulled the hair of NA rning Notice dated 02/16/16, N and signed by NA #1, was suspended for an dealing with a resident t dated 02/16/16, completed d a concern that NA #2 did ediately, remove the use situation and report to nen the charge nurse was a did not respond. are Personnel Registry al Report dated 02/16/16 ninistrator, recorded that on I, NA #1 stated she struck g to stop the Resident from lent #6 was noted with a red int thigh. NA #1 was ed. The report did not					
	written statement by t 02/19/16, which recor	s investigation revealed a he Administrator, dated ded that she spoke to the 2/16/16 around 9:00 PM					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 03/24/2016 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		345502	B. WING				R-C <b>3/14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		331	5 FAITH CHURCH ROAD		
				INC	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 226}	and was asked if she witnessed NA #1 slap about 8:00 AM. The v that the Administrator Administrator docume #2 on 02/17/16 and v witnessed NA #1 slap 02/16/16 around 8:00 thigh above her knee Resident became cor Written statements by recorded that on 02/1 witnessed Resident # morning care and NA the left side of her fac leave the Resident's at the nurse's station #6. NA #2 did not rep abuse against Reside the nursing staff hear in the shower room, N #6 grab the hair of N/ Resident #6 on the le #1 leave the shower to to Nurse #1 and Nurse Written statements by and the Administrator recorded that Nurse # aware that NA #2 with #6 on the left side of AM. NA #1 did self-re Resident #6 on the rig 10:00 AM.	was aware that NA #2 also o Resident #6 on 02/16/16 written statement recorded was not aware. The ented that she spoke to NA was informed that NA #2 o Resident #6 on the face on 0 AM and again on the right at 10:00 AM, when the mbative. / NA #2, dated 02/17/16, 6/16 at 7:30 AM, NA #2 to become combative during #1 slapped Resident #6 on ce. NA #2 witnessed NA #1 room and make a statement that she "popped" Resident ort the witnessed physical ent #6 because she thought d NA #1's statement. Later d 9:45 AM on 02/16/16, while NA #2 witnessed Resident A#1 and NA #1 slapped tg. NA #2 then witnessed NA room and report the incident se #2. / Nurse #1 dated 02/16/16 to dated 02/19/16 both #1 stated she was not made hessed NA #1 slap Resident her face on 02/16/16 at 8:00 port that she "popped" ght thigh on 02/16/16 around	{F 2	26}			

If continuation sheet Page 20 of 35

		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING			
		345502	B. WING			R-C
		545502				3/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 226}	Continued From page	<u>e</u> 20	{F 226			
			1 220	5		
	recorded on 02/16/16 immediately reported	-				
		n the leg during resident				
		/ knew what she did was				
	-	abuse was witnessed, NA #1				
		pended, law enforcement				
		M, the allegation of abuse				
	was substantiated an	d NA #1 was terminated.				
	The report did not inc	clude the witnessed physical				
	abuse that occurred of	on 02/16/16 at 8:00 AM.				
		#2 was conducted on				
		1. NA #2 stated that she				
		se training recently and knew abuse she should tell the				
		nove the resident from harm,				
		r and don't let the perpetrator				
		ooms. NA #2 stated that on				
		AM Resident #6 would not				
	cooperate with staff a	and became combative				
	during morning care	(kicking, yelling and hitting).				
		nessed Resident #6 hit NA				
		sed NA #1 slap Resident #6				
		face and said "You are				
		A #2 stated the slap was				
		on the face, but it wasn't a ed Resident #6 was already				
		upset. Both NAs continued				
		Iressed, placed her in her				
		1 took Resident #6 to the				
	dining room. NA #1 s	tated that on the way to the				
	-	topped at the nurse's station				
	-	popped (Resident #6)" and				
		NA #2 stated that she found				
		1 did not hear NA #1's				
		ted she felt that when NA #1				
		that the incident fit the				
	definition of abuse, b	ut that she didn't know how				

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If continuation sheet Page 21 of 35

	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/24/2016 DRM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION		ATE SURVEY DMPLETED R-C
		345502	B. WING			03/14/2016	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		3315	EET ADDRESS, CITY, STATE, ZIP CODE 5 FAITH CHURCH ROAD 1AN TRAIL, NC 28079		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 226}	again and thought Nu the incident and wou further stated that lat AM, both NA #1 and Resident #6 in the sh Resident became co NA #1 bent down to p and Resident #6 gral when NA #1 slapped thigh. NA #2 stated th hear, but she didn't k #6 released her grip finished pulling up the transferred her to the Resident #6 to the di she observed NA #1 nurse's station and to that she "popped" Re #2 immediately left th unit with the DON. N to NA #1 and NA #1 #2 stated the DON at happened and she to slapped Resident #6 about 8:00 AM and th 10:00 AM. NA #2 state enforcement on 02/1 her that evening on the Administrator on 02/2 on the phone. A telephone interview at 12:55 PM with NA worked on the facility permanent assignme abuse training. NA # how to identify abuse	a not think it would happen urse #1 heard NA #1 report Id take care of it. NA #2 er that morning around 10:00 NA #2 were toileting hower room when the mbative again. During care, bull up the Resident's pants obed NA #1's hair. That's Resident #6 on her right he slap was loud enough to now what to do. Resident on NA #1 hair and they e Resident's pants, e wheelchair and NA #2 took ning room. NA #2 stated that immediately go to the old Nurse #1 and Nurse #2 esident #6 on the leg. Nurse he unit and returned to the A #2 observed the DON talk was escorted off the unit. NA sked her on 02/16/16 what old the DON that NA #1 on the left side of her face hen on her right thigh about ted she also informed law 6/16 when he interviewed he phone and the 17/16 when she talked to her	{F 2	26}			

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FOF	ED: 03/24/2016 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DAT COM	TE SURVEY MPLETED
	345502	B. WING _				R-C 3/14/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE		
LAKE PARK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURC	CH ROAD		
			INDIAN TRAIL, N	C 28079		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K (EACH	VIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
Administrator, and m resident were both w 02/16/16 Resident #6 and she responded b Resident's face and s #1 stated "I just touch and NA #2 was prese the nurse's station af Resident #6 and told was a hand full, but s her face because she anything to it. NA #1 on the Resident's fac morning around 10:0 toileting Resident #6 Resident became co #1 stated that while s Resident's brief, the pulling so hard "I was smacked her on the I said stop and she s struck her gently bec hurt anyone. Resider hitting, we got her dru day room. NA #1 stat to Nurse #1 and Nurs Resident #6 on the le a statement from her A telephone interviews 02/16/16 there were unit. Around 10:00 on her that while NA #1 Resident #6 in the sh	Il law enforcement or the bake sure the perpetrator and vatched. NA #1 stated that on, 5 slapped her on the face by gently touching the said "Let's don't do that." NA hed her face with my hand" ent. NA #1 stated she went to fer providing care to Nurse #1 that the Resident she did not report touching e did not think there was stated there was no mark left ce. NA #1 stated later that 10 AM, she and NA #2 were in the shower room and the mbative, worse this time. NA she was pulling up the Resident grabbed her hair, s up on my tip toes", so "I right knee to get her to stop, topped." NA #1 stated she cause it was not her nature to nt #6 continued yelling and essed and took her to the ted afterwards, she reported	{F 2	26}			

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/24/2016 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345502	B. WING				R-C / <b>14/2016</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	315 FAITH CHURCH ROAD		
	K NURSING AND REHA	BEHATION CENTER		11	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				BE	(X5) COMPLETION DATE	
{F 226}	get her to let go. Nurse (supervisor) was also conversation. NA #1 s with Nurse #1, while I incident to the DON. took a statement from suspended. Nurse #1 with all residents on to 7:00 AM until she was AM, but Nurse #1 was incidents of abuse reg stated she had not be witnessed NA #1 slap earlier that morning. I was combative at time to give her care. Nurse trained that when resi staff should give the r try to redirect and cor care. Nurse #1 stated combative that day ar needed) twice on her and later for pain. Nur did not cooperate initi and Ativan was given Resident #6 was caln assessment was corm and she was noted w right thigh about 3 inc	e "popped" Resident #6 to se #1 stated Nurse #2 present and heard the stayed at the nurse's station Nurse #2 reported the The DON came to the unit, n NA #1 and she was stated that NA #1 worked he secure unit that day from s suspended around 10:30 s not aware of any prior garding NA #1. Nurse #1 een informed that NA #2 o Resident #6 on the face Nurse #1 stated Resident #6 es, usually required 2 staff se #1 stated that staff were idents became combative, resident time to calm down, me back later to provide I Resident #6 was very nd received Ativan (as shift that day for agitation rse #1 stated Resident #6 ially with a skin assessment, to calm her down. Once n, a full body skin opleted, around 12:30 PM ith a reddened area to her ches long and irregular in ed there were no other	{F 2	226}			
	The Administrator wa 3:52 PM. She stated the around lunch time on "popped" Resident #6 room and reported he	s interviewed on 02/24/16 at that the DON informed her					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/24/2016 MAPPROVED ). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>			(X3) DATE COMP	SURVEY LETED
		345502	B. WING				-C 14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROA	ND		
		BIEITATION GENTER		INDIAN TRAIL, NC 280	79		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 226}	investigation. The Adr working in her office a PM she obtained the the DON to complete Report. The DON left but informed the Adm she had obtained all t interviews. The Admir investigation before th thought the DON had Administrator called la PM. The Administrato Resident #6 for the fir PM when law enforce law enforcement obse any marks to either th stated later that even enforcement called he about another inciden earlier that day, but th was not aware and sh DON's investigation. called NA #2 sometim 02/17/16 and obtained the phone regarding to abuse that were withe	leting interviews for the ministrator continued and sometime before 4:00 necessary information from the HCPR 24 Hour Initial for the day around 4:00 PM, inistrator before she left that he written statements and nistrator did not review the ne DON left because she	{F 226				
	provide written statem The Administrator stat HCPR 24 Hour Initial 5 Day Working Report not complete a separa physical abuse that or 8:00 AM because it w investigation. The Adminow she realized that	tents about what she saw. ted she completed/faxed the Report on 02/17/16 and the t on 02/22/16, but she did ate report for the incident of ccurred on 02/16/16 around					

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		R-C 03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2010
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 226}	Continued From page	25	{F 226	}	
		ewed on 02/25/16 at 10:28			
	AM. Nurse #2 stated : Supervisor on the 7A	she was the Nurse M - 3PM shift on 02/16/16.			
	Nurse #2 and Nurse #	#1 were both at the nurse's			
		unit on 02/16/16 around 1 said "I just want everybody			
	to know that I just pop	oped (named Resident)." NA			
		that she "popped" Resident lent pulled her hair. Nurse			
		NA #1 to stay at the nurse's			
		It to find the DON and report ON came to the secure unit,			
		from NA #1 and she was			
	-	stated she was not aware			
	#1 and Resident #6.	ents of abuse between NA			
	Attempts to interview unsuccessful.	the DON were			
	The administrator was jeopardy on 02/24/16	s notified of immediate at 5:27 PM			
		vas conducted on 02/25/16.			
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/R	ESIDENT WELL-BEING	{F 490	}	3/18/16
		ninistered in a manner that			
		esources effectively and			
	efficiently to attain or practicable physical, r	maintain the hignest mental, and psychosocial			
	well-being of each res				
		is not met as evidenced			
	by: Based on staff intervi	iews and review of facility		A facility must be administered in a	
		dministrative staff failed to		manner that enables it to use its	

Event ID: JEBN13

Facility ID: 970828

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/24/201 RM APPROVE IO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345502	B. WING			R-C 3/14/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•	
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 490}	Continued From page	e 26	{F 490			
[			1 490	•	ionthy to	
		culture that all residents om abuse and that staff		resources effectively and effic attain or maintain the highest		
	•	facility's abuse policy and		physical, mental, and psychos		
	-	ene, protect and immediately		well-being of each resident.	Jocial	
	report abuse when w	itnessed. A combative				
	· ·	2 episodes of physical liate facility intervention,		F490		
		mentation of abuse policies		1) On 2/16/16, Resident#6 wa	s assessed	
		of 1 sampled residents		by the Medical Director. No ne		
	reviewed for abuse (I	Resident #6).		were received.		
	Immediate jeopardy I	began on 02/16/16 when		On 2/16/16, Resident#6 was	assessed by	
		slapped Resident #6 on the		Nurse #1 which included a he		
		, NA #2 did not intervene and		assessment. The findings reve		
	-	eport to administrative staff		reddened area on the upper ri		
		dent #6 and other residents.		and small healing bruises. Re	sident #6	
		physical abuse occurred on		still resides in the facility.	ndod from	
		1 slapped Resident #6 on the		On 2/16/16 NA #1 was suspe		
	right thigh and the wi	ection of Resident #6.		employment and terminated o	11 2/22/10.	
		s present and ongoing.		2) On 2/16/16, staff nurses co	mnleted	
		the State Agency and		100% body audit on all cogniti	•	
		and Medicaid an acceptable		impaired residents in the facili	•	
		nce (AOC) on 03/08/16.		evidence of abuse. No negative	-	
	A revisit survey was o	conducted on 03/14/16 to		On 2/16/16, the social worker	- interviewed	
	-	of the ongoing Immediate		all alert and oriented residents		
		provided documentation for		abuse and resulting in no neg	ative	
	review of the followin	•		responses.		
		nitively impaired residents		On 2/19/16 NA#2 was discipl		
	dated 02/16/16			failure to report immediately a	-	
		erviews regarding abuse for		abuse according to the Abuse		
		esidents dated 02/16/16		On 2/25/16 NA #2 was termin		
	Documentation of in-			providing safety for Resident#	ю.	
		abuse, caring for residents		3) On 2/25/16 the administrat	or roccived	
		currently employed staff		3) On 2/25/16, the administrat		
	completed by 03/07/	use monitoring on each shift		an in-service from the corpora President of Operations on F		
		6/16 and remained ongoing		and 490.	1093 220	
	without began on 02/2			unu 700.		1

Event ID: JEBN13

Facility ID: 970828

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		ND HUMAN SERVICES				ED: 03/24/20 RM APPROVE
STATEMENT C	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345502	B. WING			R-C 3/14/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 490}	Continued From page	e 27	{F 49	01		
[			יי די	•	that all	
	01/03/03/16 and an a	allegation of neglect on		The facility must ensure alleged violations involving r		
		rt for Resident #6 for the		neglect, or abuse, including		
	8:00 AM incident of a			unknown source and misapp	•	
		rted to the Health Care		resident property are reported	•	
		HCPR). Both reports were		immediately to the administr		
	faxed the the HCPR			facility and to other officials i	n accordance	
		staff hired since 02/16/16 to		with State law through estab		
		ground checks, reference		procedures (including to the	State survey	
		Registry checks, license		and certification agency).		
	checks, and abuse tra	•		The facility must have e		
	The facility's Abuse F	2011CY		all alleged violations are tho		
	Observations of nurs	ing care, interviews with		investigated, and must preve potential abuse while the inv		
		dents, interviews with family,		in progress.	esugation is	
		Iff present in the facility on		The results of all investi	gations must	
		Il documentation to support		be reported to the administra	-	
	the AOC and intervie			designated representative a		
	Administrator, Directo	or of Nursing and the Nurse		officials in accordance with S	State law	
		sufficient evidence to		(including to the State surve		
		tion by the facility to remove		certification agency) within 5		
		dy at F-490. The immediate		of the incident, and if the alle	-	
		ed on 03/14/16 at 7:15 PM.		is verified appropriate correct	tive action	
	-	out of compliance at F-490		Must be taken. A 24 hour and 5 day rep	ort is required	
	-	d severity of (D) isolated, no ential for more than minimal		for each allegation, including	-	
		ediate jeopardy, while the		identified during an investiga		
		process of monitoring the		additional allegations occurr		
	implementation of the			same day and/or involving th		
				employee/resident.		
	The findings included	1:		The facility must ensure	staff	
				effectively and consistently of		
		- Based on staff interviews		through the chain of comma		
		e facility failed to protect a		and in documentation, to att		
	-	free from physical abuse		maintain resident⊡s well-bei	-	
		vention when a resident		been trained to effectively an	•	
	i nacama compativa di		1	communicate through the ch	I OT	1
		uring nursing care. A Ily abused twice when a staff		command, verbally and in do		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	DMPLETED
			A. DOILDING			R-C
		345502	B. WING			03/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		03/14/2010
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 490}	Continued From page	up 29	(5.40)	0		
1 <del>4</del> 907	Continued From pag		{F 49	•		
	the right thigh for 1 c reviewed for abuse.	of 1 sampled residents (Resident #6)		from abuse.		
		- Based on staff interviews		On 2/26/16, 2/29/16, 3/1/16	or 3/2/16 all	
		he staff failed to immediately		staff and contract staff attend		
		staff of a witnessed incident		Directed □in-service present	ed by the	
	of physical abuse in	which a resident was slapped		Regional Ombudsman Area	Agency on	
		otified, the facility failed to		Aging Titled: Identification an	d Prevention	
		f physical abuse to the Health		of Elder Abuse.		
		istry in 24 hours and the		1) The Corresponde Chaff is a		
	sampled residents. (	s in 5 working days for 1 of 1		4) The Corporate Staff, i.e. c consultant and/or regional VI	-	
		- Based on staff interviews		continue to review all allegati		
	and record review, th			and interventions when report		
		rsing care when a resident		administrator in accordance		
		ne combative to prevent an		Abuse Policy including notific		
	incident of physical a	abuse, intervene when		appropriate agencies for 6 m	onths.	
	physical abuse was	observed, and immediately				
		tor from a combative resident		The monthly QI committee w		
		e facility failed to report a		results of the Administrative A		
		f physical abuse to the Health		abuse and continue to review	•	
	-	istry in 24 hours and the		allegations of abuse i.e. 24 h	•	
		rking days. The facility failed		report monthly for 6 months f		
		policy and procedures in the protection, identification,		identification of trends, action		
		g of physical abuse for 1 of 1		to determine the need for and frequency of continued	u/01	
	abuse investigation			interviews/monitoring and ma	ake	
		with the Administrator on		recommendations for monito		
		, she revealed she was		continued compliance.		
		ctor of Nursing (DON) on				
	-	ch time that abuse occurred		The administrator and/or DO		
	-	6/16 around 10:00 AM. The		the findings and recommendation		
		that the DON told her that		monthly QI committee to the		
	she had begun the in	-		executive QA committee for f		
		ued working in her office. The		recommendations and oversit	ignt.	
		that around 4:00 PM, before				
		he DON came back to the e and told her that she had				
		nd interviews, but the				
	winten statements d		1			1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/24/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345502	B. WING				-C 14/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 490}	conducted by the DO had it all together. The later she realized that thorough in her invest "captain of the ship" if make sure all parts of completed. The Admin her expectation that so combative residents of Resident #6 required staff, then depending could get to the call b or not staff could call when Resident #6 be Administrator stated so staff to immediately re combative resident and combative resident and	N and assumed the DON e Administrator stated that the DON had not been tigation and that as the t was her responsibility to f the investigation was nistrator stated that it was staff ensure the safety of during nursing care and if the assistance of 2 nursing on whether or not the staff ell would determine whether for additional assistance came combative. The she attributed the failure of eport abuse and protect a om further abuse was due to provided staff with the ow how to respond to a nd what to do when a as abused. was interviewed on The Medical Director stated on 02/16/16 and was nt #6 was combative that ember and the staff member ke back. The Medical e was very familiar with w that at times she was quite o care and would strike out The Medical Director stated eveloping the plan of the occurred in the facility in the dthat staff were abuse immediately, if it essed. If abuse was reported f, the Medical Director stated	{F 4	90}			

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TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		R-C	
		345502	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
{F 490}	continued monitoring continue to occur.	to the proper authorities and to make sure abuse did not s informed of immediate	(F 490	}		
{F 514} SS=D	483.75(I)(1) RES RECORDS-COMPLE LE	was conducted on 02/25/16.	{F 514	}	3/18/16	
	resident in accordance standards and practic	ntain clinical records on each we with accepted professional ces that are complete; ed; readily accessible; and zed.				
	resident's assessmer services provided; the	the resident; a record of the nts; the plan of care and				
	by: Based on an observa review of medical and failed to transcribe a to the treatment recor resident's indwelling (Resident #112) and	is not met as evidenced ation, staff interviews and d facility records, the facility physician order for 3 months rd regarding the change of a Foley catheter every 30 days document the correct time of enteral feeding product of 31 medical records		F 514 Resident Records 1) On 2/25/16, the staff nurse contact Resident #112'□s physician and obta an updated Foley catheter order. On 2/25/16, Resident #112□'s Foley catheter was changed according to the Foley catheter order dated 2/25/16.	ained	

Event ID: JEBN13

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		MEDICAID SERVICES			OMB NO. 0938- (X3) DATE SURVEY
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION		
		A. BUILDING	COMPLETED		
		D WING	R-C		
345502			B. WING	03/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD	
				INDIAN TRAIL, NC 28079	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	DAT
{F 514}	Continued From page	e 31	{F 514	1}	
	The findings included			On 2/25/16, the staff nurse star	rted the
				Glucema 1.2 enteral feeding at	
	Resident #112 was a	dmitted to the facility on		as ordered. On 2/25/16 the staf	
		ses of peripheral vascular		contacted Resident #36□'s phy	sician
	disease, cerebrovaso	cular accident and		regarding the resident not gettir	•
	hemiplegia.			Glucema 1.2 as ordered, the re	
	-	rly Minimum Data Set dated		not have 35 minutes of the tube	-
		esident #112 was moderately		product (29.05 cc). No new orde	ers were
		and had an indwelling Foley		received.	
	catheter.	an dated 01/20/10 revealed		On 2/25/16, the Director of Nur	
		an dated 01/28/16 revealed n altered pattern of urinary		(DON)reviewed Resident #36 for the past 3 months with no ne	•
		dwelling catheter and was at		findings.	eyalive
		goal was for Resident #112		intungs.	
		y tract infection through the			
		tions included Foley catheter		2) On 2/26/16, DON audited all	other
		col and change Foley		residents with a foley catheter a	
	catheter per physicial	n orders and/or facility		residents receiving enteral feed	lings for
	protocol.			accurate record documentation	. There
	Review of the treatme	. ,		were no negative findings.	
	Resident #112 reveal	•			
	-	n 10/31/15 - Foley catheter		3) On 2/26/16, DON initiated ar	n in-service
	care once every shift.			for 100% of nurses regarding	e
		n 11/30/15 - Change Foley		documenting the correct time of	
		ys. Documented on TAR as		administration of enteral feeding	
	changed on 11/08/15 catheter care every s	i. No mention of Foley		to include continuous feedings. in-service was completed on 3/	
		n 12/31/15 - No mention of			
		every shift or change Foley		On 3/7/16, DON initiated an ir	n-service
	catheter every 30 day			for 100% of nurses regarding th	
		n 01/31/16 - No mention of		and accurate transcription of ph	-
		every shift or change Foley		orders to the Medication Admin	-
	catheter every 30 day			Record (MAR) or the Treatment	t 🛛
	· 02/01/16 through	n 02/25/16 - No mention of		Administration Record (TAR) to	
	-	every shift or change Foley		orders to change a Foley cathe	
	catheter every 30 day			TAR. The in-service was compl	eted on
		s notes from 10/23/15		3/14/16.	
		ealed no note that Resident			1-55
	#112's Foley catheter had been changed. Review			4) On 3/7/16, DON, QI nurse, s	Iam

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 03/24/2016 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED R-C 03/14/2016			
		345502							
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	IREET ADDRESS, CITY, STATE, ZIP CODE				
				33	315 FAITH CHURCH ROAD				
	K NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			FIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE		
{F 514}	K NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 5	3315 FAITH CHURCH ROAD         INDIAN TRAIL, NC 28079         ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH CORRECTIVE ACTION SHOULD         TAG       CROSS-REFERENCED TO THE APPROF					
	A phone call was atte				The administrator and/or DON will pre	esent			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP		OMB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,		A. BUILDING			
			F	R-C			
		B. WING		03	03/14/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAF	RK NURSING AND REHA	BILITATION 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	ILD BE COMPLETIC	
{F 514}	Continued From page	e 33	(F 514	1}			
	<ul> <li>employed by the facility. A message was left but Nurse #5 did not return surveyors call.</li> <li>During an interview conducted with the Interim Director of Nursing (DON) on 02/25/16 at 3:00 PM she revealed the order to change Resident #112's Foley catheter every 30 days had not been transcribed to the TAR in 12/2015, 01/2016 and 02/2016 and she could not find any documentation in the medical record of the Foley catheter being changed since 11/08/15. The Interim DON stated it was her expectation that all orders be transcribed correctly to the TAR each month. She stated the nurse's should have been checking behind each other for transcription mistakes.</li> <li>2. Resident #36 was admitted to the facility on 09/17/14. Diagnoses included cognitive deficit, artificial opening of digestive tract, intestinal</li> </ul>			the findings from the "Foley Cath and Enteral Feeding Audit" to the QI committee for recommendation appropriate to maintain continuer compliance and to the quarterly of QA committee for further recommendations and oversight.	e monthly ons as d executive		
	Glucerna 1.2 (enteral 50 cc per hour, contir order included to prov water flush of 500 cc 10AM, 2PM, 6PM and order also indicated t medications (provided	ated 02/12/16 was written for feeding product) to infuse at nuously. The physician's vide Resident #36 with a every 4 hours at 2AM, 6AM, d 10PM. The physician's hat staff could cocktail d all together) and give via doscopic gastrostomy (PEG)					
	her bed with the head approximately 30 deg AM, the enteral feedin was empty and the en	AM Resident #36 was in d of the bed elevated to grees. On 02/24/16 at 05:48 ng bottle of Glucerna 1.2 nteral feeding pump was e #7 was observed to turn off					

DEPART CENTER		FORM APPROVED OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C		
		345502	B. WING	B. WING			-C 14/2016		
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	1			
LAKE PAR	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
{F 514}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		{F 5	514}					

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