STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 09/27/2024

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LAKESIDE HEALTH & REHAB CENTER	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 complaint investigation survey was conducted on 09/23/24 through 09/26/24. Additional information was obtained offsite on 09/27/24. Therefore, the exit date was changed to 09/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 0VAD11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 09/23/24 through 09/26/24. Additional information was obtained offsite on 09/27/24. Therefore, the exit date was changed to 09/27/24. Event ID# 0VAD11. The following intakes were investigated: NC00208585, NC00208690, NC00208763, NC00213860, NC00214551, NC0021482, NC00214841, NC00216331, NC00221213, NC00221864, NC00222279, and NC00222307. 40 of the 40 complaint allegations did not result in a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to ensure dependent residents could access the	F 558	1. The Maintenance Director added a pull cord to the over bed light pull switch for resident #2 on 9/24/2024.	10/18/24

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

Electronically Signed | 10/14/2024

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F 558	Continued From page 1 light switch located behind the bed for 1 of 1 resident reviewed for accommodation of needs (Resident #2). Findings included: Resident #2 was admitted to the facility on 08/16/23. Review of Resident #2's medical record revealed she had stayed in room 711 since 08/16/23. The quarterly Minimum Data Set (MDS) dated 08/23/24 coded Resident #2 with a moderately impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet did not occur for Resident #2 during the assessment period. During an observation conducted on 09/23/24 at 3:44 PM, the switch cord for the light fixture on the wall behind Resident #2's bed was approximately 5 feet from the floor and 6-7 feet from the bed. The switch cord was approximately 4 inches in length. Resident #2 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #2 on 09/23/24 at 3:45 PM. Resident #2 stated she was bedbound and had been in this room for over a year. She could not recall when the switch cord broke. Resident #2 indicated she could not control the light fixture behind her bed as she could hardly stand up to reach the broken switch cord on the wall. She had to rely on nursing staff to control the light fixture and it was very inconvenient to her. Resident #2 wanted the maintenance staff to fix the switch cord to	F 558	2. On 9/24/24 the Maintenance Director audited 100% of resident's rooms to ensure all over bed lights had a pull cord long enough to allow for the resident to independently turn the light on and off. Three other residents were identified needing longer pull cords for their lights, and were immediately corrected. 3.On 9/26/24 the Nursing Home Administrator educated the Interdisciplinary Team during concierge rounds they are to assess that the resident's pull cord to the over bed light is long enough to allow the resident to turn the light on and off as they choose. The Director of Nursing and or Designee educated all Nursing, Therapy and Housekeeping staff on 10-2-2024 if they find a pull cord to the over bed light is not long enough for the resident to turn the light on and off as they choose to place a work order in the maintenance book for follow up. 4.To maintain and monitor on going compliance beginning 10/7/24 the Maintenance Director and or Designee will audit 5 rooms weekly for 12 weeks to ensure the pull code on the over bed light is long enough for the resident to turn the light on and off as they choose. Results of audits will be submitted to the QAPI committee for the next 3 months for further review and recommendations. Date of Compliance: 10/18/24	

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F 558	Continued From page 2	F 558		

accommodate her needs as soon as possible.

During an interview conducted on 09/23/24 at 3:57 PM, Nurse Aide (NA) #1 stated she noticed the switch cord for the light fixture behind Resident #2's bed was broken about 3 months ago. She notified the Maintenance Manager verbally on the same day. She did not know why it had not been fixed so far.

Subsequent observations conducted on 09/24/24 at 11:38 AM revealed the switch cord for the light fixture behind Resident #2's bed remained inaccessible.

During a joint observation conducted with Nurse #1 on 09/24/24 at 11:45 AM, the switch cord for the light fixture behind Resident #2's bed remained inaccessible from her bed. Nurse #1 acknowledged that the switch cord was broken, and it needed to be fixed immediately. She explained she was assigned to work in 700 halls at times and did not notice the switch cord was broken.

An interview was conducted with Unit Manager #1 on 09/24/24 at 11:54 AM. She acknowledged that the switch cord for the light fixture behind Resident #2's bed was broken. It needed to be fixed immediately to ensure Resident #2 had full accessibility to the light fixture.

During an interview conducted on 09/24/24 at 12:01 PM, the Maintenance Manager stated he walked through the entire facility at least once daily to identify repair needs. He did not notice the switch cord for Resident #2's light fixture behind her bed was broken and stated it was his oversight. In most cases, he depended on the

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F 558	Continued From page 3 staff to report repair needs by dropping the work orders in the boxes located in both nurse stations and by verbal notifications. He checked the work order boxes at least twice daily to ensure all repair needs were addressed in a timely manner. During an interview conducted on 09/26/24 at 8:56 AM, the Director of Nursing (DON) expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. An interview was conducted with the Administrator on 09/25/24 at 4:33 PM. She expected nursing staff to pay attention to residents' home and report repair needs to the maintenance department in a timely manner. It was her expectation for all the dependent residents to have full accessibility and control of the light fixture behind the bed all the time.	F 558		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		10/18/24

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F 688	Continued From page 4 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to follow a physician order to apply a splinting device for 1 of 2 residents (Resident #14) reviewed for range of motion. The findings included: Resident #14 was admitted to the facility on 05/30/2019 with a diagnosis that included contracture to the left hand. Occupational Therapy (OT) discharge summary dated 11/02/2023 indicated recommendations that stated palm guard to left hand 8 hours to facilitate contracture management. On 09/25/2024 at 10:58 AM, an interview with the Director of Rehabilitation revealed on 11/2/2023 Occupational Therapy educated nursing how to don and doff the palm guard to the left hand of Resident #14. A physician order dated 04/04/2024 stated a palm guard should be applied to Resident #14's left hand every day for 8 hours as tolerated. A care plan dated 06/19/2024 revealed Resident #14 had limited physical mobility related to contracture, left-side hemiplegia, and history of stroke. The approaches included first shift Nursing Assistant (NA) to apply left palm guard for wear up to 8 hours as tolerated for contracture	F 688	1. Splint was applied to resident # 14 on 9/25/2024. 2. On 9/27/24 the Director of Rehab and the Director of Nursing completed an audit of 100% of residents in the facility to ensure any resident requiring a splint had orders and their splint was available and was used correctly. No other issues were identified. 3.The Director of Nursing or Designee educated all nursing staff to ensure splints are applied per orders on 10-2-2024. 4.To monitor and maintain ongoing compliance beginning 10/7/24 The Director of Nursing and or Designee will audit 2 residents who have orders for splints weekly for 12 weeks to ensure splints are being applied per orders. Any negative findings will be immediately corrected. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months. Date of Compliance: 10/18/24	

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F 688	Continued From page 5	F 688		

management, to monitor skin integrity and to notify nurse of any changes observed.

Resident #14's quarterly Minimum Data Set (MDS) assessment dated 08/20/2024 revealed she had moderate cognitive impairment and one upper extremity impairment.

Observation of and interview with Resident #14 on 09/23/2024 at 11:08 AM revealed her left hand to be contracted as evidenced by her fingernails touched the palm of her left hand. The left hand was further observed in a tight fixed position. Resident #14 did not have a palm guard to her left hand. At an additional observation at 11:56 AM, the left hand was observed not to have a palm guard. The palm guard was not observed in Resident #14's room. Resident #14 was unable to answer if staff applied the palm guard.

Observation of Resident #14 on 09/24/2024 at 9:11 AM revealed her left hand did not have a palm guard. Additional observation on 09/24/2024 at 2:15 PM showed Resident #14 was up in the wheelchair without the palm guard to the left hand.

Upon observation on 09/25/2024 at 10:00 am, Resident #14 did not have a left palm guard in place on her left hand when she was lying in bed. At 3:40 PM on 09/25/2024, the resident was up in a wheelchair and was not wearing a left palm guard.

During an interview on 09/24/24 at 10:45 AM, Resident #14's Representatives indicated they had not seen the palm guard on Resident #14's left hand for months.

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F 688	Continued From page 6	F 688		

During the interview with the Director of Rehabilitation on 09/25/24 at 10:58 AM, she shared a referral for OT was made on 09/18/2024 for self-feeding and increased difficulty with contracture.

On 09/25/24 at 11:12 AM, an interview took place with Occupational Therapist #1 who assessed Resident #14 on 09/25/2024. The Occupational Therapist stated the referral had not indicated Resident #14 refused to wear the left palm guard. Occupational Therapist #1 disclosed the palm guard was not on Resident #14 when she entered the room. Occupational Therapist #1 saw the palm guard in a white basket on Resident #14's side table. She stated that the contracture was not worse on 09/25/2024 compared to her 11/02/2023 assessment.

Interview with NA #2 on 09/25/2024 at 2:50 PM indicated he was assigned to care for Resident #14 and had never seen Resident #14's left palm guard. NA #2 stated that if he saw a palm guard on the resident that he would ask about it.

An interview with Nurse #2 on 09/25/2024 at 11:23 AM revealed NA's were to apply Resident #14's palm guard daily. She further indicated that she had not checked to ensure that NA's applied the palm guard as ordered.

Upon interview with the Director of Nursing (DON) on 9/26/2024 at 11:00 AM, the DON revealed the nurse should have visually identified if a resident's contracture device was applied correctly. She further stated Resident #14's palm guard should have been applied according to physician order and OT recommendations.

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F 757	Continued From page 7	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to check a finger-stick blood sugar (FSBS) for 1 of 6 residents reviewed for unnecessary medications (Resident #311). The findings included: Review of the hospital discharge summary dated 2/21/2024 revealed Resident #311 had an order for Metformin (anti-diabetic medication) 500 milligrams (mg) twice a day. There were no orders for finger-stick blood sugar (FSBS)	F 757	Past noncompliance: no plan of correction required.	

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checks.

Resident #311 was admitted to the facility on 2/21/2024 with multiple diagnoses which included surgical repair of right hip fracture, diabetes, and asthma.

Documentation on the care plan initiated 2/21/2024 revealed Resident #311 had diabetes mellitus with interventions to assess, document, and report to physician signs and symptoms of hypoglycemia (low blood sugar) such as sweating, tremors, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggered gait.

A review of the facility admission orders dated 2/21/2024 revealed Resident #311 had orders for Metformin 500 mg twice a day. There were no orders for FSBS checks.

A review of the facility's physician admission history and physical dated 2/23/2024 revealed Resident #311 was admitted to the facility following a fall with a right hip fracture with surgical repair. Resident #311 was noted to be a non-insulin dependent diabetic receiving Metformin twice a day.

Review of an additional physician order dated 2/23/2024 revealed Resident #311 had an order to check FSBS every morning and at bedtime starting 2/24/2024 and to notify physician if blood sugar less than 70 or greater than 299 milligrams/deciliter (mg/dl). HgbA1C (blood test that measures person's average blood sugar level over the past 2-3 months) was also ordered for 2/26/2024.

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Review of the admission Minimum Data Set (MDS) dated 2/24/2024 revealed Resident #311 was moderately cognitively impaired, required set up for meals and was totally dependent for toileting, bathing, dressing, and transfers. The MDS also revealed Resident #311 was receiving hypoglycemic medications.

A review of the Point-of-Care Blood Sugar Summary report for Resident #311 revealed that no FSBS was obtained on the morning of 2/24/2024.

Review of the Medication Administration Record (MAR) on 2/24/2024 revealed Resident #311 took all morning medications including Metformin as ordered by the physician.

Review of the Medication Error Report dated 2/25/2024 revealed the physician had ordered FSBS to be obtained every AM and every PM for trending. Unit Manager (UM) #2 confirmed the order and did not add supplementary documentation so the order did not flow to the MAR and alert nursing to obtain the FSBS.

An attempt to conduct a phone interview on 9/25/2024 with Nurse #3 was unsuccessful. Nurse #3 was assigned to Resident #311 on 2/24/2024. The phone number was no longer in service.

A joint interview was conducted with the Administrator and the DON on 9/25/2024 at 2:34 PM. The DON stated that the order for Resident #311's FSBS did not contain the supplemental documentation so the order did not flow to the MAR which would have alerted the nursing staff to collect the FSBS. The Administrator stated

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that the facility had developed a robust educational plan which included demonstration of order entry with supplemental documentation that was required for all nursing staff.

The facility provided the following corrective action plan with a completion date of 2/28/2024.

Address how corrective actions will be accomplished for those residents to have been affected by the deficient practice:

On 2/24/2024 the Director of Nursing became aware that the facility had failed to obtain a FSBS on the morning of 2/24/2024 as ordered by the physician for Resident #311.

On 2/24/2024 the Director of Nursing audited Resident #311's chart and noted that on 2/23/2024, the physician entered orders for blood sugars to be obtained twice a day for monitoring starting the morning of 2/24/2024. The order was confirmed by UM #2, but she failed to ensure the supplemental documentation was ordered to ensure it fired out to the Medication Administration Record for the nurse to obtain the blood sugar as ordered.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

On 2/25/2024 the Regional Director of Clinical Services completed an audit of all orders of residents who required blood sugar monitoring to ensure the supplemental documentation was in the order and that the blood sugars were being monitored per orders. One additional order was identified that supplemental documentation was

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missing for blood sugar and was corrected immediately. Resident noted with no adverse side effects.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?

On 2/25/2024 the Director of Nursing educated all Licensed Nurses via demonstration on entering orders requiring supplemental documentation to include blood sugars and when confirming orders to ensure supplementary documentation is in place if indicated.

On 2/26/2024 the Regional Director of Clinical Services verbally instructed and demonstrated entering orders requiring supplemental documentation with the Medical Director.

This education is already embedded into the Orientation for Licensed Nurses.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

An AD HOC Quality Assurance Performance Improvement Plan meeting was held on 2/27/2024 to determine the root cause analysis of the deficient practice, put a plan of action in place to ensure all orders requiring supplemental documentation are reviewed for accuracy. The monitoring for the plan was initiated on 2/29/2024 and completed on 4/29/2024 with no revision needed and a 100% compliance was achieved.

The results of the monitoring will be brought to the Quality Assurance Performance Improvement meeting for the next 3 months, ending May 2024.

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Quality Improvement Monitoring schedule will be modified based on the findings of monitoring.

Alleged Date of Compliance: 2/28/2024.

The facility's corrective action plan with correction date of 2/28/2024 was validated onsite by observations, record reviews, and interviews with the Administrator, DON, Medical Director, and nursing staff.

An observation was conducted during a medication pass for a FSBS collection on 9/25/2024. The FSBS was collected according to physician's orders at the correct time of day utilizing appropriate infection control measures. The results were documented in the Electronic Medical Record (EMR) correctly and no follow-up action was required by nursing.

Interviews with nursing staff including Licensed Practical Nurses, (LPN), and Registered Nurses (RN) confirmed they had received education related to FSBS, order entry including supplemental order documentation, and confirmation of the supplemental documentation. The nurses were able to describe the order entry process including documentation of supplemental orders and verbalized understanding of the education received.

Review of audit records revealed all residents receiving FSBS were audited by the DON for 8 weeks beginning 2/25/2024. Then monthly for 1 month to ensure all orders for FSBS had supplemental documentation and were being performed as ordered by the physician. The findings were reported to the Administrator and to the Quality Assurance Performance Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE HEALTH & REHAB CENTER	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 757	Continued From page 13 Committee monthly for 3 months for suggestions and/or recommendations; the quality improvement monitoring schedule will be modified based on finding of the monitoring. Interviews with the Administrator, Regional Director of Clinical Services, and the DON revealed the facility launched an in-service related to FSBS and supplemental documentation immediately after the incident to re-educate all licensed nurses. The Director of Clinical Services and the DON audited the supplemental orders for FSBS to ensure all orders contained supplemental documentation. The Administrator, Regional Director of Clinical Services, and the DON stated the interventions were successful as the facility did not have any further issues with FSBS and supplemental documentation standards. The corrective action plans completion date of 2/28/24 was validated.	F 757		
F 761 SS=D	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	F 761		10/18/24

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F 761	Continued From page 14 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 by: Based on observations, staff interviews and record reviews, the facility failed to date a bottle of eye medication after it was opened and failed to discard 2 bottle of expired eye medications from the medication cart as specified by manufacturer's guidelines for 2 of 5 medication carts observed during medication storage checks (100 hall and 700 hall medication carts). The findings included: a. The manufacturer's package inserts for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36° to 46° Fahrenheit (F) and protected from light. Once it was opened, Latanoprost could be stored at room temperature up to 77° F for up to six weeks. A medication storage audit was conducted on 09/24/24 at 2:46 PM for the 100 hall medication cart in the presence of Nurse #2. One opened bottle of Latanoprost 0.005% eye drops without an opened date was found in the medication cart at room temperature and available for use.	F 761	1. Unlabeled eye drops were discarded and replaced by the Unit Manager on 9-24-2024. 2. On 10/2/24 the Director of Nursing and Unit Managers completed an audit of all medication carts to ensure all medications were stored appropriately. No other unlabeled or expired medications were noted on medication carts. 3. On 10/2/24 the Director of Nursing and or Designee educated all Licensed Nurses on medication storage to include medication storage for eye drops. 4. To monitor and maintain compliance beginning 10/7/24 the Director of Nursing or Designee will audit 1 medication cart weekly x 12 weeks for proper medication labeling and storage. Any negative findings will be immediately corrected. Results of audits will be submitted to the QAPI committee for further review and recommendation monthly for 3 months.	

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F 761	Continued From page 15 An interview was conducted with Nurse #2 on 09/24/24 at 2:47 PM. She acknowledged that the bottle of Latanoprost eye drops was opened but did not know how long it had been stored in the medication cart. She was unsure how long Latanoprost could be stored under room temperature once it was opened. b. During a medication storage audit conducted on 09/24/24 at 3:01 PM for the 700 hall medication cart in the presence of Nurse #1, two opened bottles of Latanoprost 0.005% with opened date of 08/01/24 and 08/03/24 respectively were found in the medication cart and available for use. An interview was conducted with Nurse #1 on 09/24/24 at 3:01 PM. Nurse #1 stated both bottles of latanoprost should be discarded after they were opened and stored under room temperature for over 30 days. Nurse #1 explained she did not work in 700 hall on regular basis and most of her shifts were day shift. Nurse #1 further stated the eye drop was scheduled to be administered by nurses working night shift. During an interview conducted on 09/24/24 at 3:19 AM, Unit Manager #1 stated all 3 bottles of Latanoprost eye drops needed to be discard. She indicated all the nurses were instructed to check each medication for expiration before administration. In addition, as one of the Unit Managers, she checked each medication cart in her area at least once weekly and stated it was her oversight. She added many nursing staff were still unclear about the storage guidelines for Latanoprost, and they needed to be re-educated as soon as possible.	F 761	Date of compliance 10/18/24.	

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F 761	Continued From page 16 During an interview conducted on 09/26/24 at 8:56 AM, the Director of Nursing (DON) stated it was her expectation for the nurses to remove all the expired medications from the medication cart according to manufacturer's expiration date and date the eye drops once it had been opened. An interview was conducted with the Administrator on 09/25/24 at 4:33 PM. She expected nurses to date latanoprost eye drops once it was opened and remove all expired medications from the medication carts. It was her expectation for the Unit Managers to check each medication cart at least once weekly to ensure the facility was free of expired medications.	F 761		