CENTER		ND HUMAN SERVICES			FORM APPROVE
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C
	ROVIDER OR SUPPLIER	040002		STREET ADDRESS, CITY, STATE, ZIP CODE	03/30/2017
				3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 224 SS=E	483.12(b)(1)-(3) PRC MISTREATMENT/NE	DHIBIT EGLECT/MISAPPROPRIATN	F 22	14	4/22/17
	abuse, neglect, misa property, and exploit subpart. This include freedom from corpora seclusion and any ph	t has the right to be free from ppropriation of resident ation as defined in this s but is not limited to al punishment, involuntary hysical or chemical restraint the resident's symptoms.			
	483.12(b) The facility implement written po	r must develop and licies and procedures that:			
		event abuse, neglect, and nts and misappropriation of			
	(b)(2) Establish polici investigate any such	ies and procedures to allegations, and			
	§483.95,	g as required at paragraph Γ is not met as evidenced			
	facility neglected to fe	views and record review the eed and provide incontinence esidents for 4 of 6 sampled #4, #5 #6 and #7).		Lake Park Nursing and Rehabil Center acknowledges receipt of Statement of Deficiencies and p this plan of correction to the exter the summer of findings is fortu	the roposes ent that
	The findings included	1:		the summary of findings is facture correct and in order to maintain compliance with applicable rules	
	01/21/12 with diagno hemiparesis, dement	idmitted to the facility on ses that included hemiplegia, ia and others. A care plan specified the resident		provisions of quality of care of re The plan of correction is submitt written allegation of compliance.	esidents. red as a
		et and staff were to report to		Lake Park Nursing and Rehabili Center s response to this State Deficiencies does not denote ag	ment of greement
	 - - - - - - - - -	imum Data Set (MDS) dated		with the Statement of Deficienci	1

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			TE SURVEY MPLETED
						С
		345502	B. WING		0	3/30/2017
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CC	DE	
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 224	Continued From page	e 1	F 22	4		
	-	e resident's cognition was		does it constitute an admiss	ion that any	
		e required extensive to total		deficiency is accurate. Furth		
		ities of daily living including		Nursing and Rehabilitation (
	eating.			reserves the right to refute a		
				deficiencies on this Stateme		
	The facility provided			Deficiencies through informa		
		cord. Review of the meal		resolution, formal appeal pro		
	intake record reveale	ed there was no		and/or any other administrat	ive or legal	
	#4.	011 03/20/17 101 Resident		proceedings.		
		PM nurse aide (NA) #3 was		F 224 Prohibit		
	worked on 03/26/17			Mistreatment/Neglect/Misap Property	propriation of	
	-	cal unit. NA #3 explained he 3 PM to 11 PM shift the		What measures did the facil	ity put in place	
		rse aides on the medical unit		for the resident affected:	ity put in place	
		je and usually the medical				
		es. He added that during the		On 3/29/17, the director of n	ursing (DON)	
		5 was in the dining room		and/or assistant director of r		
	assisting residents w	hich left him and NA #4 to		(ADON) assessed Resident	s #4, #5, #6,	
		esidents, answer call lights,		and #7. Resident assessme		
		feed dependent residents.		no obvious signs of poor nut		
		e entered Resident #4's		in mental status, or weight lo		
		al tray when he found the or bleeding. NA #3 stated he		of not receiving assistance v 3/26/17 evening meal. On 3	-	
		ssisted the nurse with caring		DON/ADON notified the phy		
		t because she was injured.		Residents #4, #5, #6, and #		
		ne was unable to feed		physician gave no new orde		
		e he was assisting with		and 5 day report was submi		
		added that due to the time it		administrator for Residents		
	took attending to the	-		and #7 to the department of		
	-	d some of them had to be		human services (DHHS). The		
		en and were not offered to		administrator has received a DHHS.	lietter from	
	fed the evening meal	ted that Resident #4 was not				
				What measures were put in	place for	
	On 03/29/17 at 12:40) PM NA #4 was interviewed		residents having the potentia		
		I stated she worked on		affected		

Facility ID: 970828

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DA	<u>NO. 0938-039</u> TE SURVEY MPLETED
		345502	B. WING			C 03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/00/2011
				3	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		11	NDIAN TRAIL, NC 28079		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 224	Continued From page	a 2	Í -	224			
1 224			F	224			
		to 11 PM. NA #4 explained vere the only nurse aides on			On 3/29/17, the social worker and		
		to pass trays and that Nurse			admissions/social worker conducted		
	#1 was in the dining				interviews with alert and oriented		
		short staffing. NA #4 added			residents regarding abuse/neglect wi	th no	
	that while passing tra	iys she heard NA #3 call for			negative findings.		
		esident had fallen. The NA					
		further behind passing trays			On 4/19/17, the social worker reviewe		
		helping the nurse attend to			the past 60 days of Resident Concern	ns to	
	-	She explained that she was ent #4 because she ran out			identify any potential abuse/neglect concerns. No unaddressed abuse/neglect	aloct	
		stated that she told the nurse			concerns were identified.	gieci	
	that she had not been						
	residents.				On 4/6/17, the activity director called	for a	
					resident council meeting to ensure		
	On 03/30/17 at 2:36 I				resident council members had an		
		lephone and explained the			opportunity to express any abuse/neg	glect	
		staffing was a problem and			concerns.		
	-	late being delivered. She			What evotome ware put in place to		
		assisting residents in the to leave to attend to a			What systems were put in place to prevent the deficient practice from		
	-	en. The nurse stated she			reoccurring:		
		ne got fed that night and			l lococcinity.		
		nurse aides telling her they			On 4/3/17, the DON initiated an in-se	rvice	
		all the dependent residents.			for all staff on abuse/neglect. After		
	Nurse #1 stated she	did not feed Resident #4.			4/22/17, staff will not be allowed to		
					complete their shift until this		
		PM NA #5 was interviewed			abuse/neglect in-service is completed		
		e worked 3 PM to 11 PM on ined that she assisted			This in-service will be incorporated in new employee orientation.	10	
		in the dining room and fed					
		00 Hall which was not			On 4/4/17, the DON verified the posti	na of	
	Resident #4.				the DON, ADON, and administrator p	-	
					numbers at the nurse stations so stat		
	On 03/30/17 at 6:07	PM NA #8 was interviewed			may contact the DON, ADON, and/or		
		I stated she worked in the			administrator when the need arises to)	
		6/17 from 3 PM to 11 PM but			prevent and/or report abuse/neglect.		
	-	sidents with eating on the				 :	
	medical unit. She sta	ated that neither she nor NA			How the facility will monitor systems	outin	

Facility ID: 970828

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		ND HUMAN SERVICES				FORI	D: 04/26/20 M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345502	B. WING				/30/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
		-			IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 224	Continued From page	e 3	E 2	224			
		nit on 03/26/17 to assist		-27	place:		
	feeding residents on						
	-	to contact NA #7 for an			On 3/29/17, the DON, ADON, staff nu	rse,	
	interview but she was	s unable to be reached.			weekend supervisor, weekend manag on duty, and/or corporate consultant	er	
		PM the Director of Nursing			began auditing dining rooms and resid	lent	
		ed ad explained she was			rooms during meal times to ensure	6	
		rtage on 03/26/17 and even all lights and pass ice on the			residents are receiving assistance with eating meals. The audits are recorded		
		ut left at the end of the shift.			the Showers/CHOICES/ADLs audit to		
		't aware that 3 PM to 11 PM			If the auditor identifies a resident is no		
		staffed and would have			receiving assistance with eating a mea		
		o contact her if there had			the auditor will take prompt corrective		
		DON added that she			action and document the intervention	on	
		03/27/17 but was unable to			the audit tool. The		
	-	dministration meeting			Showers/CHOICES/ADLs audit tool w		
		work a medication cart. The			be completed for five (5) residents dai	-	
		nat Resident #4 did not get			five (5) times per week for four (4) wee		
	fed on 03/26/17.				then five (5) residents weekly for four		
	Op 03/30/17 at 4:45	PM the Administrator was			weeks, then five (5) residents monthly two (2) months. Completed the	101	
		ained that the facility had			Showers/CHOICES/ADLs audit tool w	ill	
		g additional resources into			be forwarded to and reviewed by the I		
	-	with resident care and that it			and/or ADON.		
		to not feed a resident					
	-	fing. The Administrator			The DON or ADON will present the		
		are that on 03/26/17 on the			findings of the Showers/CHOICES/AD	Ls	
		did not have enough staff to			audit tool at the monthly Quality		
	ensure all residents v	were fed the evening meal.			Improvement (QI) Committee meeting		
					The QI Committee will review the result of the audite monthly for four (4) monthly		
	2 Resident #5 was a	idmitted to the facility on			of the audits monthly for four (4) mont with recommendation and follow-up as		
		ses that included femur			needed or appropriate for continued		
		others. The most recent			compliance.		
	Minimum Data Set (N				• · · · · ·		
	specified the resident	-			Also, the DON and/or ADON will prese	ent	
	•	quired extensive assistance			findings at the quarterly Executive QI		
		living and required setup			Committee meeting for further		
	and assistance with e	eating.			recommendations for follow up as nee	eded	

Facility ID: 970828

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		MEDICAID SERVICES	(¥2) MI II TID	PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	MPLETED
						С
		345502	B. WING	·····	0	3/30/2017
NAME OF P	ROVIDER OR SUPPLIER		· 1	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				3315 FAITH CHURCH ROAD		
LAKE PAP	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 4	F 22	24		
				or continued compliance in		
		t provided) specified staff		to determine the need for a		
	were to provide tray a provide assistance w	set up, encourage and		frequency of the continued	QI monitoring.	
		din eating.				
	The facility provided	Resident #5's meal				
		cord. Review of the meal				
	intake record reveale					
		e on 03/26/17 for Resident				
	#5.					
	On 03/29/17 at 12:21	I PM nurse aide (NA) #3 was				
		lephone and explained he				
	worked on 03/26/17					
	-	ical unit. NA #3 explained				
		he 3 PM to 11 PM shift the rse aides on the medical unit				
		ge and usually the medical				
		es. He added that during the				
	•	5 was in the dining room				
	-	hich left him and NA #4 to				
		esidents, answer call lights,				
		feed dependent residents. /hile delivering trays, he				
		room and found a resident in				
		IA #3 stated he called for				
	-	e nurse with caring for the				
		se she was injured. NA #3				
		unable to feed Resident #5 isting with another resident.				
		the time it took attending to				
		ays became very late and				
		be returned to the kitchen				
		to residents. NA #3 stated				
	that Resident #5 was	s not given the evening meal.				
	0n 03/29/17 at 12·40) PM NA #4 was interviewed				
		d stated she worked on				
		to 11 PM. NA #4 explained				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/201 FORM APPROVEI OMB NO. 0938-039	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 03/30/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•	
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
		-		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE	
F 224	the medical unit floor #1 was in the dining r residents because of that while passing tra help and was told a re reported that she got because NA #3 was h the injured resident. unable to serve Resid ran out of time. The N usually ate in the dini night. NA #4 also sta that she had not beer residents. On 03/30/17 at 2:36 f interviewed on the tel night of 03/26/17 the the meals trays were added that she was a dining room but had to resident that had falled didn't know if everyor didn't remember the r were unable to feed a Nurse #1 stated she 03/26/17. She explait residents with eating one resident on the 4 Resident #5. On 03/30/17 at 6:07 f	vere the only nurse aides on to pass trays and that Nurse room helping to feed short staffing. NA #4 added ys she heard NA #3 call for esident had fallen. The NA further behind passing trays helping the nurse attend to She explained that she was dent #5 her tray because she VA added that Resident #5 ng room, but hadn't that thed that she told the nurse in able to feed all the PM Nurse #1 was lephone and explained the staffing was a problem and late being delivered. She assisting residents in the	F 2			
	secured unit on 03/26	Stated she worked in the 6/17 from 3 PM to 11 PM but idents with eating on the				

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345502	B. WING				C 30/2017	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	#7 left the secured un feeding residents on the Attempts were made interview but she wass On 03/30/17 at 4:15 F (DON) was interviewed aware of staffing shore came in to answer ca 7 AM to 3 PM shift but She stated she wasn's shift had been short se expected the nurse to been problems. The returned to work on 0 attend the morning ac because she had to w DON was unaware the served a meal tray or On 03/30/17 at 4:45 F interviewed and explay procedures for calling the facility to assist w would never be okay because of short staff stated she was unawa 3 PM to 11 PM shift d ensure all residents w 3. Resident #6 was an 03/12/17 with diagnos adult failure to thrive a Minimum Data Set (M validation errors and the Review of the medical	ted that neither she nor NA it on 03/26/17 to assist the medical unit. to contact NA #7 for an a unable to be reached. PM the Director of Nursing ed ad explained she was tage on 03/26/17 and even Il lights and pass ice on the it left at the end of the shift. t aware that 3 PM to 11 PM taffed and would have o contact her if there had DON added that she 3/27/17 but was unable to dministration meeting vork a medication cart. The at Resident #5 did not get	F	224				

Facility ID: 970828

If continuation sheet Page 7 of 54

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2017 FORM APPROVED OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING _		C 03/30/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	•
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 224	diet and was receivin The medical record a was dependent on st The facility provided I percentage intake rec intake record reveale documentation made #6. On 03/29/17 at 12:21 interviewed on the tel worked on 03/26/17 f assigned to the medi- that on 03/26/17 on th facility only had 3 nur because of a shortag unit had 4 nurse aide evening meal, NA #5 assisting residents with monitor "about 30" re pass meal trays and 5 The NA stated that we entered a resident's re the floor bleeding. Na help and assisted the fallen resident because reported that he was because he was assis He added that due to the fallen resident, tra some of them had to and were not offered that Resident #6 was On 03/29/17 at 12:40 on the telephone and 03/26/17 from 3 PM t	g Palliative Care services. Ilso indicated the resident aff for eating. Resident #6's meal cord. Review of the meal d there was no o n 03/26/17 for Resident PM nurse aide (NA) #3 was lephone and explained he	F 2		

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345502	B. WING _				C 30/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 224	the medical unit floor #1 was in the dining r residents because of that while passing tra help and was told a re reported that she got because NA #3 was h the injured resident. unable to feed Reside ran out of time. The N took an extremely lon not have time to feed the other residents. N told the nurse that she all the residents. On 03/30/17 at 2:36 F interviewed on the tel night of 03/26/17 the the meals trays were added that she was a dining room but had t resident that had falle didn't know if everyon didn't remember the r were unable to feed a Nurse #1 stated she o 0n 03/30/17 at 3:50 F and reported that she 03/26/17. She explai residents with eating one resident on the 4 Resident #6. On 03/30/17 at 6:07 F on the telephone and secured unit on 03/26	to pass trays and that Nurse oom helping to feed short staffing. NA #4 added ys she heard NA #3 call for esident had fallen. The NA further behind passing trays helping the nurse attend to She explained that she was ent #6 her tray because she IA added that Resident #6 g time to eat and she did the resident and attend to NA #4 also stated that she e had not been able to feed PM Nurse #1 was ephone and explained the staffing was a problem and late being delivered. She ssisting residents in the o leave to attend to a en. The nurse stated she he got fed that night and hurse aides telling her they all the dependent residents. did not feed Resident #6. PM NA #5 was interviewed worked 3 PM to 11 PM on	F	224					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	. 0938-0391 SURVEY LETED
		345502	B. WING				C 30/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER			3315 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 PROVIDER'S PLAN OF CORRECTION (x5) FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) or NA F 224 or NA f st sing was even on the shift.		COMPLETION		
F 224	#7 left the secured un feeding residents on the Attempts were made interview but she wass On 03/30/17 at 4:15 F (DON) was interviewed aware of staffing shore came in to answer ca 7 AM to 3 PM shift but She stated she wasn's shift had been short ster expected the nurse to been problems. The returned to work on 0 attend the morning action because she had to w DON was unaware the the evening meal on 0 On 03/30/17 at 4:45 F interviewed and explain procedures for calling the facility to assist with would never be okay because of short staff stated she was unawast 3 PM to 11 PM shift d ensure all residents w 4. Resident #7 was at 02/05/16. His diagno behaviors, diabetes, of having repeated falls. The significant chang dated 11/02/16 coded	ted that neither she nor NA it on 03/26/17 to assist the medical unit. to contact NA #7 for an a unable to be reached. PM the Director of Nursing ed and explained she was tage on 03/26/17 and even Il lights and pass ice on the it left at the end of the shift. t aware that 3 PM to 11 PM taffed and would have o contact her if there had DON added that she 3/27/17 but was unable to dministration meeting vork a medication cart. The at Resident #6 was not fed 03/26/17. PM the Administrator was ained that the facility had a dditional resources into ith resident care and that it to not feed a resident fing. The Administrator are that on 03/26/17 on the id not have enough staff to vere fed the evening meal. admitted to the facility on ses included dementia with congestive heart failure, and e Minimum Data Set (MDS) I his cognition with long and	F	224			
	dated 11/02/16 coded						

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG .			C
		345502	B. WING				30/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 224	impaired decision ma as requiring total assi eating and extensive toileting. He was also nonambulatory and a The quarterly MDS, d cognition as not being extensive to total assi nonambulatory, and a On 03/29/17 at 11:46 conducted with Resid (RP) who stated he ca feed Resident #7. He were working short ar finding Resident #7 ly included the top shee He stated that he four to replace the soiled of at this time about Resi changed and the nurs return after she passe residents. RP stated 12:15 PM, the RP fed meal. The RP stated return to change Resi Review of the staffing aide (NA) responsible 03/18/17 during first s NA #2 was interviewe NA #2 stated that she Resident #7 needed to by the RP. NA #2 stated when the RP told her #2 stated she told him	king abilities. He was coded stance of one staff for assistance of 2 staff for o coded as being lways incontinent. ated 02/02/17, coded his g assessed, requiring istance with ADLs, being always being incontinent. AM an interview was ent #7's responsible party ame several times a week to e stated that he felt the staff and gave the example of ring in a soaked bed which t on 03/18/17 at 11:40 AM. and a clean sheet in the room one. He stated he told staff sident #7 needing to be se aide stated she would ed trays and fed other Resident #7's tray arrived at I Resident #7 his lunch the nurse aide did not ident #7 until 2:00 PM.	F	224			

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345502	B. WING		0	C 3/30/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AKE PAF	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 224	first. She stated that received hot food and 2 staff to provide care change him until after aides were busy with finished passing out t residents. She then of returned to change R it was as late as 2:00 in care was not relate pass trays and feed re hot. During interview on 0 Director of Nursing st provide the necessary seek assistance for h telling a family to wait was not acceptable. not think this was neg provide the incontinent finished with the othe Interview with the Adr 4:39 PM revealed her check for incontinenc resident was noted to she expected staff to passing trays so care	she had to be sure residents I since Resident #7 required e she decided to wait to the meal as other nurse the meal. NA #2 stated she he trays and fed 3 other collected the trays and esident #7 but did not think PM. NA #2 stated the delay d to staffing but the need to esidents so their food was 3/30/17 at 12:00 PM, the ated she expected staff to y care to the resident and elp if needed. She stated to trans were passed She further stated she did glect as the aide intended to at care when she was r residents. ministrator on 03/30/17 at the expectation was for staff to e prior to meal delivery. If a meed care during a meal, seek assistance with could be provided timely.	F 224			
F 241 SS=D	resident in a manner promotes maintenance	reat and care for each and in an environment that æ or enhancement of his or gnizing each resident's ity must protect and	F 241			4/22/17

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		ND HUMAN SERVICES			PRINTED: 04/26/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 03/30/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 241	Continued From page	e 12	F 241		
		Γ is not met as evidenced	1 271		
	by:	i is not met as evidenced			
	Based on record rev	view, staff interview and facility failed to maintain the		F 241 Dignity and Respect of Individ	uality
		dents sampled for dignity		What measures did the facility put in	place
	when staff failed to cl	hange Resident #7 timely d staff he was soiled and		for the resident affected:	
	•	esulting in him being fed by		On 3/18/17, at 2:00 PM the nursing	
	family soiled.			assistant (NA) returned to assist Resi	ident
	The findings included	d:		#7 with incontinence care.	
				On 3/29/17, the director of nursing (D	ON)
		nitted to the facility on		assessed Resident #7. Resident #7	-
		oses included dementia with		skin clean and intact and the brief wa	S
	having repeated falls	congestive heart failure, and		dry.	
	The significant change	ge Minimum Data Set (MDS)		What measures were put in place for residents having the potential to be	
		d his cognition with long and		affected	
		npairments and severely			
		aking abilities. He was coded		On 3/29/17, the director of social serv	vices
		istance of one staff for		and the social worker conducted	
	-	e assistance of 2 staff for		interviews with alert and oriented	et of
	toileting. He was als nonambulatory and a			residents regarding dignity and respe individuality, including incontinence ca	
				before meals. The interviews resulted	
	The quarterly MDS. o	dated 02/02/17, coded his		with no negative findings.	-
		g assessed, requiring			
	extensive to total ass	sistance with ADLs, being		On 4/6/17, the activity called for a res	
	nonambulatory, and	always being incontinent.		council meeting to ensure resident co members had an opportunity to expre	
	On 03/29/17 at 11:46	AM an interview was		any dignity and respect of individuality	
		dent #7's responsible party		concerns.	
		came several times a week to			
		e stated that he felt the staff		On 4/19/17, the social worker reviewe	
		nd gave the example of		the past 60 days of Resident Concern	
		ying in a soaked bed which		identify any potential dignity and resp	
		et on 03/18/17 at 11:40 AM.		of individuality concerns. No unaddre	essed
	ne stated that he fou	ind a clean sheet in the room		dignity and respect of individuality	

Facility ID: 970828

If continuation sheet Page 13 of 54

GENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u>IO. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		345502	B. WING			C 03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page	e 13	F 24	41			
	to replace the soiled	one. He stated he told staff sident #7 needing to be		concerns were identif	ïed.		
	return after she pass residents. RP stated	se aide stated she would ed trays and fed other Resident #7's tray arrived at d Resident #7 his lunch		What systems were p prevent the deficient p reoccurring:			
	return to change Res	I the nurse aide did not ident #7 until 2:00 PM.		On 3/31/17, the DON in-service for all nursi and Respect of Individ	ng staff on Dignity duality. As of		
	aide (NA) responsible 03/18/17 during first			4/22/17, nursing staff to complete their shift Respect of Individuali completed. This in-se	t until this Dignity and ity in-service is		
	NA #2 stated that she Resident #7 needed	ed on 03/29/17 at 2:42 PM. e was the aide who was told to be changed on 03/18/17		incorporated into new orientation.			
	when the RP told her #2 stated she told hir to pass out the trays first. She stated that received hot food and	ated it was around 11:40 AM Resident #7 was wet. NA n she would return but had and feed other residents she had to be sure residents d since Resident #7 required e she decided to wait to		On 4/4/17, the DON w the DON, ADON, and numbers at the nurse may contact the DON administrator when th protect a resident s o individuality.	administrator phone stations so staff I, ADON, and/or ne need arises to		
	aides were busy with finished passing out	r the meal as other nurse the meal. NA #2 stated she the trays and fed 3 other collected the trays and		How the facility will m place:	onitor systems put in		
	it was as late as 2:00 in care was not relate	Resident #7 but did not think PM. NA #2 stated the delay ed to staffing but the need to residents so their food was		On 4/22/17, the DON weekend supervisor, manager on duty, and consultant began aud and resident rooms d ensure residents are	the weekend d/or corporate liting dining rooms uring meal times to		
	Director of Nursing st provide the necessar seek assistance for h	03/30/17 at 12:00 PM, the tated she expected staff to y care to the resident and help if needed. She stated t until the trays were passed		incontinence care and meal when incontinen The audits are record Showers/CHOICES/A the auditor identifies a receiving assistance	d not having to eat a nce care is needed. led on the ADLs audit tool. If a resident is not		

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		ND HUMAN SERVICES			PRINTED: 04/26/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 03/30/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD	
				INDIAN TRAIL, NC 28079	I
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETIO
F 241	Continued From page	e 14	F 24	1	
				incontinence care prior to eating	-
		ministrator on 03/30/17 at r expectation was for staff to		the auditor will take prompt co action and document the inter-	
		e prior to meal delivery. If a		the audit tool. The	
		need care during a meal,		Showers/CHOICES/ADLs and	
	she expected staff to passing travs so care	e could be provided timely.		be completed for five (5) resid five (5) times per week for four	
				then five (5) residents weekly	for four (4)
				weeks, then five (5) residents two (2) months. Completed	monthly for
				Showers/CHOICES/ADLs aud	it tool tools
				will be forwarded to and review DON and/or ADON.	ved by the
				The DON or ADON will preser findings of the Showers/CHOI audit tool at the monthly Quali Improvement (QI) Committee The QI Committee will review of the audits monthly for four (with recommendation and follo needed or appropriate for cont compliance in this area.	CES/ADLs ty meeting. the results 4) months ow-up as
				Also, the DON and/or ADON w findings for four (4) months at quarterly Executive QI Commi meeting for further recomment follow up as needed or continue compliance in this area and to the need for and/or frequency continued QI monitoring.	the ttee dations for led determine of the
F 281 SS=D	483.21(b)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F 28	31	4/22/17
	(b)(3) Comprehensive	e Care Plans			
	The services provide	d or arranged by the facility,			

Event ID: 7NY911

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345502	B. WING		03/30/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY)	BE COMPLETION
F 281	Continued From page	e 15	F 281		
	as outlined by the co must-	mprehensive care plan,			
	(i) Meet professional This REQUIREMENT by:	standards of quality. Γ is not met as evidenced			
	Based on record rev interviews, the facility	-		F 281 Professional Standards	
	physician's order for (Resident #8) review	1 of 3 sampled residents		What measures did the facility put in for the resident affected:	place
	micrograms (mcg) pe	er hour 1 patch to skin every ninistered correctly for		On 3/23/17, the nurse removed the o of two Fentanyl patches, leaving one Fentanyl patch 25 micrograms (mcg) ordered by the physician. On 3/23/17	as
	Findings included:			medication error of having two Fental 25 mcg patches on at the same time	nyl
	08/11/16 with diagnost cerebral infarction, he	nitted to the facility on ses which included cancer, emiplegia affecting the right t infection (UTI). He was		reported to the prescribing practitione The prescribing practitioner gave no orders.	
	discharged from the tanother facility.	facility on 03/27/17 to		What measures were put in place for residents having the potential to be affected	
	Set (MDS) dated 12/0 assessment of intact	cognition.		On 3/29/17, the director of nursing (D assistant director of nursing (ADON), corporate facility consultants reviewe	and
	revealed he was care and services. The ca	#8's care plan dated 12/20/16 e planned for Hospice care are plan stated that he was		residents with narcotic medication patches, including Fentanyl patches, ensure that orders had been carried of properly and residents had the correct	out
	cancer, dementia and for the resident to not appropriate nursing in			number of narcotic medication patche their person. There were no negative findings.	es on
	and assist with good fluids as tolerated, er	d diet as ordered, encourage oral hygiene, encourage ncourage resident to s of daily living (ADL) as		What systems were put in place to prevent the deficient practice from reoccurring:	

Facility ID: 970828

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 03/30/2017	
	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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
F 281	tolerance level allows significant changes, p environment for resid reposition frequently. A review of Resident revealed an order on resident's Fentanyl p micrograms (mcg) ev also orders for the fol Morphine sulfate (MS milliliter (ml) - give 5 m for pain or shortness equal 5 mg and Lorat every 4 hours as nee restlessness and Lorat every 4 hours as needed for 03/16/17 an order wa Fentanyl patch with to falling off. A review of Resident revealed a health sta 12:43 AM by Nurse # patch found on reside upper back between comfortably in bed." A review of Resident Administration Recor revealed that he had micrograms (mcg) pe every 72 hours on 03 03/19, 03/22 and 03/2 sign out sheet reveal came in boxes of 5 a signed out on 03/07, (completing one box)	s, notify physician of provide supportive, private ent and family and turn and #8's physician orders 03/03/17 to change the atch from 12.5 to 25 rery 72 hours. There were lowing medications: 3) 20 milligrams (mg) per mg every 2 hours as needed of breath - give 0.25 ml to zepam 0.5 mg - give 1 tablet ded for nausea or azepam 0.5 mg every 4 anxiety/anxiousness. On is written to please cover egaderm to keep patch from #8's progress notes tus note written 03/20/17 at 5 and it read "no Fentanyl ent. New patch applied to shoulders. Resident #8's Medication d (MAR) for March, 2017	F 28	1 On 3/29/17, the DON initiated an in-service for RNs, LPNs, and me aides regarding medication patch patches must be changed as ord old patches must be removed wh applying a new patch or as order How the facility will monitor systel place: Beginning 4/22/17, the DON, AD treatment nurse, nurse superviso nurse, and/or corporate consultation conduct an audit of eight (8) med patches applied to residents, to v facility is following the physician for the medication patch to ensure patches are administered correct there are less than eight patches will continue of four (4) patches will continue of four (4) patches will continue of four (4) patches will committee meeting. The QI Comwittee meeting. The QI Comwill review the results of the audit monthly for four (4) months with recommendation and follow-up a or appropriate for continued committee meeting. The QI Comwill findings at the quarterly Executive Committee meeting for further recommendations for follow up at the monthly for four (4) months with recommendation and follow-up a or appropriate for continued committee meeting for further recommendations for follow up at the monthly for four (4) months with recommendations for follow up at the monthly for four (4) months with recommendation and follow-up a or appropriate for continued committee meeting for further recommendations for follow up at the monthly for four (4) months with recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further recommendations for follow up at the meeting for further re	edication nes: 1) ered, 2) nen ed. ems put in ON, nr/charge nt will lication verify the Ds order re dy (if De eted s, audits veekly x 8 he Audit tool ent (QI) nmittee ts s needed pliance. present e QI	

Facility ID: 970828

				OMB NO. 0938-03 (X3) DATE SURVEY			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL		
		345502	B. WING			C 03/30/2017	
	ROVIDER OR SUPPLIER	545502		TREET ADDRESS, CITY, STATE, ZIP CODE	03/3		
			3				
LAKE PA	RK NURSING AND REHA	BILITATION CENTER	INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 281	Continued From page	a 17	F 281				
	out on 03/19 as indic MAR; however, there of 2 different boxes a	ated that it was given on the were 2 patches signed out nd applied to 2 different	1 201	or continued compliance in this a to determine the need for and/or frequency of the continued QI mo			
	arm.	e to the back and one to the					
	03/29/17 at 10:06 AM the resident to anothe 27, 2017. The family concerned Resident a medicated. She state visited him she discor patches on his body. the patches were dat she could not recall w stated one patch was from the front and on The family member s groggy but aroused. 2 patches to the atter #2 also saw the patch removed the oldest p on Resident #8. The nurse assessed the r his normal limits and except that the reside	ed on 03/23/17 when she vered that he had 2 Fentanyl The family member stated ed with 2 different dates but what the dates were. She is on his back and not visible e patch was on his chest. tated Resident #8 was She stated she brought the ntion of Nurse #1 and Nurse hes. She stated Nurse #1 atch and left the newest one family member stated the esident and he was within there was no adverse effect ent was sleepy.					
	PM revealed she reca 2 Fentanyl patches o not remember exact o gone into the room w was witnessing Nurse	se #3 on 03/29/17 at 2:46 alled seeing Resident #8 had n sometime last week (could date). She stated she had ith Nurse #1 because she e #1 give the resident 2 nurses have to be present tion of the medication					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILII TID	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	, ,		` '	IPLETED
						С
		345502	B. WING		03	8/30/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REH		3315 FAITH CHURCH ROAD			
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 281	Continued From pag	e 18	F 28	1		
		on him. Nurse #1 went into	1 20			
	the room and assessed the resident and Nurse #3 followed her to check his vitals and Nurse #1					
		atch and left the patch from				
		dent. Nurse #3 stated the				
		e drowsy than usual and ive outcomes to the resident				
	from the 2 patches.	ve outcomes to the resident				
	A phone interview wi	th Nurse #1 on 03/29/17 at				
		e remembered Resident #8				
		atches on during the previous				
		at it was around shift change mily member brought to her				
		ident had 2 Fentanyl patches				
		#1 stated she went into the				
		atches on the resident - one				
		another was on his chest.				
		e both dated - one being				
		but could not recall the exact				
		her stated apparently on me off the resident and a				
		obtained from the Nurse				
		another patch. She stated				
	that the one -time or	der was not recorded in the				
	physician's orders or	the nurse's notes.				
	A phone interview wi	$\frac{1}{2}$				
		ith Nurse #4 on 03/29/17 at at he remembered Resident				
		/20/17 he was working with 2				
	medication aides (M	As) and Resident #8's patch				
		e called the nurse practitioner				
		one-time order to place a				
		e resident. Nurse #4 stated e patch and Medication Aide				
	-	patch to the resident's arm.				
		the resident was not having				
		ain when MA #2 applied the				
		ted the Administrator had met				

Facility ID: 970828

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>			(X3) DATE		
		345502	B. WING _				C 30/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00/2011	
	K NURSING AND REHA			3	315 FAITH CHURCH ROAD			
	IN NURSING AND REHA	BILITATION CENTER		I	NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 281 F 312 SS=D	upset because his pa so Nurse #4 said he r tegaderm over it to ke that he was not aware found with 2 patches happened and did not on the resident when 03/20/17. A phone interview witt 2:03 PM revealed that that Resident #8 had remember ever taking that she worked on the most of the time. A phone interview witt attempted on 03/30/1 call. A phone interview witt 03/30/17 at 2:15 PM v An interview with the on 03/30/17 at 4:12 P was for the nurses an administer medication physician and with pa patch and destroy it p new patch. 483.24(a)(2) ADL CAL DEPENDENT RESID (a)(2) A resident who activities of daily living	nily member and she was tch had come off in the bed, made sure the patch had eep it in place. He stated a the resident had been on him until after it had t recall seeing another patch MA #2 applied the patch on h Nurse #2 on 03/30/17 at t she did not recall a time 2 patches and did not g care of him. She stated he other medication cart h Medication Aide #2 7 at 2:13 PM with no return h Nurse #5 attempted on with no return call. Director of Nursing (DON) PM revealed her expectation nd medication aides to hs as ordered by the atches to remove the old prior to the application of a RE PROVIDED FOR ENTS is unable to carry out g receives the necessary good nutrition, grooming, and		312			4/22/17	
	(a)(2) A resident who activities of daily living services to maintain g	is unable to carry out g receives the necessary good nutrition, grooming, and						

Facility ID: 970828

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM): 04/26/2017 / APPROVED). 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345502	B. WING			C 03/30/2017			
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•			
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 312	This REQUIREMENT	e 20 「 is not met as evidenced ons, record reviews and	F	312	F 312 ADL Care Dependent Resider	nts			
	resident and staff inter provide incontinence and oral care as need	arviews, the facility failed to care, showers, bed baths ded for 1 of 6 residents ed for activities of daily living			What measures did the facility put in p for the resident affected: On 3/30/17, two nursing assistants assisted Resident #9 with personal ca and repositioning.	blace			
	Resident #9 was adm 06/03/14 and readmit diagnoses included n	nitted to the facility on tted on 01/23/17. Her nultiple sclerosis (MS), otension. Review of her			What measures were put in place for residents having the potential to be affected				
	quarterly Minimum D 01/30/17 revealed an cognition. The MDS extensive to total ass aspects of activities of totally dependent with personal hygiene. Th Resident #9 frequent	ata Set (MDS) dated assessment of intact revealed Resident #9 was ist of 1 to 2 persons with all of daily living (ADL), and n 2 persons for bathing and ne MDS also revealed ly had pain at a level of 10			On 4/2/17, the director of nursing (DO assistant director of nursing (ADON), nurses, and medication aides audited 100% of residents to ensure residents received assistance with personal car Any areas of concern were immediate addressed by the auditors.	hall had e.			
	A review of Resident 01/31/17 revealed that urinary incontinence tone and physical imit the resident to be free (UTI) through the new The interventions incl fluid intake, monitor fu UTI such as frequent smelling urine, dysuri flank pain and hemat obtain labs as ordere	at she was care planned for related to her loss of muscle mobility. The goal was for e of urinary tract infection tt review period 04/31/17. luded encourage adequate or signs and symptoms of cy, urgency, malaise, foul ia, fever, nausea, vomiting, uria and notify physician, d and notify physician of erineal care after each			What systems were put in place to prevent the deficient practice from reoccurring: On 3/31/17, the DON and ADON initia an in-service for 100% of registered nurses (RNs), licensed practical nurse (LPNs), and nursing assistants (NAs). The in-service instructed staff to provi to a resident who is unable to carry ou activities of daily living the necessary services and to maintain good nutrition grooming, and personal and oral hygie After 4/22/17, no RN, LPN, or NA will allowed to work until the in-service is completed. All newly hired RNs, LPN	es de ut n, ene. be			

Facility ID: 970828

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY PLETED
		345502	B. WING		03	C 3/30/2017
NAME OF P	ROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CO			
			3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER	1	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	Continued From pag	e 21	F 312			
	containment program	n.	1 012	and NAs will receive the in-servic new employee orientation.	ce during	
	12:25 PM revealed h lunch. The head of h	esident #9 on 03/29/17 at ler being assisted with her her bed was slightly elevated sing with the nurse aide (NA)		How the facility will monitor system place:	ems put in	
	#6 who was feeding An observation of Re	her lunch. esident #9 on 03/29/17 at		On 4/22/17, the DON, ADON, ha staff nurses, medication aides, tr nurse, MDS nurses, social worke	eatment	
		r resting in bed and talking		activities director, staff facilitator, corporate consultants began aud ensure residents who are unable	and/or liting to	
	at 5:45 AM revealed everything done for h	rse aide (NA) #8 on 03/30/17 that he did his best to get his patients but made it hard needed to get residents up		out activities of daily living receiv necessary services to maintain g nutrition, grooming, and persona hygiene. The audits are docume	ood I and oral	
	did not always get ev because there were	nift. The NA stated that he verything done on his shift not enough NAs working on		the Showers/CHOICES/ADLs au The Showers/CHOICES/ ADLs a will be completed for five (5) resi	udit tool dents	
	2 persons he would I	ated when residents required have to find someone who th their residents and wait for		daily five (5) times per week for f weeks, then five (5) residents we four (4) weeks, then five (5) resid	ekly for	
		ssist him. He stated that it cult with so few staff on night		monthly for two (2) months.	ho	
		esident #9 on 03/30/17 at		The DON or ADON will present to findings of the Showers/CHOICE audit tool at the monthly Quality		
	bed clothing on and on The curtain was pulle	hat she was lying in bed with covers pulled up over her. ed around her roommate's		Improvement (QI) Committee me The QI Committee will review the of the audits monthly for four (4)	e results months	
		r her. NA #6 told Resident #9 o change her when she found		with recommendation and follow- needed or appropriate for continu compliance in this area.		
	10:45 AM revealed th	sident #9 on 03/30/17 at hat she had been at the ears and that care had been		Also, the DON and/or ADON will findings at the quarterly Executiv Committee meeting for further recommendations for follow up a	e QI	
		the last 3 years." She stated		or continued compliance in this a		

Facility ID: 970828

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	S FOR MEDICARE &			LE CONSTRUCTION	(V2) DA	10. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	TE SURVEY MPLETED
			A. BOILDING			С
		345502	B. WING		0	3/30/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/00/2011
				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 CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 212	Continued From non	- 22				
F JIZ	Continued From pag		F 31		-1/	
		showers like she should (2		to determine the need for an		
	. ,	had not really had complete		frequency of the continued C	a monitoring.	
	bed baths as often as she would like (every other day). She stated the nurse aides (NAs) did the					
		Resident #9 stated it was				
		the shower because it took 2				
		were really busy. She stated				
		nower team but because of				
	budget reasons (acc	ording to the staff) there was				
	no longer a team. R	esident #9 stated that she				
		are 2 times a day, and she				
		e done, and it was not even				
	-	he stated that she was wet				
		anged since 10:00 PM last				
	change her when sh	A #6 would be back to				
	change her when she					
	Incontinence care pr	ovided by NA #6 and NA #7				
		observed on 03/30/17 at				
	11:24 AM. The resid	ent had a wet brief and there				
	was a large amount	of loose brown stool leaking				
	out of the resident's I	brief onto the pad on the bed.				
		spot on the bottom sheet as				
		ad some brown material				
		ea that NA #6 had to rub				
		ove from her skin. NA #6				
		wiping front to back and				
		he hip area. NA #6 applied reddened areas of Resident				
		an brief was applied and the				
		ned with pillows for comfort.				
	-					
	-	entation of showers and bed				
		9 was made to NA #6 on				
		A and the NA stated that she				
		enting care because there to document and take care				
		to uocument and take cale				
	of the residente NA	#6 stated the documentation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345502 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 03/30/2017 LAKE PARK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (X5) COMPLE COMPLE			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345502 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD LAKE PARK NURSING AND REHABILITATION CENTER 3115 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE (X5) COMPLE	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKE PARK NURSING AND REHABILITATION CENTER 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 INDIAN TRAIL, NC 28079 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5)			345502	B. WING			-	
LAKE PARK NURSING AND REHABILITATION CENTER INDIAN TRAIL, NC 28079 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFINITION OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFINITION OF DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BY FULL (EACH DEFICH DEFICIENCY MUST BY FULL (EACH DEFIC FULL (EACH DEFICH DEFICI	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
INDIAN TRAIL, NC 28079 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		RK NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE					IN	NDIAN TRAIL, NC 28079		1
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATION	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 312 Continued From page 23 F 312	F 312	Continued From page	e 23	F	312			
An interview on 03/30/17 at 11:57 AM with NA #6 and NA #7 revealed that Resident #9 was assigned to NA #6. NA #6 stated that she had not been able to change the resident before then because she had to wait for someone to assist her. NA #6 stated that she had told Resident #9 that she would be back to change her as soon as she could find someone to help her. Both NA #6 and NA #7 stated they rounded and changed the residents that only required 1 person and then worked together to change the residents that required the assistance of 2 staff members. They both stated they had 14 to 16 residents assigned to them and it was difficult to get showers/baths, incontinence care and oral care done with that many residents. NA #6 and NA #7 stated it was especially hard to care for the residents like Resident #9 that required 2 persons for all activities of daily living except eating and oral care to Resident #9 yet because she still had to shower and change other residents and did not remember the last time she offered oral care to the sident. A phone interview with NA #8 on 03/30/17 at 1:55 PM revealed that the NA #8 on 03/30/17 at 1:55 PM revealed that the had not asked them to change her during the night last night but stated that the had not asked them to change her but they knew she had to be changed and would not allow a male NA to change her. A phone interview with NA #9 on 03/30/17 at 2:11 PM revealed that she had worked the previous		and NA #7 revealed to assigned to NA #6. No not been able to char because she had to wher. NA #6 stated that that she would be back she could find someo and NA #7 stated they residents that only rev worked together to char every the assistant both stated they had to them and it was dif incontinence care and many residents. NA a especially hard to car Resident #9 that requires activities of daily living care. NA #6 stated the care to Resident #9 y shower and change of remember the last time the resident. A phone interview witt PM revealed that he with the previous evening Resident #9 preferred he did not change her but stated that the NA changed her. He stat them to change her b changed and would no change her. A phone interview witt	that Resident #9 was NA #6 stated that she had onge the resident before then wait for someone to assist at she had told Resident #9 ck to change her as soon as one to help her. Both NA #6 cy rounded and changed the quired 1 person and then hange the residents that ce of 2 staff members. They 14 to 16 residents assigned fficult to get showers/baths, d oral care done with that #6 and NA #7 stated it was re for the residents like uired 2 persons for all g except eating and oral hat she had not offered oral vet because she still had to other residents and did not he she offered oral care to th NA #8 on 03/30/17 at 1:55 was assigned to Resident #9 on 03/29/17. He stated that d females to change her so r during the night last night As he worked with had ted that he had not asked but they knew she had to be not allow a male NA to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345502	B. WING		03/30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER	3315	EET ADDRESS, CITY, STATE, ZIP CODE 5 FAITH CHURCH ROAD IAN TRAIL, NC 28079	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 312 F 323 SS=G	evening on 03/29/17 NA #10. NA #9 state incontinence care for She stated that NA # #10 to change the rest An interview on 03/30 Administrator and Dir they were aware the documenting their ca agreed that it would r resident care. An interview on 03/30 Director of Nursing re was for residents to r least every 2 to 3 hou stated that she also e bathed according to t care be provided to re day. 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu (1) The resident rec and assistance devic (n) - Bed Rails. The appropriate alternativ bed rail. If a bed or s must ensure correct i	on the halls with NA #8 and d that she did not provide Resident #9 that evening. B had not asked her and NA sident. 0/17 at 4:10 PM with the ector of Nursing revealed NAs had not been re for some weeks and not be an accurate record of 0/2017 at 4:12 PM with the evealed that her expectation eccive incontinence care at urs and as needed. She expected residents to be heir preference and that oral esidents at least 2 times per -(3) FREE OF ACCIDENT SION/DEVICES ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility	F 312		4/22/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/26/2017 1 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		CONSTRUCTION		LETED
		345502	B. WING			03/3	C 30/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				33	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
F 323	Continued From page	25	E:	323			
	to the following eleme						
	(1) Assess the resider from bed rails prior to	nt for risk of entrapment installation.					
	(2) Review the risks a	nd benefits of bed rails with					
		nt representative and obtain					
	informed consent prio						
	-						
	(3) Ensure that the be						
	This REQUIREMENT	sident's size and weight. is not met as evidenced					
	by: Based on observation	ns, staff interviews and			F 323 Accident		
	record review the faci				Hazards/Supervision/Devices		
		for a resident with a history					
		fell out of bed and was			What measures did the facility put in pl	ace	
	injured. The resident	was sent to the Emergency			for the resident affected:		
		d with right eye contusion					
		morrhage. The facility also			On 3/24/17, the assigned staff nurse		
		ecautions were in place for			assessed Resident #2 post-fall, contac	ted	
	2 of 4 sampled reside	nts (Resident #2 and #7).			the physician, and received physician		
	The findings included				orders to send Resident #2 to the emergency department for further		
		•			evaluation. Resident #2 was transferre	ed	
	1. Resident #2 was ad	dmitted to the facility on			to the hospital emergency department.		
	03/30/15 and readmit	ted on 02/13/16 with			The assigned staff nurse also contacte		
	diagnoses that include	ed aphasia, dementia,			Resident #2□s responsible party.		
		ners. The most recent					
	Minimum Data Set (M				On 3/26/17, the assigned staff nurse		
	specified the resident	•			assessed Resident #2 post-fall, contac	ted	
	assessed, the resider				the physician, and received physician		
	had 1 fall with a minor	nobility and transfers and			orders to send Resident #2 to the emergency department for further		
		i ingur y.			evaluation. Resident #2 was transferre	d	
	A care plan (not dated	d with the most recent			to the hospital emergency department.		
		esident #2's risk for falls			The assigned staff nurse also contacte		
	identified measure in				Resident #2 s responsible party.		
	related injury. The mo						

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			OMB	DRM APPROVEI NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		ATE SURVEY OMPLETED C
		345502	B. WING			03/30/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 26	F 32	23		
	 Bed in lowest po Fall mat on floor Sensor alarm wh A nurses' entry made 4:00 AM specified Ref floor next to her low b to the cheek. Nurses contacted the physici send Resident #2 to the for evaluation of fall. Review of the Emerg dated 03/24/17 specified Ref closed head injury with (concussion) and reconstruction. A physician's order date send Resident #2 to the for evaluation of a fall. There was no nurses record related to a fall provided an incident #1 dated 03/26/17 at nurse aide found the side next to her bed. Resident #2 and note reopened the right che sustained an injury to documented that she physician and received 	sition hile in bed and in chair a by Nurse #2 on 03/24/17 at esident #2 was found in the bed with a 1 inch laceration #2 documented that she an and received orders to the Emergency Department ency Department evaluation fied Resident #2 had a thout loss of consciousness eived treatment to the facial ated 03/26/17 specified to the Emergency Department I. ' entry made in the medical II on 03/26/17. The facility report completed by Nurse 7:18 PM that specified a resident lying on her right Nurse #1 assessed ed the resident to have beek laceration and o the right eye. Nurse #1 contacted the on-call		 On 3/28/17, the assistant direct nursing assessed Resident #7 Resident #7 was assessed as injury. The assistant director or notified Resident #7's responsi and physician. Resident #7's responsi and physician. Resident #7's gave no new orders. On 3/29/17, the medication aid the bed alarm on Resident #7' 4/7/17, the nurse replaced the again. On 4/12/17, the MDS nurse up Resident #7 s care plan to incomplete clarify the expectation that a perial alarm-bed alarm will be provide Resident #7 slides out of bed of on floor beside bed. On 4/14/17, the interdisciplinant team, including the hospice nuisocial worker, met with Reside responsible party to discuss Re #7 s plan of care, including fa interventions, new chair, and michoices. The care plan team a Resident #7 s responsible part 1) use of new Broda chair, 2) of with air mattress, and 3) continuat and bed alarm to help previous the resident slides himself or What measures were put in plaresidents having the potential to affected 	post-fall. having no if nursing ble party physician le replaced s bed. On bed alarm, dated clude and ersonal ed because often to mat y care rse and nt #7 s esident lls, fall nattress and rty agreed: continue ue with fall vent injury nto floor.	
	-	were obtained for Resident esident #2 remained in		By 4/22/17, the DON, ADON, t nurse, staff nurse, social worke		

Facility ID: 970828

						IO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	E SURVEY	
			A. BUILDING	J		С	
		345502	B. WING		0	03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		5/30/2017	
				3315 FAITH CHURCH ROAD	OODE		
LAKE PAP	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	COMPLETIO	
F 323	Continued From page	e 27	F 32	3			
	Intensive Care Unit (ICU) for sepsis from		director, staff facilitator, w	veekend		
	pneumonia. The Em			supervisor, the weekend			
		26/17 specified Resident #2		duty, and/or corporate co			
	sustained a right eye			completed a 100% audit			
	subconjuctival hemor	rrhage.		care guides, comparing th	-		
	0 00/00/47 1 40.04			the resident/resident roor			
		PM nurse aide (NA) #3 was		chair/resident bed to ensu			
		lephone and explained he from 3 PM to 11 PM and was		from accident hazards as			
		2 starting at 7 PM. The NA		2) safety interventions are	-		
	-	en told that same day by		functioning properly, to in			
		hat Resident #2 had been		to make sure bed alarms	•		
	making several atterr	npts to get out of bed. NA #3		working. Any environme	nt safety hazards		
	reported that Resider	nt #2 was at risk for falls and		present and/or intervention	ons not in place		
	had a sensor alarm ir	n her bed and chair, along		were immediately correct	ed by the		
		er bed was to be in low		auditor.			
		sident #2 was unable to					
		eds because she could not		By 4/22/17, the administr			
		she needed something. NA 03/26/17 on the 3 PM to 11		use of the quality improve administrative round tool			
		nly had 3 nurse aides on the		as an audit tool to monito	•		
		se of a shortage and usually		that: 1) the resident envi			
		4 nurse aides. He added		as free from accident haz			
		ng meal, NA #5 was in the		possible; and 2) safety in			
		residents which left him and		place and functioning pro			
		out 30" residents, answer		check to make sure bed a			
	call lights, pass meal	trays and feed dependent		and working. Any enviror	•		
	residents. The NA st			hazards present and/or ir			
		o deliver a meal tray when		in place were immediately	y corrected by		
		t on the floor bleeding. He		the auditor.			
		not sounding. He called for			n laco to		
		I that he examined Resident the alarm was not in place		What systems were put in prevent the deficient prace			
		her wheelchair. NA #3		reoccurring:			
		naware how long Resident		recoccurring.			
		por. NA #3 stated that he		On 4/18/17, the DON initi	ated an		
		ble to adequately supervise		in-service for all staff on F			
		floor and pass meal trays		The in-service addressed	-		
	because of the short			measures including: call			

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		ND HUMAN SERVICES				MAPPROVE 0. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 1 30/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD			
				3315 FAITH CHURCH ROAD			
LAKE PAP	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 323	Continued From pag	e 28	F 32	23			
				frequently used items within r	each,		
	On 03/29/17 at 12:40	PM NA #4 was interviewed		non-skid footwear, assisting r			
	on the telephone and	I stated she was assigned to		the bathroom, provide incontin	nence care,		
S r b F r t t t d	Resident #2 on 03/26	6/17 from 3 PM to 7 PM.		utilize protective equipment se	uch as		
		uring the shift she had to		personal alarms, keep pathwa	-		
		nt several times back in the		lock bed and wheelchair whee			
		s leaning to one side. The		transfers, and safe positioning	•		
	NA added that she w	as told in report that ough day" and to encourage		4/22/17, staff will not be allow			
		d and rest. NA #4 reported		complete their shift until this F Safety in-service is completed			
	-	#2 was up and ate in the		in-service will be incorporated			
	2	3/26/17 stayed in bed for the		employee orientation.			
	÷	4 also stated that around					
	5:30 PM she assisted the resident back in the			On 4/4/17, the DON verified th	ne posting of		
	bed, made sure the b	bed was in the lowest		the DON, ADON, and adminis	strator phone		
		next to the bed. NA #4		numbers at the nurse stations			
		#2 was to have a sensor		may contact the DON, ADON			
		d but because the resident		administrator when the need a	arises to		
	•	hen the shift started, she		protect a resident⊡s safety.			
		alarm was in place and/or		$D_{\rm M} 4/22/17$ the administrator	diracted the		
		xplained that she and NA #3 aides on the floor to pass		By 4/22/17, the administrator continued use of the quality in			
	•	#1 was in the dining room		(QI) administrative round tool	•		
	•	ents because of short		basis as an audit tool to monit			
		d that around 7 pm she		ensure that: 1) the resident e			
	-	help and was told Resident		remains as free from accident			
		stated that she was busy		is possible; and 2) safety inter	ventions are		
		d not been able to go back in		in place and functioning prope			
	the room to check on			include bed alarms are on and			
		eeping because she seemed		working. Any environment sa	•		
	"out of it."			present and/or interventions r were immediately corrected b			
	On 03/30/17 at 11.25	AM the Director of Nursing		auditor.	y ule		
		ed and explained that fall					
		pected to be in place and it		How the facility will monitor sy	stems put in		
	-	y of staff to put them in place.		place:			
		are of the staffing challenges					
		PM to 11 PM shift and		On 4/22/17, the administrator	, DON,		
	stated there should h	ave been 4 nurse aides on		ADON, treatment nurse, staff			

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		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		E SURVEY
		345502	B. WING		0;	C 3/30/2017
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
0(0)15	CUMMADY C	TATEMENT OF DEFICIENCIES			N OF CORRECTION	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 323	Continued From pag	e 29	F 3	23		
	unaware Resident #2 the bed at the time o been. On 03/30/17 at 12:00 made of Resident #2 wheelchair folded be the wheelchair folded be the wheelchair was a closet, Resident #2 h that instructed staff to whereabouts and an On 03/30/17 at 2:36 interviewed on the te she was assigned to one showed up to re work until 7 PM on 0 day was very chaotic during the 7 AM to 3 made attempts to ge	PM Nurse #1 was elephone and explained that work 7 AM to 3 PM but no lieve her and she agreed to 3/26/17. She added that the c due to short staffing and PM shift, Resident #2 had t out of bed. Nurse #1		social worker, activity d facilitator, weekend sup weekend manager on c corporate consultant be resident rooms, hallway and dining rooms to en resident environment re from accident hazards a 2) each resident receive supervision and assista prevent accidents. The recorded on the Showe audit tool. If the auditor resident is not safe or s not in place, the auditor corrective action and do intervention on the aud Showers/CHOICES/AD be completed for five (5 five (5) times per week then five (5) residents v	pervisor, the duty, and/or egan auditing ys, activity rooms, sure that: 1) the emains as free as is possible; and es adequate ance devices to a audits are ers/CHOICES/ADLs r identifies a safety devices are r will take prompt pocument the it tool. The DLs audit tool will 5) residents daily for four (4) weeks, weekly for four (4)	
	residents with the ev told Resident #2 had she assessed the resident events the right eye and the 03/24/17 had reopen contacted the physic send the resident to Nurse #1 reported th resident's sensor ala of fall because NA #2	s in the dining room assisting ening meal when she was fallen. She explained that sident and noted an injury to right cheek laceration from hed. Nurse #1 stated she ian and received orders to the Emergency Department. hat she was unaware if the rm was sounding at the time 3 was with the resident and ng Resident #2 sent out to		weeks, then five (5) res two (2) months. Compl Showers/CHOICES/AD will be forwarded to and DON and/or ADON. The DON or ADON will findings of the Showers audit tool at the monthly Improvement (QI) Com The QI Committee will of the audits monthly fo with recommendation a needed or appropriate	leted DLs audit tool tools d reviewed by the present the s/CHOICES/ADLs y Quality mittee meeting. review the results or four (4) months and follow-up as	
	02/05/16. His diagno	admitted to the facility on oses included dementia with congestive heart failure, and		compliance in this area Also, the DON and/or A findings at the quarterly	ADON will present	

Facility ID: 970828

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	COMPLETED	
						C	
		345502	B. WING			30/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
	K NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE	
F 323	Continued From page	e 30	F 32	23			
				Committee meeting for furt			
		vas developed for his risk of		recommendations for follow	-		
fr ti in ic a tr c c	•	l on 02/17/16. The goal was ot sustain any serious injury		or continued compliance in to determine the need for a			
	through the next revie			frequency of the continued			
	Interventions include	d his bed was to be in the			-		
		mat was to be on the floor,					
		be on each side of the bed					
	of Resident Care Gui	ameters. Under the section ide initiated 02/16/16					
		d an alarm in the bed and					
	chair initiated on 02/2	27/16.					
		ge Minimum Data Set (MDS)					
		d him with long and short nents and having severely					
		aking abilities. He was coded					
		e to total assistance with all					
		ng skills (ADLs). In addition,					
		led as having impaired					
	-	sistance to steady himself d having had 2 or more falls					
	since the previous as						
	The quarterly MDS, o	dated 02/02/17, coded his					
	•	g assessed, requiring					
		sistance with ADLs, being					
		ting assistance to steady tions and having had 2 or					
	more falls since the p						
		ide was located in Resident					
		directed nurse aides of					
		he resident. This care guide, cated alarms were to be in					
	both the bed and the						
	Review of the medic	al record revealed nursing					
	notes dated 03/28/17	a resolution for calculation in sing					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/26/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345502	B. WING				C / 30/2017
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD		
					NDIAN TRAIL, NC 28079		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 31	F	323	3		
		nd on the floor beside the					
		ed as having no injury. The					
	nursing note did not s sounding.	specify if the alarm was					
		it report dated 03/29/17 at ident #7 was observed on					
		ed and received no injuries					
		on if the alarm was in place					
	or sounding. This wa Assistant Director of						
	Observations dated 0 Resident #7 was obs)3/29/17 at 10:11 AM, erved in a low bed with a					
		ne bed. An alarm box was					
		and blinking which indicated					
	it was on. This box w	as not connected to nt was lying on a pressure					
		re which led from the pad					
	was traced to the floo	or under the bed. The wire					
		connected to any type of					
	plug as the end was f remained not connec	ted during observations of					
		n 03/29/17 at 10:48 AM and					
		29/17 at 11:25 AM, Nurse					
	Aide #1 entered the r sleeping in bed, com	oom, woke him from bed his hair, asked if he was					
		d left the room without					
	checking the alarm w connected or function	hich remained not					
		AM, Resident #7 was					
		the cord to the alarm was d was frayed at the end.					
		AM, Medication Aide #1					
	and noticed the alarm	stated she had just entered was not connected. She					
	stated she was not in	formed about the bed alarm					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345502	B. WING				C 30/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Resident #7's care or on 03/29/17 at 12:03 not think she checked further stated she pro- while in bed this more to side and the alarm the resident was on a and believed that was sound as she rolled h During interview with (DON) on 03/30/17 at expected Resident #7 alarm in place. She fu- care, she expected not the care guide in the of followed including che and in functioning ord The Administrator sta 03/30/17 at 4:39 PM to checked and in working	who was responsible for a 03/29/17, was interviewed PM and stated that she did the alarm this date. She vided him incontinent care ning and rolled him from side did not sound. She stated wide pressure alarm pad s why the alarm did not im. the Director of Nursing 12:00 PM, DON stated she to have a working bed wither stated that during ursing assistants to review closet and make sure it was ecking for alarms in place ter.	F	323			
F 353 SS=G	STAFF PER CARE P		F	353			4/22/17
	the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res	ces e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care					

Facility ID: 970828

If continuation sheet Page 33 of 54

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/26/2017 / APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	LETED
		345502	B. WING			C 30/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	and considering the n diagnoses of the facili accordance with the f at §483.70(e). [As linked to Facility A be implemented begin (Phase 2)] (a) Sufficient Staff. (a)(1) The facility mus sufficient numbers of of personnel on a 24- nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides (a)(2) Except when w this section, the facilit nurse to serve as a cl duty. (a)(3) The facility mus nurses have the spec sets necessary to car identified through resi described in the plan (a)(4) Providing care i assessing, evaluating resident care plans an needs. This REQUIREMENT by:	aumber, acuity and ity's resident population in acility assessment required Assessment, §483.70(e), will anning November 28, 2017 Assessment, §483.70(e), will anning November 28, 2017 Assessment of the following types hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not aived under paragraph (e) of ay must designate a licensed harge nurse on each tour of at ensure that licensed ific competencies and skill e for residents' needs, as ident assessments, and	F 353	F 353 Staffing		

Facility ID: 970828

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG		
		345502	B. WING		a	C 3/30/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,		
				3315 FAITH CHURCH ROAD		
	RK NURSING AND REHA			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 353	Continued From page	e 34	E 3	353		
		ility failed to have sufficient				
		onitor a resident at risk for		What measures did the	facility put in place	
		and was injured for 1 of 4		for the resident affected	• • •	
		Resident #2); and the facility				
		ent quantity of staff to ensure		On 3/24/17, the assign		
		were fed and provided		assessed Resident #2		
		4 of 7 sampled residents		the physician, and rece		
		and #7). The facility also		orders to send Resider		
		ent quantity of staff to have a netion fulltime as a Director		emergency department evaluation. The assign		
	of Nursing.			contacted Resident #2		
	of Haloing.			party.		
	The findings included	1:				
				On 3/26/17, the assign		
	1. Cross refer to F 32	23:		assessed Resident #2		
	Decod on obcometic	na staff interviews and		the physician, and rece orders to send Resider		
	record review the fac	ns, staff interviews and		emergency department		
		for a resident with a history		evaluation. The assign		
		Il precautions were in place.		contacted Resident #2		
		of bed and was injured. The		party.		
	resident was sent to	the Emergency Department				
	diagnosed with right	•		On 3/30/17, the admini		
		rrhage for 2 of 4 sampled		Director of Nursing (DC	-	
	residents (Resident #	#2 and #7).		staffing schedule to ens		
	On 03/30/17 at 10.25	AM the staffing coordinator		numbers of staff to prov	•	
		5 AM the staffing coordinator stated that staffing was hard		to all residents to inclue residents with activities	-	
		she used a list to call and		(ADLs) such as shaving	, ,	
		se aides to fill in vacancies		(,	
	-	le. She added that she was		On 3/30/17, the admini	strator, DON,	
	aware of instances w	hen the vacancies had not		assistant director of nu	rsing, activity	
		nad to work short. The		director, social worker,	-	
	staffing coordinator r			facility consultant moni	-	
	Administrator was aw	vare of the staffing shortage.		room and resident roor		
	On 02/20/17 at 1.45	DM the Administrator was		dependent residents w		
		PM the Administrator was ed she was aware the facility		eating and provided inc including Residents #4		
		The Administrator explained			$, \pi 3, \pi 0, a \Pi 0 \# 1.$	

Facility ID: 970828

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			()(0) 1		OMB NO. 09	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
					с	
		345502	B. WING		03/30/2	2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
	1			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	FION SHOULD BE CC THE APPROPRIATE	(X5) DMPLETION DATE
F 353	Continued From page	e 35	F 35	53		
	1.5	to try to hire staff but faced		What measures were put i	n place for	
		nge. The Administrator		residents having the poten		
		been working with the		affected:		
		o ways to encourage more				
	employment.			On 3/30/17, the administra		
	On 02/20/47 at 5:24	DM the Vice Dresident of		DON reviewed the staffing		
		PM the Vice President of viewed and stated he was		ensure sufficient numbers provide nursing care to all		
a H s		challenge within the facility.		include assisting residents		
	-	d implemented bonus pay for		of daily living (ADLs) such		
	staff willing to cover e	· · ·		showers.	<u><u></u></u>	
	-	ne vacancies each week.				
		f Operations reported that		On 3/30/17, the administra		
		e to enlist the help of an		assistant director of nursin		
	agency staffing comp	bany.		activity director, social wor		
	2. Cross refer to F 22	04.		corporate facility consultar dining room and resident r		
		.4.		dependent residents were		
	Based on staff intervi	ews and record review the		eating and provided incont		
		eed and provide incontinence				
	care for dependent re	esidents for 4 of 7 sampled		Starting 4/22/17, a staff me	ember or	
	residents (Resident #	t4, #5 #6 and #7).		members will be assigned		
				residents with ADLs daily a		
		AM the staffing coordinator		and/or outlined in the resid		
		stated that staffing was hard she used a list to call and		including assistance with r incontinence care, shaving		
		she used a list to call and se aides to fill in vacancies			J, and showers.	
	-	le. She added that she was		By 4/22/17, the administra	tor notified the	
		hen the vacancies had not		Regional Vice President (F		
		nad to work short. The		facility staffing needs to pr		
	staffing coordinator re	-		care to all residents in acc	ordance with	
	Administrator was aw	vare of the staffing shortage.		resident care plans.		
	On 03/30/17 at 4:45	PM the Administrator was		What systems were put in	place to	
		ed she was aware the facility		prevent the deficient pract	ce from	
		he Administrator explained		reoccurring:		
		to try to hire staff but faced		0- 0/07/47 // - 5 05/ - **	te d. e.e.	
		nge. The Administrator		On 3/27/17, the DON initia		
	reported that she had	been working with the		in-service for all registered	nuises (RNS),	

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		MEDICAID SERVICES				0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			A. BUILDING	G		С
		345502	B. WING		03	/30/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		130/2017
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 353	Continued From page	e 36	F 35	53		
	facility's corporation t	o ways to encourage more		licensed practical nurses	(LPNs), nursing	
	employment.			assistants (NAs), and ge		
				(GAs) related to assisting		
		PM the Vice President of		ADLs (meals, showers, s		
		viewed and stated he was		positioning, etc.). After 4		
		challenge within the facility.		LPN, NA, or GA will be a until this in-service is cor		
	staff willing to cover e	d implemented bonus pay for		hires will receive in-servi	•	
		e vacancies each week.		employee orientation.	ces during new	
		f Operations reported that		employee onemation.		
		e to enlist the help of an		On 3/30/17, the vice pres	sident of	
	agency staffing comp			operations implemented		
		,		staff willing to cover extra		
	3. Cross refer to F 35	4:				
				Before 4/22/17, the vice	president of	
		ns, staff interviews and		operations directed the fa	acility have an	
		ility failed to have a fulltime		afternoon meeting, in ad		
		ction as a fulltime Director		morning meeting, during		
	of Nursing.			review daily operations, i		
	0 00/00/47 1 40 05			mealtime serving/eating		
		AM the staffing coordinator		resident concerns, staffir	-	
		stated that staffing was hard		(applications, interviews,	nires) and	
		she used a list to call and se aides to fill in vacancies		staffing coverage.		
	•	le. She added that she was		Before 4/22/17, the DON	and	
	-	hen the vacancies had not		administrator began mee		
		ad to work short. The		set the expectations for:		
	staffing coordinator re			to communicate at the da	-	
		vare of the staffing shortage.		what the scheduling nee		
				upcoming day, 2) for the		
		PM the Administrator was		verify with staff any sche		
		d she was aware the facility		the scheduler to provide		
		he Administrator explained		on of the weekend sched		
		to try to hire staff but faced		administrator and directo		
		nge. The Administrator		for the staff to call out to		
		l been working with the		nursing, administrator, w		
		o ways to encourage more		supervisor, or manager of acceptable for staff to ca	-	
	employment.			out message with other s		

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES			F	ITED: 04/26/2017 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		345502	B. WING _			C 03/30/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
	RK NURSING AND REHA		3315 FAITH CHURCH ROAD			
	IN NORSING AND REHA	BIEITATION CENTER	INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 353	On 03/30/17 at 5:34 I Operations was inter- aware of the staffing He added that he had staff willing to cover e strategies for filling th The Vice President of	PM the Vice President of viewed and stated he was challenge within the facility. d implemented bonus pay for extra shifts and other le vacancies each week. f Operations reported that e to enlist the help of an	F 3	 Weekend nurse supervision duty have access to agencies to request addineeded to cover call out On 4/22/17, the director verified the posting of the and administrator phone nurse stations so staff in DON, ADON, and/or ad the need arises to report concerns. By 4/22/17, the administic president of operations staffing agencies to provide assistants and nurses or basis until additional fact hired and trained. Before 4/22/17, the administic president of operations on-site assistance of concomputants, MDS consultants, MDS consultants, MDS consultants, including in the staff have been hired departments, including in nursing assistants. New is ongoing. By 4/22/17, the administic president of operations on site assistance of concomputants, MDS consultants, including in nursing assistants. New is ongoing. By 4/22/17, the administic the DON, quality improves facilitator, and floor nursing assistants and present and the daily assignment each resident has staff to the staff to	the staffing ditional staff, if ts. r of nursing again be DON, ADON, e numbers at the hay contact the ministrator when t staffing trator and vice had secured three vide nursing n an as needed cility staff can be ninistrator and vice coordinated the rporate nursing ultants, medical ary consultant, and the facility in hiring, and/or f. Since 3/30/17, ed for multiple nurses and v staff orientation trator in-serviced rement nurse, staff ses that a staff ust be assigned t sheet to ensure	

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Facility ID: 970828

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2017 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345502	B. WING				30/2017
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 000	
	RK NURSING AND REHA	BILITATION CENTER					
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From page	- 38	F	353	resident with ADLs. No administrative nurse or floor nurse will be allowed to work until this in-service is completed. new administrative nurses and floor nurses will receive this in-service durin new employee orientation. How the facility will monitor systems p place: On 4/22/17, the Administrator initiated Sufficient Staff audit tool to monitor for sufficient staffing will be scheduled to provide residents with ADL assistance enable them to reach their highest practicable physical, mental, psychoso well-being, including mealtime assistant shaving, showers, and positioning. The administrator and/or the DON will utiliz the Sufficient Staff tool five times week to include nights and weekends for fou- weeks, twice weekly for four weeks, weekly for four weeks, and monthly tim three months. Any identified issues w be addressed immediately. The administrator and/or the DON will present findings from the Sufficient Staff tool at the monthly QI committee meet for six months for further recommendations. Beginning 4/22/17, the administrator w monitor the Sufficient Staff tool to ensu- proper completion of the Sufficient Staff	All ng ut in the that bocial nce, le cly ur nes ill aff ings vill ure	
					tool. The administrator will initial the for with the date as completed to acknowledge completion and follow-up		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 03/30/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER	-	315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 353	Continued From page	39	F 353		
F 354 SS=F	 (1) Except when waiv (f) of this section, the services of a registered consecutive hours a consecutive hours to see nursing on a full time (3) The director of numerical consecutive hours and the secutive hours and the formation of the secutive hours and the sec	IE DON red under paragraph (e) or facility must use the ed nurse for at least 8 day, 7 days a week. red under paragraph (e) or facility must designate a erve as the director of basis. rsing may serve as a charge facility has an average daily	F 354	The administrator will submit the findin at the monthly Quality Improvement (C Committee meeting. The QI Committee will review the results of the audits monthly for four (4) months with recommendation and follow-up as nee or appropriate for continued compliance this area. Also, the administrator will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as nee or continued compliance in this area at to determine the need for and/or frequency of the continued QI monitori F 354 Waiver RN \square 8 hrs 7 Days/Wk Full Time DON	l) ee ded e in ded nd ng. 4/22/17

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/201 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345502	B. WING				30/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 354	Continued From page	e 40	F 3	54			
	of Nursing.				What measures did the facility put in p for the resident affected:	place	
	The findings included						
	On 03/29/17 at 10:15 AM the Director of Nursing (DON) was observed passing medications to residents.				On 4/17/17, the administrator began aggressively recruiting, interviewing, a hiring additional nurses, nursing assistants, and geriatric assistants for nursing department. The newly hired	the	
	to interview the Direc	AM the State Agency asked otor of Nursing and was told ation cart and would be view later.			will work to assist residents with care medications thus allowing the director nursing (DON) to perform the duties of director of nursing on a fulltime basis.	and of of the	
	working on a medicat				What measures were put in place for residents having the potential to be affected		
	On 03/30/17 at 4:15 I interviewed and state	PM the DON was ed 03/06/16 was her first day			On 4/17/17, the administrator began		
	a challenge and in ef	l explained that staffing was fort to help cover vacancies,			aggressively recruiting, interviewing, a hiring additional nurses, nursing		
		rses, including herself, took all nurse. The DON stated			assistants, and geriatric assistants for nursing department. The newly hired		
	that she was aware o	of the Federal requirements			will work to assist residents with care		
	reported that she had morning management	have dual roles. The DON been unable to attend a thmeeting as result of on cart. She reviewed her			medications thus having a fulltime registered nurse function as a full time director of nursing.	e	
	schedule and worked				What systems were put in place to prevent the deficient practice from		
	 - 03/17/17 from 7 - 03/18/17 day off 	-			reoccurring:		
	 - 03/19/17 day off - 03/20/17 7 am to - 03/21/17 7 am to 	o 3 pm			By 4/22/17, the administrator in-servic the administrative nurses (director of nursing, assistant director of	ced	
	- 03/22/17 day off - 03/23/17 8 hours				nursing/quality improvement nurse, s facilitator, treatment nurse) and nursing		
	 03/24/17 12 hou 03/25/17 7 am to 				staff scheduler that a staff member or members must be assigned on the da assignment sheet to ensure each res	aily	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY
		345502	B. WING _		C 03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
				INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CO	(X5) DMPLETION DATE
F 354	On 03/30/17 at 4:45 I interviewed and state Federal regulation tha Nurse to function as f She added that due t the facility the current working as a hall nurs Administrator stated	PM the Administrator was ed she was aware of the at required a Registered fulltime Director of Nursing. o the staffing challenges of t Director of Nursing was	F 3	 has staff to assist the resident and medication thus allowing t of nursing to function as a full t director of nursing. After 4/22/ administrative nurse or the sch be allowed to work until this in- completed. All new administrat and schedulers will receive this during new employee orientation How the facility will monitor syst place: By 4/22/17, the administrator in Sufficient Staff Audit tool to mo scheduling of sufficient staffing residents care and medication allowing the director of nursing registered nurse, to function as director of nursing. The admin utilize the Sufficient Staff Audit times (5) weekly for four (4) we weekly for four (4) weeks, wee (4) weeks, and monthly times f months. Any identified issues addressed immediately by the administrator. The administrator will present f from the Sufficient Staff Audit t monthly QI committee meeting months for further recommend Also, the administrator will present of findings at the quarterly Execu Committee meeting for further recommendations for follow up or continued compliance in this to determine the need for and/ 	he director time 17, no heduler will service is tive nurses is in-service on. stems put in hitiated the phitor for the thus to provide thus thus to provide thus to a full time histrator will tool five eeks, twice kly for four three will be findings ool at the tive QI o as needed s area and	

Event ID: 7NY911

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				0RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY
		345502	B. WING		C 03/30/20	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 354	Continued From page	e 42	F 354			
F 431 SS=D	483.45(b)(2)(3)(g)(h) LABEL/STORE DRU		F 431	frequency of the continued QI n	nonitoring.	4/22/17
	drugs and biologicals them under an agree §483.70(g) of this par unlicensed personnel law permits, but only supervision of a licen (a) Procedures. A far pharmaceutical servic that assure the accur dispensing, and admi biologicals) to meet th (b) Service Consultat employ or obtain the pharmacist who (2) Establishes a sys disposition of all cont detail to enable an ac (3) Determines that d that an account of all maintained and perio (g) Labeling of Drugs Drugs and biologicals	rt. The facility may permit I to administer drugs if State under the general sed nurse. cility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. ion. The facility must services of a licensed tem of records of receipt and rolled drugs in sufficient ccurate reconciliation; and rug records are in order and controlled drugs is dically reconciled. and Biologicals. s used in the facility must be e with currently accepted s, and include the y and cautionary				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>			(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C / 30/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO		TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	the facility must store locked compartments controls, and permit of have access to the kee (2) The facility must p permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio facility failed to lock a cart for 1 of 2 medica The findings included On 03/29/17 at 8:00 <i>A</i> left unattended on the medication cart was u staff member and res The housekeeping sta #2 inside the nurses' On 03/29/17 at 8:05 <i>A</i> interviewed about the Nurse #2 locked the r explained that she wa waiting for relief from two residents had fall forgot to lock the medication cart for a context the medication cart was u	and Biologicals. In State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to eys. Provide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and ind other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced Ins and staff interviews, the n unattended medication tion carts. M a medication cart was a medical unit hallway. The unlocked. A housekeeping idents were in the hallway. aff member located Nurse station. M Nurse #2 was unlocked medication cart.	F	431	F 431 Drug Records, Label/Store Dru & Biologicals What measures did the facility put in pl for the resident affected: On 3/29/17, upon finding the medication cart unattended and not properly secur on the medical unit hallway, the nurse immediately took action to ensure the of was properly secured. On 3/29/17, the director of nursing (DON) educated the nurse assigned to the medical unit hall medication cart. What measures were put in place for residents having the potential to be affected On 3/29/17, upon finding the medical un hallway medication cart was unlocked,	ace n ed cart way	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/2017 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345502	B. WING		03	6/ 30/2017	
	ROVIDER OR SUPPLIER	BILITATION CENTER		3315	ET ADDRESS, CITY, STATE, ZIP CODE FAITH CHURCH ROAD AN TRAIL, NC 28079	00	
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	On 03/29/17 at 10:00	or at least 20 minutes. AM the Administrator was rted that medication carts	F	n fr S V P r C irrili n o c S irre C tt n n a P F P E tt irrn T tr w	administrator, DON, assistant director bursing (ADON), and/or corporate consultant complete a 100% audit or nedication carts to ensure the facilit ree of carts that were not properly becured or left unattended. What systems were put in place to orevent the deficient practice from eoccurring: On 3/29/17, the DON initiated an n-service for all registered nurses (F censed practical nurses (LPNs) and nedication aides on Resident Safety of 4/22/17, staff will not be allowed to complete their shift until this Resider Safety in-service is completed. This n-service will be incorporated into n employee orientation. On 4/4/17, the DON verified the pos he DON, ADON, and administrator numbers at the nurse stations so sta nay contact the DON, ADON, and/or administrator when the need arises for orotect a resident⊟s safety. How the facility will monitor systems place: By 4/22/17, the DON initiated the us he Medication Cart Audit tool, which ncludes monitoring for properly sector nedication carts and proper drug sto The administrator, DON, ADON, reatment nurse, staff nurse, social worker, activity director, staff facilitative ekend supervisor, the weekend	f all y was RNs), d y. As o nt ; ew ting of phone aff or to put in e of n ured orage.	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/26/2017 RM APPROVED IO: 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345502	B. WING		0:	C 3/30/2017
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490 SS=G	483.70 Administration A facility must be adm enables it to use its re efficiently to attain or i practicable physical, r well-being of each res	ESIDENT WELL-BEING inistered in a manner that sources effectively and maintain the highest nental, and psychosocial	F 43	 manager on duty, and/or corpolic onsultant will complete the Met Cart Audit tool. The Medication tool will be completed for all met carts daily five (5) times per wet (4) weeks, then weekly for four then monthly for two (2) months Completed Cart Audit tools will forwarded to and reviewed by trand/or ADON. The DON or ADON will present findings of the Medication Cart monthly Quality Improvement (Committee meeting. The QI Cowill review the results of the aumonthly for four (4) months with recommendation and follow-up or appropriate for continued conthis area. Also, the DON and/or ADON will present findings at the quarterly Execut Committee meeting for further recommendations for follow up or continued compliance in this to determine the need for and/or frequency of the continued QI results and/or for the continued QI results and fo	edication a Cart Audit edication eek for four (4) weeks, s. be he DON t the Audit at the QI) ommittee dits n as needed mpliance in ill present ive QI as needed area and or	4/22/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/26/2017 ORM APPROVED 3 NO. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 03/30/2017		
NAME OF PF	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			3315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 490	Continued From page	e 46	F	490				
	record review the faci	ns, staff interviews and liity's Administration failed to needs of residents in the			F 490 Effective Administration What measures did the facility put in	nlace		
	building for Resident				for the resident affected:	place		
	The findings included				On 3/29/17, the director of nursing (E and/or assistant director of nursing	-		
	1. Cross refer to F 22	4: ews and record review the			(ADON) assessed Residents #4, #5, and #7. Resident assessment revea	led		
	facility neglected to fe	eed and provide incontinence esidents for 4 of 7 sampled			no obvious signs of poor nutrition, ch in mental status, or weight loss as a of not receiving assistance with eatin	result		
	residents (Resident #	•			3/26/17 evening meal. On 3/29/17, t DON/ADON notified the physician for	he		
	interviewed and state residents were not fee	PM the Administrator was d she was unaware that d on 03/26/17 during the			Residents #4, #5, #6, and #7 and the physician gave no new orders.	;		
	additional resources a	dministrator explained available for staff to use if			On 3/18/17, at 2:00 PM the nursing assistant (NA) returned to assist Res			
	stated, the facility had number and that she would have come in t				 #7 with incontinence care. On 3/29/⁷ the director of nursing (DON) assess Resident #7. Resident #7□s skin clear and intact and the brief was dry. 	ed		
	Duty" and that persor	at served as "Manager on n could have been called, the porate oversight and access			On 3/30/17, two nursing assistants assisted Resident #9 with personal c and repositioning.	are		
	Administrator reported contacted on the even	d that she should have been ning of 03/26/17 so that be made to feed residents.			On 3/26/17, the assigned staff nurse assessed Resident #2 post-fall, conta the physician, and received physiciar	acted		
	2. Cross refer to F 24	1:			orders to send Resident #2 to the emergency department for further evaluation. The assigned staff nurse			
	interview, the facility f	ew, staff interview and family failed to maintain the dignity ampled for dignity when staff			contacted Resident #2⊡s responsible party.			
		dent #7 timely when family			On 3/30/17, the Administrator and the	е		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345502 B. WING C LAKE PARK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OGRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLET COMPLET F 490 Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. F 490 Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care Director of staff to provide nursing care			ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/26/2017 RM APPROVED NO. 0938-0391
345502 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD LAKE PARK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE F 490 Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. F 490 Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care ID	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				COMPLETED	
LAKE PARK NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 490 Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. F 490 Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care Image: Construction of the staff to provide nursing care			345502	B. WING			0	-
LAKE PARK NURSING AND REHABILITATION CENTER INDIAN TRAIL, NC 28079 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE F 490 Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. F 490 Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care Image: Construction of the provide nursing care	NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 490 Continued From page 47 informed staff he was soiled and needed assistance resulting in him being fed by family soiled. F 490 Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care Complet Date	LAKE PAI	RK NURSING AND REHA	BILITATION CENTER					
informed staff he was soiled and needed assistance resulting in him being fed by family soiled.Director of Nursing (DON) reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
 3. Cross refer to F 312: Based on observations, record reviews and resident and staff interviews, the facility failed to provide incontinence care, showers, bed baths and oral care as needed for 1 of 6 residents (Resident #3) sampled for provide activities of daily living. 4. Cross refer to F 323: Based on observations, staff interviews and record review the facility failed to provide adequate supervision for a resident with a history of falls and ensure fall procusion and subconjuctival hemorrhage for 1 of 4 sampled residents (Resident #2). 5. Cross refer to F 353: Based on observations, staff interviews and record review the facility failed to have sufficient quantity of staff to monitor a resident at risk for falls; the resident fiel and was injured and the facility failed to have sufficient quantity of staff to have a sufficient quantity of staff to have sufficient quantity of staff to have a Registered Nurse function fulltime as a Director of Nursing. 6. Cross refer to F 354: 	F 490	 informed staff he was assistance resulting i soiled. 3. Cross refer to F 31 Based on observation resident and staff interprovide incontinence and oral care as need (Resident #9) sampled daily living. 4. Cross refer to F 32 Based on observation record review the fact adequate supervision of falls and ensure fat The resident fell out or resident was sent to the diagnosed with right of subconjuctival hemory residents (Resident # 5. Cross refer to F 35 Based on observation record review the fact adequate supervision of falls and ensure fat The resident fell out or resident was sent to the diagnosed with right of subconjuctival hemory residents (Resident # 5. Cross refer to F 35 Based on observation record review the fact quantity of staff to more falls; the resident fell facility failed to have a sampled residents (Residents (Resident fell facility also failed to hemore sampled residents (Resident fell facility also failed to have a sampled residents (Resident fell facility also failed to have a set to hemore a construction facility also failed to hemore a construction facility failed to have a construction facility fa	 a soiled and needed in him being fed by family 2: as, record reviews and erviews, the facility failed to care, showers, bed baths ded for 1 of 6 residents and for provide activities of care: as: as, staff interviews and ility failed to provide in for a resident with a history Il precautions were in place. of bed and was injured. The the Emergency Department eye contusion and rhage for 1 of 4 sampled t2). as: as, staff interviews and ility failed to have sufficient onitor a resident at risk for and was injured and the sufficient quantity of staff to sidents were fed for 4 of 11 tesident #2, #4, #5, #6). The nave sufficient quantity of ered Nurse function fulltime ing. 	F	490	 staffing schedule to ensure sufficient numbers of staff to provide nursing cat to all residents to include assisting residents with activities of daily living (ADLs) such as shaving and showers What measures were put in place for residents having the potential to be affected On 4/3/17, the DON initiated an in-set for all staff on abuse/neglect. After 4/3/17, staff will not be allowed to complete their shift until this abuse/neglect in-service is completed This in-service will be incorporated int new employee orientation. On 4/4/17, the DON verified the posting the DON, ADON, and administrator pl numbers at the nurse stations so staff may contact the DON, ADON, and/or administrator when the need arises to prevent and/or report abuse/neglect. On 3/30/17, the social worker and admissions/social worker conducted interviews with alert and oriented residents regarding dignity and respect individuality, including incontinence cat before meals. The interviews resulted with no negative findings. On 4/6/17, the social worker called for resident council members had an opportunity to express any dignity and construction. 	re vice o ng of none ct of are t	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2017 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 03/30/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PAP	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 490	Continued From page	e 48	F 490		
	record review the faci	hs, staff interviews and ility failed to have a fulltime action as a fulltime Director		On 4/19/17, the social worker revision the past 60 days of Resident Condi- identify any potential dignity and re- of individuality concerns. No unact dignity and respect of individuality concerns were identified. On 3/31/17, the director of nursing assistant director of nursing (ADO) hall nurse audited 100% of resided ensure residents had received assist with personal care. Any areas of 0 were immediately addressed by the auditors. On 4/22/17, the DON, ADON, treat nurse, staff nurse, social worker, a director, staff facilitator, weekend supervisor, the weekend manager duty, and/or corporate consultant completed a 100% audit of all resist care guides, comparing the care go the resident/resident room/resider to ensure that: 1) the resident environment remains as free from accident hazards as is possible; a safety interventions are in place a functioning properly. Any environed safety hazards present and/or interventions not in place were immediately corrected by the audi What systems were put in place to prevent the deficient practice from reoccurring:	cerns to espect ddressed (DON), N), and nts to sistance concern ne utment activity r on dent juide to nt chair nd 2) nd ment tor.
				By 4/22/17, the administrator begathe Administrator Audit tool. The	an using
	7(02-99) Previous Versions Obs	solete Event ID: 7NY	۲Q11 E	acility ID: 970828	continuation sheet Page 49 of 54

Event ID: 7NY911

Facility ID: 970828

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	MENT OF HEALTH AN					FORM	D: 04/26/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
345502			B. WING				30/2017
NAME OF F	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
LAKE PA	LAKE PARK NURSING AND REHABILITATION CENTER			3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 490 F 514 SS=D	483.70(i)(1)(5) RES	e 49	F 4		Administrator Audit tool is an audit summary tool covering tags F224, F24 F281, F312, F323, F353, F354, F431, F490, and F 514. The purpose of the administrator audit tool is to help the administrator ensure the facility is using resources effectively and efficiently to attain or maintain the well-being of eac resident. The administrator will complet the Administrator Audit tool twice week for 12 weeks then once weekly for 12 weeks. How the facility will monitor systems pu- place: The administrator will present the findin of the Administrator Audit tool at the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review the results of the audits monthly for six (6) months with recommendation and follow-up as need or appropriate for continued compliance this area. Also, the administrator will present findings for six (6) months at the quartee Executive QI Committee meeting for further recommendations for follow up needed or continued compliance in this area and to determine the need for and frequency of the continued QI monitorin	g ch ete ly ut in ngs ee ded e in erly as s d/or	4/22/17

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	-	ND HUMAN SERVICES	-			MAPPROVE 0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED C	
		345502	B. WING			30/2017	
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 514	 (1) In accordance with standards and practic maintain medical recare- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically or (5) The medical reco (i) Sufficient informat (ii) A record of the rest (iii) The comprehension provided; (iv) The results of any and resident review of determinations conduct (v) Physician's, nurse professional's progret (vi) Laboratory, radio services reports as rest this REQUIREMENT by: Based on staff interview facility failed to docum 	th accepted professional ces, the facility must ords on each resident that hented; le; and ganized rd must contain- ion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed	F 5	I4 F 514 Resident Records What measures did the facility	put in place		
	(Resident #2)			for the resident affected:			
	The findings included	1.		On 3/30/17, the director of nurs	sing (DON)		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/20 M APPROVE O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C / 30/2017
NAME OF PROVIDER OR SUPPLIER				SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	ABILITATION CENTER					
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 514	Continued From page	e 51	E:	514			
	1.0				reviewed Resident #2⊡s medical reco	rd	
		nitted to the facility on			to ensure the medical record progress	;	
	03/30/15 and readmi				notes reflected Resident #2 s fall on		
	diagnoses that includ aphasia, hypertensio				3/26/17.		
	apriasia, hypertensio	n and history of falls.			What measures were put in place for		
	Review of the medica	al record revealed a			residents having the potential to be		
		ed 03/26/17 to send the			affected		
		gency Department for				_	
	evaluation of a fall.				By 4/22/17, the DON, assistant directo	or of	
	Further review of the	medical record revealed			nursing (ADON), staff nurse, and/or corporate consultant audited 100% of	the	
		ade that documented a fall			last 15 days of resident progress note		
	on 03/26/17.				and resident incident/accident reports		
					ensure residents who had a fall have		
	The facility provided				proper documentation in the medical		
	Resident #2 dated 03	#1 that read in part, resident			record. Any areas of concern were immediately addressed by the auditors	-	
		th right eye trauma and a			initiately addressed by the additor	5.	
	laceration to cheek.	3 ,			What systems were put in place to		
					prevent the deficient practice from		
		AM the Director of Nursing			reoccurring:		
		ed and reported that nurses cument events, such as falls,			By 4/22/17, the DON initiated an		
		. The DON reviewed the			in-service for all registered nurses (RN	ls).	
		sident #2 and reported there			licensed practical nurses (LPNs), nurs		
		on regarding the fall on			assistants (NAs), relaying the important	nce	
	03/26/17 in the media	cal record.			of, after a resident incident/accident,		
	On 03/30/17 at 2:36	PM Nurse #1 was			documenting in the medical record the assessment which includes intervention		
		lephone and explained that			taken, first aid provided, and notification		
		imentation she made on the			the physician and resident s respons		
	incident report autom	natically populated into the			party. After 4/22/17, no RN, LPN, or N	A	
	electronic medical re				will be allowed to work until this in-ser		
		o documentation in the			is completed. All new hires will receiv	е	
	on 03/26/17.	ding the fall for Resident #2			this in-service during new employee orientation.		
					How the facility will monitor systems p	ut in	

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		MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345502			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		B. WING	C 03/30/2017		
		STREET ADDRESS, CITY, STATE, ZIP CODE		•	
LAKE PARK NURSING AND REHABILITATION CENTER			:		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 514	Continued From page	e 52	F 514	place:	
				By 4/22/17, the administrator, DON ADON, treatment nurse, staff nurse social worker, activity director, staff facilitator, weekend supervisor, the weekend manager on duty, and/or corporate consultant began auditing resident medical record progress m and incident/accident reports to en- that resident records are complete/accurate/accessible, to in documenting a resident □s fall in the medical record. The audits are rec on the RP Notification/Resident Re Review tool. If the auditor identifies resident medical record is not complete/accurate/ accessible, to in documentation of a resident □s fall, auditor will take prompt corrective a and document on the audit tool the intervention taken. The RP Notification/Resident Record Revie will be completed for five (5) reside daily five (5) times per week for fou weeks, then five (5) residents week four (4) weeks, then five (5) resider monthly for two (2) months. Compl RP Notification/Resident Record Revie tool will be forwarded to and review the DON and/or ADON. The DON or ADON will present the findings of the RP Notification/Resi Record Review tool at the monthly Improvement (QI) Committee meet The QI Committee will review the re- of the audits monthly for four (4) me with recommendation and follow-up	e, g otes sure clude e orded cord s a nclude the action w tool nts r (4) cly for nts leted eview red by dent Quality ing. esults onths

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		D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/26/2017 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C / 30/2017	
NAME OF PF	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	K NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD			
		-			IDIAN TRAIL, NC 28079		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 514	Continued From page	53		514				
1 014	Continued i form page			514	needed or appropriate for continued compliance in this area.			
					Also, the DON and/or ADON will pre- findings at the quarterly Executive Q Committee meeting for further recommendations for follow up as ne or continued compliance in this area to determine the need for and/or frequency of the continued QI monit	eeded and		
	7/02-99) Previous Versions Obs	olete Event ID: 7N			sility ID: 970828			

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