PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	COMI	E SURVEY PLETED	
		345502	B. WING			C 11/02/2016	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F 00	00			
		complaint survey was 5/2016 through 09/29/2016. was identified at:					
	(J) CFR 483.75 at tag F	F323 at a scope and severity 490 at a scope and severity					
	(J) CFR 483.75 at tag F (J)	520 at a scope and severity					
	Tag F323 constituted Care.	Substandard Quality of					
		began on 09/22/2016 and 29/2016. An extended ed on 09/29/2016.					
	was decided that the the immediate jeopa On 10/27/16 at 4:08	PM, the administrator was					
	F309. The administrator proof compliance on 10.						
	validated on 11/2/16	on of compliance was was changed to 11/2/16.					
F 157 SS=J	483.10(b)(11) NOTIF (INJURY/DECLINE/I	Y OF CHANGES	F 1	57		11/2/16	
	consult with the residence known, notify the resor an interested family	diately inform the resident; dent's physician; and if ident's legal representative ly member when there is an e resident which results in					
ABORATORY	 DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE		(X6) DATE	

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

Electronically Signed 10/21/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345502	B. WING_			C 1/02/2016	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		1/02/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	intervention; a sign physical, mental, of deterioration in her status in either life clinical complication significantly (i.e., a existing form of tree consequences, or treatment); or a determent the resident from the status in either the resident from the status in either the resident from the status in either esident from the status in existing the status in existing the status in existing the status in either esident in the status in either existing the status in existing the status in either existing the	potential for requiring physician inficant change in the resident's or psychosocial status (i.e., a alth, mental, or psychosocial threatening conditions or ons); a need to alter treatment in need to discontinue an eatment due to adverse to commence a new form of ocision to transfer or discharge the facility as specified in Iso promptly notify the resident resident's legal representative or member when there is a roommate assignment as 15(e)(2); or a change in the Federal or State law or cified in paragraph (b)(1) of the cord and periodically update thone number of the resident's the or interested family member. INT is not met as evidenced was with resident, family, staff, and physician, and record failed to notify the resident's the physician and the physician dent's fall in the transportation of in a laceration at the back of sident #96) of 1 sampled	F1	Lake Park Nursing and Reha Center acknowledges receipt Statement of Deficiencies an this Plan of Correction to the the summary of findings is fa correct and in order to mainta compliance with applicable ruprovisions of quality of care of The Plan of Correction is subwritten allegation of compliance	t of the d proposes extent that ctually ain ules and of residents. omitted as a		

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OND NO. 0936-039 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
						С
		345502	B. WING		-	11/02/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
				3315 FAITH CHURCH ROAD)	
LAKE PAR	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)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFEREN	TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	
F 157	Continued From page	e 2	F 19	5.7		
1 107				71		
	1	sician assistant was not t #96 and his wheelchair fell		Lake Bark Nursing	and Dobabilitation	
				Lake Park Nursing a		, f
		nsportation van and the laceration to the back of his		Center□'s response Deficiencies does n		
		e jeopardy was removed on		with the Statement		iii.
		ility's acceptable credible		does it constitute ar		
		nce was verified. The facility		deficiency is accura		
		npliance at a scope and		Nursing and Rehabi		
		ictual harm with potential for		reserves the right to		
		arm that is not immediate		deficiencies on this	•	
		e facility time to monitor and		Deficiencies through		
	fully implement the n	ew procedure for notification		Resolution, formal a	appeal procedure	
	of responsible party a	and physician of a resident's		and/or any other ad	ministrative or legal	
	significant change in	condition.		proceeding.		
	Findings included:					
	Resident #96 was ad	lmitted to the facility on				
	_	s of pyogenic arthritis		F 157 - Notification		
	I -	ith pus formed), abnormal		Credible Allegation		
	posture, muscle wea					
		ve muscle weakness and		Lake Park was plac		
	1	chronic kidney disease, and		Jeopardy at 4:08 pn		
	infection of a shoulde	er surgical wound.		2016, related to an i		
	During on intervious	- 0/20/40 at 44:20 AN tha		Park van on Septen		,
	resident revealed he	on 9/26/16 at 11:28 AM, the		facility was placed in		gos
		was being transported from		jeopardy for F 157 N		yes
		the facility via the facility		and F 309 Quality o	u Galt.	
		ited he landed on the van		A. How the correcti	ve action was	
		. He had a little cut on his		accomplished for the		t to
	head but he was oka			have been affected		
		ndwritten statements dated		practice. Outcome.	-	
		ntenance staff who was				
		time of the accident. The		On 9/22/16, the mai	intenance worker ar	nd
	three written stateme			housekeeper assist		
		I as he was pulling the		to an upright positio		
		to the van and the resident		the van and returne		
	fell backwards on top	of the maintenance staff		an assessment by a	•	
		ne chair or the seat behind		professional, registe		
	the driver seat. The	maintenance staff asked the		practitioner, physicia		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		345502	B. WING _			1	C 1/02/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/02/2010
				33	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND RE	HABILITATION CENTER			NDIAN TRAIL, NC 28079		
	0.11.11.15	ACTITEMENT OF DEFICIENCIES			·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	age 3	f F	157			
	-	- -			medical doctor or notifying the facility.		
	resident if he was okay and the resident responded yes. The maintenance staff noticed a				medical decier of flothlying the identity.		
		the resident's head, with no			On 9/22/16, the maintenance worker		
		ey got back to the facility and			immediately returned the resident to th	е	
		the van and took him to the			facility and informed the director of		
	DON (director of n	ursing) and told her what			nursing (DON).		
	happened.				On 9/22/16, the DON immediately		
An interview with t		he Physician Assistant (PA)			assessed the resident. The resident ha		
		was conducted on 9/26/16 at 5:30 PM. The PA			no complaint of pain and exhibited nor		
		about the laceration today.			behavior and activity. The resident had		
	She said if there was a fall with the resident hitting his head, she expected the facility to				small scratch on the back of his head v	vith	
	_				two drops of blood. The director of		
		urochecks. The staff were			nursing left a voice message for the	ما:ما	
	about the resident	nd notify her of the fall and			responsible party to return her call, but not speak to, the responsible party (wif		
		AM, the resident's Medical			The director of nursing sent a text	C).	
		nterviewed. The MD said he			message, but did not speak to the		
		if he was notified about the			physician. The director of nursing notif	ied	
		that happened last week in the			the treatment nurse. The director of		
		xpected the staff to call him			nursing performed a neuro check without	out	
	and let him know if	there was head injury. He			negative findings. The director of nursi	ng	
	also expected the	staff to assess the resident			gave the neuro-check paperwork to the	;	
		whatever was needed.			assistant director of nursing with verba	l	
		pm, the resident was			instructions to continue the neuro-chec		
		presence of the responsible			through the night. The director of nurs	ng	
		nt repeated the same			did not notify the physician or the		
	· •	van incident on 9/22/16. The			responsible party (wife). The		
		ne fell backwards in the			neuro-checks were not performed thro	ugh	
		e was being transported from			the night.		
	-	to the facility via the facility stated he landed on the van			On 9/22/16, the treatment nurse		
		ad. He had a little cut on his			immediately initiated a treatment to the		
		kay. The resident's			back of the resident s head. The		
		said the facility called her and			treatment nurse left a message for the		
		sident had a fall but they never			responsible party (wife). The responsil	ole	
		at happened. The resident told			party (wife) returned the treatment	-	
	her what happened				nurse s call. The treatment nurse		
		ogress Note " , written by the			notified the resident□s responsible par	ty	
		6 revealed the resident			(wife) about the resident⊟s head woun	•	

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 11/02/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	1	1
LAKE DAE	W NUIDOING AND DE	HARWITATION OF NITER		3315 FAITH CHUR	CH ROAD		ı
LAKE PAR	K NURSING AND REI	HABILITATION CENTER		INDIAN TRAIL, N	NC 28079		l
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
F 157	Continued From pa	age 4	F 1	57			
	laceration on the bawere initiated and this time. Another Nurse #2, dated 9/3 received treatment back of the head. It erythema. The note made aware and thand a message was return call. An interview was conursing (DON) on sesident arrived at maintenance staff to DON and told her wishe notified the Dot text message via the MD never received know about the accided not follow up wisher received the text. On 10/27/16 at 4:00 notified of the immediate initiated and the second interval in the second in the sec	sessment and there was a cack of the head. Neurochecks they were within normal limit at "Progress Note", written by 22/16 revealed the resident to a small laceration to the Per-wound area had slight e indicated the physician was be responsible party was called as left on the voice mail to conducted with the director of 2/28/16 at 8:35 AM. When the the facility from dialysis, the brought the resident to the what happened. The DON said cotor by sending him a phone the phone. The DON stated the the text and the MD did not coident until 9/27/16. The DON with the doctor to make sure he ded the following credible		relating to he happened. notify the photograph of nursing in involved in tresident gave and incident on 9/26/16 practitioner with lacerati on 9/26/16, responsible during the 9 when the rewheelchair of to the of his on 9/27/16, attending photograph of the photograp	the administrator and direction terviewed the resident the incident on the van. The very an account of the events to the DON notified the nurse (NP) of Resident #96 s fation. The DON notified the party of what happened 1/22/16 accident on the van sident fell backwards in his causing a laceration (scrato	etor e	
	A. How the correct accomplished for the been affected by the On 9/22/16, the mathousekeeper (floor resident back in to wheelchair on the without an assessing professional, registed.	iance on 10/31/16 at 6:04 PM: ctive action will be nose residents found to have ne deficient practice. Outcome. aintenance worker and technician) assisted the an upright position in the van and returned to the facility nent by a qualified medical ered nurse, nurse practitioner, c, or medical doctor or notifying		residents hat affected by the affected by the control of progress was comple nursing (AD nurse practities).	facility identified other aving the potential to be the same deficient practice 5, an audit for the past 30 d notes of 100% of residents sted by the assistant director (ON) to ensure the physicial tioner, and/or physician as been notified of all falls lils with injury.	ays or of	

Facility ID: 970828

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		1	C / 02/2016
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		702/2010
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 157	Continued From pag	e 5	F 1			
	returned the resident the director of nursin On 9/22/16, the DON	tenance worker immediately to the facility and informed g (DON). I immediately assessed the nt had no complaint of pain		On 10/27/16, an audit for the of incident reports was compl ADON to ensure the respons been notified of change in correlated to incident/accidents. responsible parties had been significant changes, incidents	eted by the ible party has ndition All notified of	
	and exhibited normal resident had a small head with two drops nursing left a voice mparty to return her caresponsible party. The text message, but did the director of nursin nurse. The director of check without negatinursing gave the neurosistant director of mistructions to continuthe night. The direct the physician or the meuro-checks were might. On 9/22/16, the treat initiated a treatment.	behavior and activity. The scratch on the back of his of blood. The director of nessage for the responsible III, but did not speak to, the he director of nursing sent a d not speak to the physician. In not speak to the physician of nursing performed a neuro we findings. The director of the incomplete incomp		On 10/31/16, an audit for the of progress notes was comple DON, ADON, staff facilitator, administrator, facility consulta corporate clinical director to e physician and/or nurse practif responsible party are notified changes in condition, includin C. Specific dates of the correactions. On 9/26/16, the DON notified responsible party of what hap during the 9/22/16 accident o when the resident fell backwa wheelchair causing a laceration to the of his head.	past 34 days eted by the ant, and ensure the tioner and of significant ag falls. ective the opened on the van ards in his	
	responsible party. The treatment nurse's notified the resident's resident's head wour was in progress relating happened. The treating physician. On 9/22/16, the adminursing interviewed to	nurse left a message for the he responsible party returned call. The treatment nurse is responsible party about the hid and that an investigation ling to how the head wound rement nurse did not notify the dinistrator and director of he resident involved in the The resident gave an and incident.		On 9/26/16, the administrator corporate clinical services dirinstructed the DON she was a communicate solely by text of the attending physician, nurse and/or physician assistant who resident incident/accident required physician notification. On 9/27/16, the administrator the attending physician the D communicate a resident incident corporate incident incident.	ector verbally not to nessages to e practitioner, nen there is a juiring verified with ON would	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING _			1	C (02/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	02/2010
				3:	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER			NDIAN TRAIL, NC 28079		
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	· ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	(X5) COMPLETION	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFI: TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
F 157	Continued From page	e 6	F	157			
					in addition to text messaging, by an		
	On 9/26/16 the DON				in-person communication and/or phone	9	
	1 7	Resident #96's fall with			call to the attending physician, nurse		
	laceration.	laceration.			practitioner, and/or physician assistant		
	On 9/26/16, the DON	On 9/26/16, the DON notified the responsible			On 10/20/16, the DON began in-servic	ing	
	party of what happened during the 9/22/16				all registered nurses (RNs) and license	: d	
	accident on the van when the resident fell				practical nurses (LPNs) on the importa		
	backwards in his wheelchair causing a laceration				of notifying the physician and/ or NP of	i all	
	(scratch) to the of his	s head.			resident falls, including immediate		
	0.007/40 // 0.00				notification regarding falls with injury. T		
On 9/27/16, the DON talked					in-service was completed 10/24/16. At		
	laceration.	Resident #96's fall with			10/24/16, no RN or LPN was allowed to work until the in-service is completed.		
	laceration.				RN and LPN new hires will receive the		
	B. How did the facil	lity identify other residents			in-service during new employee		
		o be affected by the same			orientation.		
	'				On 10/28/16, the DON, ADON, staff		
	On 10/20/16, an audi	it for the past 30 days of			facilitator, administrator, and corporate		
	progress notes of 10	0% of residents was			facility consultant, began in-servicing a	ıII	
		sistant director of nursing			RNs and LPNs on the requirement to		
	(ADON) to ensure the				contact the responsible party (RP) of a		
		hysician assistant has been			resident that has a fall to notify the RP		
	notified of all falls inc	luding falls with injury.			a change in condition. The in-service w		
	On 10/07/10 on avel	it for the most 20 days of			completed 10/28/16 of all RNs and LPI		
	I .	it for the past 30 days of			currently working. The in-services was changed and restarted on 10/31/16.	į	
		completed by the ADON to le party has been notified of			changed and restarted on 10/31/16.		
					On 10/31/16, the DON, ADON, staff		
	change in condition related to incident/accidents. All responsible parties had been notified of				facilitator, administrator, and departme	nt	
	significant changes, i				heads began in-servicing all staff on th		
]				importance of staff informing the nurse		
	On 10/31/16, an audi	it for the past 34 days of			and the nurse notifying the physician,		
		completed by the DON,			physician assistant, and/or nurse		
		r, administrator, facility			practitioner of a resident ☐s change in		
	consultant, and corpo	orate clinical director to			condition (not just for falls). Also, the		
		and/or nurse practitioner			nurses must notify the resident□s		
	and responsible party are notified of significant				responsible party of a change in the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING			1	0
NAME OF D	ROVIDER OR SUPPLIER	343302	B: Willo		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	02/2016
NAIVIE OF PI	ROVIDER OR SUPPLIER						
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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 157	F 157 Continued From page 7		F 1	157	,		
	changes in condition, including falls.				resident□s condition with basic		
	C. Give specific date	es of the corrective actions.			information. If the RP has additional questions, the nurse is to inform the D or administrator for follow-up with the I		
	On 9/26/16, the DON	notified the responsible			The in-service was completed 11/01/1	3 of	
	party of what happen	•			all staff working. After 11/01/16, no sta	aff	
	accident on the van w				is allowed to work until the notification		
	backwards in his wheelchair causing a laceration				in-service is completed. All new hires v		
	(scratch) to the of his				receive the notification in-service durin new employee orientation.	g	
	On 9/26/16, the administrator and corporate clinical services director verbally instructed the DON she was not to communicate solely by text						
					D. How the facility is monitoring syste	ทร	
		nding physician, nurse			to prevent recurrence.		
	_	nysician assistant when			On 11/02/16, the ADON began auditing	a	
		sident/accident requiring	100% of resident progress notes to			3	
	physician notification.				ensure that the physician and/or NP at	nd	
		nistrator verified with the			responsible party were notified of resid		
		ne DON would communicate			significant change in condition, including		
		cident, in addition to text			accidents, using the progress note aud	-	
	messaging, by an in-p	person communication			tool. The audit will be completed by the	•	
	and/or phone call to the	he attending physician,			DON, ADON, staff nurse, and/or		
	nurse practitioner, an	d/or physician assistant.			corporate consultant 5x/week x 4 weel		
					then weekly x 8 weeks, then monthly x	. 3	
		N began in-servicing all			months.		
	, •	Ns) and licensed practical			The manufacture of the control of th	U	
	, ,	importance of notifying the			The monthly QI committee will review	:ne	
		of all resident falls, including			results of the Progress Note Audit tool		
		n regarding falls with injury.			monthly x 6 months for identification of		
		ompleted 10/24/16. After PN was allowed to work until			trends, actions taken, and to determine the need for and/or frequency of	;	
		bleted. All RN and LPN new			continued monitoring, and make		
	hires will receive the i				recommendation for monitoring for		
	employee orientation.	S .			continued compliance. The administra	itor	
	Spiojos onomation.	•			and/or DON will present the finding an		
	On 10/28/16. the DOI	N, ADON, staff facilitator,			recommendations of the monthly QI		
		rporate facility consultant,			committee to the quarterly executive C	ıA.	
		RNs and LPNs on the			committee for further recommendation		
		ct the responsible party (RP)			and oversight.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C I 1/02/2016	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2016	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	of any resident the change in condition completed 10/28/currently working, and restarted on a completed on a complete of a complete of a resident's resident's resident's condition of all staff working allowed to work uncompleted. All new	at has a fall to notify the RP of a on. The in-service was 16 of all RNs and LPNs The in-services was changed	F	57			
	assistant and phy facility failed to no physician assistar transportation var at the back of the sampled resident. Findings included Resident #96 was 9/6/16 with diagno (infectious arthritis						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
NAME OF P	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, Z	IP CODE	
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	
F 157	Continued From page	e 9	F ·	157		
		ive muscle weakness and chronic kidney disease, and er surgical wound.				
	resident revealed he wheelchair while he was character to van. The resident star floor and hit his head head but he was oka There were three har 9/22/16 from the mai driving the van at the three written stateme maintenance staff fel resident from the lift of fell backwards on top and hit his head on the driver seat. The resident if he was okaresponded yes. The cut on the back of the blood draining. They got the resident off the DON (director of nurshappened. An interview with the was conducted on 9/2 said that she knew all She said if there was hitting his head, she assess and do neuro expected to call and about the resident hit On 9/27/16 at 9:20 A Doctor (MD) was interview of the said that she said that she said that she said that she said there was hitting his head, she assess and do neuro expected to call and about the resident hit On 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27/16 at 9:20 A Doctor (MD) was interview with the was conducted on 9/27	was being transported from the facility via the facility via the facility ated he landed on the van I. He had a little cut on his y. Indwritten statements dated intenance staff who was a time of the accident. The ents included that the I as he was pulling the to the van and the resident of the maintenance staff ine chair or the seat behind maintenance staff asked the ay and the resident maintenance staff noticed a resident's head, with no got back to the facility and he van and took him to the sing) and told her what Physician Assistant (PA) 26/16 at 5:30 PM. The PA bout the laceration today. In a fall with the resident expected the facility to ochecks. The staff were notify her of the fall and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
	345502	B. WING			C
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	11/02/2016
PREFIX (EACH DEFICIENC			((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
and let him know if the also expected the state after a fall and do what An interview was connursing (DON) on 9/2 resident arrived at the maintenance staff brought by the maintenance staff brought brought by the maintenance staff brought	ected the staff to call him ere was head injury. He ff to assess the resident atever needed. ducted with the director of 18/16 at 8:35 AM. When the expectation from dialysis, the bught the resident to the at happened. The DON said or by sending him a phone phone. The DON stated the expectant the MD did not ent until 9/27/16. The DON the doctor to make sure he credible allegation was 6 at 5:45 PM by doing the emonstrates a change in emotion, behavior, it, talking, increased etc) or any time a resident emal tell the nurses what you have sand Licensed Medication Aides) must condition, document the fy the physician or nurse exponsible party with the nent findings. If the resident ent causing injury, one in person or via to the communication book.	F1	57		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	C	X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2010
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	Continued From page	e 11	F 1	157		
	has questions give be Director of Nursing/A follow-up is needed.	asic information and let dministrator know a				
	schedules and all sta 11/01/16 had particip change inservice train Development Coordir inservice licensed sta	re reviewed with staffing ff working in the facility since ated in the notification of ning. The Staff nator had working plans to aff that had not participated to their return to work.				
	were interviewed regard and demonstrated un	departments and all shifts arding the inservice training aderstanding and response in a resident and notification of				
	development were re	lls and pressure ulcer viewed and timely made to the physician/nurse				
F 309 SS=J	that notification of cha physician/nurse pract party. 483.25 PROVIDE CA		F3	309		11/2/16
	provide the necessar or maintain the highe mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment				

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	` '		(X3) DATE COMP	SURVEY LETED
		345502	B. WING				0
NAME OF PROVIDER OR S	IIPPI IFR	343502	B. WING_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	02/2016
TO THE OF THE VIDER OF	OI I LILIX				315 FAITH CHURCH ROAD		
LAKE PARK NURSING	AND REHA	BILITATION CENTER			NDIAN TRAIL, NC 28079		
	CH 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 Continued	From page	2 12	F3	809			
by: Based on physician review, the to assess fall in the and drivin (Resident accident. the back of also failed intervention) Immediate facility state assess Resin the transdriving the facility. Resident the reside jeopardy of acility's a compliance out of come (no actual minimal heallow the facility and monitic condition. Findings in Resident 19/6/16 with the sale of the resident 19/6/16 with the sale of the s	interviews assistant are facility fail the resident ransportating the resident #96) of 1 s. Resident # of the head to do neuron. I Jeopardy ff failed to gesident #96 sportation versident fresident #96 of his head. Sks per nursent for brain vas removed the was verificated at the new proving a resident included: I the new proving a resident was addingnoses.	with resident, staff, and physician, and record ed to get professional staff to possible injury after a con van and before moving ent to the facility for 1 ampled resident with a van end sustained a laceration on from the fall. The facility bechecks per nursing to began on 9/22/16 when the let professional staff to for possible injury after a fall van and before moving and com the dialysis center to the esustained a laceration to a sustained a laceration to the facility failed to do sing interventions to monitor injury. The immediate d on 11/2/16 when the redible allegation of ed. The facility will remain a scope and severity level Depotential for more than anot immediate jeopardy) to to monitor and fully rocedure for assessment dent's significant change in mitted to the facility on sof pyogenic arthritis the pus formed), abnormal			F 309 Provide Care/Services for Higher Well Being A. How the corrective action will be accomplished for those residents found have been affected by the deficient practice. Outcome. On 9/22/16, the maintenance worker at housekeeper assisted the resident bact to an upright position in the wheelchair the van and returned to the facility with an assessment by a qualified medical professional, registered nurse, nurse practitioner, physician assistant, or medical doctor. On 9/22/16, the maintenance worker immediately returned the resident to the facility and informed the director of nursing. On 9/22/16, the director of nursing immediately assessed the resident. The resident had no complaint of pain and exhibited normal behavior and activity. The resident had a small scratch on the back of his head with two drops of blood. The director of nursing left a message but did not speak to, the responsible paid (wife). The DON sent a text message to the attending physician. The director of nursing notified the treatment nurse. To director of nursing performed a neurological check assessment without	d to nd k in on out e de de de de de de de de de	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			TE SURVEY MPLETED
			B. WING			С
		345502	B. WING _		11	1/02/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē	
I VKE DVE	DK MIIDGING VND D	EHABILITATION CENTER		3315 FAITH CHURCH ROAD		
LAKE PAR	KK NUKSING AND K	ENABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)
PREFIX TAG	,	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
F 309	Continued From p	page 13	F 3	009		
	posture, muscle v	veakness, Guillain-Barre		negative findings. The DON g	ave the	
	Syndrome (progre	essive muscle weakness and		neurological check paperwork	to the	
	paralysis), scolios	sis, chronic kidney disease, and		ADON with verbal instructions	to continue	
	infection of a short	ulder surgical wound. The		the neurological checks through	ghout the	
	resident was adm	itted to the facility for wound		night. The DON did not speak	to the	
	treatment and reh	abilitation for his shoulder with		responsible party (wife). The r	neurological	
	a plan to return he	ome.		checks were not performed th		
				night. There was no policy or	standing	
		nission Minimum Data Set		order established at the time f	or	
	, ,	sessment reference date (ARD)		neurological checks.		
		ed the resident had a Brief				
		al Status (BIMS) score of 10		On 9/22/16, the treatment nur		
		icated the resident was		immediately initiated a treatme		
		rately impaired). The resident		back of the resident s head in		
		ce of staff in activities of daily		presence of the DON, after as	-	
		resident was coded for		resident⊡s scalp. The treatme		
		range of motion of both upper		left a message for the respons		
		ities. The resident was coded		(wife) and the responsible par	-	
	I	I only able to stabilize with		the call which was the first not		
	Tiuman assistance	e during transition and walking.		the injury to the responsible party ha		
	Dovious of the res	ident's care plan of 9/26/16		returned the call to the directo		
		dent was at risk for falls		The treatment nurse did not n	_	
		actual falls with injury. The		physician for additional assess	•	
		iple risk factors related to		to the injury presenting more I		
		The goal was the resident will		scratch to the scalp.	ino a	
		ough the next review. The		corator to the coarp.		
		uded for the staff to assist during		On 9/22/16, the administrator	and director	
		lity and provide frequent		of nursing interviewed the resi		
	observation of the	*		involved in the incident on the		
				resident gave an account of the		
	During an intervie	w on 9/26/16 at 11:28 AM, the		and incident.		
	_	he fell backwards in the		On 9/26/16 the DON notified t	he nurse	
	wheelchair while	he was being transported from		practitioner (NP) of Resident #	#96□s fall	
	the dialysis cente	r to the facility via the facility		with laceration. No new order	w orders were	
	· ·	stated he landed on the van		received after the NP□s asses	ssment.	
	floor and hit his he	ead. He had a little cut on his				
	head but he was	okay.		On 9/27/16, the DON talked to	the	
	Review of a writte	en statement by the		attending physician regarding	Resident	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION (X3) DATE COMI		SURVEY
		345502	B. WING				C 02/2016
NAME OF P	ROVIDER OR SUPPLIER	0.0002	<u> </u>	\$1	TREET ADDRESS, CITY, STATE, ZIP CODE	111/	02/2016
INAME OF T	TO VIDER OR OUT LIER						
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD		
				IN	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 14	F 3	309			
	administrator dated 9				#96□s fall with laceration (scratch) to t	he	
		ent regarding a reported fall.			scalp. No new orders were received a		
		administrator he fell straight			MD assessment. On 9/27/16, the DON		
		on a raised area on the van			also spoke with the responsible party	•	
		aid that the driver pulled to			(wife) about the incident/accident on the	e	
	the side of the road a	·			van.	·	
		d floor technician) picked					
		n if he was okay. He told			As of 9/28/16, Resident #96 has been		
		to just take him back to the			transported by contracted van services		
	facility.	•			The contracted van services are traine		
	There were three han	dwritten statements dated			safe transfer, safe transport, and safe		
	9/22/16 from the main	ntenance staff who was			securement techniques and equipped	with	
	driving the van at the	time of the accident. The			a cellular telephone. The drivers know	to	
	three written stateme	nts included that the			call 911 if professional staff are not		
	maintenance staff fell	as he was pulling the			available to assess a resident.		
		o the van and the resident					
	fell backwards on top	of the maintenance staff			 B. How did the facility identify other 		
		e chair or the seat behind			residents having the potential to be		
	the driver seat. The f the lift and picked up	loor technician jumped on the resident and the			affected by the same deficient practice		
	wheelchair off of the	maintenance staff. The			On 9/28/16 at 1:15 pm, the corporate v	rice	
	maintenance staff asl	ked the resident if he was			president of operations removed the La	ake	
		t responded yes. The			Park van from Lake Park premises		
		ticed a cut on the back of			indefinitely. Effective 9/28/16, the		
		vith no blood draining. The			residents are transported by contracted	t	
		ext to the resident as they			services.		
		back to the facility and got					
		an and took him to the			On 10/27/16, the DON, ADON,		
	• ,	ON) and told her what			administrator, and corporate facility		
	happened.				consultant performed a 100% audit of	_	
	·	the Floor technician was			residents with a fall involving a head in	jury	
		the van accident. The floor			within the past 72 hours to ensure		
		en the resident fell on top of			assessment with neuro-checks are bei	•	
		f, he (floor technician) got on			performed and the physician has been		
		resident wheelchair off the			notified of the fall. The audit findings	olco	
		d asked the resident if he			reveled two residents neurological che		
	-	ent said he was okay. They			needed to be restarted. The neurologi	Udl	
	brought him to the fac	wheelchair in the van and cility.			checks were restarted for the two residents on 10/27/16.		

OL. VILLI	C . C	· · · · · · · · · · · · · · · · · · ·				~	0. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	` ',	SURVEY PLETED
			7 BOILD!	_			С
		345502	B. WING			1	/02/2016
NAME OF PE	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				33	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		IN	NDIAN 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)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 15	F	309			
		M, the maintenance staff	' '	503			
	was interviewed, in the				C. Give specific dates of the corrective	۵	
		ing the accident in the van			actions.	,	
	_	when the resident fell on			dollorio.		
		ht have hit his head on the			On 10/20/16, the DON, ADON, staff		
	seat or on the seat be				facilitator, administrator, and corporate	;	
	passenger bench whi	ich might have caused the			facility consultant, began in-servicing a		
	laceration on the resi	dent's head. The			RNs, LPNs, medication aides, nursing		
		id that the floor technician			assistants, housekeepers, maintenand	e,	
	•	ot the wheelchair off of him.			dietary, administrative, activities, and		
		ff said he asked the resident			therapy staff on the requirement to not		
	-	ne resident said yes. The			move the resident after an		
		id he tried to call the DON's			incident/accident until a complete		
	•	not answer and he did not			assessment has been completed by a		
		ry to call someone else. He			nurse, nurse practitioner, physician		
		about asking the dialysis resident before driving back			assistant, or medical doctor. If no licensed professional is available, call	011	
		asked if he received any			If the accident/incident happens outsid		
	_	ng resident via the van, he			the facility, the patient must still be	C	
	_	ceived any training from this			assessed by a professional and if a		
		d training from another			licensed professional is not available,	call	
	-	terview, the administrator			911. The in-service was completed		
	_	a facility policy against the			10/31/16 of all staff. After 11/1/16, no		
		r personal cell phone while			staff person is allowed to work until the	<u>ڊ</u>	
	on duty. So the main	itenance staff was afraid he			in-service is completed. All new hires v	will	
	would get in trouble if	f he used his personal			receive the in-service during new		
		rator said there was no			employee orientation.		
	facility phone on the						
	-	phone was available if the			On 10/27/16, the DON, ADON, staff		
	driver asked for it.				facilitator, administrator, and corporate		
		ff was interviewed again via			facility consultant, began in-servicing a	łII	
	telephone on 9/27/16				registered nurses (RNs) and licensed	nao	
		id the DON asked him to go			practical nurses (LPNs) on the importation of performing neurological assessmen		
		rom the dialysis center and by via the facility van. The			including a neurological check schedu		
	_	bout 20 -25 minutes away			according to nursing standard of practi		
		maintenance staff said "we			when a resident has an accident/injury		
	_	the dialysis center. (The			involving their head. The in-service wa		
		okay (after the resident			completed 10/28/16 of all RNs and LP		

OLIVILIV	OT OIL MEDIO, ILL G	MEDIO ND CEITHOLC					2. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	NG _		l ,	С
		345502	B. WING				02/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKEDAE	OK MITBEING AND BEHA	DII ITATION CENTED		33	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 16	F:	309			
		phone (to let the facility			currently working. After 10/28/16, no F	≀N	
). (The) Receptionist could			or LPN is allowed to work until the		
		The Maintenance staff said			in-service is completed. All RN and LP	N	
	he drove the van to the				new hires will receive the neuro-check		
		ated he did not think of			in-service during new employee		
	calling 911 or getting	the dialysis center's			orientation.		
	professional staff to a	assess the resident because					
	the resident said he v	vas okay.			On 10/31/16, the DON, ADON, staff		
		ducted with the DON on			facilitator, administrator, and departme		
		When the resident arrived at			heads began in-servicing all staff on th		
		sis, the maintenance staff			importance of staff informing the nurse		
	_	to the DON and told her			and the nurse notifying the physician,		
		treatment nurse and the			physician assistant, and/or nurse		
	DON did a head to to	-			practitioner of a resident □s change in		
		him with no bleeding. There he hair and that was how			condition (not just for falls). Also, the nurses must assess the resident □s		
		a cut. There was no drip			condition, document the assessment,		
	_	initiated neurochecks. They			then notify the physician or nurse		
	-	notion. Then they used the			practitioner and resident⊟s responsible	د	
	_	n in bed. The DON said she			party. To ensure proper assessment	•	
		sending him a phone text			when a resident has an incident/accide	ent	
		ne. The DON stated the MD			causing injury, physician or nurse		
		xt and the MD did not know			practitioner notification must be done in	า	
	about accident until 9	9/27/16.			person or via telephone in addition to t	he	
	Interview with the trea	atment nurse was conducted			communication book, including calling		
	on 9/27/16 at 5:56 PM	M. This treatment nurse			911. The in-service will be completed		
	provided treatment fo	or the resident's head			11/01/16 of all staff working. After		
	laceration when he ca	ame back from dialysis on			11/01/16, no staff is allowed to work ur		
		ent nurse stated the resident			the notification/assessment in-service i		
		riented and he answered her			completed. All new hires will receive th	е	
		ely. The treatment nurse			notification in-service during new		
		as not bleeding but had			employee orientation.		
	some redness.	ont titled "Necroslasias"			D. How the facility will assent as		
		ent titled "Neurological aled neurochecks were			D. How the facility will monitor process	ses	
					to prevent recurrence		
		t 3:30 PM. The neurochecks			On 11/02/16 the ADON began auditing	,	
		e done every 30 minutes for M till 7:30 PM on 9/22/16),			On 11/02/16, the ADON began auditing 100% of resident progress notes to	3	
		s (from 8:30 PM till 11:30			ensure that the physician and/or NP ar	nd	
	Overy Hour for Tillour	0 (11 0 11 0 .00 1 W W U 11 11 .00	1		i choose that the physician and/of M. at	IM	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION	(X3) DATE S COMPLI	
					С
	345502	B. WING _		1	1/02/2016
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE DADK MUDONIO AND DE	HARM ITATION OF NITER		3315 FAITH CHURCH ROAD		
LAKE PARK NURSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
3:30 AM on 9/23/1 shift starting on the 9/24/16 and ending 9/25/16. The neur scheduled on 9/22 and 5:00 PM and to normal limits. Neur documented as do PM, 6:30 PM, 7:00 PM, and 10:30 PM scheduled thereaft limits. The nurse that was returned from dialy interviewed on 6:0 nothing was report accident and the noresident did not tell she went at 4:30 PM did not do neuroch on 9/22/16). An interview with the (ADON) on 11/2/16 have always used Sheet to document resident's name are implement neuroch with a suspected high provided the follow frequency of the neurose' station and 10/27/16: Neurological Reconserved to the reconserved to the second	very 4 hours for 24 hours (from 6 till 3:30 AM 9/24/16), every 27:30 AM-3 PM shift on 39 on the 3 PM-11 PM shift on 39 on the 3 PM-11 PM shift on 39 on the 3 PM-11 PM shift on 39 on the 3 PM, 4PM, 4:30 PM, 4he neurochecks were within rochecks were not 39 ne on 9/22/16 at 5:30 PM, 6:00 PM, 7:30 PM, 8:30 PM, 9:30 PM, 9:30 PM, 7:30 PM, 8:30 PM, 9:30 PM, 9	F3	responsible party were notified of significant change in condition, in accidents, using the progress not tool. The audit will be completed DON, ADON, staff nurse, and/or corporate consultant 5x/week x 4 then weekly x 8 weeks, then monmonths. The monthly QI committee will re results of the Progress Note Audi monthly x 6 months for identificat trends, actions taken, and to dete the need for and/or frequency of continued monitoring, and make recommendation for monitoring for continued compliance. The admit and/or DON will present the finding recommendations of the monthly committee to the quarterly executive committee for further recommendation and oversight.	cluding e audit by the weeks, thly x 3 view the t tool ion of ermine or nistrator ng and QI cive QA	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION	(X3) DATE S	
	345502	B. WING		C	
	345502	B. WING _		11/0)2/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PARK NURSING AND REHABILI	TATION CENTER		3315 FAITH CHURCH ROAD		
			INDIAN TRAIL, NC 28079		
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	I	(X5) COMPLETION DATE
An interview with the DON revealed, "We have alwa Neurological Observation neuro checks. We used the were posted at the nurses above) and that has been years I have worked at the policy and not sure the orient because it was not consist of practice in the industry revised by our medical direction Now we have new parame which were put into place include: Every 15 minutes X 1 houres Every 30 minutes X 2 houres Every 4 hours X 12 houres Every 4 hours X 12 houres Then every shift till 72 houres Then every shift till 72 houres and that she knew about She said if there was a fall hitting his head, she expensasses and do neuroched expected to call and notify about the resident hitting On 9/27/16 at 9:20 AM, the Doctor (MD) was interview the staff to assess the resident of the staff to assess the resident of the changes. If the resident of headache, had symptoms consciousness, then they	N on 11/2/16 at 2:37 PM ays used the a Sheet to document the parameters which s' station (same as a our practice for the five se facility. It was not a rigin of the parameters. stent with the standard rector after the survey. Setents for neurochecks at on 10/27/16 and survey. The second set is a continuous second	F3	309		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(c
		345502	B. WING			11/	02/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		3:	315 FAITH CHURCH ROAD		
				II.	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	technician and the mithe resident and drow without assessment. serious harm to the right of the factor of nursing him to the factor of nursing led to the director of nursing led to the fall. The MD said internal injuries with the director of compliant A. How the correction accomplished for the been affected by the complished for the been affected by the considerable of the main housekeeper (floor to resident back in to an wheelchair on the valuation without an assessment professional, register physician assistant, on 9/22/16, the main returned the resident the director of nursing on 9/22/16, the director of nursing led the back of his head director of nursing led	o was told that the floor aintenance staff picked up we him back to the facility. The MD said the risk of esident from moving and ility without assessment was dent was alert and oriented is level of consciousness. dent could have intracranial or neck injury/discomfort from define the resident could have but symptoms for a while. PM, the administrator was liate Jeopardy. The led the following credible ince on 10/31/16 at 6:04 PM: The ve action will be see residents found to have deficient practice. Outcome. Intenance worker and echnician) assisted the in upright position in the in and returned to the facility and practical doctor. Intenance worker immediately into the facility and informed	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	NG _		Ι,	С
		345502	B. WING				02/2016
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAVEDAG	DE MUDEING AND DE	HARII ITATION CENTER		3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REI	HABILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 309	Continued From pa	age 20	F	309			
	-	notified the treatment nurse.		000			
		sing performed a neurological					
		without negative findings. The					
		rological check paperwork to					
	_	bal instructions to continue the					
		s throughout the night. The					
		to the responsible party. The					
		s were not performed through					
	_	as no policy or standing order					
	_	ime for neurological checks.					
(On 9/22/16, the tre						
		at to the back of the resident's					
		ce of the DON, after assessing					
		o. The treatment nurse left a					
		sponsible party and the					
		eturned the call which was the					
		he injury to the responsible					
		consible party had not returned					
		tor of nursing. The treatment					
		the physician for additional					
		the injury presenting more like					
	a scratch to the sca						
		ministrator and director of					
		the resident involved in the				ĺ	
	incident on the van	. The resident gave an					
	account of the ever					ĺ	
	On 9/26/16 the DO	N notified the nurse				ĺ	
	practitioner (NP) of	Resident #96's fall with					
		orders were received after					
	the NP 's assessm	nent.					
		ON talked to the attending				ĺ	
		g Resident #96's fall with				ĺ	
		to the scalp. No new orders				ĺ	
		MD assessment. On 9/27/16,				ĺ	
	· ·	e with the responsible party				ĺ	
	about the incident/a	accident on the van.					
	As of 9/28/16, Resi	ident #96 has been transported					
	by contracted van	services. The contracted van					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345502	B. WING		11/02/2016	
	ROVIDER OR SUPPLIER RK NURSING AND REH	ABILITATION CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	, , , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 309	transport, and safe equipped with a cell know to call 911 if p available to assess B. How did the fact having the potential deficient practice. On 9/28/16 at 1:15 president of operation van from Lake Park Effective 9/28/16, the by contracted service. On 10/27/16, the Docorporate facility conduit of residents with the passessment with ne performed and the passessment with ne performed and the passessment with ne performed and the passessment of the fall. The audit fineurological checks residents on 10/27/16. C. Give specific date on 10/20/16, the Document of the passessment with ne performed and the passessment with ne performed and the passessment with ne performed and the fall. The audit fineurological checks residents on 10/27/16.	in safe transfer, safe securement techniques and dular telephone. The drivers rofessional staff are not a resident. cility identify other residents to be affected by the same on the corporate vice on the removed the Lake Park premises indefinitely. The residents are transported ces. CN, ADON, administrator, and insultant performed a 100% of the fall involving a head of the transported ces. The removed the Lake Park premises indefinitely. The residents are transported ces. CN, ADON, administrator, and insultant performed a 100% of the fall involving a head of the transported ces. The removed the transported ces.	F 309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ODE	11/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	happens outside the be assessed by a professional is not in-service was con After 11/1/16, no suntil the in-service receive the in-service administrator, and began in-servicing and licensed pract importance of perf assessments, incluschedule accordin practice, when a reinvolving their hea completed 10/28/1 currently working, is allowed to work completed. All RN the neuro-check in orientation. On 10/31/16, the Eadministrator, and in-servicing all statinforming the nurse physician, physician practitioner of a re (not just for falls), the resident's concassessment, then practitioner and reensure proper assan incident/accide	If the accident/incident ne facility, the patient must still professional and if a licensed available, call 911. The neleted 10/31/16 of all staff. taff person is allowed to work is completed. All new hires will ice during new employee OON, ADON, staff facilitator, corporate facility consultant, all registered nurses (RNs) ical nurses (LPNs) on the priming neurological check of the in-service was 6 of all RNs and LPNs After 10/28/16, no RN or LPN until the in-service is and LPN new hires will receive reservice during new employee OON, ADON, staff facilitator, department heads began if on the importance of staff and the nurse notifying the in assistant, and/or nurse sident's change in condition Also, the nurses must assess lition, document the notify the physician or nurse sident's responsible party. To essment when a resident has not causing injury, physician or notification must be done in	F3	309		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DPLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X BUILDING			X3) DATE SURVEY COMPLETED		
		345502	B. WING			C I 1/02/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2016
(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)	N SHOULD BE	(X5) COMPLETION DATE
F 309	in-service will be corworking. After 11/01 work until the notification completed. All new notification in-service orientation. The validation of the completed on 11/02/following: Inservice training maincluded: -If a resident has a faimmediately notify the assessment to be coresident. If resident member when fall or assessed by a profemember is not present to assessed by a profemember is not present to assessed by a profemember is not present to assessed. Inservice records we schedules and all standard and all standard profemember in the presenting all were interviewed regand demonstrated under the profession of the profession of the presenting all were interviewed regand demonstrated under the profession of the presenting all were interviewed regand demonstrated under the profession of the p	one in addition to the st, including calling 911. The impleted 11/01/16 of all staff /16, no staff is allowed to ation/assessment in-service whires will receive the eduring new employee credible allegation was 16 at 5:45 PM by doing the aterial was reviewed which all the staff member must	F3	09		
	involving falls were r	of residents with incidents eviewed and documentation ment had been completed by				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED	
		345502	B. WING _		C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	11102/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION
F 323 SS=J	and completed consimplemented by the six residents were in licensed nurse had fall. Audits were reviewed that assessments at and documented by 483.25(h) FREE OF HAZARDS/SUPERV The facility must ensenvironment remain as is possible; and 6	euro checks were idents with a suspected injury istent with parameters medical director. Two of the iterviewable and verified a assessed them after a recent and and included verification iter a fall had been completed a licensed nurse. ACCIDENT	F3		11/2/16
	by: Based on observati family, facility staff, physician, and recor transport a resident facility in a safe mar resident fell in the vain the back of the he sampled resident (R Immediate Jeopardy Resident #96 and hi in the transportation sustained a laceration	on, interviews with resident, ohysician assistant and of review, the facility failed to from the dialysis center to the an and sustained a laceration and. This is evident in 1 of 2 desident # 96). To began on 9/22/16 when see wheelchair fell backwards and the resident on to the back of his head.		F 323 Free of Accidents On 9/22/16, the maintenance worker housekeeper assisted the Resident aback in to an upright position in the wheelchair on the van and returned afacility. On 9/22/16, the maintenance worker immediately returned the resit to the facility and informed the direct nursing (DON). On 9/22/16, the DON immediately assessed the resident #96. The resident	#96 to the e ident or of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED				
			A. BOILDI			، ا	С
		345502	B. WING				02/2016
NAME OF PI	ROVIDER OR SUPPLIER	1	'	S	TREET ADDRESS, CITY, STATE, ZIP CODE		02.2010
				33	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 25	F;	323			
	at 3 PM when the fac	cility's acceptable credible			had no complaint of pain and exhibited		
		nce was verified. The facility			normal behavior and activity. The		
	will remain out of con	npliance at a scope and			resident had a small scratch on the bad	ck	
	severity level D (no a	ctual harm with potential for			of his head with two drops of blood. The	ne	
	more than minimal ha	arm that is not immediate			director of nursing left a message for the	ne	
	1	e facility time to monitor and			responsible party. The director of nurs		
		ew procedure for residents'			notified the treatment nurse. On 9/22/		
	transportation to app	ointments and other			the treatment nurse immediately initiate		
	activities.				a treatment to the back of the resident	S	
	Findings included:				head and notified the resident □s		
	responsible party/wife. On 9/22/16, the						
		mitted to the facility on			assigned second shift nurse assessed		
		s of pyogenic arthritis			resident # 96 during medication		
	posture, muscle wea	th pus formed), abnormal			administration for pain without negative findings. Resident #96 denied pain or	;	
	1 -	ve muscle weakness and			discomfort and ate dinner as usual.		
		chronic kidney disease, and			discombined and atc difficit as usual.		
	1	er surgical wound. The			On 9/22/2016, the administrator stoppe	h	
		d to the facility for wound			all facility transports with the facility var		
	I .	litation for his shoulder with			and secured the van keys.	•	
	a plan to return home	2.					
	•				On 9/23/2016, the corporate facility		
	Review of the admiss	sion Minimum Data Set			consultant and the corporate clinical		
	(MDS) with an asses	sment reference date (ARD)			director reviewed the appointment bool	k to	
	of 9/13/16 revealed the	he resident had a Brief			verify outside transportation had been		
	Interview of Mental S	tatus (BIMS) score of 10			arranged for Resident #96□s		
	(score of 8-12 indicat				appointments through 9/27/2016.		
		ly impaired). According to					
	· ·	t had no symptoms of			On 9/23/2016, the corporate facility		
	delirium and did not h				consultant and the corporate clinical		
	1	sistance of staff in activities			director reviewed the appointment book	k to	
		The resident was coded for			identify residents requiring transports		
	l •	ige of motion of both upper			9/23/2016 - 9/27/2016 and verified		
		s. The resident was coded			transportation was scheduled to be		
	_	ly able to stabilize with iring transition and walking.			provided by an outside transportation company.		
	Tiullian assistance ut	ing dansidon and walking.			Company.		
	The resident Care Ar	ea Assessment (CAA) for			On 9/26/2016, the administrator review	ed	
	I .	led the resident was at risk			the appointment book for all currently	-	

345502 B. W	WING		С
ENTER		TREET ARRESON OUTV OTATE ZIR CORE	11/02/2016
FNTFR		STREET ADDRESS, CITY, STATE, ZIP CODE	
		3315 FAITH CHURCH ROAD	
	I	NDIAN TRAIL, NC 28079	
FICIENCIES FEDED BY FULL F S INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	F 323		
d difficulty d impaired actors included airment), loss nce, arthritis, l pain. Care nimize risks of ayment system) evealed the -15 indicated of 9/26/16 or falls njury. The elated to e resident will view. The to assist during	F 323	scheduled appointments and verified transportation will be provided by an outside transportation company. On 9/27/2016, the facility administrator and the corporate vice president of operations determined the facility van vermain out of service indefinitely. On 9/28/2016, the corporate vice president of operations removed the various facility premises. On 9/28/2016, the administrator and the outside transportation services added addendum to each of the three outside service contract. The addendum included that transport staff have been trained in safe transfer, transport, and securement while transporting resident vans. On 9/28/2016, the administrator and D	will e an
assessments ent on the social worker improved ved that his DS of 9/20/16 lert, oriented omes back ouble focusing		president of operations related to ensu the resident environment remains free hazard, ensuring staff are trained and performance monitored prior to delega a task, and ensuring assigned tasks ar within the staff scope of practice. On 9/29/2016, the corporate clinical director completed an audit of a reside transport to ensure the resident was be transported by a contracted outside transportation agency and safe securement of the wheelchair. Beginnin 10/24/2016, the administrator, DON,	of ting e nt eing
	e and mobility. It difficulty It difficulty It dimpaired Factors included	e and mobility. It difficulty It difficulty It difficulty It dimpaired It actors included It pain. Care It pain. C	d difficulty d impaired actors included pairment), loss ance, arthritis, d pain. Care nimize risks of agyment system) revealed the 3-15 indicated b. of 9/26/16 or falls anjury. The elated to e resident will wiew. The to assist during requent 29/16 at 1 PM assessments dent on the assessment on perations removed the various remains free hazard, ensuring assigned

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER.		IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
							С	
		345502	B. WING _			<u> </u>	11/02/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE DAE	OK NITIDOING AND D	ELIADU ITATION CENTED		3	315 FAITH CHURCH ROAD			
LAKE PAR	KK NUKSING AND K	EHABILITATION CENTER		II	NDIAN TRAIL, NC 28079			
(X4) ID PREFIX	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE	(X5) COMPLETION DATE	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	5/112	
F 323	Continued From p	page 27	F3	323				
	last week. The re	esident revealed there were two			and/or the corporate clinical director w	/ill		
	facility staff memb	pers on the van during transport.			begin auditing the outside transportati	on		
	The resident reve	aled the driver did not know			services using the Transportation Aud	it		
	exactly how to tie	down the wheelchair in the van,			tool. The audit will be completed week	dy x		
	and the driver and	d the other person with him did			12 weeks, then monthly x 3 months.			
	not tie down the f							
	correctly. When the van turned on highway 74, it				On 10/21/2016, an in-service was initi	ated		
	accelerated to me			for all staff related to not completing ta	ısks			
	1 1 1	s, and the resident stated he			that are not within their scope of pract			
		n floor and hit his head. He had			and reporting to the administrator whe			
	a little cut on his h	nead but he was okay.			asked to perform a task the staff person			
					not trained to perform. The in-service			
		5 PM, the resident was			be completed by 10/24/2016. No staff	will		
	_	with a family member present.			be allowed to work a shift until they			
		aled (referring to the van			complete the in-service. All new hires	will		
		16), the van turned on highway			receive the in-service during new			
		celerate to merge into traffic			employee orientation.			
		nair tilted backwards and he fell						
		van floor. When asked where			Beginning 10/24/2016, the administra			
	_	his head, he said on the curb (a			DON, ADON, corporate facility consul	tant,		
		back of the van) in the back of			and/or the corporate clinical director			
		dent said one of the staff was			began auditing the outside transportat	ion		
	_	on how to secure the wheelchair			services for safe securement of the			
		know what they were doing. The			wheelchair using the Transportation A			
		aid the facility never told her			tool. The audit will be completed week	lly x		
		ut the resident told her that he			12 weeks, then monthly x 3 months.			
		the van as it accelerated into			The	41		
		erge into traffic and the			The monthly QI committee will review			
		packwards and the resident fell			results of the Transportation Audit tool			
	on the floor.				monthly x 6 months for identification o			
	Povious of a suritte	on statement by the			trends, actions taken, and to determin	E		
		en statement by the			the need for and/or frequency of			
		ed 9/22/16 revealed she esident regarding a reported fall.			continued monitoring, and make recommendation for monitoring for			
		the administrator he was picked			continued compliance. The administra	ator		
		center by two men. The			and/or DON will present the finding ar			
		their way back to the facility on			recommendations of the monthly QI	u		
		an accelerated and the resident			committee to the quarterly executive (٦Δ		
		nitting his head on a raised area			committee for further recommendation			
	i ion onaigint back t	many mo mode on a raisca area	1		, sommittee of further recommendation		1	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345502	B. WING			C 1/02/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2010	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	pulled to the side of picked him up and a told them he was fin the facility. Review of a written so nursing (DON) dated that both the administration and the resident did not. administrator and the accelerated, he fell to on the curved area are resident noted that of trained by the other. Review of an accide DON and dated 9/22 wheelchair tilted bactransported from the Staff caught the resident noted that of trained by the other. Review of an accide DON and dated 9/22 wheelchair tilted bactransported from the Staff caught the resident position. The was stationary at the thead) laceration centimeters (cm) by "Incident Description he fell backwards in The incident report in oriented to person, semployee reported to	e resident said that the driver the road and the two men sked him if he was okay. He e and to just take him back to statement by the director of 19/22/16 at 4 PM revealed strator and the DON lent together. The resident at happened when the van way 74 and it accelerated and The resident told the DON that when the van backwards and hit his head at the door in the back. The one staff member was being the report prepared by the lend to inside the van detail and returned him to an e staff reported that the van et time. Occipital (the back of	F 32	,			
	notified on 9/22/16 a There were three ha	ealed the physician was t 3:45 PM. ndwritten statements dated intenance staff who was					

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345502	B. WING _			11/02/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				3315 FAITH CHURCH ROAD			
LAKE PAI	RK NURSING AND RE	EHABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	three written state description of the amaintenance staff from the dialysis of the floor technicial side entrance doo maintenance staff lift, the maintenance staff lift, the maintenance and the maintenance of the mainten jumped on the lift at the wheelchair off three written state resident fell backwoff the chair in the chair or the seat be maintenance staff okay and the resident fell backwoff the chair in the chair or the seat be maintenance staff the floor technician the wheelchair to the technician sat next dialysis. The maintenance staff the back of the resident off the valuation of the val	the time of the accident. The ments contained the following accident of 9/22/16: the was picking the resident up enter around 3:00 or 3:15 PM. In went with him. The van had a r with the lift. As the was putting the resident on the ce staff started backing into the enance staff fell backwards. The the wheelchair came back on ance staff. The floor technician and picked up the resident and of the maintenance staff. The ments included that when the ward his head hit either the side back of the van, the corner of a ehind the driver seat. The asked the resident if he was dent responded yes. The strapped the back wheels and in strapped the front wheels of the floor tie down. The floor it to the resident as they left intenance staff noticed a cut on sident's head, with no blood is back to the facility and got the in and took him to the DON go and told her what happened. The resident was being wheelchair from the floor the maintenance staff slipped the resident in the wheelchair and landed on top of the intenance the certain the look are resident in the wheelchair and landed on top of the intenance staff slipped the resident back to a sitting the sident back to a si	F3				

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED			
		345502	B. WING _			C 11/02/2	2016
	ROVIDER OR SUPPLIER	BILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		_	(X5) OMPLETION DATE
F 323	okay. The resident's small scratch on the resident bumped the back of the driver sear resident in the wheel strapped down in the drove straight back to technician sat next to talked and seemed of told the director of number of of num	trepeatedly said he was eemed okay except for a back of his head. The back of his head on the lat. Then they moved the chair to the place to be van. The maintenance staff of the facility while the floor of the resident. The resident kay. The maintenance staff rsing what happened. The Floor technician was go the van accident and also of how the resident and the vards in the van on 9/22/16. The floor was on the ground operating finician demonstrated with a son sitting in the wheelchair estaff placed the resident on the tothe van and walked lel to the bench seat driver seat), with the fine rear two wheels only, to chair in the van. The floor how the maintenance staff liking backwards (with the fineles only) and fell on the swith the wheelchair fell on resident's wheelchair off the dasked the resident if he ent said he was okay. They is wheelchair in the van and	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
			A. BOILD			Ι ,	c
		345502	B. WING				-
NAME OF D	ROVIDER OR SUPPLIER	0.10002			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	02/2016
NAIVIE OF PI	ROVIDER OR SUPPLIER						
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER			3315 FAITH CHURCH ROAD		
				I	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From pag	ne 31	F	323			
	was interviewed and	also did a demonstration of					
	how the resident and	the wheelchair fell					
	backwards in the var	n on 9/22/16. The					
	maintenance staff de	•					
	•	rson sitting in the wheelchair.					
		aff said he was on the lift with					
		heelchair. He backed the					
		an perpendicular to the					
	bench seat. He tripped and fell backwards and the wheelchair fell on top of him. The resident						
	might have hit his head on the seat or on the seat						
	belt buckle lying on the passenger bench which might have caused the laceration on the						
	_						
		maintenance staff said that got on the van and got the					
	_	i. The maintenance staff					
		eelchair back on only two rear					
	_	the wheelchair in the van.					
		aff said he asked the resident					
		the resident said yes. The					
	_	aid he tried to call the DON's					
		not answer and he did not					
	•	try to call someone else. He					
		sident back to the facility.					
		ceived any training on					
	transporting resident	ts via the van, he said that he					
		raining from this facility but					
	he received training	from another facility. The					
	floor technician joine	ed the demonstration and the					
	interview with the ma	aintenance staff. The floor					
	technician recanted	his description of how the					
		ted the wheelchair on only					
	the two back wheels	-					
	maintenance staff de	emonstration and statement.					
		AM, the floor technician was					
	_	he floor technician said he					
		aintenance staff fall or the					
	resident fall from who	ere he was standing on the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 1 1/02/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2016	
(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 323	happened (on 9/26/1 description and them he said, "what happen now." Then the floor describe what happen of the maintenance is sat beside the reside. "I did not want any metchnician said that he transport of residents the accident happened. The maintenance staff sat pick up the resident of bring him to the facility maintenance staff statelephone on 9/27/16 maintenance staff in the facility voff highway 74. The the accident happened facility know of the accould not find (the) Destaff said he drove the the maintenance staff said he drove the maintenance staff said no 74."	why there were en his description of what 6 at 1 PM), the resident naintenance staff description, ened is what I am describing rechnician proceeded to ned to match the description taff. When asked why he nt on the way back, he said ore accidents. "The floor was never trained on safe by the van, not even after ed. If was interviewed again via at 6:38 PM. The did the DON asked him to go from the dialysis center and the viated he rode along with the abody gave him a skill test to now to transport residents an. The dialysis center was maintenance staff said when ed, the van was stationary. The maintenance staff said front of the dialysis center.	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345502	B. WING			C I1/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	there was no formal they drove the van. maintenance staff an never trained on how facility's van. There staff on what to do we the van. The admin the resident what had different story. She that he fell backward van was turning on had to accelerate to administrator said the confusion so she did accurately describing no reason to believe the maintenance staff or the van drivers. Transportation safety by the driver that left During an interview administrator confirm technician and the notation trained on van transportation safety by the driver that left was an employee of the facing was an employee of company. The residualysis by a contraction the morning of 9/have anybody scheet dialysis, therefore, the asked to get the residents.	cted. The administrator said training for drivers before The administrator said the and the floor technician were to to transport residents in the was no policy on how to train with securing the wheelchair in istrator said that she asked ppened and he told her a said that the resident told her dis in his wheelchair when the highway 74 when the driver merge into traffic. The at the resident had periods of	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 11/02/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2016	
(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 E APPROPRIATE	(X5) COMPLETION DATE	
F 323	that date. Observation and den securement system vince 10:10 AM. The floor maintenance staff we administrator and the demonstration was disconsisted wheelchair was raise and the maintenance maintenance staff se frame on the back of technician attached to the front wheelchair frame. We pushed on from the braised up from floor. Review of the manufacture securement system in the two front tie down to a solid frame close. An interview with the was conducted on 9/ said that she learned the laceration today. Today that the accide center when the main resident fell on top of PA said that the resident fell on top of PA said that the resident fell on the same ditimes with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure memory. The secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the survey family, she said "I we form the secure with the secure wit	nonstration of the van was done on 9/28/16 at technician and the ere present, as well as the corporate staff. The one in the facility van. The d via the lift with a surveyor staff on the lift. The cured the floor straps to the the wheelchair. The floor the straps to the loop wheels instead of the then the wheelchair was back, the front wheels slightly acturer's instructions of the in the facility's van revealed in straps should be attached to the level of the seat. Physician Assistant (PA) 26/16 at 5:30 PM. The PA about the van accident and The PA said staff told her in thappened at the dialysis intenance staff fell and the the maintenance staff. The lent had problems with short hort term recall was not as told that the resident escription of the accident two ors and one time with the	F3	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Doctor (MD) was inte self and place. When resident repeated the happened on the van MD said, he would sa falsifying the facts. T goal was to go back he interview with the MD AM revealed that he to therapist and she told more confused when facility. He seemed to (PT) was interviewed with the resident on board transfer. The Pfor therapy. The resident was oriented dialysis he was tired a reliable and he can reresident was already lethargic and he did not so she worked with his saw a little blood on the saw a little blood on the saw a little blood on the saw all the driver did not and when the van turn accelerated and the versident stated he fell coming back from dial that the person who versident was all the person who versident was all the person who versident stated the fell coming back from dial that the person who versident was all the person who versident stated the fell coming back from dial that the person who versident was all the person who versident stated the perso	ryiewed. He was oriented to the MD was told that the same description of what three separate times, the y the resident was not he MD said the resident nome. again on 9/27/16 at 10:15 alked with the physical him that the resident was he was first admitted to the phave improved cognition. AM, the physical therapist she said she was working ed mobility and his slide. The saw him five times a week dent followed commands and the day he went to and lethargic. He was secall. On 9/22/16, the in the bed and he was not want to get out of the bed im on bed mobility. The PT he pillow so she asked the ed. The resident told her secure the strap tie down and on highway 74, the van wheel chair fell backwards. The resident told PT was bringing him back to the the strap and when the van	F3	23		

	NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	'	11/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	on 9/27/16 at 5:56 F provided treatment in the came back from resident did tell her it said something about appeared alert and of questions appropriated in it would believe not bleeding but had on 9/28/16 at 6:55 Feat 1) that worked with the 11PM-7AM shift was the resident told her the van on the way of the NA stated the resident what happened. On 9/27/16 on 7:24 DON, the regional vector consultant DON said that the resident what happened. On 9/27/16 on 7:24 DON, the regional vector consultant DON said that the resident up. The additional made aware of the feassess the resident investigation and su staff. Then she took it in her office. The transportation since administrator said sli	eatment nurse was conducted PM. This treatment nurse for his head laceration when dialysis on 9/22/16. The that he fell in the van. He at falling on highway 74. He priented. He answered her tely. The treatment nurse is him." The laceration was it some redness. PM, a nursing assistant (NA # the resident on the is interviewed. The NA stated the accident happened on coming back from dialysis. Pesident was credible. Inducted with the DON on when the resident arrived at the visit, the maintenance staff into the DON and told her PM, the administrator, the discepresident and the tree interviewed. The pesident was at dialysis and he is were interviewed. The pesident was at dialysis and he is were interviewed. The pesident was at dialysis and he is go in the van and pick the ministrator said she was all. She instructed the staff to right away. She began an spended the maintenance is the keys to the van and put van had not been used for	F3			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 11/ 02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2010
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	she asked the maint happened. This is wout that the floor tech the accident happen that she wanted the and get checked out safety tie down. The facility management technician and asked of what happened. On 9/27/16 at 7:15 Fnotified of the immediadministrator provide allegation of compliant How the corrective afor those residents for those residents for those residents for the direction in the returned to the facility on 9/22/16, the main returned the resident the director of nursing submitted a written serenactment prior to suspension. On 9/22/16, the director of nursing seems of the back of his head director of nursing le responsible party. The treatment nurse.	ay 74. The administrator said enance staff to reenact what when the administrator found inician was with them when ed. The administrator said wan to be taken out of service for the functionality of the enext day (9/23/16) the interviewed the floor did him to do a demonstration of the end the following credible ince on 9/28/16 at 6:55 PM: action will be accomplished bund to have been affected tice. Internance worker and floor the resident back in to an end wheelchair on the van and end of the facility and informed and the facility and informed and leaving on administrative considered that a small scratch on with two drops of blood. The	F 32	23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345502	B. WING _			11/0	02/2016
	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	DDE	•	
(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 ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 323	initiated a treatment thead and notified the On 9/22/16, the adminursing interviewed the incident on the van. account of the events On 9/22/16, the adminate maintenance worker, worker re-enact the estatement from the maintenance worker resident on the van. On 9/22/16, the admitransports with facility keys. How did the facility id the potential to be aff practice. On 9/22/16, the admitverified with the maintechnician there was 9/22/16 and furtherm transported other reson 9/22/16, the admitfacility's use of three services. In the eventransportation services pick-up or return trantransportation services on 9/23/16, the corporate clinical direct appointment book to transports 9/23/16 of transportation from a company was scheduled with providers.	ment nurse immediately to the back of the resident's resident's responsible party. Inistrator and director of the resident involved in the The resident gave an to and incident. Inistrator interviewed the had the maintenance event, and obtained a written raintenance worker. The verified there was no other Inistrator stopped all facility van and secured the van entify other residents having ected by the same deficient Inistrator interviewed and tenance worker and floor only the one resident on the ore they had not previously idents. Inistrator validated the outside transportation It the scheduled outside It was unable to provide It syntam and interviewed the interviewed the interviewed the interviewed the interviewed the identify residents requiring	F3	023			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING		C 11/02/2016	
	ROVIDER OR SUPPLIER	IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		111022010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 323	appointments and v provided by outside Specific dates of the On 9/22/16, the adr keys and stopped a van. On 9/22/16, the adr three transport serv services when need On 9/27/16, the facil Corporate Vice Predetermined the facil service indefinitely. On 9/28/16 at 1:15 President of Operat from facility premise administrator and the services added an accurate outside transportation addendum included service had policies addition, the addend staff have been train and securement who van. The validation of the	or all currently scheduled erified transportation will be transportation providers. e corrective actions. Ininistrator collected the van III facility transports with facility eninistrator verified there are ices used to provide transport led. It is administrator and sident of Operations ity van will remain out of PM, the Corporate Vice ions removed the facility van es indefinitely. On 9/28/16, the ene outside transportation addendum to each of the three on service's contracts. The the outside transportation in place to ensure safety. In dum included that transport ille transporting residents in excredible allegation was	F 323			
	following: Observation and de 12:05 PM were con in the transportation 12:05 pm. The driv and then he shook that it did not move wheelchair did not r straps and the resid facing the van door.	monstration on 9/27/16 at ducted. The resident arrived a van of a sister facility at er brought down the lift first the wheelchair to demonstrate and it was secure. The move. The driver untied the lent was pushed to the lift. The lift was lowered with the en the driver was asked to				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 1/02/2016	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 372 SS=C	The driver put the whestrap anchored in the around the upper back and hooked it back to he secured the front wheelchair and tighte the wheelchair to mai On 9/29/16 at 11:55 / observed being unload facility. The resident dialysis to the facility. one of the transportar contracted. The resident dialysis to the facility one of the transportar contracted. The resident dialysis to the facility one of the transportar contracted. The resident dialysis to the facility one of the transportar contracted. The resident dialysis to the facility one of the transportar contracted. The resident dialysis to the facility one of the transportar contracted. The resident dialysis to the facility one of the transportar the floor and seat belt and wheelet backward. Interview with the add PM revealed she and received inservices a resident environment hazard and that the facility provided a happened on 9/28/16 of the contracts of the company.	secured the wheelchair. eelchair in place, pulled a floor of the van and put it ck frame of the wheelchair of the floor securement. Then wheels to the frame of the ened the straps and shook ke sure it did not move. AM, Resident #96 was aded from the van at the was transported from The van had the logo of tion company the facility dent was in the wheelchair ad four point straps to the ross the resident. The driver int securement and then the d the resident out of the van ministrator on 9/29/16 at 2:25 I the director of nursing bout the ensuring the remains free of accident acility will ensure that staff in the task that is asked of a log of the QI meeting that it. The facility provided copies	F 32			11/2/16	
33-0		ose of garbage and refuse					
	This REQUIREMENT	is not met as evidenced					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 1/02/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	1/02/2016
	10115211 011 001 1 2.2.1			3315 FAITH CHURCH ROAD		
LAKE PAF	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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 372	Continued From page	e 41	F 37	2		
	Based on observation documentation review	on, staff interview and w, the nursing home failed to e compactor and did not		F372 Dispose Garbage & Refu Properly	se	
	identify that liquid wa compactor onto the g had one large compa			On 9/28/16, the regional vice prensured the floor technician rentrash behind the dumpster area On 9/29/16, the waste company	noved the	
	The compactor was on Dietary Aide #1 at 2:4 behind the kitchen.	observed in the presence of 45 pm on 9/25/16 outside The door was not shut. It		the leaking dumpster with a rep dumpster which was free of leal requested by the regional vice p	lacement kage, as oresident.	
	was some brown wat dumpster with odor a brown water was on and dripping on the g	nd numerous flies. The the edge of the dumpster fround. When Dietary Aide dumpster door, the door was closed and the		On 10/21/16, the director of nur (DON) in-serviced the dietary st importance of monitoring the duarea during garbage disposal arroutinely in order to discover an from the dumpster and to ensur and garbage are properly dispoinside the dumpster/compactor.	taff on the umpster nd y leakage e trash sed of	
	on 9/28/16 with the Compactor door consultant was not all constant dripping from compactor about half compactor to the background below the least observed on and around the same observed behind the cardboard.	ole to shut it. There was in the left side of the i way from the front of the ik. Liquid had pooled on the k. Flies and ants were und the compactor. ervation a lot of trash was		On 10/21/16 the dietary staff wi monitoring the dumpster and the dumpster/compactor area durin disposal. Each staff member act the dumpster will report any observation for correction. Dieta will immediately correct trash for outside of the dumpster/compact Starting 10/24/16, the dietary m	e g garbage ccessing servations ger and/or pon ary staff ound ctor.	
	was observed. On 9/28/16 at 7:58 P Supervisor said the h	M, the Housekeeping service was utside of the building and		cook, administrator, environmer services director, maintenance, technician, and/or corporate corwill monitor the dumpster area & 4 weeks, then weekly x 8 weeks	ntal floor nsultant 5x/week x	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY IPLETED
		345502	B. WING _		11	C I/ 02/2016
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		102/2010
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
F 372	Continued From pag- that maintenance wa On 9/29/16 at 8:25 A		F 3	monthly x 3 months and will record observations on the Dumpster Are		
	Consultant said she compactor and surro Administrator and the	reported the condition of the unding area to the Regional Vice President		tool and forward the completed to administrator.	ol to the	
	(RVP). She said the housekeeping cleaned cardboard container. note that the RVP cat 11:55 AM on 9/28/16 about removing the coshe saw a problem somaintenance man. The not available for inter On 9/29/16 at 8:31 A if she saw a problem or Housekeeping. Si responsibility if there On 9/29/16 at 8:31 a waste company was representative said hand send it to the ow	Floor Tech from ed up the trash behind the She provided a handwritten lled the waste company at and talked to their staff dumpster. She added that if he would tell the The Maintenance man was view. M the Dietary Manager said she would tell Maintenance he said, " It is everyone's is a problem." representative from the		The monthly QI committee will reversults of the Dumpster Area Audit monthly for 6 months for identification trends, actions taken, and to deter the need for and/or frequency of continued monitoring, and make recommendations for monitoring frontinued compliance. The admin and/or dietary manager will present findings and recommendations of monthly QI committee to the quart executive QA committee for further recommendations and oversight.	t tool tion of rmine or istrator nt the the terly	
F 490 SS=J	A facility must be adr enables it to use its r efficiently to attain or	RESIDENT WELL-BEING ministered in a manner that esources effectively and maintain the highest mental, and psychosocial	F 4	90		11/2/16
	by:	Γ is not met as evidenced riews and review of facility nome administration		F 490 Effective Administration/Re Well-Being	esident	

OLIVILIY	O I OIT MEDIO/ ITE &	WEDIO/ ND OLIVIOLO				<u> </u>	7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
							С
		345502	B. WING				02/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IVKE DVE	RK NURSING AND REHA	ARII ITATION CENTED		33	315 FAITH CHURCH ROAD		
LANL FAI	IN NONSING AND INCHA	CENTER 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
			+		,		
F 490	Continued From page	- 43	F	490			
	delegated a transport			100			
		no was not trained in van			On 9/22/16, the maintenance worker a	nd	
		ng home to pick up 1:2			housekeeper assisted the Resident #9		
		om dialysis and return the			back in to an upright position in the	J	
		g home. Resident #96			wheelchair on the van and returned to	the	
		began on 9/22/16 when the			facility. On 9/22/16, the maintenance		
	administrative staff m				worker immediately returned the reside	ent	
		transport Resident #96 in			to the facility and informed the director		
		he dialysis center back to the			nursing (DON).		
	facility. The employed						
	safe transporting of a	resident. The resident fell in			On 9/22/16, the DON immediately		
	the van and sustaine	he van and sustained a laceration in the back of			assessed Resident #96. The resident	had	
	his head. The immed	iate jeopardy was removed			no complaint of pain and exhibited nor	mal	
	on 9/29/16 at 3 PM w	hen the facility provided an			behavior and activity. The resident had	a t	
		allegation of compliance. The			small scratch on the back of his head v	vith	
	facility will remain out	t of compliance at a scope			two drops of blood. The DON left a		
	,	no actual harm with potential			message for the responsible party. Th	е	
		al harm that is not immediate			DON notified the treatment nurse. On		
	1	e facility time to monitor and			9/22/16, the treatment nurse immediate	эly	
		ew procedure for residents'			initiated a treatment to the back of the		
	transportation to app	ointments and other			resident □s head and notified the		
	activities.				resident s responsible party/wife. On		
	Findings included:	Danad an abanasatian			9/22/16, the assigned second shift nurs		
		Based on observation,			assessed Resident #96 for pain during medication administration without		
		ent, family, staff, physician				4	
		an, and record review, the port a resident in a safe			negative findings. Resident #96 denie pain or discomfort and ate dinner as	J	
		staff from the dialysis center			usual.		
		sident fell in the van and			usuai.		
	· ·	n in the back of the head.			On 9/22/16, the administrator stopped	all	
		f 2 sampled residents			facility transports with the facility van a		
	(Resident # 96).	2 campion residente			secured the van keys.		
	During an interview o	on 9/28/16 at 7:24pm, the			On 9/23/16, the corporate facility		
		ector of Nursing (DON), the			consultant and the corporate clinical		
	regional vice preside	nt and the corporate			director reviewed the appointment boo	k to	
		erviewed. The DON said the			verify outside transportation had been		
	-	sis and he needed to be			arranged for Resident #96□s		
	picked up. So she as	ked the maintenance staff to			appointments through 9/27/2016.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDI				С
		345502	B. WING				/02/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		02/2010
				3:	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 490	Continued From page	e 44	F.	490			
	go in the van and pic	k the resident up. The					
		e was made aware of the			On 9/23/16, the corporate facility		
	fall. She instructed th				consultant and the corporate clinical		
		She began an investigation			director reviewed the appointment book	k to	
		naintenance staff. Then she			identify residents requiring transports		
		van and put it in her office.			9/23/2016 - 9/27/2016 and verified		
		n used for transportation			transportation from an outside		
		he administrator said she			transportation company was scheduled	l to	
	asked the maintenan	ice staff to reenact what			transport the resident.		
	happened. This is wh						
	out the floor technicia	an was with the maintenance			On 9/26/16, the administrator reviewed		
	man when the accident happened. The				the appointment book for all currently		
	administrator said that	at she wanted the van to be			scheduled appointments and verified		
	taken out of service a	and get checked out for the			transportation will be provided by an		
	-	afety tie downs. The next day			outside transportation company.		
		management interviewed the					
	floor technician and a				On 9/27/16, the facility administrator ar		
	demonstration of wha				the corporate vice president of operation		
		the time of the survey			determined the facility van will remain of	out	
		that role at the facility on labels began her role on 2/19/16.			of service indefinitely.		
					On 9/28/16, the corporate vice preside	nt	
	The administrator wa	as informed of immediate			of operations removed the van from		
	jeopardy on 9/27/16	at 7:15pm.			facility premises.		
		ction will be accomplished			On 9/28/16, the administrator and DON	1	
		ound to have been affected			were in-serviced by the corporate vice		
	by the deficient pract	ice?			president of operations related to ensu	-	
					the resident environment remains free	of	
		tenance worker and floor			hazard, ensuring staff are trained and		
		he resident back in to an			performance monitored prior to delega	•	
		e wheelchair on the van and			a task, and ensuring assigned tasks ar	Э	
	returned to the facility	2 '			within the staff□s scope of practice.		
		tenance worker immediately			On 0/20/40 the vice received of		
		to the facility and informed			On 9/28/16, the vice president of		
		g. The maintenance worker			operations, vice president of clinical		
		tatement and performed a			services, the corporate clinical director		
	reenactment prior to suspension.	leaving on administrative			and the corporate facility consultant be	-	
	เ อนอบติเเอเบเเ.		1		∟ brovidina subervision and oversioni io i	aut:	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
				_			
		345502	B. WING		· · · · · · · · · · · · · · · · · · ·	11/0	02/2016
	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		315 FAITH CHURCH ROAD		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	assessed the residen complaint of pain and and activity. The resi the back of his head of director of nursing lef responsible party. The the treatment nurse, performed a neuro chindings. On 9/22/16, the treatment thead and notified the party/wife. On 9/22/16, the adminursing interviewed the incident on the van. account of the events On 9/22/16, the adminursing interviewed the statement from the maintenance worker, worker re-enact the estatement from the maintenance worker resident on the van. On 9/22/16, the adminuratement from the maintenance worker resident on the van. On 9/22/16, the adminustrance worker worker resident on the van. On 9/22/16, the adminustrance worker worker the adminustrance worker and the van. On 9/28/16, the Vice in-serviced the Adminursing regarding ad to ensure staff are ap working within their seadministrator and direction in appropriate delegated.	tor of nursing immediately t. The resident had no lexhibited normal behavior dent had a small scratch on with two drops of blood. The t a message for the ne director of nursing notified The director of nursing neck without negative ment nurse immediately to the back of the resident's resident's responsible mistrator and director of ne resident involved in the The resident gave an and incident. mistrator interviewed the had the maintenance vent, and obtained a written aintenance worker. The verified there was no other mistrator stopped all facility van and secured the van President of Operations histrator and Director of ministration's responsibility propriately trained and cope of practice; the ector of nursing must avoid	F	490	facility s administration to ensure the facility will not assign duties to staff out their scope of practice. Beginning 9/28/16, the regional vice president of operations, the corporate clinical director, and/or corporate facility consultant will visit the facility weekly x weeks then every other week x 12 wee then monthly x 3 months. Beginning 10/24/16, the administrator, DON, ADON, corporate facility consultand/or corporate clinical director will be auditing the outside transportation services using the transportation audit tool. The audit will be completed weekly 12 weeks, then monthly x 3 months. The monthly QI committee will review the results of the Transportation Audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrate and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QL committee for further recommendations and oversight.	y 8 ks, ant, gin y x he of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	
F 490	On 9/22/16, the adm verified with the mair technician there was 9/22/16 and furtherm transported other results of the event the scheduservice is unable to puransportation, other services will be contained on 9/23/16, the corp corporate clinical direct appointment book to transports 9/23/16 - 9 transportation from a company was schedusen scheduled with providers.	inistrator interviewed and intenance worker and floor only the one resident on the nore they had not previously sidents. inistrator validated the facility de transportation services. In uled outside transportation provide pick-up or return outside transportation acted. iorate facility consultant and ector reviewed the identify residents requiring 9/27/16 and verified an outside transportation uled. Appointments had an outside transportation	F	190		
	appointments and very provided by outside of the provided by outside of the provided by outside of the provided the Admi of the provided t	r all currently scheduled erified transportation will be transportation providers. President of Operations nistrator and Director of dministration 's responsibility opropriately trained and scope of practice; the rector of nursing must avoid tion of duties. of the corrective actions.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 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 PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	
F 490	three transport services when needed on 9/27/16, the Lake Corporate Vice President of the Lake service indefinitely. On 9/28/16 at 1:15 president of Operation of Coperation of Coperation of the Lake service indefinitely. On 9/28/16, the admitransportation service each of the three ours contracts. The additransportation service ensure safety. In addinctudes that transportation service ensure safety. In addinctudes that transportation service in-serviced the Admit Nursing regarding action ensure staff are a working within their sadministrator and dirinappropriate delegation on 9/28/16, the Vice of Vice on 9/28/16, the Vice on 9/28/	inistrator verified there are ces used to provide transport ed. Park administrator and ident of Operations Park van will remain out of m, the Corporate Vice ons removed the Lake Park premises indefinitely. Inistrator and the outside es added an addendum to tside transportation service 'dendum includes the outside e has policies in place to dition, the addendum out staff have been trained in out and securement while is in van. President of Operations inistrator and Director of diministration 's responsibility oppropriately trained and scope of practice; the rector of nursing must avoid	F	490		
	s administration of the administration would of the scope of pract	n and oversight to the facility ' ne facility to ensure the I not assign duties to staff out ice. credible allegation was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345502	B. WING		1 1	C / 02/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	. , .,	102/2016	
(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)	LD BE	(X5) COMPLETION DATE	
F 490 F 514 SS=D	completed on 9/29/16 An observation and of 12:05PM was conducted transportation van of demonstrated that the resident was secured On 9/29/16 at 11:55 observed being unload facility. The resident dialysis to the facility one of the transportation contracted. The resident dialysis to the facility one of the transportation and seat belt and unhooked the four poseat belt and wheele backward. Interview with the add 2:25PM revealed she services about the eneutronnent remains that the facility provided Improvement) meeting facility provided copie three transportation of 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice.	demonstration on 9/27/16 at cted. A resident arrived in the a sister facility. The driver e wheelchair and the diproperly in the van. AM, Resident #96 was added from the van at the was transported from. The van had the logo of tion company the facility dent was in the wheelchair ad four point straps to the ross the resident. The driver oint securement and then the difference of accident hazard and insuring the resident of the van alog of the QI (Quality ing that on 9/28/16. The es of the contracts of the companies. ETE/ACCURATE/ACCESSIB Intain clinical records on each ce with accepted professional ces that are complete; ed; readily accessible; and zeed.	F 4			11/2/16	

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345502	B. WING		C 11/02/2016	
	OVIDER OR SUPPLIER	ABILITATION CENTER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	11/02/2010	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
i r s	resident's assessme services provided; th	y the resident; a record of the nts; the plan of care and	F 514			
	Based on record revinterviews and observed and medication of received and medicate A medication over the appeared in the commedication even though a subsequent assest an accurately listed Somedication because reviewed from the control of the appeared in the ap	the current medications were omputer. A handwritten oratadine for Resident #28 d per order on the medication d. Inaccurate records led residents reviewed for tions (Residents #60 and ded: March Medication rd, Seroquel, (also known as e) was ordered for Resident e order read, "Quetiapine lligram) tab. Take ½ tablet vice daily for behaviors." A ed 2/22/16 discontinued the telephone order dated		F 514 Resident Records On 9/29/16, the assistant director of nursing (ADON) ensured Resident #20 Claritin medication was discontinued if the medication administration record (MAR). On 10/20/16, the ADON updated Resilfeo selectronic health record in Poir Click Care (PCC), showing the medical Seroquel was discontinued. On 10/20/16, the director of nursing (DON), ADON, staff nurse, and/or corporate consultant completed a 100 audit of each resident sorders for the past 30 days to ensure orders to discontinue medications were discontinued from the MAR and electron health record in PCC. On 10/20/16, the DON began in-service 100% of licensed staff on correctly transcribing an order and ensuring the entire order is carried out, including if medication is discontinued that it need be discontinued from the MAR and PC correctly. This in-service will be completed by 10/24/16. No licensed practical nur	ricom ident int ation % e ronic cing e a ds to CC leted	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRU			(X3) DATE SURVEY COMPLETED			
		345502	B. WING			C 11/02/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	I DE	11/02/2016
				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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From page	e 50	F 5	14		
	User Scale (DISCUS scale, dated 7/19/16 indicated Resident #6 had no tardive dyskin On 9/14/16 a psychia Resident #60 had no included several of he including dementia w of manic type, psychologicated the resident was written by the Ps On 9/26/16 at 12:09 for medication orders for reviewed. Quetiaping 12.5 milligrams at been date was indefinited to Observation of Resid 12:31PM and 3:44 Pt she was happy and he on 9/27/16 at 3:35 Pt should discontinue the being told it was discontinue the being told it was discontinue the being told it, then the computer. On 9/28/16 at 10:02 A said the floor nurse discontinue was a pinurse was supposed	on involuntary movement completed by Nurse #1 so was taking Seroquel and esia. Itric consult note indicated hallucinations. The note or diagnoses and problems ith behavior, mood disorder osis, anxiety and insomnia. It is was on Seroquel. The note cychiatric Nurse Practitioner. PM, the computerized Resident #60 were or Fumarate was ordered at a dtime for behaviors. The steel the ste	F 3	(LPN) or registered nurse (R allowed to work after 10/24/1 complete the in-service. All L new hires will receive in-serv new employee orientation. On 10/20/16, the DON, ADO nurse began auditing 100% orders for discontinuing med accuracy using the Discontin Medications Audit Tool. The completed by the DON, ADO facilitator, treatment nurse, s administrator, and/or facility of 5x/week x 4 weeks then weethen monthly x 3 months. Ar findings will be corrected imphysician will be notified. The monthly QI committee we results of the Discontinued Madit Tool monthly for 6 mon identification of trends, action to determine the need for and frequency of continued monimake recommendations for recontinued compliance. The anand/or DON will present the recommendations of the more committee to the quarterly excommittee for further recommand oversight.	6 until they PN and RN rice during N, and staff of resident ications for ued audit will be N, staff taff nurse, consultant ekly x 8 weeks ny negative mediately and vill review the fledications ths for ns taken, and d/or toring, and monitoring for idministrator findings and inthly QI kecutive QA	
		pectation they update and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 11/02/2016
	ROVIDER OR SUPPLIER	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	11102/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 514	Continued From pag	ge 51	F 51	4	
	Practitioner was inte	AM, the Psychiatric Nurse erviewed by telephone. He used the computer record to nedications that were listed in AM, Nurse #1 was			
	DISCUS on 7/19/16 medications on the	aid when she completed the she would have reviewed the computer because she would form on the computer.			
	August and Septem indicate any administ. Review of the ha	h, April, May, June, July, ber 2016 MARs did not stration of Seroquel. Indwritten telephone orders Vealed an order dated			
	no indication on the to indicate the amous chedule of the Clark	ntinue the Claritin. There was handwritten telephone order unt of the dose or the ritin to be discontinued. Nurse #1 on 09/29/2016 at			
	took the telephone of Claritin on 09/21/20	ed she was the nurse who order to discontinue the 16, and that she simply forgot claritin on the medication rd.			
	on 09/29/2016 at 11 facility used handwr	the director of nursing (DON) :13 AM, she stated that the itten physician orders and nd that the nurse who			
	process the order, of another nurse, then medication administ order was complete	e order was expected to check it for accuracy with write the order on the tration record to ensure the d and carried out by nursing			
	night shift nurses to	o stated she expected for the also check the orders for sure that the order was placed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245502		B. WING			0	
	201/1252 02 01/221/152	345502	B. WING		TREET ARRESTS OF A STATE THE CORE	11/	02/2016	
	ROVIDER OR SUPPLIER RK NURSING AND REHA	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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 514 F 520 SS=J	at 1:10 PM, he stated handwritten orders to received medications medications were dis added that he expect discontinue medication	tord. The physician on 09/29/2016 If that he relied on ensure that residents as ordered, or that continued as ordered. He led the telephone orders to ons to be reflected dication administration ERS/MEET		514			11/2/16	
	assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessme committee meets at least assurance activite develops and implementation to correct identification to correct identific	east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies. eary may not require ords of such committee th disclosure is related to the ommittee with the section. by the committee to identify eficiencies will not be used as						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			С	
		343502	D. WING _			11/	02/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I VKE DVE	RK NURSING AND REHA	ARII ITATION CENTER		3	315 FAITH CHURCH ROAD		
LANL FAN	IN NORSING AND REITA	RDIENATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 520	Continued From page	e 53	F 5	520			
	by: Based on record rev facility's Quality Assu	iew and staff interview, the rance and Performance			F 520 QAA Committee		
		committee failed to maintain			On 9/28/16, the facility Executive QI	-I	
	•	inistering the nursing home eveloping and implementing			Committee held a meeting. The Medica Director, Administrator, Director of	d1	
	- ·	action to correct identified			Nursing (DON), Assistant Director of		
		= 520); assessing a resident			Nursing (ADON), MDS nurse, treatmer	nt	
	· · · · · · · · · · · · · · · · · · ·	incident involving a head			nurse, staff facilitator, medical records,		
		naintaining accurate clinical			dietary manager, and/or housekeeping		
		ese four regulations were			supervisor will attend QI Committee		
		cies on 1/15/16 (490 & 514),			Meetings on an ongoing basis and will		
		14 & 520) and 3/14/16 (309,			assign additional team members as		
	490, 514 & 520).	,			appropriate.		
		began on 9/22/16 when			On 9/28/16, the corporate facility		
		ized an employee who was			consultant in-serviced the facility		
		ility in van transportation to			administrator, director of nursing, MDS		
		from dialysis (F 490 and F wheelchair fell backwards in			nurse, treatment nurse, maintenance director, dietary manager, and		
		n and the resident sustained			housekeeping supervisor related to the		
	a laceration to the ba				appropriate functioning of the QI		
		was removed on 9/29/16 at			Committee and the purpose of the		
		cility provided an acceptable			committee to include identifying issues		
		compliance. The facility will			related to quality assessment and		
	•	ance at a scope and severity			assurance activities as needed and		
		rm with potential for more			developing and implementing appropria	ate	
	than minimal harm th				plans of action for identified facility		
	jeopardy) to allow the	e facility time to monitor (F			concerns, to include F 309 Necessary		
		nent the new procedure for			Care and Services, F490 Effective		
	•	ion to appointments and			Administration, F 514 Maintaining		
	· ·)). The scope and severity			Accurate Clinical Records, and F 520		
		at level D (no actual harm			Quality Assessment and Assurance		
	· · · · · · · · · · · · · · · · · · ·	e than minimal harm that is			Committee.		
		dy). Findings included:					
	This tag is cross refer	rred to:			As of 9/28/16, after the facility consulta in-service, the facility QI Committee wil		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345502	B. WING		1	C 1/02/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	1/02/2010	
				3315 FAITH CHURCH ROAD			
LAKE PAF	RK NURSING AND R	EHABILITATION CENTER		INDIAN TRAIL, NC 28079			
(V4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 520	Continued From p	page 54	F 5	20			
	1) F 490: Admini	-		begin identifying other areas	of quality		
				concern through the QI review			
				for example: review rounds to	•		
	During the compla	aint investigation dated 1/15/16,		of work orders, review of Poi			
	the recertification	survey dated 2/15/16 and the		(Electronic Medical Record),	resident		
	subsequent revisi	t survey of 3/14/16, the nursing		council minutes, resident con	icern logs,		
		or failing to create and impose a		pharmacy reports, and regior	nal facility		
		sidents would be protected from		consultant recommendations			
		aff would implement the facility's					
		procedures to intervene, protect		The facility s Executive QI C			
		report abuse when witnessed. A		meet at a minimum of Quarte			
		nt experienced 2 episodes of ithout immediate facility		issues related to quality asse			
	· •	ection and implementation of		develop and implement appro			
		d procedures. This was cited at		of correction for identified fac			
	•	ppardy level on two of the three		concerns.			
	surveys.	, , , , , , , , , , , , , , , , , , , ,					
	,			Corrective action has been ta	aken for the		
	On the current su	rvey, the nursing home		identified concerns related to	F 309		
	administration de	legated a transportation task to		Necessary Care and Service			
		member. The individual was		Effective Administration, F51			
		up a resident from dialysis and		Accurate Clinical Records, ar			
		t to the nursing home.		Quality Assessment and Assi	urance		
	2) 520 Quality As	surance and Assessment		Committee.			
	During the recerti	fication survey dated 2/15/16		The QI Committee will contin	ue to meet at		
		ent revisit survey of 3/14/16, the		a minimum of monthly. The E	executive QI		
	nursing home's Q	uality Assessment and		Committee, including the Med	dical		
		committee was cited for failing		Director, will review monthly			
		mented procedures and monitor		report information, review tre			
		that the committee put into place		review corrective actions take			
		190 & F 514). This was cited at		dates of completion. The Ex			
		ppardy level on one of the two		Committee will validate the fa	•		
	surveys.	ryoy, the facility foiled to		progress in correction of defic			
		rvey, the facility failed to nce with F 309, F 490, F 514		practices or identify concerns administrator will be responsi			
	and F 520.	106 WILLI F 309, F 490, F 314		ensuring QI Committee and E			
	anu i JZU.			Committee concerns are add			
	On 9/27/16 at 7:1	5 PM, the administrator was		through further training and/o			

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING _	B. WING		l	C 02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 815 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079	<u>, , , , , , , , , , , , , , , , , , , </u>	02/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 520	incident on the facility 2016. Nursing home the transport of the re effective nursing hom repeatedly on 2/15/16 survey (F 520). The administrator proallegation of compliant A. How the correcting accomplished for the been affected by the On 9/22/16, the main Technician assisted the upright position in the returned to the facility On 9/22/16, the main returned the resident the director of nursing submitted a written streenactment prior to suspension. On 9/22/16, the direct assessed the resident complaint of pain and activity. The rest the back of his head director of nursing left responsible party. The treatment nurse performed a neuro chindings. On 9/22/16, the treatminitiated a treatment the dand notified the party/wife.	iate jeopardy related to an y van on September 22, administration authorized esident (F 490). Lack of the administration was cited 6, 3/14/16 and on the current sovided the following credible fince on 9/28/16 at 6:55 PM: we action will be see residents found to have deficient practice. Itenance worker and Floor the resident back in to an expendent worker immediately to the facility and informed g. The maintenance worker tatement and performed a leaving on administrative to for nursing immediately to the facility and instructive to form the sident had no dexhibited normal behavior ident had a small scratch on with two drops of blood. The fit a message for the the director of nursing notified the director of nursing	F	520	interventions. The administrator, DON and/or ADON will report back to the Executive QI Committee at the next scheduled meeting.	,	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		345502	B. WING			C 11/02/2016	
	ROVIDER OR SUPPLIER	1 111		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	<u> </u>	11/02/2016	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	nursing interviewed to incident on the van. account of the events On 9/22/16, the admit maintenance worker, worker re-enact the estatement from the maintenance worker resident on the van. On 9/22/16, the admit transports with facility keys. On 9/28/16, the Vice in-serviced the Admir Nursing regarding adto ensure staff are appropriate delegated by the potential to deficient practice? On 9/22/16, the admit deficient practice? On 9/22/16, the admit verified with the maintechnician there was 9/22/16 and furtherm transported other residently use of three services. In the event transportation services or return transportation services or return transportation services.	the resident involved in the The resident gave an and incident. Inistrator interviewed the had the maintenance event, and obtained a written maintenance worker. The verified there was no other inistrator stopped all facility your and secured the van instrator and Director of ininistration's responsibility propriately trained and cope of practice; the ector of nursing must avoid tion of duties. It yi identify other residents to be affected by the same instrator interviewed and intenance worker and floor only the one resident on the ore they had not previously idents. Inistrator validated the outside transportation at the scheduled outside is unable to provide pick-up on, other outside es will be contacted.	F 52				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11102/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From pag		F 5	20		
	transports 9/23/16 - 9 transportation from a company was sched	identify residents requiring 9/27/16 and verified in outside transportation uled. Appointments had an outside transportation				
	appointment book fo appointments and ve	inistrator reviewed the rall currently scheduled briting transportation will be transportation providers.				
	in-serviced the Admi Nursing regarding ac to ensure staff are ap working within their s	ector of nursing must avoid				
	C. Give specific date	es of the corrective actions.				
		inistrator collected the van facility transports with facility				
		inistrator verified there are ses used to provide transport ed.				
	Corporate Vice Presi	e Park administrator and dent of Operations Park van will remain out of				
		m, the Corporate Vice ons removed the Lake Park oremises indefinitely.				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 11/02/2016
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	DE	11/02/2016
(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 C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 520	On 9/28/16, the admitransportation service each of the three out is contracts. The additransportation service ensure safety. In additransportation service ensure safety. In additransporting resident of the safe transfer, transporting regarding at the ensure staff are a working within their sadministrator and disinappropriate delegation of the safe of t	sinistrator and the outside es added an addendum to tside transportation service ' dendum includes the outside e has policies in place to dition, the addendum ort staff have been trained in ort and securement while ts in van. President of Operations nistrator and Director of dministration's responsibility ppropriately trained and scope of practice; the rector of nursing must avoid ation of duties. ity Executive QI Committee Medical Director, QI nurse, MDS nurse, ff facilitator, maintenance eeping supervisor will attend ings on an ongoing basis and	F	520		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	(X:	3) DATE SURVEY COMPLETED
		345502	B. WING _			C 11/02/2016
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	identifying other are the QI review process behavioral manager Care (Electronic Me activities of daily livi consultant recomme Corrective action has concerns related to Supervision and F 4 in the plan of correct The Executive QI Comme actions taken and the Executive QI Comme progress in correctic identify concerns. Tresponsible for ensuaddressed through interventions. The awill report back to the the next scheduled D. The alleged IJ re The validation of the completed on 9/29/following: On 9/29/16 at 11:55 observed being unlefacility. The resident dialysis to the facility contracted transport was in the wheelche four point straps to the resident out of the Interview with the activities with the ac	as of quality concern through ss, for example: environment, ment, review of Point Click dical Record) orders and ng, and regional facility endations. It is been taken for the identified F 323 Accidents Hazards 190 Administration as reflected tion. It is is been taken for the identified F 323 Accidents Hazards 190 Administration as reflected tion. It is is including the lit review compiled QI report the dates of completion. The sittee will validate the facility's for of deficient practices or the administrator will be suring Committee concerns are further training or other administrator or his designee the Executive QI Committee at meeting. If all the end of the acceptance of the administrator will be acceptance and the second of the acceptance of the accepta	F5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 11/02/2016	
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		11/02/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE COMP COMP COMP COMP COMP COMP COMP COMP		
F 520	s environment rema and that the facility trained to perform the The facility provided happened on 9/28/1 of the contracts of the companies. 3) F 309 Acute Asset During the recertificand the subsequent nursing home was of resident in her wheeled prevent a decline in On the current survey professional staff to possible injury after before moving the resident to the facilical laceration on the bath the facility also fails nursing intervention 4) F514: Accurate the During the recertificand the subsequent nursing home was of physician order for a record regarding the indwelling urinary can document the correcenteral feeding proferecords reviewed.	s about ensuring the resident ' sins free of accident hazard will ensure that staff are ne task that is asked of them. If a log of the QI meeting that life. The facility provided copies the three transportation ressment ation survey dated 2/15/16 to revisit survey of 3/14/16, the cited for failing to position a tel chair with foot/leg support to range of motion. rey, the facility failed to get assess a resident for a fall in the transportation van the esident and driving the ty. The resident sustained a tack of the head from the fall. The resident of the fall. The resident sustained a tack of the head from the fall. The resident sustained a tack of the head from the fall. The resident sustained a tack of the head from the fall.	F 5	20			

AND PLAN OF CORRECTION IDE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345502	B. WING _				0 2/2016	
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER			331	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	02/2010	
	TON OZNIZIN		INI	DIAN TRAIL, NC 28079			
PREFIX (EACH DEFICIENCY MUST E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 520 Continued From page 61	0 Continued From page 61		520				
medication orders in the coneven though verbal orders he medications had been discommedication order for Seroque appeared in the computerized medication even though it had a subsequent assessment an inaccurately listed Seroquel medication because the currical reviewed from the computer telephone order for loratadin was not discontinued per order administration record. An interview was conducted PM with the Administrator and Nursing. During the interview reported the facility's QAA Conquarterly. The Administrator aware of inaccurate record keprior deficiencies and chang catheter. Corporate oversigning related to medication and treadministration records. The concerns and noted trending She said the facility looked for trends and then decided when problem to QAA. The current with the previous Administrations and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions and tracking tools we areas not identified by the Questions are tracking tools we areas not identified by the Questions are tracking tools are track	and been received and intinued. A sel for Resident #60 and record as an active and been discontinued. Indicate a psychiatric note as an active ent medications were an analyse and the for Resident #28 der on the medication on 9/29/16 at 5:10 and Director of ws, the Administrator ommittee met a said the facility was reeping regarding ing a resident's and was in progress and enter to take the ant Administrator had enter to take the ant Administrator had instrator and verified ere validated. New AA committee were hey were unsure of orders in the written orders. The macy has to be fully the software system histration records.		520				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) I	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C	
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	I	11/02/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 520	The Administrator sta noted the root cause there was no backup	ted the facility should have of the van incident because plan for transportation. She with the root cause before can	F 5	20			