		ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		345502	B. WING				C / <b>03/2017</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					3315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	BILITATION CENTER			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166 SS=D	<ul> <li>483.10(j)(2)-(4) RIGH TO RESOLVE GRIEV</li> <li>(j)(2) The resident ha must make prompt ef grievances the reside with this paragraph.</li> <li>(j)(3) The facility must to file a grievance or or resident.</li> <li>(j)(4) The facility must to ensure the prompt regarding the residen paragraph. Upon requ a copy of the grievance grievance policy must</li> <li>(i) Notifying resident i postings in prominent facility of the right to f (meaning spoken) or grievances anonymous of the grievance offici can be filed, that is, h address (mailing and number; a reasonable completing the review</li> </ul>	IT TO PROMPT EFFORTS /ANCES s the right to and the facility forts by the facility to resolve ont may have, in accordance t make information on how complaint available to the t establish a grievance policy resolution of all grievances ts' rights contained in this uest, the provider must give ce policy to the resident. The t include: ndividually or through clocations throughout the ile grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone e expected time frame for v of the grievance; the right cision regarding his or her		160	DEFICIENCY)	KIATE	5/25/17
	independent entities of be filed, that is, the pe Quality Improvement Agency and State Los	with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system;					
	responsible for overse	eeing the grievance process, g grievances through to their					
	DIRECTOR'S OR PROVIDER/9	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

**Electronically Signed** 

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

05/25/2017

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345502	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	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 .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 166	by the facility; maintai information associate example, the identity grievances submitted written grievance dec coordinating with state necessary in light of state (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged v abuse, including injurt and/or misappropriation anyone furnishing ser provider, to the admir as required by State I (v) Ensuring that all w include the date the g summary statement of the steps taken to inv summary of the pertir regarding the residen as to whether the grie confirmed, any correct taken by the facility as and the date the writte (vi) Taking appropriate of the residents' rights or if an outside entity	any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to tial violations of any resident d violation is being 483.12(c)(1), immediately iolations involving neglect, ies of unknown source, on of resident property, by vices on behalf of the histrator of the provider; and aw; rritten grievance decisions rievance was received, a of the resident's grievance, estigate the grievance, a nent findings or conclusions t's concerns(s), a statement evance was confirmed or not ctive action taken or to be s a result of the grievance, en decision was issued;	F	166			

Facility ID: 970828

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/20 FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 05/03/2017	
	ROVIDER OR SUPPLIER	BILITATION CENTER	S 3. 	05/03/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC	
F 166	Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issue decision. This REQUIREMENT by: Based on resident and facility record review, resolve a grievance for related to receiving a week for 2 weeks (Ref Resident #23 was ad 12/29/16. Diagnoses and chronic pain syne Review of an admissi Care Area Assessme Resident #23 was as able to understand and cognition, very import decisions about bathin required total staff as personal hygiene due the thigh fracture/chro On 4/30/17 at 11:33 / interviewed and state shower in 2 weeks. For that staff provided hir his face, "but that's its spoken to the social weeks of the soci	I law enforcement agency or any of these residents' of responsibility; and ence demonstrating the es for a period of no less than ance of the grievance T is not met as evidenced and staff interviews, and the facility failed to promptly or 1 of 3 sampled residents ssistance with 2 showers per esident #23). mitted to the facility on included left thigh fracture drome, among others. ion MDS assessment and nt dated 1/5/17 revealed sessed with clear speech, and be understood, intact tant to be involved in ing preferences, and sistance of 2 persons with e to impaired mobility from	F 166	F 166 What measures did the facility put in for the resident affected: On 5/24/17 resident #23 was intervie by the social worker to discuss conc related to shower schedule. Residen is satisfied with receiving two showe week What measures were put in place fo residents having the potential to be affected: On 5/24/17 the director of social wor reviewed all resident concerns for th thirty days to ensure residents and/or resident RP are satisfied with the resolution and follow-up. Any areas of concern were addressed immediated What systems were put in place to prevent the deficient practice from reoccurring: On 5/24/17, the administrator initiate in-service for the administrative staff Follow Up to Resident Concerns whi	ewed ern nt #23 rs per r k e past or the of y.	

Event ID: GUI211

Facility ID: 970828

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			0.00				3 NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· · ·	DATE SURVEY COMPLETED
			A. BUILDIN	NG			С
		345502	B. WING				05/03/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		05/03/2017
					15 FAITH CHURCH ROAD		
LAKE PA	RK NURSING AND REH	ABILITATION CENTER		IND	DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 166	Continued From pag	10 <b>3</b>		166			
1 100	10			100	included: 1) When addressing reside	nt	
	1	r's April 2017 Grievance Log 23 filed 2 grievances, dated			included: 1) When addressing reside concerns, you must include detailed	111	
		related to not receiving			information for resolution of concern	to	
		ed. Review of the grievances			include a date and 2) Any needed au		
		received by the SWA. There			or observations to support monitoring		
	-	on of resolution to these			should be documented. This in-service	-	
	grievances.				was completed 5/25/17. All newly hir		
	grievariees.				administrative staff will receive the Fe		
	Review of the showe	er schedule on 4/30/17 at			Up to Resident Concerns in-service	0110 11	
		hat the week of 4/16/17 -			during new employee orientation.		
		23 was scheduled to receive			during new employee enemation.		
		day/Friday during the 7AM -			How the facility will monitor systems	nut in	
		ent shower schedule, revised			place:	putin	
		esident #23 was scheduled to			place.		
		Monday/Thursday during the			The Administrator and/or DON will re	view	
		view of the shower log			resident concerns weekly for six mor		
		k regarding Resident #23's			to ensure concern have been addres		
		from 4/16/17 - 4/30/17.			and the resolution reviewed with the resident/RP in a timely manner to inc		
	An interview on 5/1/	17 at 11:45 AM with Nursing			a written response on the concern fo		
		vealed she typically worked			include details of the follow up that		
		n the 7AM - 3PM shift. NA #1			occurred with a date.		
		used to receive showers on					
	Wednesdays/Friday	s until the shower schedule			The QI nurse will present all findings	at	
		f 4/23/17. NA #1 stated that			the monthly QI committee meeting for		
		urrently scheduled to receive			months. The QI committee will review		
		days/Thursdays. NA #1			minutes of the resident council meeti		
		ne was the assigned NA for			monthly for 6 months for identification	•	
		st few weeks, but the days			trends, actions taken, and to determi		
	she was his assigne	d NA were not the days he			the need for and/or frequency of		
	was scheduled to re	ceive a shower. Review of			continued monitoring, and make		
	the NA assignment a	and shower schedule during			recommendations for monitoring for		
	the interview, reveal	ed NA #1 was the assigned			continued compliance. The administr		
		on the following days that he			and/or DON will present the findings	and	
	was scheduled to re	ceive a shower or requested			recommendations of the monthly QI		
	a shower, but did no	t receive a shower:			committee to the quarterly executive	QA	
	Friday, 4/21/17				committee for six months for further		
	Monday, 4/24/17				recommendations and oversight.		
	Wednesday, 4/26/17	7					

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/30/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA			3	315 FAITH CHURCH ROAD		
	TR NORSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 166	166 Continued From page 4		F	166			
	could not recall why s #23 a shower on Frid shower day) and on N that she was not awa scheduled changed a scheduled shower da Wednesday, 4/26/17, shower according to I schedule, but becaus changed and Wednes schedule, but becaus changed and Wednes schedule shower da provide Resident #23 he requested, but ratil receive a shower the 4/27/17). An interview on 5/1/1 Director of Nursing (D implemented a new s to balance the NA wo she was made aware expressed that he wa week as requested. T expected residents to per week or to receive preference. The DON resident requested a shower was not sche shower should still be the resident when a s DON stated she revie no further documenta received 2 showers p 4/16/17 - 4/30/17.	<ul> <li>and this was his current</li> <li>by. NA #1 also stated that on</li> <li>c. Resident #23 requested a</li> <li>b) revious shower</li> <li>b) the shower schedule had</li> <li>b) sdays was no longer his</li> <li>b) NA #1 stated she did not</li> <li>c) with a shower that day as</li> <li>b) her told him that he would</li> <li>c) with a shower that day as</li> <li>c) her told him that he would</li> <li>c) next day (Thursday,</li> </ul> 7 at 2:45 PM with the DON) revealed the facility Shower schedule on 4/23/17 ork load. The DON stated e that Resident #23 as not getting 2 showers per The DON stated that she o receive at least 2 showers e showers per their					

Facility ID: 970828

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DEPARTMENT OF HEAL CENTERS FOR MEDICA							FOR	D: 06/30/2017 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345502	B. WING					03/2017	
NAME OF PROVIDER OR SUPPL	ER		•		STREET ADDRESS, CITY, STATE, ZIF	P CODE	-		
LAKE PARK NURSING AND	REHAR	BILITATION CENTER			3315 FAITH CHURCH ROAD				
					INDIAN TRAIL, NC 28079				
PREFIX (EACH DEI	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE A CROSS-REFERENCED TO	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION CED TO THE APPROPRIATE DATE EFICIENCY)			
<ul> <li>showers for ea stated that whe she advised that whe advised that shower the day and 4/26/17, NA #1 directed, she si followed up to a followed up to a followed up to a shower on a dat scheduled. The the facility had showers as a quere months ago with The Administrator si shower on a dat scheduled. The facility had showers as a quere for the facility had showers as a quere months ago with The Administrator si shower on a dat scheduled. The facility had showers as a quere months ago with The Administration of the facility had showers as a quere months ago with The Administration of the facility had showers as a quere months ago with a shower on a dat scheduled. The facility had showers as a quere months ago with a shower of the facility had showers as a quere that the facility had shower as a scheduled. The facility had showers as a quere that the facility had shower as a quere that the facility had shower as the week. NA #3 states with a shower of the facility had shower as the file regarding not mor more provided that shower as the file of the facility had shower as the set of the facility had shower as the shower as the set of the facility had shower as the set of the facility had shower as the shower as the set of the facility had shower the hot receiving 2 she was his as the set of the facility had shower as the set of the facility had shower the hot receiving 2 she was his as the facility had shower the hot receiving 2 she was his as the facility had shower the hot receiving 2 she was his as the facility had shower the hot receiving 2 she was his as the facility had shower the hot receivin</li></ul>	26/17, t ch of th en she r e assign v each g but now did nov tated th ensure view or tated th ensure view or tated R ay he as e Admir identific juality in th ongo tor stat /19/17 1 wer tha hen file A #1 was that sh f 5/3/17 he was cated sh on Thur ecciving erview on tated sh on Thur ecciving erview on tated sh on Thur she was cated sh on Thur ecciving	5 hat he had not received 2 lose weeks. The SWA received the grievances, ned NA to provide him a grievance was filed (4/19/17 understands that on t provide the shower as lat she should have the shower was given. a 5/3/17 at 11:54 AM, the resident #23 should get a sks, even if it not histrator further stated that ed assistance/provision of mprovement issue several ing auditing/monitoring. ed that Resident #23 filed a regarding showers and t day. She also stated that d another grievance on is instructed to shower him, e is saying she did not a t 12:59 PM with NA #3 aware Resident #23 s not getting 2 showers per he assisted Resident #23 sday, 4/27/17, as directed evance on 4/26/17 g 2 showers per week. was conducted on 5/03/17 and revealed she was dent #23 expressed he was rs per week. NA #4 stated NA a few times, but was er schedule and so she did	F	16	36				

Facility ID: 970828

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	-	ND HUMAN SERVICES			PRINTED: 06/30/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345502	B. WING		05/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 166 F 242 SS=D	of that. NA #4 stated Resident #23 on Mor did not assist him wit she was not aware th shower day. NA #4 s schedule changed th was not aware of the Resident #23 filed a not receive 2 shower 483.10(f)(1)-(3) SELF RIGHT TO MAKE CH (f)(1) The resident ha schedules (including health care and prov consistent with his or and plan of care and of this part. (f)(2) The resident ha about aspects of his are significant to the (f)(3) The resident ha members of the com community activities	shower a few times because she was the assigned NA for nday, 4/24/17, but that she h a shower that day because hat it was his scheduled tated that the shower e week of 4/23/17, but she new schedule and so grievance because he did s that week. F-DETERMINATION - HOICES as a right to choose activities, sleeping and waking times), iders of health care services ther interests, assessments, other applicable provisions as a right to make choices or her life in the facility that	F 160	3	6/7/17
	by: Based on observation interviews, and faciliting failed to provide 1 of	<ul> <li>is not met as evidenced</li> <li>on, resident and staff</li> <li>y record review, the facility</li> <li>4 sampled residents with 2</li> <li>r 2 weeks as requested</li> </ul>		F 242 What measures did the facility put in p for the resident affected:	lace
		mitted to the facility on included left thigh fracture		On 5/3/17, the corporate facility consul interviewed Resident #23 related to	tant

Facility ID: 970828

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 06/30/20 FORM APPROVE B NO. 0938-03
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C 05/03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	315 FAITH CHURCH ROAD		
	RK NURSING AND REHA	ABILITATION CENTER		11	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 242	Continued From page	e 7	F	242			
	and chronic pain syn	drome, among others.			receiving 2 showers per week as requested.		
	Data Set (MDS) asse	ecent quarterly Minimum essment dated 4/6/17 f completion was recorded			On 5/3/17, the assigned nursing as assisted Resident #23 with a showe		
	Review of an admiss Care Area Assessme Resident #23 was as	ion MDS assessment and ent dated 1/5/17 revealed sessed with clear speech, nd be understood, intact tant to be involved in			On 5/4/17, the corporate facility con offered Resident #23 a shower. Or 5/4/17, Resident #23 declined a sho on 5/4/17 stating he had received a shower on 5/3/17.	ower. On ned a shower	
	decisions about bath required total staff as	ing preferences, and sistance of 2 persons with e to impaired mobility from			On 5/4/17, the corporate facility con updated the facility shower schedul updated shower schedule includes Resident #23 s requested 2 showe week.	e. The	)
	Resident #23 require staff to restore/mainta self-sufficiency relate hygiene/bathing. Stat	ff were to assist and #23 to participate in personal			On 5/19/17, the social worker asked Resident #23 how it was going and Resident #23 got two showers that Resident #23 stated It is getting bet confirmed he got 2 showers as requ that week.	if week. tter an	
	On 4/30/17 at 11:33 / interviewed and state shower in 2 weeks. F that staff provided hir his face, "but that's it spoken to the social of several times regard helped."	AM, Resident #23 was ed that he had not received a Resident #23 further stated m with a wash cloth to wash ." He revealed that he had worker assistant (SWA) ing this, "but it had not 's April 2017 Grievance Log 23 filed 2 grievances, dated			<ul> <li>On 5/22/17, Resident #23 s electron health record reflected Resident #2 received a shower on 5/15/17 and 5/19/17.</li> <li>On 5/22/17, the director of social segment interviewed Resident #23 regarding bathing. Resident #23 stated he is two showers per week as requested director of social services also compan updated Bathing Preference Questionnaire for Resident #23 white the sector of the sector</li></ul>	3 ervices J getting d. The pleted	)
	4/19/17 and 4/26/17	related to not receiving ed. Review of the grievances			again reflected Resident #23 s des 2 showers each week.		

Facility ID: 970828

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SU	938-039 RVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLET	
					с	
		345502	B. WING		05/03/	2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.00	
				3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	020 02	DATE
F 242	Continued From page	- 8	F 242	2		
	revealed they were re		1 2 7			
		convertibly the OWA.				
	Review of the shower	r schedule on 4/30/17 at		What measures were put in place	for	
	11:50 AM revealed th	at the week of 4/16/17 -		residents having the potential to be		
	4/22/17, Resident #23	3 was scheduled to receive		affected:		
	2 showers per week of	on Wednesday/Friday during				
	the 7AM - 3PM shift.			On 5/22/17, the corporate facility		
		esident #23 was scheduled		consultant audited 100% of reside	-	
	to receive 2 showers	-		Bathing Preference Questionnaire		
		ring the 7AM - 3PM shift, a		verify all current residents had a B	athing	
		began on 4/23/17. Review		Preference Questionnaire sheet	a abaat	
	-	ealed it was blank regarding ot of a shower from 4/16/17 -		completed. The bathing preference includes what type of bath (showe		
	4/30/17.			bed bath, or other) and how many		
	4/50/17.			per week the resident prefers to be		
	On 5/1/17 at 11:30 Al	M Resident #23 was		bathed. Two residents did not have		
		his room from the shower		resident Bathing Preference		
		NA) #1. Resident #23 stated		Questionnaire completed on file.	On	
	"This was my first sho	ower in about 2 weeks."		5/22/17, the social worker interview two residents and completed a Ba	wed the	
	An interview on 5/1/1	7 at 11:45 AM with NA #1		Preference Questionnaire. As of 5		
	revealed she typically	/ worked with Resident #23		100% of current residents have a	Bathing	
		ift. NA #1 stated that she		Preference Questionnaire sheet		
	-	sident #23 with a shower		completed. The Bathing Preference		
	-	to staff that he was not		Questionnaire binder is maintained	d in the	
		ber week and she was		social worker office.		
	-	ctor of nursing (DON) to give				
		y. NA #1 stated Resident		On 5/23/17, the corporate facility	odulo to	
	#23 used to receive s	until the shower schedule		consultant audited the shower sch ensure all the facility s current res		
		4/23/17. NA #1 stated that		rooms are represented on the sho		
		rrently scheduled to receive		schedule and the schedule reflects		
		lays/Thursdays. NA #1		resident s preferred type of bath		
		e was the assigned NA for		full bed bath, or other) and the nur		
		few weeks, but the days		times per week the resident prefer		
		NA were not the days he		bathed. The corporate facility con	sultant	
		eive a shower. Review of		updated the shower schedule, add	ling	
		nd shower schedule during				
	the interview reveale	ed NA #1 was the assigned		On 5/23/17, the corporate MDS co	nsultant	

Facility ID: 970828

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CLINILIN	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938	3-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	(
					С	
		345502	B. WING		05/03/201	7
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD		
	1			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DAT	
F 242	Continued From page	e 9	F 24	42		
		on the following days that he		audited 100% of the Bath	ing Preference	
		ceive a shower or requested		Questionnaires, comparin		
	a shower, but did not	•		questionnaire preference	•	
				care plan and care guide.		
	Friday, 4/21/17			consultant updated sever	al resident care	
	Monday, 4/24/17			plans and care guides to	reflect resident	
	Wednesday, 4/26/17			bathing preferences.		
	Continued interview	with NA #1 revealed, she		What systems were put in	place to	
	could not recall why	she did not provide Resident		prevent the deficient prac	tice from	
		lay, 4/21/17 (a scheduled		reoccurring:		
		Monday, 4/24/17 she stated				
	that she was not awa			On 5/23/17, the staff deve		
	-	and this was his current		coordinator began a new		
		ay. NA #1 also stated that on , Resident #23 requested a		orientation. The new emp orientation will ensure add	-	
	shower according to	-		supervisors, nurses, and		
		se the shower schedule had		assistants will be available		
		sdays was no longer his		services honoring residen		
		ay, NA #1 stated she did not		self-determination-right to		
	provide Resident #23	3 with a shower that day as		including providing bathin	g/showers twice	
	he requested, but rat	her told him that he would		weekly as requested by R	esident #23.	
	receive a shower the	next day (Thursday,				
	4/27/17).			On 5/24/17, the corporate	-	
	An internet			consultant initiated an in-s		
		7 at 2:45 PM with the		admissions, social service		
		DON) revealed the facility shower schedule on 4/23/17		departments related to the right to make choices abo		
		ork load. The DON stated		or her life in the facility that		
	she was made aware			to the resident to include	-	
		as not getting 2 showers per		providing showers as requ	-	
		nd that she advised NA #1 to		resident⊡s Bathing Prefer		
		r on Monday, 5/1/17. The		Questionnaire. The in-ser		
		expected residents to		100% complete by 6/7/17		
		owers per week or to receive		staff and agency staff will		
		eference. The DON also		shower in-service during i	new employee	
		ent requested a shower on a		orientation.		
		as not scheduled for that			formation staff	
	resident, a shower sh	nould still be provided or		On 5/24/17, the director o	i nursing, staπ	

Facility ID: 970828

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						D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · /	E SURVEY PLETED
						С
		345502	B. WING			/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
LAKE PAF	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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 242	Continued From page	e 10	F 24	2		
		sident when a shower could		scheduler, social services d	lirector. MDS	
		tated she reviewed the		nurse, treatment nurse, and		
	•	no further documentation that		consultant began twice wee		
	Resident #23 receive	d 2 showers per week		Bath Type report. The revie	ew of the Bath	
	during the weeks of 4	4/16/17 - 4/30/17.		Type report is to ensure res		
				including Resident #23 are		
		on 5/3/17 at 11:54 AM, the		showers twice weekly as re	•	
		Resident #23 should get a		indicated on the Bathing Pre		
		asks, even if it was not inistrator further stated that		Questionnaire. The review		
		ied assistance/provision of		documented by the reviewe date review noted on the Ba		
	-	improvement issue several		report. Any residents not ge		
		oing auditing/monitoring.		bathed/showered as reques	-	
	• •	ated that Resident #23 filed a		immediately be offered a ba		
		regarding showers and		resident s preference and	• •	
	-	at day. She also stated that		documented in the electron	ic health	
	Resident #23 then file	ed another grievance on		record. This review of the B	ath Type	
	4/26/17 and NA #1 w	as instructed to shower him,		report will continue for a per	riod of three	
		he is saying she did not		months to prevent the defici		
	shower him."			from reoccurring, allowing the		
				opportunity to get used to the		
		7 at 12:59 PM with NA #3		bathing/shower routine. An		
		s aware Resident #23		immediately addressed and	•	
	•	as not getting 2 showers per the assisted Resident #23		attention of the director of n	ursing.	
		irsday, 4/27/17, as directed		On 5/24/17, the director of r	nursing placed	
	because he filed a gr			the bathing preference-base		
	-	ng 2 showers per week.		schedule in the two shower		
	0 0			and posted it also at the nu		
	A telephone interview	was conducted on 5/03/17		(charting room). The postin		
		4 and revealed she was		bathing preference-based s		
		sident #23 expressed he was		schedule in the shower roor	· · · /	
		ers per week. NA #4 stated		at the nurse station will assi		
		NA a few times, but was		communicating to the nursing	-	
		wer schedule and so she did		what days the residents have		
		shower a few times because		bathing, based on the Bathi	ng Preterence	
		she was the assigned NA for		Questionnaire.		
	Resident #23 on Mon	nday, 4/24/17, but that she				

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/30/2017 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED
		345502	B. WING				C 03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER					
		ATEMENT OF DEFICIENCIES			IDIAN TRAIL, NC 28079 PROVIDER'S PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 242	she was not aware th shower day. NA #4 st schedule changed the was not aware of the	hat it was his scheduled tated that the shower e week of 4/23/17, but she new schedule and so grievance because he did	F	242	implemented the use of a new daily st assignment sheet. The new daily assignment sheet will include room numbers of residents who have reque to have a bath/shower on that day, ba on their Bathing Preference Questionnaire. The new daily staff assignment sheet is expected to impro- communication to the nursing assistar of resident requested showers. The n daily staff assignment sheet will also a the nurses to follow-up with the nursin assistants to ensure resident choices honored, including Resident #23 being assisted with 2 showers per week. How the facility will monitor systems p place: On 5/23/17, resident shower preference began being audited by the social services worker, social services direct treatment nurse, nurse supervisor, and corporate nurse consultant to ensure residents are receiving showers accor to their preference. The audit will be documented on shower audit tool. The shower audit tool will be completed for residents daily 5 x per week x 4 weeks then 5 residents weekly x 4 weeks, the residents monthly x 2 months. The monthly Quality Improvement (QI Committee will review the results of th audits monthly x 6 months with recommendation and follow up, as needed or appropriate, for continued compliance in this area and to determ	sted sed ove ts ew illow g are g ut in ces or, d/or ding e f 5 s, en 5	
		poloto Event ID: CI			compliance in this area and to determ	ine	

Event ID: GUI211

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
			3	315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	BILITATION CENTER		NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 242	Continued From page	e 12	F 242	the need for and or/ frequency of continued QI monitoring.	
F 273 SS=D	483.20(b)(2)(i) COMF ASSESSMENT 14 D		F 273		6/7/17
	prescribed in §413.34 must conduct a comp resident in accordance specified in paragrap this section. The time §413.343(b) of this cf (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) This REQUIREMENT by: Based on staff interv Minimum Data Set (M failed to complete a cf MDS assessment wit the facility for 1 of 3 s (Resident #120). Resident #120 was a 4/1/17. On 5/1/17 a review of assessment dated 4/4 sections A, B, E, G, C	<ul> <li>is not met as evidenced</li> <li>iews and review of the</li> <li>ADS) assessment, the facility comprehensive admission</li> <li>hin 14 days of admission to</li> <li>campled residents reviewed</li> <li>dmitted to the facility on</li> <li>f an admission MDS</li> <li>8/17 revealed the status of</li> <li>GG, H, I, J, K, L, M, N, P and</li> <li>he status of sections C, D, F</li> </ul>		F 273 What measures did the facility put in for the resident affected: On 5/9/2017 the admission Minimum Set (MDS) for resident #120 with the 4/8/2017 was completed by the Corpo RAI/Reimbursement Auditor. The assessment was transmitted and accepted on 5/10/2017. What measures were put in place for residents having the potential to be affected:	Data ARD

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED	
		245500	B. WING			С	
		345502	B. WING_			5/03/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
		ATEMENT OF DEFICIENCIES	ID		N OF CORRECTION	(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 273	Continued From page	e 13	F 2	73			
	incomplete 30 days a			facility Corporate RAI/F	Peimhursement		
				Auditor using the MDS			
	An interview with the	Resident Assessment		MDS scheduler to iden			
	Instrument (RAI) Rei	mbursement Auditor		assessments. No late a	•		
	(corporate consultant			identified.			
		Resident #120 occurred on					
		<ol> <li>During the interview the</li> </ol>		What systems were pu	•		
		Auditor stated that she had		prevent the deficient pr	actice from		
		vith MDS assistance over the		reoccurring:			
		se some MDS assessments e RAI Reimbursement		On 5/23/17 & 5/24/17 t			
		e facility was in the process		were in-serviced by the			
	of hiring a full-time M			RAI/Reimbursement Au			
		ime MDS Coordinators. She		timely completion of MI			
		Imission MDS dated 4/8/17		include admission asse			
	for Resident #120 wa facility was currently	as incomplete and that the working on MDS		RAI manual.	·		
		e most current due date to		How the facility will mo	nitor systems put in		
		further assessments. She		place:			
	stated that the currer	nt MDS assessments that					
		ain late until the facility could		On 5/30/17, the directo			
	get caught up.			assistant director of nu			
	During on interviews	D E/0/17 at 11/54 ANA the		administrator, and/or a	-		
	-	on 5/3/17 at 11:54 AM, the the facility was currently		consultant began moni monitoring the MDS ad			
	behind on the comple			assessments to ensure			
	assessments due to			assessments are comp			
		ninistrator stated that the		due date using the MD			
	facility currently had			assessment tool. The			
	Coordinators, was in	the process of hiring a		completed weekly for 1	2 weeks then		
		nator and was currently		monthly for 3 months.			
	using corporate supp on the MDS assessm	oort in order to get caught up nents that were late.					
				The administrator and/ all findings from the MI			
				assessment tool at the	-		
				committee. The month			
				will review the results o	•		
				completion audit tool m	onthly for 6		

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 05/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO	
F 273	Continued From page	e 14	F 273	months for identification of trends, acti taken, and to determine the need for and/or frequency of continued monitor and make recommendations for monitoring for continued compliance. administrator and/or DON will present findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	ing, The	
F 274 SS=D	AFTER SIGNIFICAN (b)(2)(ii) Within 14 da determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplina care plan, or both.)	ays after the facility I have determined, that	F 274		5/27/17	
	by: Based on staff intervi review, the facility fail change comprehensiv assessment within 14 nutrition/wound status residents (Resident # Resident #72 was orig	iews and medical record ed to complete a significant ve Minimum Data Set (MDS) days after a change in s for 1 of 6 sampled 72). ginally admitted to the facility s included Alzheimer's		F Tag 274 late Sig Change MDS assessments What measures did the facility put in p for the resident affected: On 5/3/2017 the Significant Change Minimum Data Set (MDS) for resident with the ARD 4/8/2017 was completed the Corporate RAI/Reimbursement Auditor. The assessment was transmit	#72 by	

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		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	OMB N	RM APPROVE IO. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· , ,				MPLETED C	
		345502	B. WING			0	5/03/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	K NURSING AND REHA			33	315 FAITH CHURCH ROAD			
	IN NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 274	Continued From page	e 15	F	274				
					and accepted on 5/8/2017.			
	· ·	essment dated 12/24/16						
	assessed Resident #				What measures were put in place for			
		physical assistance of 1 staff			residents having the potential to be			
	•	eceived 100% of her nutrition altered diet and had no			affected:			
	ulcers, wounds or ski				On 5/24/17 an audit was completed b	v the		
					facility Corporate RAI/Reimbursement	-		
	Review of a Discharg	e MDS assessment dated			Auditor using the MDS in progress list			
		sident #72 had an unplanned			MDS scheduler to identify late signific			
	hospital discharge or				change assessments. No late			
	-	the facility. Resident #72 was			assessments were identified.			
		cility on 3/22/17 after an						
	acute hospital stay re	equiring surgery.			What systems were put in place to			
	Poviow of the bespit	al discharge summary dated			prevent the deficient practice from reoccurring:			
		sident #72 had a surgically			reoccurring.			
		endoscopic gastrostomy			On 5/23/17 & 5/24/17 the MDS nurses	S		
	(PEG) tube which rec				were in-serviced by the Corporate	-		
		ical wound and she now			RAI/Reimbursement Auditor related to	the		
	received 100% of her	r nutrition via a tube feeding			timely completion of MDS assessmen	ts to		
	product.				include significant change assessmer	nts		
	Evently and the l				per the RAI manual.			
		rd review revealed Resident			How the facility will manifer exeterne	utic		
	-	ed hospital discharge on ange in mental status and			How the facility will monitor systems p place:	ut m		
	was re-admitted to th				place.			
					On 5/30/17, the director of nursing (D	ON).		
	A significant change	MDS assessment dated			assistant director of nursing (ADON),			
		and revealed it was coded			administrator, and/or a corporate			
		had not been completed			consultant began monitoring began			
		significant changes for			monitoring the MDS significant chang	е		
		al placement of a PEG tube,			assessments to ensure all parts of			
	0	al status and dressing			assessments are completed on or bef	ore		
	changes for a surgica	ai wound).			due date using the MDS completion			
	During an interview of	on 5/3/17 at 11:54 AM, the			assessment tool. The audit will be completed weekly for 12 weeks then			
	-	the facility was currently			monthly for 3 months.			
	behind on the comple				monuny for o monuto.			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			<b>IPLETED</b>
		345502	B. WING		0	C 5/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3315 FAITH CHURCH ROAD		
ANE PAR	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 274	Continued From pag	e 16	F 274	1		
1 27 1			F 274	+		
	assessments due to	ninistrator stated that the		The administrator and/or DON	will present	
	facility currently had			all findings from the MDS comp		
		the process of hiring a		assessment tool at the monthly		
		inator and was currently		committee. The monthly QI co		
	using corporate supp	port in order to get caught up		will review the results of the ME	DS	
	on the MDS assessr	nents that were late.		completion audit tool monthly for		
				months for identification of tren		
		Corporate Nurse Consultant		taken, and to determine the new		
		sessment Instrument (RAI) itor (corporate consultant)		and/or frequency of continued and make recommendations for	-	
		7 at 4:21 PM. The interview		monitoring for continued compl		
		72 discharged to the hospital		administrator and/or DON will p		
		ned to the facility on 3/22/17		findings and recommendations		
	with a PEG tube that	was surgically placed in the		monthly QI committee to the qu		
	hospital and required	d dressing changes to the		executive QA committee for fur	ther	
	-	erview also revealed that		recommendations and oversigh	nt.	
		rged to the hospital again on				
		urned on 4/1/17, and a				
		DS dated 4/8/17 was still in the teen completed. During the				
		imbursement Auditor stated				
		d the facility with MDS				
		prior 4 weeks because some				
		vere incomplete. The RAI				
		itor stated that the facility				
		f hiring a full-time MDS				
		ently had 2 part-time MDS				
		onfirmed that the significant				
	-	4/8/17 for Resident #72 was the facility was currently				
		essments with the most				
		prevent being late on further				
	-	tated that the current MDS				
		ere late would remain late				
	until the facility could	l get caught up.				
F 276		RLY ASSESSMENT AT	F 270	6		6/7/17
SS=D	LEAST EVERY 3 MO	NITUC				

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CENTER STATEMENT	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			FOR OMB N (X3) DATE	D: 06/30/2017 M APPROVED O. 0938-0391 E SURVEY PLETED
		345502	B. WING			05	C 5/03/2017
	ROVIDER OR SUPPLIER			S <sup>-</sup> 3:	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	05	///////////////////////////////////////
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 276	(c) Quarterly Review	Assessment. A facility must	F	276			
	instrument specified to by CMS not less frequent months. This REQUIREMENT by: Based on staff intervent Minimum Data Set (M failed to complete a q months of the previou assessment for 1 of 6 reviewed (Resident # Resident #23 was ad 12/29/16. An admission MDS w #23 on 1/5/17. On 5/1/17 review of th MDS assessment dat status of completion w Progress", 118 days a admission MDS dated E, G, GG, H, I, J, L an Progress" and section "Complete." An interview with the Instrument (RAI) Rein (corporate consultant MDS for Resident #22 10:29 AM. During the Reimbursement Audit provided the facility w prior 4 weeks becaus	s sampled residents 23). mitted to the facility on vas completed for Resident he most recent quarterly ted 4/6/17 revealed the was recorded as "In after completion of the d 1/5/17. Sections A, C, D, nd N were all coded as "In ns C and K were coded as Resident Assessment mbursement Auditor ) and review of the quarterly 3 occurred on 05/03/17 at			F 276 What measures did the facility put in p for the resident affected: On 5/15/2017, the quarterly Minimum Data Set (MDS) for resident #23 with t ARD 4/6/2017 was completed by the Corporate MDS Consultant. The assessment was transmitted and accepted on 5/16/2017. What measures were put in place for residents having the potential to be affected: On 5/24/17, an audit was completed by the Corporate RAI/Reimbursement Auditor using the MDS in progress list MDS scheduler to identify late quarterl assessments. No late assessments we identified. What systems were put in place to prevent the deficient practice from reoccurring: On 5/23/17 & 5/24/17, the MDS nurses were in-serviced by the Corporate RAI/Reimbursement Auditor related to timely completion of MDS assessment	he y and y ere	

Facility ID: 970828

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TATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY PLETED
		345502	B. WING		0	C 5/03/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 276	Continued From page	e 18	F 276	5		
	Auditor stated that the facility was in the process of hiring a full-time MDS Coordinator and currently had 2 part-time MDS Coordinators. She			include quarterly assessments RAI manual.	per the	
	confirmed that the qu Resident #23 was inc	arterly MDS dated 4/6/17 for complete and that the facility		How the facility will monitor sys place:	tems put in	
	the most current due on further assessmer current MDS assessmer	g on MDS assessments with date to prevent being late hts. She stated that the nents that were late would acility could get caught up.		On 5/30/17, the director of nurs assistant director of nursing (AI administrator, and/or a corporat consultant began monitoring be	DON), e	
				monitoring the MDS quarterly assessments to ensure all parts assessments are completed on due date using the MDS comple assessment tool. The audit will	or before etion	
	facility currently had 2 Coordinators, was in	ninistrator stated that the 2 part-time MDS the process of hiring a nator and was currently		completed weekly for 12 weeks monthly for 3 months.	then	
		ort in order to get caught up		The administrator and/or DON of all findings from the MDS comp assessment tool at the monthly committee. The monthly QI con will review the results of the ME completion audit tool monthly for	letion QI nmittee S or 6	
				months for identification of trend taken, and to determine the nee and/or frequency of continued r and make recommendations fo monitoring for continued compli administrator and/or DON will p findings and recommendations monthly QI committee to the qu executive QA committee for fur- recommendations and oversigh	ed for nonitoring, r ance. The resent the of the arterly her	
F 282 SS=D	483.21(b)(3)(ii) SERV PERSONS/PER CAR		F 282	_		6/7/17

Facility ID: 970828

If continuation sheet Page 19 of 52

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/30/2017 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRU		· · ·	TE SURVEY MPLETED
		345502	B. WING _			0	C 5/03/2017
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
LAKE PA	RK NURSING AND REHA	BILITATION CENTER			CHURCH ROAD AIL, NC 28079		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE AC           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	<ul> <li>(b)(3) Comprehensive The services provide as outlined by the commust-</li> <li>(ii) Be provided by quaccordance with each care.</li> <li>This REQUIREMENT by: Based on observation and staff interviews the plan interventions by bell in reach for for 1 (Resident #78).</li> <li>The Findings included Resident #78 was ad 12/23/16 with diagnost Parkinson's disease, altered mental status</li> <li>Review of care plan in revised on 04/14/17 mwas at risk for falls of falls and actual falls with process of Parkinson stated care plan was sustain further seriou Interventions included and answer timely.</li> <li>Review of the most red data set (MDS) dated Resident #78 was ab understood and was impaired. The MDS at</li> </ul>	e Care Plans d or arranged by the facility, mprehensive care plan, alified persons in n resident's written plan of " is not met as evidenced ms, record reviews, resident he facility failed to follow care not having a resident's call of 5 residents sampled d: mitted to the facility on ses that included anxiety, dysphagia, and nitiated on 02/07/17 and read in part, Resident #78 haracterized by history of with injury related to disease 's disease. The goal of Resident #78 would not s injury through next review. d, keep call light within reach	F 2	F282 The se facility person resider 1)On 5 and ca update (MDS) resider include reach a resider bell to 5/1/17 repaire was ful 2)On 5 began and ca through ensurir guides approp comple	ervices provided or arrange must be provided by qual is in accordance with each nt swritten plan of care 5/24/17 Resident #78 s ca are guide were reviewed a do by the Minimum Data S to be accurate and up to nt care plan and care guid es risk for falls focus with of as an intervention. On 5/1 nt # 78 was provided with use until call bell was reparesident # 78 s call bell vas resident # 78 s call bell vas resident # 78 s call bell vas resident # 78 s call bell vas reviewing 100% of the cal reviewing 100% of the cal in the MDS process with fa and resident care plans and are up to date including priate interventions. The are teted by 5/27/17. All reside ll in reach listed as an intervantional sectors.	ified n are plan nd set Nurse date. The le call bell in /17 a ding aired. On was ector and sultants re plans identified all risk d care udit will be ents with	

Facility ID: 970828

If continuation sheet Page 20 of 52

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	3		С
		345502	B. WING		c	5/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				3315 FAITH CHURCH ROAD		
LAKE PAI	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 282	Continued From pag	e 20	F 28	32		
		pility, and dressing. The		were audited by the cor	porate consultant	
	0.	hat Resident #78 was		on 5/24/17 ensuring the		
	occasionally incontin	ent of bowel and bladder.		call light within resident	reach.	
	An observation on 04	4/30/17 at 11:27 AM of		3) On 5/24/17, the staff	facilitator began	
		revealed, Resident #78 was		in-servicing a 100% all r		
		om. No call bell was present		aides, and nursing assis		
		her means noted in the room		following resident care p		
	for Resident #78 to c	contact the nurse's station.		guides to ensure each r provided quality care an		
	An observation on 04	4/30/17 at 12:40 PM of		maintained to include ke	-	
		revealed, Resident #78 was		light in reach. In-service		
		at bedside. No call bell was		by 6/7/17. During orier	-	
		as no other means noted in		employees nurses and		
		nt #78 to contact the nurse's		will continue to be educ		
	station.			importance of following		
	An observation on O	4/30/17 at 4:16 PM of		plans and care guides a each form.	ind locations of	
		revealed, Resident #78 was		each ionn.		
		lo call bell was present and		4)The administrative nu	rses, DON, staff	
		neans noted in the room for		facilitator, corporate co		
	Resident #78 to cont	act the nurse's station.		MDS nurse began utilizi	ing the care	
				plan/guide audit tool on		
		5/01/17 at 10:42 AM of		care plans and care gui		
		revealed, Resident #78 was		followed to include inter	-	
	-	lo call bell was present and neans noted in the room for		to assist with managem identified with fall risk in		
		act the nurse's station.		include keeping call ligh		
				Random audit of 10% of		
	An observation on 0	5/01/17 at 2:51 PM of		reviewed weekly x 12 w		
		revealed, Resident #78 was		x 3 months.		
	-	lo call bell was present and			· · · · · · · · · · · · · · · · · · ·	
		neans noted in the room for act the nurse's station.		5)The monthly QI comm		
				results of the audits x 6 trends, actions taken an	-	
	An interview with NA	#2 was conducted on		need for and /or frequer		
		. NA #2 stated that she		monitoring and make re		
		esident #78. NA #2 stated		for monitoring for contin	ued compliance.	
	that Resident #78 us	ed her call bell frequently to		The administrator and/o	r DON will present	

Facility ID: 970828

If continuation sheet Page 21 of 52

						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	E SURVEY
			A. DOILDING			С
		345502	B. WING		0	5/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD		
	AND AND AND AND			INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 282	Continued From page	e 21	F 28	32		
	make staff aware of h	ner needs. NA #2 stated		the findings and recomme	ndation to the	
		ring her call light if she was		quarterly executive QA con		
		up out of bed or if she		further recommendations a	and oversight.	
	wanted to get back into bed. NA #2 stated that the last thing she does before leaving the					
		ke sure the call light was				
	within reach.	6				
	An interview with Me	dication Aide (MA) #1 was				
		17 at 2:39 PM. MA #1 stated				
		red for Resident #78. MA #1				
	-	worked extensively with				
		her to use the call light. MA				
		ent #78 would try to get up				
	-	MA #1 stated that after				
		sident #78 she now used her				
	call bell to alert staff	that she needed to use the				
		wanted to get up or be laid				
		that Resident #78 would also ert staff that she was in pain.				
	-	mething happened to her call				
		ter her shift ended on				
		ad given Resident #78 a bell				
	to use to call for help					
	An interview with the	interim Director of Nursing				
	(DON) was conducte	d on 05/02/17 at 4:00 PM.				
		ted that Resident #78 used				
		uently to alert staff of her				
		ON stated that all care plan ected to be followed and she				
		sident #78 was able to call				
	for assistance when	she did not have a call bell				
	available to her.					
	An interview with the	Administrator was				
	conducted on 05/02/					
	Administrator stated	that all aaro plana aro				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 282 F 312 SS=D	working then everyor the resident a bell im An interview with Res 05/03/17 at 1:27 PM. used her call bell whe restroom or when she Resident #78 stated 04/30/17 she did not had to wait until staff Resident #78 stated 05/01/07 someone ha until they fixed her ca 483.24(a)(2) ADL CA DEPENDENT RESID (a)(2) A resident who activities of daily livin services to maintain of personal and oral hyo This REQUIREMENT by: Based on observation and staff interviews the resident for incontine 4 residents sampled (Resident #72 was rea 04/01/17 with diagno pneumonia, Alzheime	red and if the call bell is not ne has been trained to give mediately. sident #78 was conducted on Resident #78 stated she en she needed to use the e wanted to get out of bed. that on the evening of have a call bell and "she just came into her room." that on Monday afternoon ad given her a bell to use ill bell. RE PROVIDED FOR DENTS is unable to carry out g receives the necessary good nutrition, grooming, and giene. T is not met as evidenced ons, record reviews, family he facility failed to check a nce on the day shift for 1 of for activities of daily living the facility failed to the facility on ses that included er's disease, non-Alzheimer's h, and other psychotic	F 282	F 312 What measures did the facility put in pl for the residents affected: On 4/30/17, the nursing assistant wash dried, replaced the brief, put lotion on Resident #72, and changed the bed lin On 4/30/17, the administrator assigned the department heads to made incontir rounds every two hours to ensure residents were being attended to and t	ned, ien. i nent
	Review of the most re			nursing assistants were providing incontinent care for dependent residen	

Event ID: GUI211

Facility ID: 970828

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		MEDICAID SERVICES					<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	TE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	G			
		0.45500					С
		345502	B. WING			0	5/03/2017
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETIO DATE
				_	DEFICIENCY)		
F 312	Continued From page	e 23	F 31	12			
	Minimum Data Set (N	/IDS) dated 04/08/17			Non-nursing department heads (Activit	ties.	
	,	nt #72 was severely impaired			accounts payable, accounts receivable		
		king and was rarely/never			dietary, maintenance, social services)		
	understood. The MD				check residents' clothing for cleanlines	s	
	Resident #72 require	d total assistance of 1 staff			(dry and unsoiled) and for odors and		
		and was always incontinent			document on the Administrative		
	of bowel and bladder				Staff/Department Head Rounds Sheet		
					Nursing department heads (director of		
	Review of the Urinary	y Incontinence Care Area			nursing, assistant director of nursing, s	staff	
	Assessment (CAA) d	ated 04/08/17 read in part,			facilitator, MDS, quality improvement		
	that Resident #72 wa	is dependent for toileting			nurse) check residents' briefs/pull-ups	for	
	tasks and was totally	incontinent of bowel and			wetness and/or soiling and document	on	
	bladder.				the Administrative Nursing Rounds Sh	eet.	
		sident #72's family member			On 4/30/17, the administrator, director		
		/30/17 at 12:30 PM. The			nursing (DON), and scheduler reviewe		
		orted that she had just came			the staff assignment sheet and the sta		
	to visit and when she	•			schedule to ensure there was a nursin	g	
	member's room it sm	elled very strongly of			assistant assigned to assist Resident #	¥72	
		The family member was			with incontinent care.		
		dorizing spray from her					
		in the room to alleviate the			On 5/8/17 through 5/19/17, the corpora	ate	
		of urine. The family went on			facility consultants began checking		
		ad just arrived to the facility			Resident #72 on a daily basis to ensur		
	-	y member was incontinent			the facility had provided incontinent ca		
		their family member had not			Resident #72 was dry and had no odo		
	-	ng time. The family member			during most checks. When the resider	nt	
		the covers back off of			was wet or with odor, the facility		
		ted a large brown ring on the			consultant obtained immediate assista		
	·	t. The family member further			to provide incontinent care for Resider	nt	
		vas visibly soiled and the pad			#72.		
	was also very wet to	-					
		to a member of the facility			On 5/24/17, the corporate facility		
	-	nd asked why their family			consultant checked Resident #72 to		
	member had been let	-			ensure the facility had provided		
		ad apologized and offered to			incontinent care. Resident #72 was cl	ean	
		are to Resident #72. The			and dry.		
	family member stated and stated, "If they co	d she had declined the help					

Facility ID: 970828

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(X3) DATE SURVEY COMPLETED C	
05/03/2017	
CTION (X5) DULD BE COMPLETIO ROPRIATE DATE	
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Facility ID: 970828

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						B NO. 0938-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		. ,	DATE SURVEY COMPLETED
			A. BUILDING	3		С
		345502	B. WING		_	05/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	00/00/2011
				3315 FAITH CHURCH ROAD	)	
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 2807	9	
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION	(X5) COMPLETIC
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFEREN	ICED TO THE APPROPRIATE EFICIENCY)	DATE
F 312	Continued From page	e 25	F 31	2		
	been removed NA #6	stated that she and NA #5		Incontinent rounds f	findings and corrective	
	had started a round to	o provide care to the		actions taken are do	•	
		ed she had been in Resident		non-nursing departr	•	
	#72's room providing	care to the roommate when		Administrative Staff	/Department Head	
	she overheard Reside	ent #72's family get upset		Rounds Sheet and	-	
		was soiled. NA #6 stated		department heads v		
		g care to the roommate and			on the Administrative	
		esident #72. NA #6 stated		Nursing Rounds Sh	eet.	
		ent care to Resident #72 at				
		as the first time she had		What systems were		
		ident #72 since arriving for stated that Resident #72		prevent the deficien reoccurring:	it practice nom	
		anged at 6:30 AM on 3rd		reoccurring.		
		#6 stated that at 12:15 PM		On 4/30/17 the adm	ninistrator, director of	
		nd put lotion on Resident		nursing (DON), assi		
	#72 and replaced her			- · ·	eatment nurse, social	
				services director (a		
	An interview with NA	#7 was conducted on		social services assis		
	04/30/17 at 1:19 PM.	NA#7 stated she had		assistant), activities	director, staff	
	worked 3rd shift and	was the only NA on the		facilitator, and/or co	prporate facility	
	medical unit which ha	ad approximately 55		consultants conduct	t daily administrative	
		ed that she generally tried to		rounds, to include n	nonitoring for	
		h night on her shift. NA #7			ensure the facility is	
	-	was only able to change			nt care for dependent	
		she changed Resident #72			ninistrator, department	
		rtunately that was the only		heads, hall nurses,		
		ovide any care to Resident			onitor dining rooms and	
		#7 stated that Nurse #2 that help as much as she could		for residents needin	daily basis, watching	
	•	medications and doing other			ment heads (Activities,	
		that if there would have			accounts receivable,	
		lent #72 would have been		dietary, maintenanc		
		every 2 hours like she was		•	thing for cleanliness	
	supposed to be.			(dry and unsoiled) a	•	
				document on the Ac		
	An interview with NA	#5 was conducted on		Staff/Department He	ead Rounds Sheet.	
		NA #5 stated that she and		Nursing department	-	
	NA #6 were working t	together on their assignment		nursing, assistant d	irector of nursing, staff	
		esponsible for Resident #72.		facilitator, MDS, qua		

Facility ID: 970828

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	E SURVEY
		245500				С
		345502	B. WING			5/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (		(X5)
PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETIC DATE
F 312	Continued From pag	e 26	F 31	12		
		en she arrived for her shift	-	nurse) check residents' b	riefs/pull-ups for	
		another unit in the facility		wetness and/or soiling ar	· ·	
	-	had not shown up for work.		the Administrative Nursin		
		e supervisor had called in 2		Any issues of a resident	-	
		to come and help out so		incontinent care is immed	•	
		ved to work I was reassigned		by the auditor who will er		
		lent #72. NA #5 stated this		is escorted to their room	•	
	-	ed at 9:00 AM which was breakfast. NA #5 explained		a registered nurse, licens nurse, and/or nursing ass	-	
	-	he assignment for Resident		Incontinent rounds finding		
		passing breakfast trays,		actions taken are docum		
		vith eating, and then picking		non-nursing department		
	-	fter all the breakfast trays		Administrative Staff/Depa		
		IA #5 stated that she and NA		Rounds Sheet and the nu	ursing	
	#6 had started a rou	nd to provide care to the		department heads will do	ocument	
		ted she had been in Resident		incontinent rounds on the	Administrative	
		care to the roommate when		Nursing Rounds Sheet.		
		lent #72's family get upset			,, <b>,</b>	
		as soiled. NA #5 stated she		On 5/17/17, the administ		
		re to the roommate and then ent #72. NA #5 stated that		nursing, and corporate co received consultation from		
		sist Resident #72 the room		Improvement Organizatio	-	
		y of ammonia and urine. NA				
		sisted Resident #72 with		On 5/22/17, ongoing thro	ough 5/30/17. the	
		2:15 PM and that was the		staff facilitator continued	•	
	first time she had pro	ovide care to Resident #72		orientations for new regis		
	-	shift. NA #5 stated that		(RNs), licensed practical		
		have been changed at 6:30		medication aides, nursing		
		st round. NA #5 stated that		geriatric care assistants (		
		Resident #72 there was a		there is enough staff, eve		
		went from the pad to the		members do not show up		
		e mattress. NA #5 stated that		provide incontinent care		
	-	esident #72's neck and er knees. NA #5 stated that		residents, including Resident		
		was soaked and was heavy		On 5/24/17, the corporate	e facility	
	to the touch.	the sound and was neavy		consultant reviewed the	-	
				assignment to ensure all	, ,	
	An attempt to speak	to Nurse #2 was		current resident rooms a	-	
	unsuccessful on 05/0		1	the staffing assignments.		1

Facility ID: 970828

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/30/2017 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING				C 03/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	RK NURSING AND REHA	BILITATION CENTER			315 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 312	An interview with the (DON) was conducted The interim DON statts should be provided at needed. The interim I expected Resident #77 changed every 2 hout 1st shift should have AM. The interim DON me that Resident #772 ADL care provided to An interview with Adm 05/02/17 at 4:42 PM. that she expected Reservery 2 hours and as stated that it was not the resident's once a stated that she also expected that the the that she also expected that the the also expected that the the that the the the the the that the the the the the the the the the th	interim Director of Nursing d on 05/02/17 at 4:03 PM. red that incontinent care t least every 2 hours and as DON stated that she 72 to be checked and rs through the night and then provided care to her by 8:00 I stated "it is disturbing to 2 had no incontinent care or her by 12:00 PM." ninistrator was conducted on The administrator stated rsident #72 to be changed needed. The administrator acceptable to only change shift. The Administrator expected the nurses that as needed with providing	F	312	multiple staff expressed concern over being able to read/understand/adjust t assignment sheet, especially when sta members do not show up to work, "po communication" was identified as a ro cause for not providing incontinent/AE care for dependent residents, including Resident #72 on 4/30/17. On 5/25/17, the administrator began review and discussion of the administrative rounds tool in the daily department head meeting and DON began review and discussion of the administrative nurse rounds tool in the daily clinical meeting. Both rounds to include checking the resident for cleanliness (wetness, soiled) and odor The purpose of reviewing and discuss the administrative nursing rounds tool duri the daily meetings, rather than independent review only by the administrative operational team and the nursing clinical teams. Improved coordination of resident-centered care including incontinent care, for dependent residents. On 5/31/17, the director of nursing (Do and staff facilitator initiated an in-servit for all RNs, LPNs, medication aides, a nursing assistants on providing incontinent care for dependent resider The focus of the in-service is the importance of communication during	aff or ot DL g ols rs. ing ing e le , ent DN) ce nd	

Facility ID: 970828

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		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345502	B. WING		05/03/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1
	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 312	Continued From page	228	F 312	change of shift, when assignments at changed, and if provision of assistant with incontinent care/ADLs is not bein provided as scheduled; communication must include verbal and written communications "up-down and down to ensure dependent residents are assisted with incontinent care. This in-service will be completed on 6/7/17 After 6/7/17, no RN, LPN, medication aide, or nursing assistant will be allow to work until the incontinent care in-service is completed. This incontin care in-service will be incorporated in new employee orientation. On 6/1/17, the administrator, director nursing (DON), assistant director of nursing (ADON), quality improvemen nurse, treatment nurse, MDS nurse, to supervisor, charge nurse, social serv director (a nursing assistant), social services assistant (a nursing assistant activities director, staff facilitator, and corporate facility consultants conduct conduct Shift incontinent rounds twice each shift to ensure the facility is pro- incontinent care for dependent reside Any issues of a resident needing incontinent care is immediately addres by the auditor who will ensure the res- is escorted to their room and assisted a registered nurse, licensed practical nurse, and/or nursing assistant. Shiff incontinent rounds findings and correr actions taken are documented by the Incontinent Rounds Sheet for four we The Shift Incontinent Round Sheet w completed and turned in to the direct	ce ng ng -up" -up" 7. ved hent to of t (QI) hurse ices ht), l/or : will e viding ents. essed sident d by t cctive : Shift eeks. ill be

Event ID: GUI211

Facility ID: 970828

If continuation sheet Page 29 of 52

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PA	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD	
				NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 312	Continued From page	e 29	F 312	nursing. The director of nursing w review the Shift Incontinent Round five times weekly at the clinical me for four weeks. How the facility will monitor system place: Using, the quality improvement (Q Tool the administrator, DON, assis director of nursing, quality improve (QI) nurse and/or the nursing supe will review the resident concerns n summary, the administrative round the Administrative nursing rounds t the Shift Incontinent Round Sheets the daily staffing sheets, to identify trends and/or patterns related to pu of incontinent/ADL care for depend residents. The administrator and/or DON will any issues of failure to provide inco care for a dependent resident will n retraining and additional monitoring Findings and results of the QI tools reviewed by the monthly QI comm and the quarterly QAA committee n for 6 months. The QI and QAA committees will focus on improving resident care, including incontinent through developing communication	I Sheets beting I) Audit tant imment ervisor nonthly is tools, tools, s, and v any rovision dent ensure ontinent result in g. s will be ittee meeting g t care, n. As
				any issues of failure to provide inco- care for a dependent resident will a retraining and additional monitoring Findings and results of the QI tools reviewed by the monthly QI comm and the quarterly QAA committee a for 6 months. The QI and QAA committees will focus on improving resident care, including incontinent	ontinent result in g. s will be ittee meeting t care, n. As of the m, use

Event ID: GUI211

Facility ID: 970828

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD IDIAN 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 312 F 315 SS=D	483.25(e)(1)-(3) NO ( RESTORE BLADDEF (e) Incontinence.	CATHETER, PREVENT UTI,	F 312 F 315	process failures, including incontinent care for dependent residents. Once the communication is opened u identify factors causing nonconformat the administrator and/or DON will pre the monthly QI committee recommendations to the quarterly executive QAA committee for addition recommendations for monitoring and continued compliance. The QAA committee will continue consulting wit the QIO until substantial compliance i achieved.	p to nce, sent nal
	<ul> <li>continent of bladder a receives services and continence unless his or becomes such that to maintain.</li> <li>(2)For a resident with on the resident's com facility must ensure th</li> <li>(i) A resident who ent indwelling catheter is resident's clinical con catheterization was n</li> <li>(ii) A resident who ent indwelling catheter or is assessed for removies</li> </ul>	and bowel on admission assistance to maintain or her clinical condition is t continence is not possible urinary incontinence, based prehensive assessment, the nat- ers the facility without an not catheterized unless the dition demonstrates that			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345502	B. WING		05/03/2017
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 315	and (iii) A resident who is receives appropriate prevent urinary tract is continence to the ext (3) For a resident with on the resident's com facility must ensure th incontinent of bowel of	theterization is necessary incontinent of bladder treatment and services to infections and to restore ent possible. In fecal incontinence, based uprehensive assessment, the nat a resident who is	F 315		
	by: Based on record rev staff interviews the fa urinalysis and culture	is not met as evidenced iews, nurse practitioner, and cility failed to respond to a that was positive for 2 of 3 residents with an Resident #69).		F 315 No Catheter, Prevent UTI, Res Bladder What measures did the facility put in p for the residents affected: On 3/21/17, the staff nurse collected Resident #69's urine specimen. On 3/25/17, the laboratory received Resid	blace
	10/23/15 with diagnor vascular accident with diabetes mellitus, and disease. Review of the most re Data Set (MDS) date Resident #69 was se decision making. The Resident #69 require toileting and was alw The MDS further reve	mitted to the facility on ses that included cerebral h hemiplegia, dysphagia, d peripheral vascular ecent quarterly Minimum d 04/13/17 revealed that verely impaired for daily MDS also revealed that d total assistance with ays incontinent of bowel. ealed that Resident #69 had r and 1 Stage 4 pressure		#69's urine specimen. On 3/25/17, th laboratory results for Resident #69's u specimen were available in the electro laboratory reporting system. On 3/27/17, the staff nurse collected Resident #69's urine specimen. On 3/27/17, the laboratory received Resid #69's urine specimen. On 3/27/17, th laboratory results for Resident #69's u specimen were available in the electro laboratory reporting system. On 4/2/17, the nurse called the on-cal physician regarding Resident #69's u culture and sensitivity report. On 4/3/ Resident #69's physician/nurse	urine onic dent e urine onic ll rine

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/30/2017 APPROVED D: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED
		345502	B. WING			C 05/03/2017	
NAME OF PF	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	K NURSING AND REHA	BILITATION CENTER	NTER 3315 FAITH CHURCH ROAD				
		ATEMENT OF DEFICIENCIES			NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC 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 315	Continued From page	e 32	F	315			
					practitioner ordered an antibiotic to be		
		n's order dated 03/20/17			given and contact precautions. On		
		s with culture and sensitivity.			4/3/17, the nurse notified Resident #69 responsible party.	9's	
		y result of the urinalysis for 03/25/17 indicated that the			What measures were put in place for		
		imen was 03/21/17 and it			residents having the potential to be		
		aboratory on 03/25/17. The			affected:		
	-	to be positive and was noted			On 4/3/17, the staff facilitator initiated		
		isms. The microorganisms			in-service for 100% of nurses regardin		
	were Escherichia coli	nase (ESBL) (resistant to			the physician must be notified when an abnormal laboratory result is received		
	-	viotics) and proteus mirabilis.			2) notification of the physician must be		
	•	ted that the microorganisms			documented in the medical record with		
	were resistant to Leva	aquin (antibiotic) and most			any new orders.		
	susceptible to amikad	cin (antibiotic).			On 4/3/17, the corporate facility consu	ltant	
	Deview of a laborator				initiated a 4-point plan titled MD		
		y results of urinalysis for 03/27/17 indicated the			Notification of Abnormal Labs. The 4-point plan included corrective action	for	
	specimen was collect				Resident #69, corrective action for oth		
	•	atory on 03/27/17. The			residents in the facility, measures put i		
	urinalysis was noted	to be positive and was noted			place to prevent recurrence, and		
		isms. The microorganisms			measures to monitor for sustained		
	were Escherichia coli				improvements. On $E/2/47$ the director of purging and		
	-	nase (ESBL) (resistant to iotics) and proteus mirabilis.			On 5/3/17, the director of nursing and corporate facility consultants met to		
	-	ted that the microorganisms			perform a root cause analysis using the	е	
	-	aquin and most susceptible			"5-Whys" process. Communication as		
	to amikacin.	·			evidence by lack of information and la		
					of access to electronic health records		
		note dated 04/02/17 at 8:11			determined to be the root cause of wh		
		to on call physician about sitivity report. To return call.			the facility failed to respond to a urinal and culture that was positive for two	ysis	
	Signed by Nurse #3.	Simily report. TO return Gall.			microorganisms.		
					On 5/9/17, the corporate facility consu	ltant	
		n order dated 04/02/17 read,			began assisting facility registered nurs	es	
	isolation/contact prec	autions for ESBL.			(RNs), licensed practical nurses (LPNs		
	Review of a physiciar	n order dated 04/02/17 read,			nursing assistants (NAs) with accessing the electronic health record and e	-	

Facility ID: 970828

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	(X3) DATE	0. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · /	PLETED
						(	С
		345502	B. WING				03/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				331	15 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INI	DIAN 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 APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 315	Continued From page	e 33	F 31	5			
	start Levaguin 500 m				laboratory system, as appropriate for th	eir	
	gastrostomy tube (G	0 (0)			job title.		
	Diagnoses +Escheric	hia coli and + pseudomonas			On 5/25/17, the director of nursing and		
	aeruginosa. On conta	act precautions.			staff facilitator initiated an in-service for		
					100% of nurses regarding 1) the timely		
		n order dated 04/03/17 read,			collection of specimens for laboratory		
	-	500 mg. Start amikacin 250			analysis, including urine specimens, 2)		
	tract infection.	7 days for ESBL urinary			monitoring closely the electronic laboratory system for results, 3) prompt		
					(within the shift) notification of the		
	Review of nurse's no	te dated 04/03/17 at 9:42			physician and response to a positive		
		med that Resident #69's			laboratory result, including a positive		
		and sensitivity were positive			urinalysis and culture, 4) documenting		
		nd Pseudomonas A, as			notification of the physician, responsible	9	
	confirmed by morning	g charge nurse via			party, new orders, and actions taken to		
		On call was notified and			including isolation precautions, 5)		
		ng. Nurse returned call and			contacting the appropriate support syste		
		sitive urinalysis and culture			and/or supervisor if the nurse has difficu		
	and sensitivity and w				accessing the electronic health record a		
		stance and susceptibility to			electronic laboratory systems. On 6/7/1	7,	
		stated she would clarify with call. Nurse called back and			the in-service will be 100% completed. After 6/7/17, no nurse will be allowed to		
		art Levaquin 500 mg via GT.			work until this laboratory process		
		Family was notified and			in-service is completed. The laboratory		
		ncoming nurse. Signed			process in-service will be added to new		
	Nurse #2.	0			employee orientation for nurses.		
					On 5/31/17, the corporate facility		
	An attempt to intervie	ew Nurse #2 on 05/01/17 at			consultant completed a 100% audit of the		
	12:56 PM was unsuc	cessful.			past 14 days to verify the physician and	/or	
					nurse practitioner was notified of		
		Nurse Practitioner (NP) was			abnormal laboratory results and any ner	W	
		17 at 4:01 PM. The NP			orders were implemented.		
		s family was concerned like his urine was cloudy and			What systems were put in place to		
		one. The NP stated that			prevent the deficient practice from		
	-	chronic indwelling catheter			reoccurring:		
		bund and he was "colonized"			Beginning 6/7/16, the assistant director	of	
	-	no symptoms of infection but			nursing, quality improvement nurse (QI)		
		of bacteria have colonized			nurse, staff facilitator, nurse supervisor,		

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	B		IPLETED
						С
		345502	B. WING		05	5/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
	RK NURSING AND REHA			3315 FAITH CHURCH ROAD		
	TR NORSING 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	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 315	Continued From page	e 34	F 31	5		
	10	generally his urinalysis		evening charge nurse, tr	eatment nurse.	
		We don't usually treat 1		and/or corporate facility		
		is urinalysis came back with		utilize the "Laboratory Au		
	-	d that was why Resident #69		for six months to validate	e laboratory	
		the microorganisms was		orders are carried out tin	-	
	ESBL and that was w			are reported timely to the	e physician and/or	
	-	The NP stated when she		nurse practitioner.	and / an	
	discontinued the Leva	is and culture report she		The director of nursing a administrator will review		
		esistant to that antibiotic and		"Laboratory Audit" tool to		
	-	ch was the most susceptible		collection of specimens		
		n. The NP stated that		analysis and the results		
	recently the facility ha	as had an increase in new		reported to the physiciar	n and/or nurse	
		f and they have had trouble		practitioner. The director	-	
		electronic medical record.		administrator will initial th	•	
		o specimen was collected		corner of the laboratory		
		atory and then when it was ne electronic medical record		date for a period of six m The administrator and/or		
		r to look at the results." The		any issues of failure to re		
	NP also stated "that t			positive urinalysis and c		
		have been any different if the		retraining and additional		
	report would have be	en called to her sooner and			-	
		s no harm to Resident #69 in		How the facility will moni	itor systems put in	
		the appropriate treatment to		place:		
		NP stated she would like to		The director of nursing w	-	
		ess for his safety." The NP xpectation was that if a		results and findings of th Audit QI tool to the mont		
		d during the day the night		and the quarterly QAA c		
	shift would obtain the			for 6 months. The QI an	•	
		it up tomorrow and report it		committees will focus on		
		he NP also stated she		resident care, including i		
	expected much more			positive laboratory result	-	
		her so treatment could be		developing communicati		
	initiated more timely.			recommended by QIO, u		
		and #2 was conducted as		cause and effect (fishbo		
		se #3 was conducted on Nurse #3 stated that she		Pareto chart, and 5 Why Analysis (RCA) was use		
		cility on the weekends and		facility uncover the real of	-	
	I only worked at the lat		1			1

Facility ID: 970828

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	T	10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			1 Y /	MPLETED
			A. BOILDING	°			С
		345502	B. WING			05/03/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	RK NURSING AND REHA			33 <sup>.</sup>	15 FAITH CHURCH ROAD		
				IN	DIAN 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 315	Continued From page	e 35	F 31	15			
	that were drawn on th	heir residents. Nurse #3			communication: lack of nurse		
		#69 had an order for a			communication with the electronic		
	-	and sensitivity and Resident			laboratory system related to no acces		
	-	e to see if the results were			Communication in the form of access		
		tated that she researched			electronic laboratory results is identified	ed	
	the laboratory report	and discovered that urinary tract infection and I			and addressed. The QI and QAA committees will continue to monitor th	0	
		vsician and started the			laboratory systems to identify other fa	-	
		the resident on isolation at			causing the failure to respond to a	01010	
	-	tated that the "lab report was			urinalysis and culture, ensuring contin	ued	
	present in the electro	nic medical record but no			compliance. The DON will present the	;	
		on it until the family asked			monthly QI committee recommendation		
		ted that after she spoke to			to the quarterly executive QAA comm	ttee	
		she did call Resident #69's			for additional recommendations for		
	and made the	m aware of the new orders.			monitoring and continued compliance The QAA committee will continue		
	An interview with inte	erim Director of Nursing			consulting with the QIO until substanti	al	
		d on 05/02/17 at 4:20 PM.			compliance is achieved.		
	The interim DON stat	ted that she has been					
		for 2 weeks. The interim					
		e she has been at the facility					
		ng up on the laboratory					
		DON stated she printed off s each day and made sure					
		vare of the results. The					
		sure what happened with					
		because she was not at the					
		he interim DON stated that					
	-	that all laboratory specimens					
		aken to the laboratory for					
		oon as the results were					
	available the physicia immediately notified.	an and family were					
	An interview with the	Administrator was					
	conducted on 05/02/	17 at 4:54 PM. The					
		that her expectation was that					
		atory results were in the					
	electronic medical re-	cord the physician should					

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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       05/03/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       05/03/2017         LAKE PARK NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       3315 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 (EACH CORRECTIVE ACTION SHOULD BE       (x5) COMPLETED		-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (	PPROVED
345502         B. WIND         OS/03/2017           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2P CODE 3315 FATH CHURCH ROAD INDIAN TRAIL, NC 2073           CAKE PARK NURSING AND REHABULITATION CENTER INDIAN TRAIL, NC 2073         CONTROL STATE PRECIDENCES INDIAN TRAIL, NC 2073           OWIND: SUMMARY STATEMENT OF DEFICIENCES (BOD DEFICIENCY MUST BE PRECIDENCES (COD SECONDERS FLAV OF CORRECTION (PRECIN, TORY OR USC IDENTIFYING INFORMATION)         DEFICIENCES (COD SECONDERS FLAV OF CORRECTION (COD SECONDERS FLAV OF C	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		COMPLETED	
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STRL, 2P CODE       LAKE PARK NURSING AND REHABILITATION CENTER     STREET ADDRESS, CITY, STRL, 2P CODE       MAIN THAIL, KO 28079     SUMMARY STATEMENT OF DEPIOIENCES       PHETRY     EACH OPENDEV MUST ERFECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION)     PREFIX PREFIX       F 315     Continued From page 36 have immediately been notified and treatment and isolation initiated.     F 315       F 441     43.00(a) (1)(2)(4)(e)(f) INFECTION CONTROL, SS=D     F 441       SS=D     PREVENT SPREAD, LINENS     F 441       (a) Infection prevention and control program.     F 441       The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:     F 441       (1) A system for preventing, identifying, reporting, investigating, and control ing infections and communicable diseases for all registers, staff, volumeers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);       (2) Writen standards, policies, and procedures for the program, which must include, but are not limited to:       (ii) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;       (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			345502	B. WING		_	/2017
LAKE PARK NURSING AND REHABILITATION CENTER         INDIAN TRAIL, NC 28079           (M) ID PHETK TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         ID PHETK PHETK TAG         ID PROVIDER SPLATOR CORRECTION (EACH DEFICIENCY MUST ER PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         ID PREFX TAG         ID PROVIDER SPLATOR CORRECTION (EACH DEFICIENCY)         ID PROVIDER SPLATOR CORRECTION (EACH DEFICIENCY)         ID PROVIDER SPLATOR CORRECTION (EACH DEFICIENCY)         ID PREFX (EACH DEFICIENCY)         ID PROVIDER SPLATOR CORRECTION (EACH DEFICIENCY)         ID PREFX (EACH DEFICIENCY)        <	NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
Preferx TAG     (EACH DEFICIENCY MIGT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG     (EACH CORRECTVE ACTION SINULD BE CROSS-REFERENCE 10 THE APPROPRIATE DEFICIENCY)     COMMENT ECONSTRATE     ECONSTRATE     <		RK NURSING AND REHA	BILITATION CENTER				
have immediately been notified and treatment and isolation initiated.     543       F 441     \$525/17       SS=D     PREVENT SPREAD, LINENS       (a) Infection prevention and control program.     F 441       The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:     F 441       (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);     (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:       (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;       (ii) When and to whom possible incidents of communicable disease or infections should be reported;       (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE 0	(X5) COMPLETION DATE
F 441 SS=D       483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS       F 441       5/25/17         (a) Infection prevention and control program.       The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:       (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);       (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:       (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;       (ii) When and to whom possible incidents of communicable diseases or infections to be followed to prevent spread of infections;       (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 315			F 315			
<ul> <li>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</li> <li>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</li> <li>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</li> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> </ul>		483.80(a)(1)(2)(4)(e)(	(f) INFECTION CONTROL,	F 441		5/	25/17
and control program (IPCP) that must include, at         a minimum, the following elements:         (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals         providing services under a contractual         arrangement based upon the facility assessment         conducted according to §483.70(e) and following         accepted national standards (facility assessment         implementation is Phase 2);         (2) Written standards, policies, and procedures         for the program, which must include, but are not         limited to:         (i) A system of surveillance designed to identify         possible communicable diseases or infections         before they can spread to other persons in the         facility;         (ii) When and to whom possible incidents of         communicable disease or infections;         be followed to prevent spread of infections;		(a) Infection prevention	on and control program.				
<ul> <li>investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</li> <li>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</li> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> </ul>		and control program	(IPCP) that must include, at				
for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;		investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according accepted national sta	ntrolling infections and ses for all residents, staff, nd other individuals der a contractual upon the facility assessment to §483.70(e) and following ndards (facility assessment				
<ul> <li>possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> </ul>		for the program, whic					
communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;		possible communicat before they can sprea	ble diseases or infections				
to be followed to prevent spread of infections;		communicable diseas	•				
(iv) When and how isolation should be used for a			-				
		(iv) When and how is	olation should be used for a				

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE	
		345502	B. WING _				C 03/2017
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	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LD BE COMPLETION	
F 441	resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possil circumstances. (v) The circumstance: must prohibit employed disease or infected sk contact with residents contact will transmit th (vi) The hand hygiene by staff involved in dir (4) A system for recorr under the facility's IPC actions taken by the f (e) Linens. Personne process, and transpon spread of infection. (f) Annual review. Th annual review of its IF program, as necessan This REQUIREMENT by: Based on record revis staff interviews the fa isolation precautions with a urinary tract inf	t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct a or their food, if direct the disease; and e procedures to be followed rect resident contact. rding incidents identified CP and the corrective facility. ef must handle, store, rt linens so as to prevent the e facility will conduct an PCP and update their ry. is not met as evidenced iews, nurse practitioner, and cility failed to implement for a resident diagnosed fection that required isolation ampled (Resident #69).	F4	141	F 441 Infection Control What measures did the facility put in pl for the residents affected: On 3/21/17, the staff nurse collected Resident #69's urine specimen. On 3/25/17, the laboratory received Reside #69's urine specimen. On 3/25/17, the	ent	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING _		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE	, ZIP CODE
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		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	( (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) /E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE ICIENCY)
F 441	Continued From page	e 38 ion Control Program" policy	F 4	l41 laboratory results for I	Resident #60's urine
	dated 09/2014 read in precautions will be ut suspected infections transmission and/or p precautions in addition should be used for re- suspected with micro- transmitted by direct policy also indicated organisms, infections extended spectrum b require standard or c guidance of ESBL sta- recommended in sett transmission, acute of risk for transmission contained by dressing Review of a physician	n part, transmission based tilized for known or for which the route of prevention is known. Contact on to standard precautions esident with known or porganisms that are easily or indirect contact. The that multidrug-resistant s, or colonization that include peta lactamase (ESBL) would ontact isolation. The ated "contact precautions ting with evidence of ongoing care settings with increased or wound that cannot be		specimen were availa laboratory reporting sy On 3/27/17, the staff r Resident #69's urine s 3/27/17, the laborator #69's urine specimen laboratory results for f specimen were availa laboratory reporting sy On 4/2/17, the nurse of physician regarding R culture and sensitivity the nurse implemente precautions for Reside with a urinary tract infi isolation. On 4/3/17, Resident # practitioner ordered at given and contact pre 4/3/17, the nurse notif	ble in the electronic ystem. hurse collected specimen. On y received Resident . On 3/27/17, the Resident #69's urine ble in the electronic ystem. called the on-call resident #69's urine report. On 4/2/17, d contact ent #69 diagnosed ection that required #69's physician/nurse n antibiotic to be cautions. On
	Resident #69 dated 0 urinalysis positive an microorganisms. The Escherichia coli whic beta lactamase (ESB used antibiotics) and Review of a nurse's r PM read, call placed urine culture and sen Signed by Nurse #3. Review of a physician isolation/contact prec	note dated 04/02/17 at 8:11 to on call physician about isitivity report. To return call. n order dated 04/02/17 read,		responsible party. What measures were residents having the p affected: On 4/2/17, the nurse i precautions for Reside with a urinary tract infe isolation. On 4/3/17, the staff fa in-service for 100% of (RNs) and licensed pr (LPNs) regarding 1) th notified when an abno result is received and physician must be doo medical record with an On 4/3/17, the corpora	potential to be mplemented contact ent #69 diagnosed ection that required cilitator initiated an registered nurses factical nurses he physician must be formal laboratory 2) notification of the cumented in the ny new orders.

Facility ID: 970828

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		MEDICAID SERVICES				MB NO. 0938-0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(.	X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		345502	B. WING			05/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, C	ITY, STATE, ZIP CODE	03/03/2011	
				3315 FAITH CHURCH	HROAD		
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC	28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROV	/IDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLET	
F 441	Continued From page	e 39	F 44				
	conducted on 05/01/	17 at 4:01 PM. The NP		initiated a 4-p	oint plan titled MD		
	stated Resident #69'			Abnormal Labs. The			
	because his they felt			ncluded corrective action fo			
	wanted a urinalysis d			, corrective action for other			
	"because one of the			ne facility, measures put int	0		
		place him on isolation		_ · ·	ent recurrence, and		
		o also stated she expected porting of laboratory reports			monitor for sustained		
		uld have been initiated more		improvements	s. e director of nursing and		
	timely.				ility consultants met to		
					t cause analysis using the		
	An interview with Nu	rse #3 was conducted on			cess. Communication as		
	05/02/17 at 3:57 PM. Nurse #3 stated that on			evidence by la	ack of information and lack		
	04/02/17 Resident #6	59's family asked me to		of access to e	electronic health records wa	as	
	-	alysis that was done on			be the root cause of why		
		reviewed his medical record			ed to respond to a urinalys	is	
		had urinary tract infection			at was positive for two		
		. Nurse #3 stated that she		microorganisr			
		ed the on call physician and rder for antibiotic and contact			e corporate facility consulta ng facility registered nurses		
	isolation for the ESB				ed practical nurses (LPNs),		
		ed contact isolation were			tants (NAs) with accessing		
		n the door and the correct		-	health record and electron	ic	
		quipment (PPE) on the			stem, as appropriate for the		
	outside of their door.	Nurse #3 stated that		job title.			
		should have been initiated		On 5/25/17, th	he director of nursing and		
		ind culture came back on			r initiated an in-service for		
		d the ESBL. She added that			and LPNs regarding the		
		provided to Resident #69			ned nurse's responsibility fo	or	
		care, catheter care, wound			collection of specimens for		
	without the appropria	administration was provided			alysis, including urine ) monitoring closely the		
					oratory system for results, 3	3)	
	An interview with the	Director of Housekeeping			the shift) notification of the		
		d on 05/03/17 at 11:25 AM.		1	I response to a positive	-	
		each resident room was			sult, including a positive		
		ing a 3/5/7 step process. The			I culture, 4) documenting		
	-	aning the room vertically and		-	the physician, responsible		
	horizontally and emp	tying the trash. The DOH		party, new ord	ders, and actions taken to		

Facility ID: 970828

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		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	. ,	E SURVEY IPLETED
						С
		345502	B. WING			5/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
LAKE PA	RK NURSING AND REH	ABILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN		(X5)
PREFIX TAG	(EACH DEFICIENC	LIST MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETIC
F 441	Continued From pag	e 40	F 44	1		
		vas used every day for every		including initiating isolation	on precautions, 5)	
		ed that this process was also		contacting the appropriat		
	used for rooms that v	where on isolation		and/or supervisor if the n		
		that those rooms were		accessing the electronic		
		the isolation rooms were		electronic laboratory sys		
		hange our mop water and		duty RN's or LPN's respo		
		ping the room down. The		contact precautions as o	-	
		e aware of which rooms were ons by the sign that was		be 100% completed. Aft		
	-	of the room. When the house		nurse will be allowed to v		
		e sign they know they have to		laboratory process in-ser		
		bre cleaning the room and		completed. The laborate		
		nd rags. The DOH stated if		in-service will be added t	• •	
	there was no sign on	the door indicating isolation		orientation for nurses.		
		y treated the room as a		On 5/31/17, the corporat	•	
		oceed to clean it like they		consultant completed a 1		
	normally would.			past 14 days to verify the		
	An interview with inte	arim Director of Nursing		nurse practitioner was no		
		erim Director of Nursing ed on 05/02/17 at 4:20 PM.		abnormal laboratory resu orders were implemented	2	
		ted that when the urinalysis		implementation of isolation		
		d and Resident #69 was				
		esident #69 should have		What systems were put i	in place to	
	immediately been pla	aced on isolation precautions		prevent the deficient prac	-	
	and a sign placed on	his door and the correct		reoccurring:		
		to staff and visitors. The		Beginning 6/7/16, the as		
		hat Resident #69 was in a		nursing, quality improver	. ,	
		staff that was emptying his		nurse, staff facilitator, nu		
		e worn a gown and gloves		evening charge nurse, tr		
		any care to Resident #69 care, wound care, catheter		and/or corporate facility of utilize the "Laboratory Au		
		administration then they		for six months to validate		
	should have had on	-		orders are carried out tin	•	
		- <u></u>		are reported timely to the	•	
	An interview with the	Administrator was		nurse practitioner to inclu		
	conducted on 05/02/			implementation of isolation		
	Administrator stated	that her expectation was that		The director of nursing a		
		atory results were available		administrator will review		
	the physician was no	tified and indication	1	completed "Laboratory A	udit" tool to	

Facility ID: 970828

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/30/2017 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345502	B. WING			C 05/03/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
	RK NURSING AND REHA	BILITATION CENTER		33	315 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From page	e 41	F	441			
	precautions initiated.	5 4 1			ensure proper collection of specimens laboratory analysis and the results are promptly reported to the physician and nurse practitioner. The director of nurs and/or administrator will initial the bott right corner of the laboratory audit too with the date for a period of six month The administrator and/or DON will ens any issues of failure to implement isolation precautions for a resident diagnosed with a urinary tract infection that required isolation. How the facility will monitor systems p place: The director of nursing will present the results and findings of the Laboratory Audit QI tool to the monthly QI commit and the quarterly QAA committee meet for 6 months. The QI and QAA committees will focus on improving resident care, including responding to positive laboratory results, through developing communication. As recommended by QIO, utilization of th cause and effect (fishbone) diagram, Pareto chart, and 5 Whys Root Cause Analysis (RCA) was used to help the facility uncover the real cause(s) for th laboratory process failure: communication: lack of nurse communication with the electronic laboratory system related to no access electronic laboratory results is identifie and addressed. The QI and QAA committees will continue to monitor th laboratory systems at the monthly and quarterly meetings for six months to	e d/or sing om I s. sure n ut in e etting e e he s. to ed e	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 441 F 463 SS=D	ROOMS/TOILET/BAT (g) Resident Call Sys The facility must be a residents to call for st communication syste	INT CALL SYSTEM - TH	F 44	identify other factors causing the respond to a urinalysis and cultu ensuring continued compliance. will present the monthly QI comm recommendations to the quarter executive QAA committee for ad recommendations for monitoring continued compliance. The QAA committee will continue consultin the QIO until substantial complia achieved.	re, The DON nittee y ditional and A ng with
	by: Based on observatio and staff interviews th resident with the mea station for 30 hours for (Resident #78). The findings included Resident #78 was ad 12/23/16 with diagnos	is not met as evidenced ns, record reviews, resident ne facility failed to provide a nns to contact the nursing or 1 of 6 sampled residents : mitted to the facility on ses that included anxiety, dysphagia, and		F 463 Resident Call System What measures did the facility pu for the residents affected: On 4/30/17, the facility volunteer gave Resident #78's call light co facility nursing assistant (NA). A replacement call cord or call bell immediately provided to Residen On 5/1/17, the nursing assistant someone had given Resident #7 to use to call for help. On 5/2/17, the maintenance dire	turned rd to the was not it #78. reported 8's a bell

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<u>ULITER</u>	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				3315 FAITH CHURCH ROAD	
	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
F 463	Continued From page	<b>-</b> 43	F 46	3	
1 100	Review of the most re data set (MDS) dated Resident #78 was ab understood and was	ecent quarterly minimum l 04/01/17 revealed that le to make herself	1 40	became aware of Resident #7 cord not working and immedia replaced the call light cord in F #78's room.	tely
	#78 required limited a for toileting, bed mob	assistance of 1 staff member ility, and dressing.		What measures were put in pl residents having the potential affected:	to be
	facility volunteer was	/30/17 at 11:25 AM of a made. The facility volunteer		On 5/2/17, the maintenance d completed a 100% audit of all	facility
	Resident #78's call co	d Nursing Assistant (NA) #5 ord and told NA #5 that lled the cord out of the wall.		resident rooms to ensure there functioning call light cord. The revealed no other missing or	
	The call cord was not	ted to have the electrical e end and was missing the		malfunctioning call light cords	in resident
		cted the call cord to the wall.		On 5/3/17, the administrator, r director, other department hea	
		/30/17 at 11:27 AM of was made. The end of the		corporate facility consultants r the morning department head	net during
		en to NA #5 was noted to be Il cord available to Resident		perform a root cause analysis "5-Whys" process. "Communi	using the
		her means noted in the 8 to contact the nurse's		evidence by lack of information staff and lack of access to an	
	station.			light cord was determined to b cause of why the facility failed	to provide a
	Resident #78's room	/30/17 at 12:40 PM of was made. The end of the en to NA #5 earlier on the		means for Resident #78 to con nurse station On 5/30/17, the administrator	and staff
	shift was noted to be available to Resident	in the wall with no call cord #78. There was no other		facilitator initiated an in-service of facility staff regarding call co	ords. The
	contact the nurse's st	oom for Resident #78 to ation.		in-service covers 1) the regula 483.90(g)(2) Resident Call Sy Room/Toilet/Bath, 2) all reside	stem-
		was made. The end of the		have means to contact the nur station, 3) if the call cord does	rsing not work,
	shift was noted to be	en to NA #5 earlier on the in the wall with no call cord #78. There was no other		there is an extra call cord in the station, 4) if promptly replacing cord does not correct the prob	g the call
		pom for Resident #78 to		provide the resident with a tap	

Facility ID: 970828

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	3	COMPLETED
					С
		345502	B. WING		05/03/2017
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	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLE
F 463	Continued From page	e 44	F 46	3	
	contact the nurse's s	tation.		bells are promptly provided at th	e nurse
				station and shall be distributes to	D I
		5/01/17 at 10:42 AM of		resident(s) when the call cord ar	
		was made. The end of the ven to NA #5 on 04/30/17 was		bell system is not functioning pro when the call cord and/or call lig	
	-	no call cord available to		working, in addition to providing	
		was no other means noted		to contact the nursing station, th	
	in the room for Resid	lent #78 to contact the		person identifying the problem w	
	nurse's station.			their supervisor and 7) when the	
				and/or call light is not working, the	
		5/01/17 at 2:51 PM of was made. The end of the		person will complete a work orde The work order form white copy	
		ven to NA #5 on 04/30/17 was		the maintenance department and	
	-	no call cord available to		yellow copy to the administrator.	
		was no other means noted		light in-service will be provided to	
		lent #78 to contact the		staff during new employee orien	
	nurse's station.	# <b>F</b>		agency staff prior to working a sl facility.	hift in the
		#5 was conducted on NA #5 stated that she have		What systems were put in place	to
		at the facility volunteer had		prevent the deficient practice fro	
	•	30/17 to Nurse #1. NA #5		reoccurring:	
		not sure what Nurse #1 had		Beginning 5/30/17, the maintena	ince
		rd. NA #5 further stated that		director, housekeeping supervise	
		er call bell frequently to alert		assistant director of nursing, qua	-
	wanted to go to bed	I to be changed or she		improvement nurse (QI) nurse, s facilitator, nurse supervisor, even	
		or get out of bed.		charge nurse, treatment nurse, a	
	An interview with Nu	rse #1 was conducted on		corporate facility consultant will	
		I. Nurse #1 stated she was		call light audit tool weekly, for six	
		ently started coming to the		to validate the facility has provid	
		e #1 stated that NA #5 did not		resident with the means to conta nursing station and any negative	
		and this was the first she had at Resident #78 did not have		are immediately corrected by pro	
		he nursing station. Nurse #1		means for the resident to contact	-
		vould have handed her a call		nursing station (new call cord, ta	
		either fixed the call cord or		other).	
	given Resident #78 a	a bell to use.		The administrator, director of nu	
				and/or corporate consultant will	review

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		LETED
		345502	B. WING		05/0	C 03/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 463	Continued From page	e 45	F 46	33		
F 463	An interview with NA 05/02/17 at 2:22 PM. routinely cared for Re that Resident #78 use make staff aware of h Resident #78 would r wet or wanted to get wanted to get back in An interview with Cer #1 was conducted or #1 stated that she rou #78. CMA #1 stated to call bell to alert staff to bathroom or that she down. CMA #1 stated her call bell and some on 05/01/17 someone bell to use to call for 1 An interview with the (DM) was conducted The DM stated that if needed repaired a wo	#2 was conducted on NA #2 stated that she esident #78. NA #2 stated ed her call bell frequently to her needs. NA #2 stated ring her call light if she was up out of bed or if she to bed. tified Medication Aide (CMA) 0 05/02/17 at 2:39 PM. CMA utinely cared for Resident that Resident #78 used her that she needed to use the wanted to get up or be laid d that Resident #78 would to alert staff that she was in that something happened to etime after her shift ended e had given Resident #78 a	F 46	weekly the completed ca to ensure there is a mean resident to contact the nu The administrator, directed and/or corporate consulta bottom right corner of the tool with the date for a per months. Beginning 6/1/17, the add include in the daily depar meetings review of the re administrative rounds per department heads. The rounds are recorded on t rounds are recorded on t rounds tool, to include th functioning of the call ligh review at the department will include making sure have means to contact th station, 2) if the call cord extra call cord was used, replacing the call cord did problem, the resident wa tap bell, 4) tap bell(s) wa provided to resident(s) w and/or call bell system is properly, 5) when the cal	ns for every ursing station. or of nursing, ant will initial the e call light audit eriod of six ministrator will rtment head esults of the rformed by the administrative the administrative e proper nt system. The t head meeting 1) all residents ne nursing did not work, an , 3) if promptly d not correct the es provided with a s promptly then the call cord in ot functioning	
	hours. The DM stated any work order on Re had no idea anything	build follow up within 48 d that he had not received esident #78's call cord and was wrong with it. The DM nd immediately went to		light was not working the identifying the problem n supervisor and 6) when t and/or call light was not v	otified their the call cord working, the staff	
	-	nd immediately went to and replaced the call cord call bell was working		person completed a work work order form white co maintenance department copy to the administrator staff completed the work	py went to the t and the yellow r, 7) maintenance	
	(DON) was conducte	interim Director of Nursing d on 05/02/17 at 4:00 PM. ted that Resident #78 used		the completed work orde administrator as docume call cord/call light was re	er copy to the entation that the	

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					OMB NO. 0938-
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345502	B. WING	05/03/2017	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKE PA	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE
F 463	Continued From page	e 46	F 463	3	
her call bell ve needs. The int #78's call bell work order sho staff should ha staff of her nee was not aware	her call bell very freq needs. The interim D	uently to alert staff of her ON stated that if Resident ot functioning properly then a		resident has means to contact th station.	e nursing
	work order should ha staff should have give staff of her needs. Th was not aware that R not working properly	the interim DON stated she contact we have been completed and the en her a bell to use to alert he interim DON stated she cesident #78's call bell was or that she needed another		The administrator will ensure any of failure to provide a resident wi means to contact the nursing sta be addressed through additional cause analysis, process correction training, and monitoring.	ll the tion will root
	handed NA #5 the brin have written a work of #78 with a bell to call Administrator stated call bell was not work certainly would have aware of the issue. An interview with Res 05/03/17 at 1:27 PM. used her call bell whe restroom or when she Resident #78 stated 04/30/17 she did not had to wait until staff me. Resident #78 stated	17 at 4:36 PM. The that when the volunteer oken call cord, NA #5 should order and provided Resident for assistance. The she was unaware that the king properly and she wanted to have been made sident #78 was conducted on Resident #78 stated she en she needed to use the e wanted to get out of bed. that on the evening of have a call bell and "she just came into her room" to help ated that on Monday omeone had given her a bell		How the facility will monitor system place: The maintenance director or adm will present the results and findin call light cord audits to the month committee and the quarterly QAA committee meeting for 6 months. and QAA committees will focus of improving resident care, including provision of the means to contact nursing station, through developi communication. As recommend QIO, utilization of the cause and (fishbone) diagram, Pareto chart, Whys Root Cause Analysis (RCA used to help the facility uncover the cause(s) for the call light cord pro- failure: communication: lack of mic communication with the maintenand director to provide the means for to contact the nursing station. Communication in the form of us verbal communication during dep head meetings and written work forms to ensure the facility provide residents with the means to contact nursing station. The QI and QAA	ninistrator gs of the ly QI The QI n g the t the ng ed by effect and 5 A) was the real bocess urse ance residents

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/30/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C /03/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	00/2011
	RK NURSING AND REHA	BILITATION CENTER			15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 463	<ul> <li>483.75(g)(1)(i)-(iii)(2)( COMMITTEE-MEMBI QUARTERLY/PLANS</li> <li>(g) Quality assessme</li> <li>(1) A facility must mai and assurance comm minimum of:</li> <li>(i) The director of nurs</li> <li>(ii) The director of nurs</li> <li>(iii) At least three othe staff, at least one of w administrator, owner, individual in a leaders</li> <li>(g)(2) The quality ass committee must :</li> <li>(i) Meet at least quart coordinate and evalue</li> </ul>	(i)(ii)(h)(i) QAA ERS/MEET int and assurance. Intain a quality assessment ittee consisting at a sing services; tor or his/her designee; er members of the facility's who must be the a board member or other ship role; and essment and assurance erly and as needed to ate activities such as in respect to which quality	F 4		causing the failure to communication of light system failures. The administrato and/or maintenance director will prese the monthly QI committee recommendations to the quarterly executive QAA committee for additionar recommendations for monitoring and continued compliance. The QAA committee will continue consulting with the QIO until substantial compliance is achieved.	or nt al	5/27/17

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345502	B. WING _			C 05/03/2017			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
				33	315 FAITH CHURCH ROAD				
LAKE PAR	K NURSING AND REHA	BILITATION CENTER		IN	IDIAN 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 520	Continued From page	48	F 5	520					
	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;								
	(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.								
					F 520 On 5/9/17, the monthly QI Committee h a meeting. The administrator, DON, QI nurse, MDS nurse, treatment nurse, sta facilitator, maintenance director, social workers, medical records, dietary manager and housekeeping supervisor will attend monthly QI Committee meetings on an ongoing basis and will assign additional team members as appropriate. Using the "5 Whys" root cause analysis process, the QI Commit was able to determine "communication a key factor in the deficient practice are of 1) resident neglect, 2) allowing residents to make choices, 3) activities daily living, 4) sufficient nursing staff, a 5) administration.	aff ttee sas of			
	This tag is cross refer				On 5/17/17, the administrator, director nursing, and corporate consultants	of			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345502				(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		B. WING		C 05/03/2017			
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
LAKE PARK NURSING AND REHABILITATION CENTER				315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 520	Continued From page 49		F 520				
	record reviews, family facility neglected to p	ased on observations, y and staff interviews the rovide incontinent care for a		received consultation from the Qual Improvement Organization (QIO). On 5/18/17, the facility administrator	r l		
	(Resident #72).	or 1 of 3 residents sampled survey of 03/30/17, this		in-serviced the department heads (I MDS nurse, treatment nurse, maintenance director, dietary manages social workers, medical records, die	ger,		
	regulation was cited f provide incontinence	or neglecting to feed and		manager and housekeeping supervi related to the appropriate functioning the QAA Committee and the purpos the committee to include identifying related to quality assessment and	isor) g of e of		
	this regulation was ci incontinent care for a			assurance activities as needed and developing and implementing appro plans of action for identified facility concerns.	priate		
	Based on observation interviews, and facilit failed to provide 1 of	dents to make choices: n, resident and staff y record review, the facility 4 sampled residents with 2 r 2 weeks as requested		As of 5/19/17, after the administrato QAA in-service, the monthly QI Committee began identifying other a of quality concern through the QA re process, for example: review of rour	areas		
	03/10/17, this regulat provide showers accord the resident for 1 of 3	tion and complaint survey of ion was cited for failure to ording to the preference of sampled residents who		tools, review of work orders, review Point Click Care (Electronic Medical Record), resident council minutes, resident concern log.			
	this regulation was ci	(Resident #57). mpliant survey of 05/03/17, ted for failure to provide 2 the resident requested.		The quarterly Executive QAA Comm to include the medical director, will r at a minimum of quarterly. The quar Executive QAA Committee, includin medical director, will review monthly compiled QI report information, revie	neet terly g the		
	observations, record interviews the facility incontinence on the c	of Daily Living: Based on reviews, family and staff failed to check a resident for lay shift for 1 of 4 residents of daily living (Resident		trends, and review corrective action taken and the dates of completion. Findings and results of the QI tools reviewed by the monthly QI committ	s will be		

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345502		(X1) PROVIDER/SUPPLIER/CLIA	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING	C 05/03/2017			
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAF	K NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC	
F 520	03/10/17, this regulat provide assistance wi dressing for 1 of 10 s #74). During the complaint regulation was cited f incontinent care, show care as needed for 1 reviewed for activities During the current co this regulation was cit resident for incontine 1d). F353: Sufficient I observations, record the facility failed to ha to ensure a depender incontinent care for 1 (Resident #72). During the complaint regulation was cited f quantity of staff to mo falls; the resident fell sampled residents (R failed to have sufficie dependent residents for incontinence care for (Resident #4, #5, #6, failed to have sufficie	tion and complaint survey of ion was cited for failing to ith shaving, nail care, and ampled residents (Resident survey of 03/30/17, this for failure to provide wers, bed baths, and oral of 6 residents (Resident #9)	F 52	<ul> <li>and the quarterly QAA committee for 6 months. The QI and QAA committees will focus on improvin resident care through developing communication processes. As recommended by QIO, utilization cause and effect (fishbone) diagra Pareto chart, and 5 Whys Root Ca Analysis (RCA) will help the facilit uncover the real causes for reside process failures, including: 1) resi neglect, 2) allowing residents to m choices, 3) activities of daily living sufficient nursing staff, and 5) administration.</li> <li>The Executive QAA Committee w validate the facility's progress in c of deficient practices or identify co The quarterly Executive QAA Con meeting agenda, resulting plans of corrections, and audit results will documented in the meeting minut administrator will be responsible f ensuring QAA Committee concerr recommendations are addressed further training or other intervention administrator or DON will report b the Executive QAA Committee at scheduled quarterly meeting.</li> </ul>	g of the am, ause y ent care dent nake l, 4) ill orrection oncerns. nmittee of be es. The or ns and through ons. The ack to	
	During the current co	mplaint survey 05/03/17, this				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/30/2017 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
345502		B. WING		C 05/03/2017				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
	RK NURSING AND REHA	BILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAC		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 520	quantity of staff to ens was provided incontin An interview was con Administrator on 05/0 explained that the Qu committee consisted Nursing, all departme consultant, and medic monthly. The Administ a lot of discussion ab and ways they can ac compliance. The team monitoring tools and a areas that we remain Administrator stated t good and are showing explained that one of achieving substantial families and the lack Another obstacle we employees to a stand accountable for their to use disciplinary act added that they have	or failure to have sufficient sure a dependent resident nent care. ducted with the 3/17 at 3:48 PM. She ality Assurance (QA) of herself, the Director of nt heads, pharmacy cal director and they met trator stated they have had out recent survey results the substantial n was reviewing all the audits to help guide us in the out of compliance with. The hat the audits have "looked g improvement." She further the biggest barriers to compliance is difficult of consistent assignments. face is holding the current ard and holding them performance and being able ion when needed. She also been using the process of ad root cause analysis for	F	520				

Facility ID: 970828

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