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 _____	02/27/2014

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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews the facility failed to honor food preferences for 2 of 3 sampled residents reviewed for food choices. (Resident #213 and #216) Findings included: 1. Resident #213 was assessed on the most recent Minimum Data Set (MDS) dated 01/23/13 as having no cognitive deficits. During an interview with Resident # 213 on 02/24/14 at 1:07 PM the resident stated staff were not honoring his food preferences. Resident #213 explained that he had informed staff, on many occasions, that he wanted cranberry juice rather than punch but continued to receive punch. At this time, Resident #213's lunch tray was observed and he had received punch rather than cranberry juice. Observation of his tray card revealed cranberry juice was listed as a choice of beverage. On 02/25/14 at 8:46 AM Resident #213 was observed in his room eating his breakfast meal.	F 242	F 242 1) Resident 213 and resident 216 received their preferred meals immediately upon discovery. 2) Residents were interviewed on 2/27/14 by the dietary manager to ensure preferences were honored. 3) Training began with the dietary staff on 2/28/14 to ensure that meal preferences were being followed. Training began on 2/28/14 with the certified nurse assistants to ensure that resident preferences were being followed. 4) Dietary manager will complete resident preference forms for 5 residents per meal per day for one month. Dietary Manager will complete resident preference forms for 3 residents per meal per day for one month. All results will be forwarded to the facilities quality assurance committee for review. 5) Completion date: 3/29/14	3/29/14

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

Electronically Signed | 03/17/2014

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Observation of the beverages served on his tray revealed he had water and cranberry juice. Review of the tray slip, served on Resident #213's meal tray specified no orange juice under dislikes.

On 02/25/14 at 9:25 AM an interview with resident #213 revealed he had received orange juice on his tray about 4 times a week and he had told staff several times that he did not want orange juice and that it was listed as a dislike. He voiced that it was only in the last couple days when he had not been served orange juice.

On 02/27/14 at 9:21 AM an interview was conducted with Nurse Aide (NA) #4, who had served Resident #213 his breakfast and lunch meal trays. She stated she passes out the trays and sets them up for residents. The NA said the kitchen staff check the food and beverages on the meal trays before the trays leave the kitchen to make sure the food and beverages match the preferences on the tray slip or menu. NA #4 revealed nurse aides are also supposed to check the trays to make sure residents receive their choices on the tray. The NA revealed she had delivered Resident #213's meal tray and glanced at the tray slip and did not match the tray card with what the resident received. She confirmed Resident #213 was to receive cranberry juice and not punch and she had not looked closely at the tray card. The NA stated she knew Resident #213 wanted no orange juice and she said she had not recently seen orange juice on his tray.

On 02/27/14 at 9:30 AM an interview was conducted with the Dietary Manager regarding food preferences. The Dietary Manager stated the dietary aide at the beginning of the tray line

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calls out the food preferences from the selective menus or tray cards and the cook plates the food. She further stated the dietary aide at the end of the line checks again the meal tray to make sure the residents preferences match the selective menu and tray card. The Dietary Manager revealed once the cart has left the kitchen the nurse aides have been trained to look at the tray card and selective menu to make sure residents have received the correct food and beverages they requested. The Dietary Manager stated if nurse aides noted residents have not received the preferred food and beverages they should contact the kitchen and provide the resident with the correct food and beverage items.

2. Resident #216 was assessed on the most recent Minimum Data Set dated 02/20/14 as having no cognitive deficits.

On 02/26/14 at 7:00 PM Resident #216 was observed in her room with her dinner meal in front of her on the bedside table. She stated she had not received the food item she had chosen from the selective menu. She said she had circled buttered noodles and received cheesy potatoes. Observation of the selective menu revealed the buttered noodles had been circled and she had received cheesy potatoes. Further interview with Resident #216 stated another time she had selected chicken on the menu and she received lasagna.

On 02/26/14 at 7:05 PM an interview was conducted with Nurse Aide (NA) #5, who works 2nd shift and delivers trays for the dinner meal. The NA revealed nurse aides are supposed to make sure residents have received the food and beverage choices they have selected on the

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F 242	Continued From page 3 menu. NA #5 stated when she delivered Resident #216's tray she had not looked at the selective menu or the meal tray to make sure the resident had received the foods she requested. On 02/27/14 at 9:30 AM an interview was conducted with the Dietary Manager regarding food preferences. The Dietary Manager stated the dietary aide at the beginning of the tray line calls out the food preferences from the selective menus or tray cards and the cook plates the food. She further stated the dietary aide at the end of the line checks the meal tray again to make sure the residents preferences match the selective menu and tray card. The Dietary Manager revealed once the cart has left the kitchen the nurse aides have been trained to look at the tray card and selective menu to make sure residents have received the correct food and beverages they requested. The Dietary Manager stated if nurse aides noted residents have not received the preferred food and beverages they should contact the kitchen and provide the resident with the correct food and beverage item.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246		3/29/14

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F 246	Continued From page 4 Based on observations, record reviews, staff and resident interviews the facility failed to accommodate the resident needs by providing a call bell light within reach of the resident for 1 of 4 residents who had a history of falls and required assistance with transfers. (Resident #1) The findings included: Resident #1 was admitted to the facility on 12/30/09 and readmitted to the facility on 05/08/12 with diagnoses which included osteoarthrosis, muscle weakness, congestive heart failure and history of falls. A review of the quarterly Minimum Data Set (MDS) dated 12/10/13 coded Resident #1 as impaired cognitive skills. Resident #1 required extensive assistance with staff for her activities of daily living skills (ADLs). The current care plan for transferring, last updated 07/10/13, included the goal for Resident #1 to receive the necessary physical assist to transfer. Interventions included guidance and physical assist of one person The current care plan for at risk for falls with multiple risk factors related to impaired balance, impaired mobility, use of psychotropic medications an history of recurrent falls last updated on 01/05/12, included the goal to have no falls or injuries. Interventions included for staff refer to therapy as needed, fall mat on floor when in bed, place frequently used items within reach, place call bell light within reach and answer promptly and provide frequent reminders to resident to call for assistance before getting up. A review of the physician progress notes dated 1/24/13 indicated Resident #1 was functionally	F 246	F 246 1) Resident #1 call light was placed within reach immediately upon discovery by facility staff. 2) All other residents were observed to have their call bells within reach throughout survey. 3) All staff training was started on 2/28/14 to ensure call bells were within reach of the residents. 4) Call bell rounds will be completed by Administrative Nurses and Department Heads for 2 rooms per hall daily for one month. Afterwards, call bell rounds will be completed by Administrative Nurses and Department Heads for 1 room per hall daily for one month. All results will be forwarded to the facilities quality assurance committee for review. 5) Completion Date: 3/29/14	

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wheelchair bound. The note further indicated Resident #1 often gets up and down from the bed to the wheelchair on her own.

A review of a facility document entitled "Rehab Care PT/OT/ST Recommendations to Caregivers" and located with Resident #1's care sheet for the Nursing Assistant (NA) staff dated 10/23/13 noted the problem was a fall from Resident #1's bed.. The document further reported the Task was Resident #1 had a history of falls from her bed, with most recent being 10/21/13. Resident #1 was noted as unsafe for transfers and toileting. Resident #1 required one person assist for toileting and transfers. The Approaches were further noted as after providing care staff was to return bed to lowest position and ensure Resident #1's bed mat was in place, toilet every hour, transfer resident with 1 person assist with gait belt and non skid socks and provide Resident #1 with call bell before leaving the room. This form was also signed by the nursing staff who may care for Resident #1 and confirmed by NA #2 whose signature was on this form.

Resident #1 was observed on 02/26/14 at 09:43 AM lying in her bed propped up on her right arm holding disconnected oxygen tubing in her right hand and asking to get up. Resident #1 stated she did not know where her call light was. The call light was observed plugged in near the bottom of her bed with the cord coming down the wall, going under Resident #1's bed and lying on the floor. There were two signs on the wall behind Resident#1's bed. The first stated check your oxygen and the second stated for Resident #1 to ring her call bell before getting up. NA #1 entered Resident #1's room connected her oxygen and left the room. The call light remained

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on the floor under Resident #1's bed.

Resident #1 was observed on 02/26/14 at 11:17 AM sleeping on her bed with a spoon in one hand and an unfinished yogurt in then other hand. The call light was observed hanging down under the bed and on the floor away from residents reach.

Resident #1 was observed on 02/26/14 at 11:46 AM sleeping on her bed with a spoon and yogurt on the over bed table. Covers pulled up around Resident #1's shoulders. The call light was hanging down under the bed on the floor and away from Resident #1's reach.

Resident #1 was observed on 02/26/14 at 12:28 PM up in her wheelchair on the right side of her bed with her lunch tray on the tray table in front of her with her hair in disarray. The call light was hanging down under the bed on the floor and away from residents reach. Resident #1 stated she transferred herself to her wheelchair so she could eat her lunch.

Resident #1 was observed on 02/26/14 at 12:30 PM up in her wheelchair on the right side of her bed pushing her lunch tray away. Resident #1 proceeded to transfer herself from the wheelchair to her bed without assistance. The call light was hanging down under the bed on the floor and away from the resident's reach.

Resident #1 was observed on 02/26/14 at 5:35 PM lying on her left side with her eyes closed, her hair was now brushed back and a pink hair band was in her hair. The call light was hanging down under the bed on the floor and away from the resident's reach.

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Resident #1 was observed on 02/26/14 at 7:07 PM up in her wheelchair on the right side of her bed. Resident #1 proceeded to transfer herself from the wheelchair to her bed without assistance. Resident #1 stated she was not feeling well and wanted to go to bed. The call light was hanging down under the bed on the floor and away from the resident's reach.
During an observation of Resident #1 on 02/27/14 at 8:33 AM the facility activity director was leaving Resident #1's room and the resident was holding the call light in her hand.
During an interview on 02/27/14 at 8:40AM Resident #1 was asked how she used the call light. She proceeded to pick the call light up off her bed and pushed the button turning the light on. A staff member entered Resident #1's room to see what she needed and turned off the call light.
During an interview on 02/27/14 at 2:16PM NA #3 who is familiar with the care of Resident #1 stated the resident was able to answer yes or no to simple questions and she was able to use her call bell light and communicate her needs.
During an interview on 02/27/14 at 2:46 PM NA #2 who was caring for Resident #1 stated that Resident #1 was able to answer yes or no to simple questions and that Resident #1 doesn't always use the call light but she was able to use her call bell light, and had used it and was able to communicate what she needed. NA #2 further stated that staff have to make sure her call bell is in reach and answer Resident #1's call light quickly as she will not wait long before she will transfer herself.

During an interview on 02/27/14 at 3:00 PM the Director of Nursing revealed Resident #1's call light should have been in reach prior to staff

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F 246	Continued From page 8 leaving the room.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure medication was given as ordered and labwork was completed as ordered for 1 of 6 sampled residents. (Resident #189) The findings included: Resident # 189 was admitted to the facility 10/14/13 with diagnoses which included altered mental status, failure to thrive, leukocytosis, myalgia and myositis. a. The initial note by the physician of Resident #189 on 10/15/13 included, In a declining state for two to three months with decreasing intake, suspected weight loss and cognitive dysfunction. Hospitalized 10/09/13-10/14/13 secondary to delirium from hyponatremia, dehydration, failure to thrive, unexplained leukocytosis, dysphagia and hypertension. She also has some hemorrhoids externally expressed in addition to a generalized reddish rash around the groin area.	F 309	F309 1) Resident was discharged at the time of the survey 2) 100% Audit completed on 2/26/14 for all residents back 30 days to ensure all labs and medications were followed as ordered. 3) Training began on 2/26/14 for all nurses to ensure that resident labs and medications were completed per physician□s orders. 4) Labs audit forms will be reviewed daily by Administrative Nurse Supervisors for 60 days to ensure compliance with lab orders. Medication audit form will be completed daily by night nurse and reviewed by the DON/QI nurse 5x weekly for 8 weeks. All results will be forwarded to the facilities quality assurance committee for review. 5) Completion date: 3/29/14	3/29/14

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Will initiate therapy, refer to orders. Physician orders on 10/15/13 included, Annusol cream twice a day to hemorrhoids for seven days.

Review of the October 2013 Medication Administration Record (MAR) and Treatment Administration Record (TAR) noted the Annusol was not included for administration to Resident #189.

On 02/26/14 at 10:15 AM the Director of Nursing (DON) stated the 10/15/13 order for Annusol cream for Resident #189 should have been placed on the MAR for administration. The DON reviewed both the 2013 October MAR and TAR for Resident #189 and verified the Annusol had not been included for administration. The DON identified Nurse #4 as the staff member that took the order for Annusol on 10/15/13.

On 2/27/14 at 8:45 AM Nurse #4 confirmed she wrote the 10/15/13 order for Annusol for Resident #189. Nurse #4 stated she must have missed placing the Annusol on the October 2013 MAR for Resident #189. Nurse #4 stated the nurse that worked third shift on 10/15/13 and did a check of orders must have also missed noting the Annusol had not been placed on the MAR for Resident #189. Nurse #4 stated this paperwork from third shift was not kept long term so it could not be determined which third shift staff did the second check of the 10/15/13 orders for Resident #189.

Subsequent documentation in the medical record of Resident #189 included a nurses note written 10/18/13 which read, Stool noted to have a red hue to it, stool sample was collected and hemoccult was performed and noted to be positive. It is noted that the resident has

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hemorrhoids, Nurse Practitioner aware. Will continue to monitor. On 10/23/13 the Nurse Practitioner wrote, Resident seen today at nursing request secondary to reported maroon colored stool, ongoing problems with hemorrhoids, as well as associated lethargy and poor oral intake. Recent melena possibly hemorrhoid related.

b. On 10/24/13 physician orders in the medical record of Resident #189 included to check a CBC (complete blood count) on 10/28/13.

Review of lab results in the medical record of Resident #189 noted there was not a CBC from 10/28/13. The DON stated a lab slip should be completed by the nurse that takes the order and the lab slip is filed in an accordion file on the day the lab is due. The DON stated labs are contracted by an outside company with needed specimens drawn on Monday, Wednesday and Friday. The DON stated if a lab is written for any time other than Monday, Wednesday or Friday it would be drawn by facility staff. The DON noted 10/28/13 was a Wednesday and the lab would have been drawn by the contract lab. The DON reviewed lab requisition slips and noted there had not been one completed for the CBC as ordered on 10/24/13 for Resident #189. The DON identified Nurse #4 as the staff member that took the order for the CBC on 10/24/13. The DON stated nursing supervisors check lab requisitions against an internal audit sheet but the information was not kept longer than a month to help explain what happened.

On 2/27/14 at 8:45 AM Nurse #4 confirmed she wrote the order for the CBC on 10/24/13 for Resident #189. Nurse #4 stated she could not explain why the lab was not done. Nurse #4

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F 309	Continued From page 11 stated the nurse that worked third shift on 10/24/13 and did a check of orders must have also missed noting a lab requisition slip for the CBC had not been completed for Resident #189. Nurse #4 stated paperwork from third shift was not kept long term so it could not be determined which third shift staff did the second check of the 10/24/13 orders for Resident #189.	F 309		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interview's the facility failed to store a container of disposable germicidal cloths in a secure location which was not accessible to residents on one of seven halls. The findings are: A container of disposable germicidal cloths was observed unsecured and open in a resident room beside the door on one of seven halls within the facility. These observations included: 1. On 02/24/14 at 4:22 PM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.	F 465	F465 1) Germicidal wipes were removed immediately upon discovery 2) All other resident's rooms were free of germicidal wipes and/or cleaners throughout survey. 3) All staff training began 2/28/14 for ensure that all resident rooms were free of germicidal wipes and/or cleaners. 4) Wipes room rounds will be completed by Administrative Nurses and Department Heads for 2 rooms per hall daily for one month. Afterwards, Wipes room rounds will be completed by Administrative Nurses and Department Heads for 1 room per hall daily for one month. All results will be forwarded to the facilities quality assurance committee for review. 5) Completion date: 3/29/14	3/29/14

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	345502	A. BUILDING _____ B. WING _____	02/27/2014

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
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2. On 02/25/14 at 10:42 AM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

3. On 02/25/14 at 1:51 PM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

4. On 02/26/14 at 12:49 PM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

5. On 02/26/14 at 3:18 PM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

6. On 02/27/14 at 8:30 AM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

7. On 02/27/14 at 2:16 PM Disposable Super Sani germicidal cloths were observed open with the purple tab on the top of it open with wipes on

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 _____	02/27/2014

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the outside of the container on Resident #35's night side stand was beside the door and visible to the hallway.

During an interview on 02/24/14 at 4:45 PM with Resident #35 revealed he did not use the Disposable Super Sani germicidal cloths and was unaware of what they were used for. Resident #35 further revealed staff came in and got them and then returned them to his night side table.

During an interview on 02/27/14 at 2:16 PM with NA #3 caring for Resident #35 stated he was caring for Resident #35 and he was unaware of use for Disposable Super Sani germicidal cloths but he thought the family used them to wipe Resident #35's hands.

During an interview on 02/27/14 at 3:00 PM with Nurse #1 who revealed the Disposable Super Sani germicidal cloths were used to sanitize the med carts. Nurse #1 was unaware as to why they were there.

During an interview on 02/27/14 at 3:01 PM with Nurse #3 who revealed the Disposable Super Sani germicidal cloths were used to sanitize the med carts. Nurse #3 was unaware as to why they were there.

During an interview on 02/27/14 at 3:02 PM with Nurse #2 who revealed the Disposable Super Sani germicidal cloths should not be kept in a resident's room and further revealed they were to be kept at the nurses station. Nurse #2 was unaware as to why they were there.

On 02/27/14 at 3:05 PM the Director of Nursing stated chemicals such as Disposable Super Sani

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F 465	Continued From page 14 germicidal cloths should not be left accessible in a resident's room. The Director of Nursing stated these chemical cloths were used to clean things and staff should be wearing gloves when using this item.	F 465		