DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	COM	E SURVEY PLETED	
		345321	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER	0.0021		ST	REET ADDRESS, CITY, STATE, ZIP CODE	03	/15/2018	
					45 PARK AVENUE			
KERR LA	KE NURSING AND REHA	ABILITATION CENTER			ENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
	complaint investigation ID #KQV711. Intake NC00136517.	e cited as a result of the on survey on 3/15/18. Event						
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)	tinence, Catheter, UTI -(3)	F	690			3/26/18	
	resident who is contir admission receives s maintain continence	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is						
	§483.25(e)(2)For a reincontinence, based of comprehensive assesses ensure that- (i) A resident who entindwelling catheter is resident's clinical comprehensive assessed for removal possible unless that catheterization was not indwelling catheter or is assessed for removal possible unless that catheter and (iii) A resident who is receives appropriate prevent urinary tract is continence to the extension of the ext	esident with urinary on the resident's ssment, the facility must ters the facility without an not catheterized unless the adition demonstrates that becessary; ters the facility with an r subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.						
	 DIRECTOR'S OR PROVIDER/!	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE	
	cally Signed						03/23/2018	

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.

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				FOR OMB NO	D: 04/09/20 [,] M APPROVE <u>D. 0938-039</u>
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345321		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C			
		B. WING			03/15/2018		
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
KERR LAP	E NURSING AND REHA	ABILITATION CENTER			245 PARK AVENUE ENDERSON, NC 27536		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From page	a 1	Í -	690			
1 000			Г	090			
		t who is incontinent of bowel treatment and services to					
	restore as much norn						
	possible.						
		is not met as evidenced					
	by:						
		iew, observations and			Kerr Lake Nursing and Rehabilitation		
	interviews the facility			Center acknowledges receipt of the			
		was secured in a manner to			Statement of Deficiencies and propos		
		the floor and promoting the			this Plan of Correction to the extent th	at	
		and infection for 1 of 6 /ith an indwelling urinary			the summary of findings is factually correct and in order to maintain		
	catheter (Resident #6				compliance with applicable rules and		
					provisions of quality of care of residen	its.	
	Findings included:				The Plan of Correction is submitted as written allegation of compliance.		
	Resident #65 was ad	mitted to the facility on			written allegation of compliance.		
		ses including Dementia,			Kerr Lake Nursing and Rehabilitation		
		, Stage IV Pressure Ulcer to			Center□s response to this Statement	of	
	the Sacrum and Failu	ire to Thrive.			Deficiencies does not denote agreeme	ent	
					with the Statement of Deficiencies nor		
		ecent quarterly Minimum			does it constitute an admission that an	•	
		essment dated 2/20/18			deficiency is accurate. Further, Kerr L	ake	
		65 as severely impaired g an indwelling urinary			Nursing and Rehabilitation Center reserves the right to refute any of the		
	catheter.	g an indwening drinary			deficiencies on this Statement of		
					Deficiencies through Informal Dispute		
	Review of the care pl	an, dated 12/28/17 had a			Resolution, formal appeal procedure a		
		rea as Resident #65 had an			or any other administrative or legal		
	-	nary elimination with an			proceeding.		
		heter and was at risk for					
		sted was to keep Resident					
	#65 free from infectio	on through the next review.			F 600		
	During an observation	n on 3/13/18 at 12:52 PM the			F 690		
	-	was hanging on the left side			The process which led to this deficien	cv	
		was low to the floor and the			was that the facility nursing assistant	•	
		nging on the bottom frame of			#1) failed to ensure Resident #65 bed		
		nately one third of the bag			raised to a level that prevented the unit		

Facility ID: 953401

If continuation sheet Page 2 of 8

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		3 NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	. ,	COMPLETED	
						С
		345321	B. WING			03/15/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE	
KERR LAI	KE NURSING AND REHA	BILITATION CENTER		1245 PARK AVENUE		
				HENDERSON, NC 27536		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 690	Continued From page	- 2	F 69	0		
	lying on the floor.	5 -	1 00	catheter bag from lying	n on the floor and	
				promoting the possibil		
	-	n on 3/13/18 at 3:21 PM the		infection.		
		was hanging on the left side			" of the second s	
		vas low to the floor and the		On 3/14/18, Resident		
		nging on the bottom frame of nately one third of the bag		to an appropriate heig Lumpkin, RN, Director		
	lying on the floor.	hately one time of the bag		prevented the urinary	-	
	, , , , , , , , , , , , , , , , , , , ,			contacting the floor. O	•	
	-	n on 3/14/18 at 8:38 AM the		was in-serviced by the		
		was hanging on the left side		on urinary catheter ma		
		vas low to the floor and the		include raising the bec		
	the bed resting on the	nging on the bottom frame of e floor.		height at all times to e catheter bag is not in o floor.		
	During an observatio	n on 3/14/18 at 9:57 AM the				
	-	was hanging on the left side		On 3/14/18, a 100% a	udit of all residents	
		vas low to the floor and the		with urinary catheters		
		nging on the bottom frame of		#65 was completed by		
	the bed resting on the	e floor.		Nursing to ensure bed		
	During an observation	n on 3/14/18 at 12:27 PM the		appropriate height to p catheter bags from co	-	
	•	was hanging on the left side		Any concerns identifie		
		vas low to the floor and the		were immediately corr	-	
		nging on the bottom frame of		Director of Nursing to		
	the bed resting on the	e floor.		the bed height to an a		
				prevent the urinary car		
		n on 3/14/18 at 1:19 PM the		contact with the floor a	and/or staff	
		was hanging on the left side vas low to the floor and the		re-training.		
		nging on the bottom frame of		On 3/14/18, a 100% ir		
	the bed resting on the	e floor.		initiated by Tammy Lu	-	
	During on interview o	n 2/11/19 at 2:22 DM with		of Nursing for all licens		
		n 3/14/18 at 2:23 PM with bed stayed in a low position		nursing assistants on management, which ir	-	
	and the catheter bag			of a resident s bed to		
		at was the highest she could		height to prevent the u		
		g on the bed frame and the		from contacting with th		
	best she could do.			in-service will be comp	pleted by Lynn	

Facility ID: 953401

If continuation sheet Page 3 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES				I	NTED: 04/09/2018 FORM APPROVED B NO. 0938-0391
STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345321	B. WING _				C 03/15/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING AND REHA	BILITATION CENTER			245 PARK AVENUE ENDERSON, NC 27536		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	Director of Nursing sh bag and stated the be there was not any oth catheter bag resulting floor. During an interview o	n 3/14/18 2:27 PM with the ne observed the catheter ed was in a low position and her place to position the g in the bag being on the n 3/14/18 at 3:13 PM with stated she expected the	F	390	Menikos, LPN, Staff Facilitator by 3/ All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilit or the Director of Nursing on Urinary Catheter Management, which include adjustment of a resident s bed to a appropriate height to prevent the uri catheter bag from contacting with the floor. 100% of all residents with a urinary catheters will be monitored weekly f weeks, then 50 % of all residents wi urinary catheters will be monitored weekly f for four weeks, and then 10% of all residents with urinary catheters will monitored weekly for four weeks by Assistant Director of Nursing, the St Facilitator, Patient Care Coordinator and/or the Minimum Data Set Coordinators, utilizing a Resident Ca Audit tool to ensure all beds are adju at an appropriate height to prevent un catheter bags from contact with the Any identified areas of concern durit audit will be immediately addressed Assistant Director of Nursing, the St Facilitator, Patient Care Coordinator and/or the Minimum Data Set Coordinators to include staff retraini and/or bed height adjustments. The will review the results of the audits a indicated by initialing each Resident Audit tool weekly for 12 weeks.	d cator / les n nary e or four th veekly be the aff r; are usted urinary floor. ng the by the aff r; ng DON is	
	7/02-99) Previous Versions Obs	olete Event ID: KOV7			The Administrator and/or Director of Nursing will review and present the		ion shoot Page 4 of

Event ID: KQV711

Facility ID: 953401

If continuation sheet Page 4 of 8

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	1		FORM APPROV OMB NO. 0938-03
	rement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345321	B. WING		C 03/15/2018
IAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	KE NURSING AND REHA	BILITATION CENTER		245 PARK AVENUE ENDERSON, NC 27536	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIO
F 690	Continued From page		F 690	findings of the Resident Care Audit to to the Executive Quality Improvemen committee monthly for 3 months. Any issues, concerns, and/or trends ident will be addressed by implementing changes as necessary, to include continued frequency of monitoring. Person responsible for implementing plan of correction- Nancy W Hughes, Administrator.	t (QI) / ified the
F 812 SS=E	Food Procurement,St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must -		F 812		3/26/18
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. is not prohibit or prevent roduce grown in facility ompliance with applicable			
	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed to mainta	prepare, distribute and ince with professional rvice safety. is not met as evidenced ns and staff interviews the ain kitchen equipment clean dition to prevent cross		Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propos	

Event ID: KQV711

Facility ID: 953401

If continuation sheet Page 5 of 8

	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI II TI		CONSTRUCTION	OMB NO	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COMPLETED	
				<u> </u>			С
		345321	B. WING				/15/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			1 00/10/2010	
				12	245 PARK AVENUE		
	KE NURSING AND REHA	ABILITATION CENTER		Н	IENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 812	Continued From page	e 5	F 8'	12			
		ing to clean twelve of twelve			this Plan of Correction to the extent tha	ıt	
		iled clean the steam table			the summary of findings is factually		
	-	f one steam tables observed.			correct and in order to maintain		
				compliance with applicable rules and			
	The findings included			provisions of quality of care of residents			
	During an observation			The Plan of Correction is submitted as	а		
	dish room drying rack			written allegation of compliance.			
		baking sheets were observed stacked on the drying rack. The 12 baking sheets were observed			Kerr Lake Nursing and Rehabilitation		
		of black dried food residue			Center s response to this Statement o	f	
	one inch wide under			Deficiencies does not denote agreemen			
					with the Statement of Deficiencies nor		
	A second observatior			does it constitute an admission that any	y		
	dish room drying rack			deficiency is accurate. Further, Kerr La	ake		
	-	bserved stacked on the			Nursing and Rehabilitation Center		
		oaking sheets were observed			reserves the right to refute any of the		
		of black dried food residue			deficiencies on this Statement of		
	one inch wide under	the nm.			Deficiencies through Informal Dispute Resolution, formal appeal procedure ar	ad/	
	During an observation	n of the kitchen on 3/14/18			or any other administrative or legal	10/	
		steam table was observed.			proceeding.		
		of the steam table shelf was			The process that led to this deficiency		
	observed to be cover			was the facility dietary manager failed t	0		
	particles.				ensure that the assigned dietary		
					assistants cleaned kitchen equipment,	to	
		n on 3/15/18 at 10:16 AM the			include twelve baking sheets and the		
		as observed. The 6 foot			entire steam table.		
		m table shelf was observed ark dried food particles and			On 3/15/18, the twelve baking sheets		
	was sticky to touch.				were cleaned of dried food residue by		
					Doug Steiger, Dietary Manager. On		
	In an interview with th	ne Certified Dietary Manager			3/15/18, between the lunch and supper	-	
		10:25 AM he revealed he			meals, the steam table was cleaned by		
	expected staff to clea	an the whole steam table and			Pat Gee, Cook. On 3/16/18 new cleaning		
	the areas would be cl	leaned that day.			assignment sheets were posted in the		
					kitchen by Doug Steiger, Dietary Manag	ger	
		ne Administrator on 3/15/18			to ensure cleaning of all kitchen		
		ed the steam table would be			equipment is completed.		
	cleaned that day betw	ween lunch and dinner.					1

Facility ID: 953401

If continuation sheet Page 6 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 04/09/2018 RM APPROVED IO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345321	B. WING		0	C 3/15/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
KERR LA	KE NURSING AND REHA	BILITATION CENTER		1245 PARK AVENUE HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page	26	F 8	12 On 3/16/18, the admir manager inspected th schedule and the kitcl including baking shee table to ensure cleanii completed to include a residue on pans or but table. On 3/16/18, the dietar in-serviced by Nancy Administrator on ensu are following the new schedule and ensuring is cleaned to include b the entire steam table 100% of dietary staff of Doug Steiger, Dietary the new dietary cleanii cleaning kitchen equip baking sheets and the The in-service comple 3/23/18 for all dietary All newly hired dietary in-serviced by the diet orientation on using th cleaning schedule and kitchen equipment to sheets and the entire Kitchen equipment to sheets and the entire Kitchen equipment, to pans and steam table by the dietary manage manager to ensure kit maintained in a clean condition using a Diet Rounds Checklist and schedule five times wa	e dietary cleaning hen equipment, its and the steam ng had been no dried food ild up under steam ry manager was Hughes, iring all dietary staff dietary cleaning g kitchen equipment baking sheets and will be in-serviced by Manager on using ing schedule and on oment to include e entire steam table. etion date will be staff. v staff will be tary manager during he new dietary d on cleaning include baking steam table. e include baking steam table. o include baking , will be monitored er or kitchen tchen equipment is and sanitary ary Department d the dietary cleaning	

Event ID: KQV711

Facility ID: 953401

If continuation sheet Page 7 of 8

		ND HUMAN SERVICES				FORM	D: 04/09/2018	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		. ,		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		345321	B. WING _				C 15/2018	
NAME OF F	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•		
				12	245 PARK AVENUE			
KERR LA	KE NURSING AND REH	ABILITATION CENTER		H	ENDERSON, NC 27536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	Continued From pag	e 7	F	812	then three times weekly for four week then weekly for four weeks. Any ident areas of concern will be immediately addressed by the dietary manager or kitchen manager by providing addition training for any involved dietary staff. administrator will review and initial the results of the Dietary Department Rou Checklist weekly for twelve weeks. The administrator will present the find of the Dietary Department Rounds Checklist to the Executive Quality Improvement (QI) committee monthly 3 months. Any issues, concerns, and trends identified will be addressed by implementing changes as necessary, include continued frequency of monitoring. Person responsible for implementing plan of correction- Nancy W Hughes, Administrator.	tified nal The e unds lings for /or to		

If continuation sheet Page 8 of 8