STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide oral (mouth) care for 1 of 3 sampled residents (Resident #32). Findings included: Resident #32 was admitted into the facility on 6/20/11 and readmitted on 10/14/11. Cumulative diagnosis included Muscle Weakness, Muscular Atrophy (muscle wasting). The quarterly Minimum Data Set (MDS) completed on 1/19/12 indicated Resident #32's cognitive pattern was moderately impaired. The MDS revealed Resident #32 required extensive assistance with bed mobility, transfers, and personal hygiene. A review of the most recent care plan for activities of daily living dated 8/15/11 revealed Resident #32 required assistance with personal hygiene due to impaired mobility. As an intervention, approaches indicated staff would provide assistance with set up of oral (mouth)/dental supplies. A review of the resident closet care guide dated 10/14/11 indicated under mouth care: mouthwash	F 312	Kerr Lake Nursing an d Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Hughes — TITLE: Administrator — (X6) DATE: 4/10/12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING _____ B. WING _____	03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

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F 312	Continued From page 1 and swabs were to be included in Resident #32's oral care needs. In an interview on 3/27/12 at 9:23 am, Resident #32 stated the staff did not assist as necessary to clean his dentures or mouth care through a head gesture "No", and verbally indicated "No". In a follow up interview on 3/29/12 at 9:04 am, Resident #32 stated mouth/denture care had not been provided to date since the initial inquiry on 3/27/12. On 3/29/12 at 9:07 am, Resident 32's upper and lower dentures were observed yellowish in color, with white food particles on the lower dentures, when asked to smile. In an interview on 3/29/12 at 2:10 pm, Nurse Aide (NA) #1 indicated he had not assisted or provided mouth/denture care to Resident #32 since 3/26/12. NA #1 confirmed he was the primary NA for Resident #32 from 7am-3pm shift. NA #1 stated "I have no reason why I did not provide mouth/denture care. It was probably just one of those days". In an interview on 3/29/12 at 2:15 pm, NA #2 stated she had not assisted or provided mouth/denture care to Resident #32. NA #2 confirmed she was the primary NA for Resident #32 for 3pm-11pm shift. NA #2 concluded she cared for Resident #32 on 3/19/12 and 3/28/12. NA #2 gave no reason as to why oral/denture care was not provided. NA #2 concluded she would assist to date. In an interview on 3/29/12 at 3:41 pm, Nurse #1	F 312	F312 1. Resident #32 received oral care on 4/26/12 3/29/12 by C N A. 2. 100% audit completed by nursing staff by evaluation and interview of residents who have the potential to be affected with oral care needs completed by 4/10/12. 100% audit completed of all residents care guides to ensure oral care needs are communicated to direct care staff completed by 4/10/12 by DON and /or Administrative nurses. 3. Nursing staff has been in serviced on oral care procedure by the Director of Nursing and/ or Administrative Nurses starting on 4/2/12 and will be completed no later than 4/20/2012. 4. The Director of Nursing and/ or Administrative Nurses will monitor oral care on a selection of 10% of residents weekly x 4 weeks then monthly x 3 months to ensure that staff are performing oral care to meet residents individual needs utilizing a oral care QI audit tool. The Administrator will review the results of all audits weekly for 4 weeks then monthly for 3 months to assure continued compliance in this area. The results of the audits will be reviewed by the executive QI committee quarterly for follow up as deemed necessary, and to determine the frequency and continued need for monitoring.	

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	345321	A. BUILDING _____ B. WING _____	03/29/2012

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F 312	Continued From page 2 who worked 7am-3pm shift indicated she had not provided, or assisted Resident #32 with mouth/denture care this week. Nurse #1 added it was the responsibility of the primary NA to ensure oral care was completed. In an interview on 3/29/12 at 3:47 pm, the Director of Nurses stated she expected the NA staff to have assisted/provided mouth/denture care to Resident #32.	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345321	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVE HENDERSON, NC 27536

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 04/17/2012 the staff interviewed did not know about the master door release switch located at the nurses station. B. Based on observation there were doors that require more than one motion of the hand to exit the room . a. Social Workers office b.Comference Room c. Based on observation the employees patio has NC Special Locking and must have an on and off switch on both sides of the door. 42 CFR 483.70 (a)	K 038	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. RECEIVED MAY 04 2012 CONSTRUCTION SEC K038 1.All staff inserviced on master door release switch located at nurses stations. Door knobs at SW office and conference room replaced with one motion door knobs. On/ Off switch placed on outside of employee patio door so that there is switch on both sides of door.	6/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danny Hughes — TITLE: Administrator — (X6) DATE: 5/2/12

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	345321	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	04/17/2012

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 04/17/2012 there were mixed sprinkler heads (differant ratings) in the laundry. 42 CFR 483.70 (a)	K 062	K038 cont'd 2. Doors in facility were audited for one motion to open door and knobs replaced where necessary. Audit completed for NC Special Locking requirements for any other doors requiring on off switch on both sides of door with corrective action as necessary. 3. Orientation to include master door release switch at nurses station for all new employees. Maintenance will monitor any door knobs replaced for correct one motion opening knobs. K 062 1.Sprinkler heads in the laundry were corrected to be same rating in area of laundry. 2.Sprinkler heads throughout the facility were audited for correct/ same rating in each area. 3.Maintenance will check sprinkler heads when work is done on sprinkler system to ensure same rating in each area with corrective actions taken as necessary.	6/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janey Hughes	Administrator	5/2/12

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