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 03/15/2018

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey on 3/15/18. Event ID #KQV711. Intake NC00136517.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		3/26/18

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

Electronically Signed | 03/23/2018

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F 690	Continued From page 1 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to ensure a resident's urinary catheter bag was secured in a manner to keep it from lying on the floor and promoting the possibility of disease and infection for 1 of 6 residents observed with an indwelling urinary catheter (Resident #65). Findings included: Resident #65 was admitted to the facility on 10/20/15 with diagnoses including Dementia, Urinary Incontinence, Stage IV Pressure Ulcer to the Sacrum and Failure to Thrive. Review of the most recent quarterly Minimum Data Set (MDS) Assessment dated 2/20/18 identified Resident #65 as severely impaired cognitively and having an indwelling urinary catheter. Review of the care plan, dated 12/28/17 had a documented Focus area as Resident #65 had an altered pattern of urinary elimination with an indwelling urinary catheter and was at risk for infection. The goal listed was to keep Resident #65 free from infection through the next review. During an observation on 3/13/18 at 12:52 PM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed with approximately one third of the bag	F 690	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. F 690 The process which led to this deficiency was that the facility nursing assistant (NA #1) failed to ensure Resident #65 bed was raised to a level that prevented the urinary	

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F 690	Continued From page 2 lying on the floor. During an observation on 3/13/18 at 3:21 PM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed with approximately one third of the bag lying on the floor. During an observation on 3/14/18 at 8:38 AM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed resting on the floor. During an observation on 3/14/18 at 9:57 AM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed resting on the floor. During an observation on 3/14/18 at 12:27 PM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed resting on the floor. During an observation on 3/14/18 at 1:19 PM the urinary catheter bag was hanging on the left side of the bed. The bed was low to the floor and the catheter bag was hanging on the bottom frame of the bed resting on the floor. During an interview on 3/14/18 at 2:23 PM with NA #1 she stated the bed stayed in a low position and the catheter bag was covered with a protective bag and that was the highest she could hang the catheter bag on the bed frame and the best she could do.	F 690	catheter bag from lying on the floor and promoting the possibility of disease and infection. On 3/14/18, Resident # 65 bed was raised to an appropriate height by Tammy Lumpkin, RN, Director of Nursing, which prevented the urinary catheter bag from contacting the floor. On 3/14/18, NA #1 was in-serviced by the Director of Nursing on urinary catheter management to include raising the bed to an appropriate height at all times to ensure the urinary catheter bag is not in contact with the floor. On 3/14/18, a 100% audit of all residents with urinary catheters to include Resident #65 was completed by the Director of Nursing to ensure beds were raised to an appropriate height to prevent the urinary catheter bags from contact with the floor. Any concerns identified during the audit were immediately corrected by the Director of Nursing to include adjusting the bed height to an appropriate level to prevent the urinary catheter bag from contact with the floor and/or staff re-training. On 3/14/18, a 100% in-service was initiated by Tammy Lumpkin, RN, Director of Nursing for all licensed nurses and nursing assistants on urinary catheter management, which included adjustment of a resident□s bed to an appropriate height to prevent the urinary catheter bag from contacting with the floor. The in-service will be completed by Lynn	

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F 690	Continued From page 3 During an interview on 3/14/18 2:27 PM with the Director of Nursing she observed the catheter bag and stated the bed was in a low position and there was not any other place to position the catheter bag resulting in the bag being on the floor. During an interview on 3/14/18 at 3:13 PM with the Administrator she stated she expected the catheter bag to be off the floor.	F 690	Menikos, LPN, Staff Facilitator by 3/23/18. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator or the Director of Nursing on Urinary Catheter Management, which includes adjustment of a resident□s bed to an appropriate height to prevent the urinary catheter bag from contacting with the floor. 100% of all residents with a urinary catheters will be monitored weekly for four weeks, then 50 % of all residents with urinary catheters will be monitored weekly for four weeks, and then 10% of all residents with urinary catheters will be monitored weekly for four weeks by the Assistant Director of Nursing, the Staff Facilitator, Patient Care Coordinator, and/or the Minimum Data Set Coordinators, utilizing a Resident Care Audit tool to ensure all beds are adjusted at an appropriate height to prevent urinary catheter bags from contact with the floor. Any identified areas of concern during the audit will be immediately addressed by the Assistant Director of Nursing, the Staff Facilitator, Patient Care Coordinator, and/or the Minimum Data Set Coordinators to include staff retraining and/or bed height adjustments. The DON will review the results of the audits as indicated by initialing each Resident Care Audit tool weekly for 12 weeks. The Administrator and/or Director of Nursing will review and present the	

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F 690	Continued From page 4	F 690	findings of the Resident Care Audit tools to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. Person responsible for implementing the plan of correction- Nancy W Hughes, Administrator.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross	F 812	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	3/26/18

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F 812	Continued From page 5 contamination by failing to clean twelve of twelve baking sheets and failed clean the steam table under shelf for one of one steam tables observed. The findings included: During an observation on 3/14/18 at 2:52 PM the dish room drying rack was observed. Twelve baking sheets were observed stacked on the drying rack. The 12 baking sheets were observed to have 1/8 to ¼ inch of black dried food residue one inch wide under the rim. A second observation on 3/15/18 at 10:20 AM the dish room drying rack was observed twelve baking sheets were observed stacked on the drying rack. The 12 baking sheets were observed to have 1/8 to ¼ inch of black dried food residue one inch wide under the rim. During an observation of the kitchen on 3/14/18 at 2:58 PM the 6 well steam table was observed. The 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 3/15/18 at 10:16 AM the 6 well steam table was observed. The 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles and was sticky to touch. In an interview with the Certified Dietary Manager (CDM) on 3/15/18 at 10:25 AM he revealed he expected staff to clean the whole steam table and the areas would be cleaned that day. In an interview with the Administrator on 3/15/18 at 10:27 AM she stated the steam table would be cleaned that day between lunch and dinner.	F 812	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. The process that led to this deficiency was the facility dietary manager failed to ensure that the assigned dietary assistants cleaned kitchen equipment, to include twelve baking sheets and the entire steam table. On 3/15/18, the twelve baking sheets were cleaned of dried food residue by Doug Steiger, Dietary Manager. On 3/15/18, between the lunch and supper meals, the steam table was cleaned by Pat Gee, Cook. On 3/16/18 new cleaning assignment sheets were posted in the kitchen by Doug Steiger, Dietary Manager to ensure cleaning of all kitchen equipment is completed.	

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F 812	Continued From page 6	F 812	On 3/16/18, the administrator and dietary manager inspected the dietary cleaning schedule and the kitchen equipment, including baking sheets and the steam table to ensure cleaning had been completed to include no dried food residue on pans or build up under steam table. On 3/16/18, the dietary manager was in-serviced by Nancy Hughes, Administrator on ensuring all dietary staff are following the new dietary cleaning schedule and ensuring kitchen equipment is cleaned to include baking sheets and the entire steam table. 100% of dietary staff will be in-serviced by Doug Steiger, Dietary Manager on using the new dietary cleaning schedule and on cleaning kitchen equipment to include baking sheets and the entire steam table. The in-service completion date will be 3/23/18 for all dietary staff. All newly hired dietary staff will be in-serviced by the dietary manager during orientation on using the new dietary cleaning schedule and on cleaning kitchen equipment to include baking sheets and the entire steam table. Kitchen equipment, to include baking pans and steam table, will be monitored by the dietary manager or kitchen manager to ensure kitchen equipment is maintained in a clean and sanitary condition using a Dietary Department Rounds Checklist and the dietary cleaning schedule five times weekly for four weeks,	

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F 812	Continued From page 7	F 812	then three times weekly for four weeks, then weekly for four weeks. Any identified areas of concern will be immediately addressed by the dietary manager or kitchen manager by providing additional training for any involved dietary staff. The administrator will review and initial the results of the Dietary Department Rounds Checklist weekly for twelve weeks. The administrator will present the findings of the Dietary Department Rounds Checklist to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. Person responsible for implementing the plan of correction- Nancy W Hughes, Administrator.	