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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
E 000	Initial Comments An unannounced Recertification and Compliant survey was conducted on 1/13/19 through 1/16/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6PZE11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey on 1/16/2020. Event ID #6PZE11. Two of the two allegations were unsubstantiated.	F 000		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The	F 661		2/5/20

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

Electronically Signed | 01/30/2020

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 661	Continued From page 1 post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a recapitulation of stay (discharge summary) for 1 of 1 residents discharged to another facility. (Resident #88). The findings include: Resident #88 was originally admitted to the facility on 10/17/19 with diagnoses including Hypertension, Chronic Kidney Disease, stage 3 moderate and Hypothyroidism. According to the most recent Discharge Return Not Anticipated Minimum Data Set dated 11/15/19, Resident #88 had some cognitive deficits and she required limited to extensive assistance in most areas of activities of daily living and required total dependence with bathing. Resident #88 was discharged to another facility on 11/15/19. Review of a a nursing note dated 11/15/19 at 10:19 AM read in part, "Resident left facility at approximately at 10:15 AM with transportation. Resident's skin intact and resident in stable condition upon discharge from facility. Resident in good spirits upon discharge." During an interview on 1/16/2020 at 1:05 PM, the facility Social Worker stated the nurse does the discharge summary. She revealed Resident #88 was involved in discharge planning. The Social Worker revealed Resident #88 was in an assisted living facility prior to going to the hospital and she	F 661	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. 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. Corrective action for those residents found to have been affected by the deficient practice: An addendum was completed and faxed to the assisted living on 1/28/20 for Resident #88 to include a recapitulation of resident□s stay at facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit	

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 661	Continued From page 2 wanted to go back to assisted living facility. During an interview on 1/16/2020 at 1:16 PM, the Nurse stated she had not included recapitulation of stay for the discharge summary. She revealed a reconciliation of the resident's medication was completed, but she did not complete a recapitulation of stay. During an interview on 1/16/20 at 2:29 PM, the Director of Nursing stated her expectation was to follow the regulation. During an interview on 1/16/20 at 3:37 PM, the Administrator stated her expectation was to follow the regulation.	F 661	completed of all residents with an anticipated discharge from 1/20/20 to ensure a recapitulation of stay was included with no other issues noted. Measures put in place or systemic changes to ensure the deficient practice will not recur: A 100% inservice of all licensed nurses on completing a discharge summary to include a recapitulation of stay in the discharge summary on all anticipated discharges was initiated on 1/16/20 and completed by 2/1/20. All newly hired licensed nurses will be educated during orientation on completing a discharge summary to include a recapitulation of stay in the discharge summary on all anticipated discharges. Plans to monitor performance to make sure solutions are sustained: All pending discharges will be discussed in Cardinal IDT and the Discharge Item checklist/ audit will be completed. The DON, SDC, Treatment Nurse or RN Supervisor will conduct a weekly audit of all discharge summaries for residents with anticipated discharges utilizing the Discharge Summary audit tool weekly for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months. Any identified concerns will be addressed immediately by the DON, SDC, Treatment Nurse or RN Supervisor. The DON or Administrator will review and sign the Discharge Summary audit tool weekly for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months for accuracy and to ensure all areas of concern have been addressed. The Administrator and/ or Director of	

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 661	Continued From page 3	F 661	Nursing will review and present the findings of the QI for Discharge Summary 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 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. This REQUIREMENT is not met as evidenced	F 761		2/5/20

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 761	Continued From page 4 by: Based on observation and staff interview the facility failed to store narcotics in a locked permanently affixed compartment for 1of 1 store rooms checked for medication storage and facility failed to discard expired medication for 1 of 3 medication carts (Island Creek cart) reviewed for medication storage. Findings included: 1.During an observation of the medication storage room labeled as Nutbush Hall on 01/14/2020 at 02:57 PM, the narcotic lock box was inside a refrigerator that was unlocked. The narcotic locked was not permanently affixed to refrigerator, did not have a chain attached, and was removeable. An interview with Nurse #2 on 01/14/2020 at 03:05 PM indicated that the refrigerators had recently been changed out and that the narcotic box had a chain in place to secure it. An interview with the Director of Nursing (DON) on 01/14/2020 at 3:22 PM revealed that the refrigerators had recently been replaced. The DON stated that the narcotic box had been secured until that point. The DON stated she was not aware the chain had not been replaced. 2.During an observation of the Island Creek cart for medication storage on 01/16/2020 at 09:36 AM, 2 opened and accessed vials of Humulin R insulin were in the drawer. The manufacturer's label on the vial directed that the vial be discarded 31 days after opening. One vial had a handwritten sticker with an opened date of 11-26-2019, the second vial had a hand-written	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. 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. Corrective action for those residents found to have been affected by the deficient practice: The narcotic storage box for the medication refrigerator on Nutbush hall was permanently affixed in the refrigerator on 1/14/20. The two vials of expired insulins that were identified were immediately discarded on 1/16/20, new insulins were ordered from pharmacy and delivered that evening. How the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit completed on 1/14/20 of all other medication refrigerators to ensure	

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 761	Continued From page 5 date of 12-11-2019. An interview was conducted with Nurse #3 on 1/16/2020 at 9:40 AM and she indicated that insulin was to be discarded after 28 days. The nurse stated that it was the nurse administering the medications responsibility to check the expiration dates. An interview was conducted with the DON on 1/16/2020 at 9:50 PM. The DON stated that expired insulins were to be discarded after 28 days.	F 761	narcotic boxes were permanently affixed in the refrigerator with no problems noted. 100% audit of medication carts completed for expired medications with no further expired medications located. Measures put in place or systemic changes to ensure the deficient practice will not recur: A 100% inservice of all licensed nurses, to include Nurse # 2 and Nurse # 3, and medication aides on ensuring narcotic boxes are permanently affixed in medication refrigerators and to remove and discard expired medications from the medication carts and/or rooms. Night shift nurses will check medication carts/rooms weekly for expired medications. Inservicing was initiated on 1/16/20 and completed by 2/1/20. All newly hired licensed nurses and medication aides will be educated during orientation on ensuring narcotic boxes are permanently affixed in medication refrigerators and to remove and discard expired medications from the medication carts and/or rooms. Plans to monitor performance to make sure solutions are sustained: The DON, SDC, Treatment Nurse or RN Supervisor will conduct a weekly audit of all medication refrigerators to ensure the narcotic boxes are permanently affixed utilizing the Medication Refrigerator audit tool weekly for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months. Any identified concerns will be addressed immediately by the DON, SDC, Treatment Nurse or RN Supervisor. The DON or Administrator will review and sign the Medication Refrigerator audit tool weekly	

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 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 761	Continued From page 6	F 761	for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months for accuracy and to ensure all areas of concern have been addressed. The DON, SDC, Treatment Nurse or RN Supervisor will conduct a weekly audit of all medication carts to ensure there are no expired medications utilizing the Expired Medication audit tool weekly for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months. Any identified concerns will be addressed immediately by the DON, SDC, Treatment Nurse or RN Supervisor. The DON or Administrator will review and sign the Expired Medication audit tool weekly for 4 weeks, then biweekly for 4 weeks, the monthly for 2 months 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 audits and Expired Medication 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.	