| 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 ______ | C 03/28/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KERR LAKE NURSING AND REHABILITATION CENTER | 1245 PARK AVENUE 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 |
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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 03/25/2019 through 03/28/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JM7Q11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation survey of 3/28/2019. Event ID # JM7Q11. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately for discharge for 1 of 1 residents reviewed. (Resident #87).<br><br>The findings included:<br><br>Resident #87 was originally admitted to the facility on 12/24/18 with diagnoses including Diabetes Mellitus Type 2, without complications, Hypertension and Osteoarthritis. According to the most recent Discharge-Return not anticipated MDS dated 1/16/19, Resident #87's cognition was intact and he required extensive assistance in most areas of activities of daily living.<br><br>Review of Resident #87#s care plan dated 1/8/19, revealed Resident #87 desired to return home upon completion of rehabilitation therapy. | F 641 | 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 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.<br><br>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 | 4/19/19 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/10/2019

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.

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| F 641 | Continued From page 1<br>Interventions included establish a pre-discharge plan with resident./family/ representative/caregiver. Make arrangement with required community resources such as home health to support independence post discharge.<br><br>Review of the MDS, dated 1/16/19, under Section A, Discharge Status, revealed Resident #87 was coded on the MDS for discharge to Acute Hospital.<br><br>Review of a Nursing note dated 1/16/19 at 12:14 PM, read in part, "Resident discharged home with home health. Medication list, discharge instructions, and upcoming appointments reviewed with resident and responsible person.<br><br>During an interview dated 3/28/19 at 9:00 AM, MDS Coordinator #1 stated she made a data entry error.<br><br>During an interview on 16/19 at 12:14 PM, the Administrator stated her expectation was that the MDS should be coded correctly. | F 641 | deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.<br><br>Corrective action for those residents found to have been affected by the deficient practice:<br>Resident # 87 Discharge- Return Not Anticipated MDS assessment dated 1/16/19 was modified by the MDS nurse on 3/27/19 to reflect an accurate coding of discharge to community.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>A 100% audit of all Discharge- Return Not Anticipated MDS assessments completed in the last 90 days to include Resident # 87 was reviewed by the Administrator on 4/2/19 to ensure all completed Discharge- Return Not Anticipated MDS assessments are coded accurately to include correct discharge location. No further inaccuracies were noted.<br><br>Measures put in place or systemic changes to ensure the deficient practice will not recur:<br>An in-service was completed on 4/2/19 for the MDS nurses by Administrator regarding the proper coding of MDS assessments as indicated in the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are completed accurately and coded correctly to include correct location upon discharge. | |

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| F 641 | Continued From page 2 | F 641 | All newly hired MDS nurses will be provided the in-service during orientation by the Staff Facilitator regarding the proper coding of MDS assessments as indicated in the RAI manual with emphasis that all MDS assessments are completed accurately and coded correctly to include a correct location of discharge.<br><br>Plans to monitor performance to make sure solutions are sustained:<br>The DON or ADON will conduct an audit of Discharge MDS assessments utilizing the MDS Accuracy QI Tool for accuracy at 100% weekly for 4 weeks, then 50% weekly for 4 weeks, and then 10% weekly for 8 weeks. The Administrator will review and sign the MDS Accuracy QI Tool for completion weekly for accuracy and to ensure all areas of concern have been addressed. Any identified areas of concern will be immediately addressed to include additional training and modifications to the MDS assessment as indicated.<br>The Administrator and/ or Director of Nursing will review and present the findings of the QI for MDS Accuracy to the Executive QI committee monthly x 4 months. The identification of trends, issues and concerns will be addressed by implementing changes as necessary to include continued frequency of monitoring. | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals | F 761 | | 4/19/19 |

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| F 761 | Continued From page 3<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to monitor the refrigerator temperatures for 1 of 3 medication refrigerators reviewed (Satterwhite Point and Island Creek medication room refrigerator).<br><br>The findings included:<br><br>On 3/27/2019 at 4:04 PM the Satterwhite Point and Island Creek medication room refrigerator was observed with Nurse #1. The refrigerator was observed with a temperature of 26 degrees Fahrenheit (F). | F 761 | 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 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.<br><br>Kerr Lake Nursing and Rehabilitation Center□s response to this Statement of | |

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| F 761 | Continued From page 4<br><br>The temperature log was located on top of the refrigerator and indicated the refrigerator temperature range should be 35 to 41 degrees F. There was no month or year indicated on the log. There were only 2 dates documented on the log for dates 2 and 4, with a range of 34 degrees F to 38 degrees F. The temperature log located directly beneath the current chart was dated 2/2019, and dates 2/1/2019 thru 2/4/2019 were documented with temperature ranges of 32 degrees F to 38 degrees F.<br><br>Medications in the refrigerator included:<br><br>Avonex 30 milligrams (MG) - 3 vials. The medication packaging indicated to store at 36 to 46 degrees F.<br><br>Influenza vaccine - 2 prefilled syringes. The medication packaging indicated to store at 35 to 46 degrees F.<br><br>Novolog insulin- 1 vial. A pharmacy label indicated to refrigerate.<br><br>Procrit - 2 vials. The medication packaging indicated to store at 35 to 46 degrees F.<br><br>Tuberculin - 1 opened vial. The medication packaging indicated to store at 35 to 46 degrees F, do not freeze.<br><br>Humulin R insulin -2 vials. A pharmacy label indicated to refrigerate.<br><br>Detemir insulin -1 vial. The medication packaging indicated to store at 35 to 46 degrees F. | F 761 | 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.<br><br>Corrective action for those residents found to have been affected by the deficient practice:<br>All medications in Satterwhite Point/ Island Creek medication room refrigerator were discarded on 3/27/19, new medications to replace the discarded medications were ordered from pharmacy and delivered that evening. Satterwhite Point/ Island Creek medication room refrigerator was removed for maintenance, thermometer replaced and run for 48 hours holding temperatures between 35 and 41 degrees before being placed back in medication room.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>100% audit completed on 3/27/19 of all other medication refrigerators to ensure refrigerator temperatures were between 35 and 41 degrees and temperatures were being checked twice daily with no concerns noted at the other medication refrigerators located on Henderson Point and Nutbush halls. | |

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| F 761 | Continued From page 5<br>Mucomyst - 1 opened vial and 1 unopened vial. The medication packaging indicated to store at 68 to 77 degrees F. After opening store at 36 to 46 degrees F.<br><br>Acetaminophen suppositories 650 MG - 7 suppositories. The medication packaging indicated to store at 59 to 86 degrees F.<br><br>Cathflo Activase - 2 units. The medication packaging indicated to store at 36 to 46 degrees F.<br><br>On 3/27/2019 at 4:13 PM, an interview was conducted with Nurse #1. The nurse stated she was not sure who was responsible to check the refrigerator temperature. The nurse stated the temperature log was not dated but she assumed it was for March 2019.<br><br>On 3/27/2019 at 4:29 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the refrigerator should be kept at 35 to 41 degrees as indicated on the temperature log sheet. The DON stated all nurses were responsible to check the refrigerator temperatures. The DON stated she assumed the log sheet that was undated was for March 2019, but there was no date written on it. | F 761 | Measures put in place or systemic changes to ensure the deficient practice will not recur:<br>A 100% inservice of all licensed nurses to include Nurse # 1 and medication aides on the correct temperature of medication refrigerators, checks to be completed daily on refrigerator temperature and action to be taken if a medication refrigerator was not at correct temperatures was initiated by the SDC on 3/27/19. Inservicing completed by 4/3/19. All newly hired licensed nurses and medication aides will be educated during orientation on the correct temperature of medication refrigerators, checks to be completed daily on medication refrigerator temperatures and actions to be taken in a medication refrigerator is not at correct temperature.<br><br>Plans to monitor performance to make sure solutions are sustained:<br>A RN Unit Manager or Weekend Administrative Staff Manager will conduct a daily audit of all medication refrigerators to ensure the temperatures are correct and temperature logs are completed utilizing the Medication Refrigerator Temperature audit tool daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. Any identified concerns will be addressed immediately by the RN Unit Manager, Weekend Administrative Staff Manager, DON or Administrator. The DON or Administrator will review and sign the Medication Refrigerator Temperature | |

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| F 761 | Continued From page 6 | F 761 | audit tool weekly for 12 weeks, then monthly for accuracy and to ensure all areas of concern have been addressed. The Administrator and/ or Director of Nursing will review and present the findings of the QI for Medication Refrigerator Temperature audits and present the findings to the Executive QI committee monthly x 4 months. The identification of trends, issues and concerns will be addressed by implementing changes as necessary to include continued frequency of monitoring. | |
| F 814 SS=E | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris and close the lid for 1 of 2 dumpsters observed.<br><br>The findings included:<br><br>During an observation of the dumpster on 3/27/19 at 2:05 PM a clear plastic bag of trash was observed on the ground between the dumpster and dumpster deck.<br><br>A second observation on 3/28/19 at 10:48 AM a clear plastic bag of incontinent trash, 3 disposable gloves, two plastic spoons and a 2oz. medication cup were observed on the ground beside the dumpster and dumpster deck. The lid | F 814 | 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 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.<br><br>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 | 4/19/19 |

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| F 814 | Continued From page 7<br>to the first dumpster was observed open.<br><br>In an interview on 3/28/19 at 10:51 AM the Assistant Dietary Manager stated all staff were expected to shut the dumpster lid after use and to pick up any trash around the dumpster area on every shift.<br><br>In an interview on 3/28/19 at 11:02 AM the Housekeeping Supervisor stated housekeeping staff checked the dumpster area every day. | F 814 | 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.<br><br>Corrective action for those residents found to have been affected by the deficient practice:<br>On 3/28/18 area around dumpster was inspected and any areas of concern were disposed of properly.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice:<br>100% audit completed on 3/29/19 of facility dumpster to ensure dumpster area was clean, dumpster lids worked correctly and dumpster in good order with no concerns noted.<br><br>Measures put in place or systemic changes to ensure the deficient practice will not recur:<br>A 100% inservice was initiated by the SDC on 4/4/19 of all housekeeping staff, dietary staff and administrative staff to ensure the dumpster area remained free of trash, trash disposed of properly and dumpster lid to remain closed, and action to be taken if area is not in clean condition. Inservicing will be completed by 4/15/19. All newly hired housekeeping staff, dietary staff and administrative staff will be educated during orientation on ensure the dumpster area remained free of trash, | |

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| F 814 | Continued From page 8 | F 814 | trash disposed of properly and dumpster lid to remain closed and action to be taken if area is not in clean condition.<br><br>Plans to monitor performance to make sure solutions are sustained:<br>Maintenance Director, Maintenance Assistant or Weekend Administrative Staff Manager will conduct a daily audit of dumpster area utilizing audit tool daily for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. The DON or Administrator will review and sign the Dumpster Area audit tool weekly for 12 weeks, then monthly for accuracy and to ensure all areas of concern have been addressed. Any identified concerns will be addressed immediately by the Maintenance Director, Maintenance Assistant, Weekend Administrative Staff Manager DON or Administrator.<br>The Administrator and/ or Director of Nursing will review and present the findings of the QI for Dumpster audits and present the findings to the Executive QI committee monthly x 4 months. The identification of trends, issues and concerns will be addressed by implementing changes as necessary to include continued frequency of monitoring. | |