STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. BUILDING _____ B. WING _____	C 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to comprehensively accurately assess 1 of 3 sampled residents (Resident #6). The findings included: Resident #6 was admitted to the facility on 10/23/18 with a diagnosis that included pneumonia, due to methicillin resistant staphylococcus aruses (MRSA), ventricular heart disease, presence of automatic cardia defibrillator, and constipation. Review of the most recent Minimum Data Set (MDS) assessment dated 10/30/18 required extensive assistance with activities of daily living, was cognitively intact and received 4 days of an antibiotic. Section I of the MDS assessment did not identify multidrug-resistant organism as Resident #6 active diagnosis. Review of admission progress note dated 10/23/18 stated Resident #6 was on contact precautions for MRSA at this time. Review of progress note dated 10/23/18 revealed Resident #6 diagnoses included Methicillin resistant staphylococcus aureus. The note stated resident #6 had a lengthy hospital stay with MRSA sepsis related to PNA and right sided empyema with chest tube insertion and thoracentesis. Resident #6 had inpatient vancomycin and is now on Zyvox by mouth (PO).	F 641	F641 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center 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, Lake Park 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. The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility had failed to accurately code MRSA on MDS Section I-1700. 1. Address how the corrective action will be accomplished for those resident found	12/13/18

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

Electronically Signed | 12/13/2018

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F 641	Continued From page 1 Review of Resident#6 care plan revealed no interim care plan for contact isolation for MRSA. Interview with MDS Coordinator 11/15/18 at 1:20pm revealed the admitting nurse should have included the MRSA on an interim care. She stated 5 days would be too early for her to have completed the 5-day comprehensive assessment. The MDS coordinator stated Resident #6 was receiving an antibiotic for her diagnosis of MRSA at the time the 5-day MDS assessment was completed and it should have been coded on the MDS as an active diagnosis. It would be the responsibility of the admission nurse to include the contact precautions a care plan. Interview with the Director of Nursing (DON) on 11/15/18 at 2:47 pm revealed it was her expectation that the MDS coordinator identify Resident #6 active diagnosis of MRSA.	F 641	to have been affected by the deficient practice Section I- 1700 was corrected, updated and submitted by MDS (Minimum Data Set) Coordinator as 11/19/2018 for Resident #6. 2. Address how the corrective actions will be accomplished for those resident having the potential to be affected by the same deficient practice. Section I-1700 auditing for all admissions in the last 30 days was initiated 11/15/2018 and will be completed by MDS Coordinator by 12/13/2018 and MDS Coordinator will make corrections through MDS Modification as needed. All MDS Coordinators were in-serviced by 11/30/2018 by the Lead MDS Coordinator and Administrator on accurately coding Section I-1700. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur Two RN checks was implemented as of 12/3/2018 to double check that Section I -1700 is accurately coded and completed. This system change will be ongoing. Any new isolation or contact precaution orders will be reported by SDC or RN Unit Manager/s to MDS, DON and Administrator during IDT (Interdisciplinary Team) meetings. MDS Coordinator will	

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F 641	Continued From page 2	F 641	ensure that each new contact precaution supporting diagnosis will be accurately coded on Section I-1700 through the 2 RN verification check audits. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. MDS Coordinator will report compliance to IDT (Interdisciplinary Team) Meeting weekly and as needed to ensure compliance. MDS Coordinator will report results of the audit to QAPI on Section I-1700 coding compliance monthly for 3 months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		12/13/18

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F 656	Continued From page 3 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a baseline care plan 1 of 3 sampled residents (Resident #6) who was admitted with contact precautions. The findings included: Resident #6 was admitted to the facility on 10/23/18 with a diagnosis that included pneumonia, due to methicillin resistant staphylococcus aruses (MRSA), ventricular heart disease, presence of automatic cardia defibrillator, and constipation. Review of the most recent Minimum Data Set (MDS) assessment dated 10/30/18 required extensive assistance	F 656	F656 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it	

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F 656	Continued From page 4 with activities of daily living, was cognitively intact and received 4 days of an antibiotic. Section I of the MDS assessment did not identify multidrug-resistant organism as Resident #6 active diagnosis. Review of admission progress note dated 10/23/18 stated Resident #6 was on contact precautions for MRSA at this time. Review of progress note dated 10/23/18 revealed Resident #6 diagnoses included Methicillin resistant staphylococcus aureus (MRSA). The note stated Resident #6 had a lengthy hospital stay with MRSA sepsis related to PNA and right sided empyema with chest tube insertion and thoracentesis. Resident #6 had inpatient vancomycin and is now on PO zyvox. Review of Resident#6 medical record revealed no baseline care plan that included interventions for contact isolation for MRSA. Interview with MDS Coordinator 11/15/18 at 1:20pm revealed the admitting nurse should have included the MRSA on an interim care. She stated 5 days would be too early for her to have completed the 5-day comprehensive assessment. The MDS coordinator stated Resident #6 was receiving an antibiotic for her diagnosis of MRSA at the time the 5-day MDS assessment was completed and it should have been coded on the MDS as an active diagnosis. It would be the responsibility of the admission nurse to include the contact precautions a care plan. Interview with the Director of Nursing (DON) on 11/15/18 at 2:47 pm revealed it was her expectation that the admission nurse care plan	F 656	constitute an admission that any deficiency is accurate. Further, Lake Park 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. The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility had failed to include interventions for contact isolation for MRSA on the baseline care plan. 1. Address how the corrective action will be accomplished for those resident found to have been affected by the deficient practice Resident #6 was discharged on 10/30/2018 therefore Care Plan could not be updated. 2. Address how the corrective actions will be accomplished for those resident having the potential to be affected by the same deficient practice. 100% In-service will be completed by MDS Coordinator for all Licensed Nurses by 12/13/2018 to ensure that all resident requiring isolation are care planned accordingly with each new admission or new diagnosis. This in-service will be included during orientation of all new licensed nurses.	

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F 656	Continued From page 5 contact precautions for residents admitted with contact precautions.	F 656	3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur SDC / RN Unit Managers will report any new admissions or new orders for contact isolation to IDT (Interdisciplinary Team) during IDT meetings. MDS Coordinator will ensure that each admission or new order for isolation will be care planned accordingly and report audit completion to IDT for verification. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. MDS Coordinator will report to QAPI contact isolation Care Planning compliance monthly for 3 months. MDS Coordinator will report compliance thereafter to IDT (Interdisciplinary Team), DON and Administrator during IDT meetings and as needed to ensure compliance.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		12/13/18

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F 732	Continued From page 6 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to post accurate Daily Nursing Staffing that reflected the Daily Shift Assignment for licensed and non-licensed nursing totals for 16 out of 18 days reviewed for accuracy. Findings included:	F 732	F732 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and	

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F 732	Continued From page 7 A review of the daily nursing staffing information was conducted on 11/16/18 for the dates of 10/21/18 through 11/3/18 and 11/12/18 through 11/15/18. Comparison of the Daily Nursing Staffing with the Daily Shift Assignment schedule revealed the inaccurate staff numbers and hours worked by Registered Nurses, Licensed Practical Nurses and Nursing Assistants for 10/21/18 through 11/3/18 and 11/12/18 and 11/13/18. The Daily Nursing Staffing information was not updated each shift and so did not reflect the absences and/or call-outs. The Daily Nursing Staffing sheets also showed no actual hours worked and no staffing totals for several shifts on 10/21/18, 10/23/18, 10/25/18, 10/26/18, 10/27/18, 10/28/18, 10/30/18, and 10/31/18. An interview with the Staff Scheduler on 11/15/18 at 1:55 PM revealed she was responsible for filling the Daily Shift Assignment. She scheduled nursing staff to work every shift and the supervisor for the shift were responsible for updating the Daily Nursing Staffing Sheets. She stated that the supervisor was supposed to change the staffing numbers to reflect the staffing changes for call-outs and/or absences. The Staff Scheduler acknowledged the Daily Nursing Staffing posted did not reflect the shift assignments when presented to her. She further stated she needed to review updating the schedules with the supervisors. A Supervisor that worked regularly in the facility was interviewed on 11/15/18 for the Daily Nursing Staffing. The Supervisor agreed that the Daily Nursing Staffing should reflect the daily shift assignment from any absences and/or call-outs. The supervisor acknowledged that it's one of the things they were supposed to do and update it	F 732	provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center 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, Lake Park 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. The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility had failed to post accurate Daily Nursing Staffing that reflected the Daily Shift Assignment for licensed and non-licensed nursing totals. 1. Address how the corrective action will be accomplished for those postings found to have been affected by the deficient practice Daily Nursing Staffing postings were corrected as of 11/15/2018 by the Staffing Coordinator/ Scheduler to accurately match and reflect the daily Shift Assignment for licensed and non-licensed nursing totals. 2. Address how the corrective actions will be accomplished for those resident	

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F 732	Continued From page 8 every shift. The Administrator was interviewed on 11/16/18 at 1:08 PM and she stated that the Daily Nursing Staffing and Daily Shift Assignment should reflect accurate information. She stated that she will in-service her staff on updating the Daily Staffing numbers and hours to reflect the actual staffing. She further stated that the supervisor and the Director of Nursing were responsible for updating the actual time worked to reflect the Daily Staffing.	F 732	having the potential to be affected by the same deficient practice. In-service was completed by Administrator for DON, Staffing / Scheduler and Administrative RNs on accurately completing Daily Nursing Staffing to match and reflect the daily Shift Assignment for licensed and non-licensed nursing totals. Any new Administrative RNs will be educated on orientation by SDC or DON or by the Administrator. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur Staffing meeting will be held as of 12/13/2018 and ongoing at least 3x/ week by Administrator with DON, SDC and Scheduler to review accuracy of Daily Nursing Staffing report to match and reflect the Daily Shift Assignment for licensed and non-licensed nursing totals. Reports will be verified for accuracy during this meetings. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. Staffing/ Scheduler will submit Daily Nursing Staffing report for DON or SDC to review at least 5x/ week to include staffing on weekends x 2 weeks and then 3x/week for 2 weeks and then weekly x 2 months. DON or SDC will report compliance to Administrator during Staffing Meeting at	

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F 732	Continued From page 9	F 732	least weekly. DON or SDC will submit report monthly x 3 mos. to QAPI Committee to verify that Daily Nursing Staffing report matches the Daily Assignment for licensed and non-licensed nursing totals to ensure compli	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to maintain equipment for 1 of 1 resident (Resident # 1). The findings included: Resident #1 was admitted to the facility on 10/5/18 with a diagnosis that included; Alzheimer's disease, dementia with behavioral disturbance, muscle weakness, unsteadiness on feet, cognitive communication deficit, major depressive disorder, abnormality of gait and mobility, anxiety disorder, restlessness and agitation, history of falling. The most recent Minimum Data Set (MDS) assessment dated 10/19/18 revealed Resident #1 required extensive assistance with two staff persons for bed mobility and transfers. Resident #1 was coded as being severely cognitively impaired. Review of fall risk assessment dated 10/15/18 and 10/21/18 revealed Resident #1 was chair fast - total assist with transfers. Resident #1 scored a 15 that indicated she was at risk for falls. The	F 908	F908 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Park Nursing and Rehabilitation Center 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, Lake Park 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.	12/13/18

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F 908	Continued From page 10 assessment identified Resident #1 as a frequent faller and required 1:1 with staff. A continuous observation of Resident #1 on 11/14/18 at 11:24am until 11:35am revealed the resident to be in activity room. Resident #1 was observed to be very anxious as evidenced by continuously attempting to get out of her Geir-chair, grabbing at items around her and attempting to disrobe. The leg rests to Resident #1 Geri-Chair were observed as bent and leaning. Observation of Resident #1 on 11/14/18 at 3:43pm revealed the resident to be seated on the hallway with peers and staff. The resident is observed to continuously attempt to get up out of her Geri-chair and use the Geir-Chair foot rests to position herself. The Geir-Chairs was observed as having bent leg rests. Interview with NA#2 on 11/15/18 at 10:26am revealed Resident #1 Geir-chair had been crooked for some time. She indicated she overhead NA#1 stating that she reported it yesterday. She was unaware if maintenance was notified or not. Interview with NA#1 on 11/15/18 at 10:26am revealed she had reported Resident #1 Geir-chiar leg rest being bent about a week ago. She stated she did not recall the date she had reported it. NA#1 stated as an NA she did not have access to the electronic maintenance reporting, so she notified her supervisor. The supervisor that she notified was no longer employed. Interview with Maintenance Director on 11/15/18 at 10:39am revealed he was made aware of the	F 908	The position of Lake Park Nursing and Rehabilitation center regarding the process that lead to this deficiency was the facility had failed to maintain equipment for one resident□s reclining Geri-chair. 1. Address how the corrective action will be accomplished for those resident found to have been affected by the deficient practice Reclining Geri-chair for Resident #1 was immediately removed and replaced and locked & tagged-out for repair by Maintenance Supervisor on 11/14/2018. Resident #1 was placed in a chair in good repair. 2. Address how the corrective actions will be accomplished for those resident having the potential to be affected by the same deficient practice. 100% Audit of all Geri-chairs was completed by Maintenance Supervisor on 11/15/2018 to ensure proper repair. All other geri-chairs were working properly. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur In-service for nursing staff initiated 11/15/2018 by Maintenance Supervisor and DON to ensure that any equipment that is not working properly will removed immediately from use and maintenance Supervisor will be notified for repair or replacement. All new staff will be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

(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 908	Continued From page 11 issues that need repair by the nursing staff. He further revealed the facility utilized an electronic maintenance requests as well. Upon an observation of Resident #1 seated in her reclined Geir-chair, the Maintenance Director stated he was not made aware of the chair being broken. He further stated it was obvious that the frame of the Geri- chair was bent and leaning. He revealed in the instance he was made aware of Resident #1 Geir-Chair being bent he would have removed the Chair from use until the chair could have been repaired for safety. Review of maintenance requests from October 26, 2018 through November 6, 2018 revealed no maintenance request for Resident #1 Geir-Chair. Interview with the Director of Nursing (DON) on 11/15/18 at 2:47pm revealed her expectation was that staff notify maintenance verbally or filling out a maintenance request located in a mailbox located outside of the Maintenance Director's door. Staff can also send maintenance director an electronic work order. She stated she expected for Resident #1 be removed from the Geir-chair until necessary repairs could be made.	F 908	educated on orientation and as needed. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The POC is to be integrated into the quality assurance system of the facility. Maintenance Supervisor (MS) will do weekly checks to ensure all Geri-chairs in current use are in proper working order. MS will report to Administrator compliance weekly and as needed. MS will report & submit weekly audits to QAPI for compliance monthly x 3 months.	