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 _____	C 11/01/2019

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 10/29/19 to 11/01/19. The facility was found to be in compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID: EQC211.	E 000		
F 000	INITIAL COMMENTS A complaint investigation was conducted during a recertification survey from 10/29/19 through 11/01/2019. There were a total of 38 allegations investigated and 9 were substantiated. Event #: EQ2C11..	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		11/29/19

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

Electronically Signed | 11/28/2019

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations in 2 of 2 dining areas on the 100 unit, resident, family and staff interviews and review of facility records, the facility failed to maintain the dignity of residents when Residents #11, #60 and #39 did not receive their lunch meal at the same time their roommates/tablemates ate their lunch meal. This occurred during 1 of 2 dining observations on the 100 unit. The findings included: A continuous dining observation of the lunch meal on the 100 unit occurred on 10/29/19 from 12:01 PM until 12:50 PM. During this continuous dining observation on the 100 unit, the lunch meal was observed for residents who ate in the activity dining room and in their rooms. The following concerns were noted: 1a. Resident #11 was observed in his room sitting	F 550	Lake Park 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. Lake Park Nursing and Rehabilitation Center 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, Lake Park Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute	

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F 550	Continued From page 2 up in bed on 10/29/19 at 12:01 PM. His roommate was being fed by a staff member while Resident #11 watched. During this observation, Resident #11 did not have his lunch meal or a beverage to drink. Resident #11 received his lunch meal at 12:48 PM and stated that he usually got his lunch before his roommate, but for the last few weeks he received his lunch meal after his roommate received his lunch. Resident #11 further stated "Now I have to wait and that makes me mad. I don't like waiting to get my food 30 minutes or more after my roommate has eaten. I want to get my food on the early meal cart like I used to." Medical record review revealed Resident #11 was admitted to the facility 12/29/16. A quarterly minimum data set assessment dated 8/1/19 assessed Resident #11 with clear speech, able to be understood/understand others, intact cognition and required encouragement with eating after staff provided set up help only. The Administrator was interviewed on 10/30/19 at 6:16 PM. The interview revealed that the facility previously had a restorative dining program (RDP) that was not currently being used. She further explained that the RDP was the first dining cart that came from the kitchen and some residents who received their meal from this cart thought they were receiving "an early tray." The administrator continued to explain that the facility spoke to therapy staff and determined that the current RDP list of residents did not include residents who required the RDP. As a result the facility decided to revise the meal tray delivery system, but had not yet communicated to nursing/dietary the plan for implementation of the revised meal delivery plan nor had it been	F 550	Resolution, formal appeal procedure and/or any other administrative or legal proceedings. A. Plan to correct deficiency. On 10/29/19 staff was in serviced on changes to the mealtimes and delivery system. On 10/30/19 Resident # 11 stated he wanted to eat in his room and new meal delivery system was explained to resident by Administrator. On 10/30/19 Resident #60 stated he would prefer to eat in his room and the new meal delivery system was explained to the resident by Administrator. On 10/30/19 Resident #39 Responsible Party (RP) indicated preference for father to eat in dining room as frequently as he is able. On 10/31/19 Hall 100 was observed during lunch meal service and trays were passed to residents within the same room at the same time. B. The procedure for implementing the acceptable plan of correction. On 10/30/19 100% audit was conducted by Department Heads of all residents desired location for meals and Dining room seating was updated to reflect changes. Department heads provided in service to their staff members throughout the timeframe of 10/31/19- 11/15/19 regarding	

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F 550	Continued From page 3 communicated to nursing to distribute meal trays to both residents at the same time if they ate in their rooms together. The administrator also stated that she expected nursing to distribute meal trays to both residents together when both residents ate in their rooms. The Certified Dietary Manager (CDM) was interviewed on 10/31/19 at 10:19 AM. During the interview, the CDM stated that if a resident received their meal tray before their roommate, this occurred because a resident changed where they wanted to eat their meals and nursing staff did not make the adjustment to ensure all residents received their meals at the same time. An interview with the Director of Nursing (DON) occurred on 10/31/19 at 12:18 PM. The interview revealed that the facility just provided re-education that day to nursing staff on how to distribute meal trays to ensure all residents ate together, but stated "prior to today I am not sure how the NA were trained to distribute meal trays." The DON further stated that she had previously identified that some meal carts included trays for multiple halls on the same cart which made it difficult to make sure both residents in the same room received their meal tray at the same time. The DON also stated that the facility was still revising the meal delivery system, re-educating nursing staff and had not yet begun to monitor the new meal delivery plan. 1b. Resident #60 was observed in his room on 10/29/19 at 12:10 PM seated on his bed working on his computer while his roommate ate his lunch meal. Resident #60 did not have his lunch meal or a beverage to drink. During this observation, Resident #60 stated "I have been in nursing	F 550	Dining Etiquette and Dignity with Dining. Education of dining etiquette will be included in orientation training as of 11.25.19. All staff was educated to serve all residents at the same time for tables in dining room and in resident rooms during the dining etiquette in-service by the Department Mangers. Staff instructed if both resident trays are not present to leave tray on cart and go to the kitchen to obtain missing tray. C. Monitoring procedure to ensure POC is effective. Administrator or designees will conduct a random audit of dining rooms/ halls 2xs a week x 4 week and then weekly x 4 weeks, on the meal audit tool to identify residents who are not being served meals at the same time as roommate or table mate. Findings and results of audit will be brought to Quality assurance performance improvement (QAPI) committee monthly for review and changes to processes as needed monthly. The QAPI committee will make recommendation for changes to processes as need to achieve compliance.	

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F 550	Continued From page 4	F 550		

homes for many years and I know that we should have our food at the same time. It's like eating at a restaurant and some people at the table have their food and others don't. That's not right, I am hungry and we should all have our food at the same time in all fairness." A follow up interview with Resident #60 occurred on 10/29/19 at 12:45 PM. Resident #60 stated "I finally got my food about 30 minutes after my roommate, I did not like waiting 30 minutes to get my food."

Medical record review revealed Resident #60 was admitted to the facility 7/29/19. A quarterly minimum data set assessment dated 9/11/19 assessed Resident #60 with clear speech, able to be understood/understand others, intact cognition and required encouragement with eating.

The Administrator was interviewed on 10/30/19 at 6:16 PM and revealed that the facility had recently decided to revise the meal tray delivery system. The administrator further stated that this revised plan had not yet been communicated to nursing/dietary for implementation, nor had it been communicated to nursing to distribute meal trays to both residents at the same time if they ate in their rooms together. The administrator also stated that she expected nursing to distribute meal trays to both residents together when both residents ate in their rooms.

The Certified Dietary Manager (CDM) was interviewed on 10/31/19 at 10:19 AM. During the interview, the CDM stated that if a resident received their meal tray before their roommate, this occurred because a resident changed where they wanted to eat their meals and nursing staff did not make the adjustment to ensure all residents received their meals at the same time.

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F 550	Continued From page 5	F 550		

An interview with the Director of Nursing (DON) occurred on 10/31/19 at 12:18 PM. The interview revealed that the facility just provided re-education that day to nursing staff on how to distribute meal trays to ensure all residents ate together, but stated "prior to today I am not sure how the NA were trained to distribute meal trays." The DON further stated that she had previously identified that some meal carts included trays for multiple halls on the same cart which made it difficult to make sure both residents in the same room received their meal tray at the same time. The DON also stated that the facility was still revising the meal delivery system, re-educating nursing staff and had not yet begun to monitor the new meal delivery plan.

1c. A staff member brought Resident #39 into the Activity Dining Room on 10/29/19 at 12:15 PM and placed him at a table with six tablemates who were eating their lunch meal. Resident #39 sat at the table and watched his tablemates eat. At 12:30 PM Resident #39 received his lunch meal, his meal was set up and he began to drink his beverage immediately upon receipt of his lunch meal. A family member was present and stated that Resident #39 usually ate meals in his room, but that that day, he requested to eat lunch in the dining room. The family further stated that Resident #39 would not like to wait at the same table for his food while others at the table were eating. The family member continued to say "It probably would bother all of us don't you think, eating should be done together."

Medical record review for Resident #39 revealed he was admitted to the facility on 8/31/19. Diagnoses included dementia. Review of an

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F 550	Continued From page 6	F 550		

admission minimum data set assessment dated 9/10/19 assessed Resident #39 with clear speech, usually able to be understood/understand others, moderately impaired cognation and required the assistance of one staff member for encouragement/cueing with meals.

The Administrator was interviewed on 10/30/19 at 6:16 PM and revealed that the facility had recently decided to revise the meal tray delivery system. The administrator further stated that this revised plan had not yet been communicated to nursing/dietary for implementation, nor had it been communicated to nursing to distribute meal trays to all residents at the same time who ate at the same table together. The administrator also stated that she expected nursing to distribute meal trays to all residents at the same table in the dining room. The administrator clarified that if a resident decided to eat in a different location, nursing staff would have to make adjustments to ensure all residents ate together at the same table.

The Certified Dietary Manager (CDM) was interviewed on 10/31/19 at 10:19 AM. During the interview, the CDM stated that if a resident received their meal tray before their tablemate, this occurred because a resident changed where they wanted to eat their meals and nursing staff did not make the adjustment to ensure all residents received their meals at the same time.

An interview with the Director of Nursing (DON) occurred on 10/31/19 at 12:18 PM. The interview revealed that the facility just provided re-education that day to nursing staff on how to distribute meal trays to ensure all residents ate together, but stated "prior to today I am not sure

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F 550	Continued From page 7 how the NA were trained to distribute meal trays." The DON further stated that she had previously identified that some meal carts included trays for multiple halls on the same cart which made it difficult to make sure residents received their meal tray at the same time. The DON also stated that the facility was still revising the meal delivery system, re-educating nursing staff and had not yet begun to monitor the new meal delivery plan.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		11/29/19

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F 561	Continued From page 8	F 561		

interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interviews, staff interviews and review of facility records, the facility failed to provide showers to 3 Residents per their preference (Residents #11, #24, and #43) and failed to provide chicken salad sandwiches and a chocolate flavored nutritional supplement to Resident #36 as requested for 4 of 12 sampled residents reviewed for choices.

The findings included:

1a. Resident #11 was admitted to the facility 121/29/16. Diagnoses included in part, endocrine disorder, chronic pain, and left femur fracture.

A quarterly minimum data set dated 8/1/19 assessed Resident #11 with clear speech, understood/understands, intact cognition and dependent on staff for bathing.

A care plan reviewed/revised 8/13/19 identified Resident #11 required staff assistance for bashing related to limited mobility. The care plan interventions identified Resident #11 preferred showers to baths with the assistance of one female staff member.

Resident #11 was interviewed on 10/29/19 at 12:34 PM and stated that he did not always get a shower twice per week as he wanted. He stated he was scheduled to receive showers Mondays and Thursdays on the 7 AM - 3 PM shift and he liked to get his shower after breakfast. He further stated that some weeks he received only one shower and some weeks he received only bed

A. The plan of correcting the specific deficiency

On date 11/2/2019 residents # 11, 24, and 43 were interviewed by the Director of Nursing for their shower preference.
On 11/5/2019 the Director of Nursing updated the shower schedule to reflect the shower preferences of residents # 11, 24, and 43.
The Director of Nursing updated the care plans for residents # 11, 24, and 43 to reflect their shower preferences.
On 11/4/2019 the CNA provided a shower to resident # 11 per resident preference.
On 11/4/2019 the CNA provided a shower to resident # 24 per resident preference.
On 11/20/2019 the CNA provided a shower to resident # 43 per resident preference.
On 10/31/19 Resident # 36 was provided a chocolate shake and chicken salad sandwich. Dining Service manager (DSM) reviewed preferences with resident on 10/31/19 and updated for chocolate shakes and chicken salad sandwiches per resident request.

B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 11/1/2019 the Director of Nursing

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F 561	Continued From page 9 baths. Staff would say they ran out of time and would try to give him a shower the next day. Resident #11 stated he wanted to receive at least two showers each week. Review of Resident #11's shower records revealed he did not receive two showers weekly per his preference in April 2019 through October 2019. Interviews with the Director of Nursing (DON) occurred on 10/30/19 at 6:50 PM and 10/31/19 at 12:18 PM. During the interviews, the DON stated that she assumed her role in August 2019 and when she arrived she identified showers were not being provided to residents per their preference. The DON stated she questioned the nurse aide (NA) and the response was that they "ran out of time on their shift" or the NA just did not give an answer. The DON further stated that NA were re-educated and strongly encouraged to assist residents with their showers. NA #2 was interviewed on 11/01/19 at 2:58 PM and stated that she worked the 7 AM - 3 PM and 3 PM - 11 PM shifts on the 100 unit. NA #2 stated that at times she "ran out of time" on her shift to give everyone a shower per the shower schedule. She further stated that this occurred at times when she was scheduled to assist more than 3 residents with a shower during the shift. If this occurred, NA #2 stated she would offer the resident a bed bath, offer to provide them a shower the next day and then report this to the nurse. An interview with NA #3 occurred on 11/01/19 at 3:02 PM and revealed she worked on the 100 unit on the 7 AM - 3 PM shift. NA #3 also stated that if	F 561	began an audit of shower preferences for all residents currently in facility. This audit was completed on 11/2/2019. The results of this audit were used to update the shower schedule on 11/6/2019 by the Director of Nursing. The results of the shower audit were reviewed by the Director of Nursing and each resident□s care plan was reviewed and/or updated to reflect their shower presences by the Director of Nursing 11/26/2019. Beginning on 11/27/2019 new admissions will be interviewed by the Assistant Director of Nursing, Unit Manager, or Resident Care Coordinator within 72 hours of admission to determine shower preference. This preference will then be added to the shower schedule by the Assistant Director of Nursing, Unit Manager, or Resident Care Coordinator and the residents care plan will be updated by the Assistant Director of Nursing, Unit Manager, or Resident Care Coordinator to reflect this preference. On 11.22.19 the DSM audited residents for food preferences. This audit was completed by 11.28.19. Resident who requested changes were addressed and updated. On 11/6/2019 nursing administration began an in-service with nursing staff on resident□s right to have showers/baths according to their preferences. This in-service will be by 11/15/2019. On 11/27/2019 an in-service was started on	

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F 561	Continued From page 10 she could not assist a resident with a shower because "I ran out of time" she told the resident as early in the shift as possible rather than at the end of the shift because that made the residents mad. NA #3 further stated that when this occurred she gave the resident a "good bed bath" and arranged to give them a shower the first thing the next morning. NA #3 went on to say that most of the time this was agreeable to the resident, but sometimes the resident really wanted their shower and I just express to them that did the best I could and will get to them first thing in the morning. An interview with Nurse #7 occurred on 11/01/19 at 3:20 PM. Nurse #7 stated in interview that she worked full time on the 7 AM - 3 PM shift on the 100 unit. She stated that NAs had reported to her when residents refused a shower and when the NAs could not provide showers to residents when the resident wanted a shower. Nurse #7 also stated that if a NA reported to her that they ran out of time to provide a shower, she would offer to assist. 1b. Resident #24 was admitted to the facility 6/5/18. Diagnoses included in part, cerebral infarction, osteoarthritis and dementia. A quarterly minimum data set assessment dated 8/12/19 assessed Resident #24 with clear speech, understood/understands, moderately impaired cognition and required the assistance of one staff person with bathing. A care plan reviewed/revised 9/3/19 identified Resident #24 required staff assistance with bathing due to limited mobility. Interventions	F 561	the resident□s right to choose foods based on their preferences. This in-service will be completed by 11/28/2019. After date nursing staff will not be allowed to work until in-service is complete. This in-service will be included in the orientation for new nursing staff. On 11.22.19 the Administrator in serviced DSM and RD. On 11.22.19 weekly selective menus have been given to alert and oriented residents and residents update per choices. DSM will meet with new admissions to obtain food preference and will review food preference at care plan meetings. C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager and/or administrator will audit 10 residents daily 5 times per week x 12 weeks to ensure shower was provided based on resident preference (random audits including all shifts, days, and units). This audit will be documented on the choices audit tool. The director of nursing, assistant director of nursing, unit manager, and/or administrator will audit 5 residents daily 5 times per week x 12 weeks to ensure resident food preferences are being honored (random audits to include all	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 561	Continued From page 11 included that staff would assist her with showers per her preference. An interview with Resident #24 occurred on 10/30/19 at 12:34 PM. Resident #24 stated that she liked getting a shower and received a shower most of the time, "but sometimes they miss me." Review of Resident #24's shower records revealed she did not receive two showers weekly per her preference in April 2019 through July 2019 and September 2019 - October 2019. Interviews with the Director of Nursing (DON) occurred on 10/30/19 at 6:50 PM and 10/31/19 at 12:18 PM. During the interviews, the DON stated that she assumed her role in August 2019 and when she arrived she identified showers were not being provided to residents per their preference. The DON stated she questioned the nurse aide (NA) and the response was that they "ran out of time on their shift" or the NA just did not give an answer. The DON further stated that NA were re-educated and strongly encouraged to assist residents with their showers. NA #2 was interviewed on 11/01/19 at 02:58 PM and stated that she worked the 7 AM - 3 PM and 3 PM - 11 PM shifts on the 100 unit. NA # stated that at times she "ran out of time" on her shift to give everyone a shower per the shower schedule. She further stated that this occurred at times when she was scheduled to assist more than 3 residents with a shower during the shift. If this occurred, NA #2 stated she would offer the resident a bed bath, offer to provide them a shower the next day and then report this to the nurse.	F 561	units, meals, and days). This audit will be documented on the choices audit tool. DSM will review preferences with residents at Kitchen Cabinet monthly and will do a random preference audit on resident weekly x 4 weeks and then monthly x 3 months. The monthly QI committee will review the results of the choices audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 561	Continued From page 12	F 561		

An interview with NA #3 occurred on 11/01/19 at 03:02 PM and revealed she worked on the 100 unit on the 7 AM - 3 PM shift. NA #3 also stated that if she could not assist a resident with a shower because "I ran out of time" she told the resident as early in the shift as possible rather than at the end of the shift because that makes the residents mad. NA #3 further stated that hen this occurred she gave the resident a "good bed bath" and arrange to give them a shower the first thing the next morning. NA #3 went on to say that most of the time this was agreeable to the resident, but sometimes the resident really wanted their shower and I just express to them that did the best I could and will get to them first thing in the morning.

An interview with Nurse #7 occurred on 11/01/19 at 03:20 PM. Nurse #7 stated in interview that she worked full time on the 7 AM - 3 PM shift on the 100 unit. She stated that NAs had reported to her when residents refused a shower and when the NAs could not provide showers to residents when the resident wanted a shower. Nurse #7 also stated that if a NA reported to her that they ran out of time to provide a shower, she would offer to assist.

1c. Resident #43 was admitted to the facility 8/30/18. Diagnoses included in part, osteoarthritis and chronic atrial fibrillation.

An annual minimum data set assessment assessed Resident #43 with clear speech, understood/understands, intact cognition and required the assistance of one staff person with bathing.

A care plan reviewed/revised 9/17/19 identified

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561	Continued From page 13	F 561		

Resident #43 required the assistance of one staff person with bathing and that she preferred to receive a shower twice per week.

Resident #43 was interviewed on 10/30/19 at 3:00 PM and stated that staff did not always assist her with two showers each week.

Review of Resident #43's shower records revealed she did not receive two showers weekly per her preference in April 2019 through October 2019.

Interviews with the Director of Nursing (DON) occurred on 10/30/19 at 6:50 PM and 10/31/19 at 12:18 PM. During the interviews, the DON stated that she assumed her role in August 2019 and when she arrived she identified showers were not being provided to residents per their preference. The DON stated she questioned the nurse aide (NA) and the response was that they "ran out of time on their shift" or the NA just did not give an answer. The DON further stated that NA were re-educated and strongly encouraged to assist residents with their showers.

NA #2 was interviewed on 11/01/19 at 02:58 PM and stated that she worked the 7 AM - 3 PM and 3 PM - 11 PM shifts on the 100 unit. NA #2 stated that at times she "ran out of time" on her shift to give everyone a shower per the shower schedule. She further stated that this occurred at times when she was scheduled to assist more than 3 residents with a shower during the shift. If this occurred, NA #2 stated she would offer the resident a bed bath, offer to provide them a shower the next day and then report this to the nurse.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 561	Continued From page 14	F 561		

An interview with NA #3 occurred on 11/01/19 at 03:02 PM and revealed she worked on the 100 unit on the 7 AM - 3 PM shift. NA #3 also stated that if she could not assist a resident with a shower because "I ran out of time" she told the resident as early in the shift as possible rather than at the end of the shift because that makes the residents mad. NA #3 further stated that hen this occurred she gave the resident a "good bed bath" and arrange to give them a shower the first thing the next morning. NA #3 went on to say that most of the time this was agreeable to the resident, but sometimes the resident really wanted their shower and I just express to them that did the best I could and will get to them first thing in the morning.

An interview with Nurse #7 occurred on 11/01/19 at 03:20 PM. Nurse #7 stated in interview that she worked full time on the 7 AM - 3 PM shift on the 100 unit. She stated that NAs had reported to her when residents refused a shower and when the NAs could not provide showers to residents when the resident wanted a shower. Nurse #7 also stated that if a NA reported to her that they ran out of time to provide a shower, she would offer to assist.

1d. Resident #36 was re-admitted to the facility on 4/8/19. Diagnoses included in part, displaced pilon fracture, vascular dementia with behavioral disturbance, cerebral infarction, anxiety disorder, eating disorder, vitamin D deficiency, major depressive disorder, and mild cognitive impairment.

A quarterly minimum data set assessment dated 8/27/19 assessed Resident #36 with clear speech, able to be understood/understand,

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 561	Continued From page 15	F 561		

moderately impaired cognition and independent with eating requiring set up help only.

A care plan reviewed/revised 9/5/19, identified resident #36 had a history of weight loss. Interventions included for staff to assess for and provide food preferences and to update her preferences weekly.

Resident #36 was observed on 10/29/19 at 12:55 PM and 10/30/19 at 12:45 PM eating lunch in her room. Review of her tray card revealed Resident #36 requested a high calories supplement and sandwich with lunch/supper meals. With both observations, Resident #36 received a strawberry high calorie shake and a pimento cheese sandwich with her lunch meal. Resident #36 stated on 10/29/19 at 12:55 PM that she received a strawberry flavored shake, but "I always ask for chocolate, but don't get it, I send the strawberry back." She also stated that she wanted a chicken salad sandwich, but that it had been about 2 weeks since she received one and "Today I got pimento cheese, I never ate that before in my life." Resident #36 took only a few bites of the pimento cheese sandwich, but did not drink the strawberry supplement.

A follow up interview with Resident #36 occurred on 10/31/19 at 10:23 AM with the certified dietary manager (CDM). The CDM asked Resident #36 what kind of sandwiches and what flavor nutritional supplement she wanted with her meals and Resident #36 stated that she only wanted chicken salad sandwiches and a chocolate shake with each lunch/supper, "but I don't get it." Resident #36 further stated that she had previously informed the registered dietitian (RD) of this request when the RD came to update her

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F 561	Continued From page 16 food preferences. Resident #36 further stated that at first she received chocolate flavored shakes and chicken salad sandwiches and then "all of a sudden, for the past 2 weeks, I started getting strawberry shakes, I send them back and I do not drink them." Then Resident #36 stated "I wrote on the ticket that comes with my meal that I wanted a chocolate shake and gave it to a staff person and said be sure to give this to the kitchen, but for weeks I continued to get strawberry shakes and I would send it back to the kitchen, I did not drink it." The CDM stated that she updated the Resident's food preferences weekly, but that she was not aware that Resident #36 wanted chocolate flavored shakes or chicken salad sandwich with each meal. A telephone interview with the RD occurred on 11/01/19 at 09:02 AM. During the interview, the RD stated that the prior RD must have spoken to Resident #36 regarding her preferences because she was not aware. The RD further stated that she expected staff to offer the resident the sandwiches and the flavor supplement she wanted.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		11/29/19

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F 565	Continued From page 17 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with 7 of 7 residents who attended a Resident Council Meeting (Residents #57, #52, #43, #43, #32, #63 and #2) and review of Resident Council minutes, the facility failed to provide privacy during a Resident Council meeting and resolve resident grievances related to noise and staff assistance with showers for 2 of 3 months of Resident Council minutes reviewed (August 2019 and October 2019). The findings included:	F 565	A. Plan to correct deficiency. The facility held a meeting with the Resident council on Nov. 4th and discussed the concerns surrounding showers and noise. Council was made aware of the facility would be auditing and following up on the concerns. Residents # 57, 52, 43,32,42,63 and 2 were informed that audits would be conducted on showers and noise. Above residents were polled on 11.24.19	

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F 565	Continued From page 18 Review of Resident Council meeting minutes revealed the following: August 2019 - Old business included resident complaints of staff and resident noise on the 3 PM - 11 PM shift and the 11 PM - 7 AM shifts and staff assistance with nursing care. October 2019 - Old business included resident complaints of the noise of staff laughing was disrespectful. A Resident Council meeting occurred on 10/30/19 at 2:00 PM. During the meeting 7 of 7 residents who attended stated that staff noise and staff assistance with showers were unresolved concerns that were brought up during the August 2019 and October 2019 meetings. Seven of seven residents expressed that they were awaken at 1:00 AM and 2:00 AM to staff talking and laughing while having dinner and playing the piano. The residents stated they would have to go and ask staff to close the door to the activity room where they were eating in order to keep the noise down. During the meeting on 10/30/19 at 2:12 PM Dietary Aide #1 (DA #1) opened the closed door to the meeting, entered the meeting and began posting menus. DA #1 stated "It will only take me a minute and then I will be out of your way." Resident #43 informed DA #1 that a Resident Council meeting was in progress, but DA #1 again stated "I will only be a minute," and proceeded to post menus. When DA#1 exited, Resident #42 stated that staff interruptions occurred all the time which did not allow the residents to have privacy during their Resident Council meetings.	F 565	(Resident # 57 was out of facility). All other residents polled stated improvement with showers and 5 out of 6 stated improvement with noise levels. B. The procedure for implementing the acceptable plan of correction. All resident council concerns will be brought to Administrator prior to routing to Department Head for review and placed on the Cardinal prompt concern board to be followed up daily for completion. Activity Director will follow up with resident council president for permission for Department Head with council concern areas to attend the following council meeting to report on the resolution and poll council on whether or not there is proves improvement. Administrator and or designee conducted in-service with all staff from 10/31/19 □ 11/15/19 in regards to noise and showers. Administrator conducted in-service with Department Heads regarding resident Council grievances on 11/1/19. C. Monitoring procedure to ensure POC is effective. Administrator or designee will conduct random audit for noise levels on 2nd and 3rd shift will be conducted 2x week x 4 weeks and then weekly x 1month utilizing the noise audit tool. The director of nursing, assistant director of nursing, unit manager and/or administrator will audit 10 residents daily 5 times per week x 12 weeks to ensure	

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F 565	Continued From page 19 During the meeting on 10/30/19 at 2:30 PM, the Activity Assistant opened the closed door to the meeting and asked "Can I get something?" Resident #42 responded, "Not now." The Activity Assistant exited the meeting. On 10/30/19 at 3:30 PM multiple staff were observed congregated in hallway laughing in front of resident rooms on 100 hall and on 10/31/19 at 4:45 PM two staff members were observed on the 100 unit conversing with one another approximately 25 feet apart. An interview with the Activity Director (AD) and the Activity Assistant occurred on 10/30/19 at 4:45 PM. The Activity Assistant stated that she forgot there was a Resident Council meeting in progress when she entered the room. The AD stated she had a sign she should have posted to indicate a meeting was in progress. The AD further stated that residents had previously expressed concerns with staff noise and not getting staff assistance with showers. The AD also stated that when concerns were brought up during Resident Council meetings, she documented the grievance and provided a copy of the documentation to the department head for follow up. The concern was also discussed in the interdisciplinary meetings so that all department heads were aware of the grievance. An interview with the Director of Nursing (DON) occurred on 10/30/19 at 6:50 PM. The DON stated that she was aware of resident complaints of noise on the 11 PM - 7 AM shift and the residents complaints of not receiving showers weekly. The DON stated that she assumed her role in August 2019 and identified that showers	F 565	shower was provided based on resident preference (random audits including all shifts, days, and units). This audit will be documented on the choices audit tool. All finding will be brought to QAPI monthly for review and implementation of changes in process if needed.	

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F 565	Continued From page 20 were not being provided per schedule, so she asked the nurse aides why showers were not being provided and they said they ran out of time on their shift or just did not give an answer. The DON further stated that NA were strongly encouraged to give residents their showers. She also stated that she entered the facility on the 11 PM - 7 AM shift to observe for noise bur that she had not identified a concern. An interview with the Administrator occurred on 10/30/19 at 6:32 PM and revealed she expected star to complete a grievance form for follow up to Resident Council concerns. The Administrator also stated that residents should receive a shower per their preference unless the resident refused or requested their shower a different day. The Administrator also stated that she expected staff to provide privacy during resident activities and to reduce the noise level.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		11/29/19

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F 578	Continued From page 21 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have advanced directives on the medical record for 2 of 29 residents review for advanced directives (Resident #33 and #32). The finding included: 1. Resident #33 was admitted to the facility on 06/27/19 with diagnoses including heart failure, dementia, neurogenic bladder, and obstructive uropathy. Review of the electronic and hard copy medical	F 578	F578 A. Plan to correct deficiency. Resident # 33 order for full code status was obtained on 10.29.19 per resident preference. Resident #32 order for full code status was obtained on 10.29.19 per resident preference. The Administrator conducted in-service with Director of Nursing (DON), social Worker (SW) and Admissions Director (AD) on 11/1/19 regarding code status	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 22	F 578		

records for Resident #33 revealed there were no advanced directives for a full code or Do Not Resuscitate directives in the chart.

During an interview conducted on 10/29/19 at 3:13 PM, Resident #33 stated his preference was to have a full code. He denied any staff had asked him about his preferred code status since admission.

A phone interview was attempted on 11/01/19 at 9:10 AM with the former Admission Director who admitted Resident #33 to the facility from the hospital. A voice mail message was left but no return phone call was received from her.

An interview conducted on 11/01/19 at 9:12 AM with the Director of Nursing (DON) revealed the former Admission Director who had admitted Resident #33 was responsible to document the advanced directives. The DON did not know why the advanced directives were not in place. She expected the current Admission Director to update and document the advanced directives in the electronic and hard copy medical records immediately. She further stated the advanced directive should have been on Resident #33's chart along with a physician order of preferred code status immediately after admission.

2. Resident #32 was re-admitted to the facility on 09/13/19 with diagnoses included anemia, anxiety, depression, and asthma.

Review of the electronic and hard copy medical records for Resident #32 revealed there were no advanced directives for a full code or Do Not Resuscitate (DNR) directives in the chart.

and responsibilities for obtaining status.
A facility wide audit was conducted by the Medical Records clerk and SW on 10/31/19 which revealed 10 residents with incomplete code status orders. Orders were obtained by nursing.

Social Worker (SW) will review code status in quarterly and as needed in care plan meetings with resident and resident representation (RP). Changes will be made to code status as indicated by resident or RP.
On Admission nurses will review advance directives with resident or RP and obtain code status orders.

B. The procedure for implementing the plan of correction

Director of nursing and / or designee were in-serviced by 11.27.19 on the admission process and advance directives. Nurses will explain advance directive on admission to resident or RP and initiate order for code status. Code status order will be printed and placed on record as well as sticker will be placed on the chart to indicate status. This in-service will be a part of new hire orientation and agency orientation.
SW will follow up with review code status with families at all care plan meeting to ensure any change in preference have been made and initiated.

C. Monitoring procedure to ensure POC is effective.

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 578	Continued From page 23 During an interview conducted on 10/30/19 at 9:20 AM, Resident #32 stated her preference was to have a full code and her preference had not been changed in the past few months. A phone interview was attempted on 11/01/19 at 9:10 AM with the former Admission Director who re-admitted Resident #32 to the facility from the hospital. A voice mail message was left but no return phone call was received from her. An interview conducted on 11/01/19 at 9:12 AM with the Director of Nursing (DON) revealed Resident #32 had multiple times of re-admissions in the past few months. The DON indicated the former Admission Director who had admitted Resident #32 on 08/11/19 was responsible to document the advanced directives. The DON did not know why the advanced directives were not in place. She expected the current Admission Director to update and document the advanced directives in the electronic and hard copy medical records immediately. She further stated the advanced directive should have been on Resident #32's chart along with a physician order of preferred code status immediately after admission.	F 578	The DON and or designee will review the Day of Admission Item Checklist/ Audit within 72 hours of admission for code status. Information from the Audit will be brought to Cardinal IDT 5 x week. Medical Records will audit monthly code status for QAPI on the advance directive audit tool. Social Work (SW) will review code status changes with nursing after care plan meeting to ensure orders have been initiated. Administrator or designee will audit code status orders in PCC every 2 weeks x 4 weeks then monthly x 3 months on the advance directive audit tool. Advance Directives audit tool finding will be brought to QAPI monthly for review and implementation of changes in process if needed.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		11/29/19

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 657	Continued From page 24 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to revise a care plan related to pressure ulcer prevention and treatment for 1 of 3 sampled residents with pressure ulcers (Resident #58). The findings included: Resident #58 was admitted to the facility on 09/04/19 with diagnoses which included end stage Alzheimer's disease. Review of Resident #58's admission Minimum Data Set (MDS) dated 09/10/19 revealed an assessment of severely impaired cognition. The MDS indicated Resident #58 was always incontinent of bladder and bowel with no pressure ulcers.	F 657	A. Plan to correct deficiency. Resident #58□s care plan was updated by MDS nurse on 10/31/19. Administrator conducted in-service with Minimum Data set (MDS) nurse on 10/31/19 regarding care plan revision. MDS nurse was instructed to educate the nursing staff on how to revise the care plans. MDS nurse completed in-service education during 11.15.19-11.27.19 for care planning and in-service education was added to orientation for all new hire nurses. B. The procedure for implementing the plan of correction.	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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LAKE PARK NURSING AND REHABILITATION CENTER	3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079

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F 657	Continued From page 25 Review of Resident #58's care plan dated 09/11/19 revealed interventions to prevent pressure ulcers included incontinent care, provision of assistance with repositioning and turning and pressure relieving devices. The care plan contained an undated addition of unstageable ulcer under the problem section of the care plan. There were no revised goals or additional interventions documented. Review of a skin treatment note dated 09/23/19 revealed presence of an unstageable pressure ulcer on Resident #58's left hip. The pressure ulcer was cleansed with normal saline with application of a foam dressing. Resident #58's family member and the Nurse Practitioner (NP) received notification. Review of the NP's order dated 09/24/19 revealed direction to cleanse Resident #58's left hip open area with normal saline, apply medi-honey and cover with a foam dressing every 3 days and when needed. Review of a NP's order dated 10/26/19 revealed direction for skin prep application to Resident #58's right lateral ankle and foot twice daily. The NP ordered used of bunny boots to both feet. Observation on 10/31/19 at 9:16 am revealed Resident #58 used an air mattress and bunny boots. Resident #58's left hip was covered with a gauze dressing. Interview with Nurse #1 on 10/31/19 at 09:20 AM revealed Resident #58 received an air mattress when the left hip pressure ulcer occurred. Nurse #1 reported staff kept Resident #58's heels	F 657	Corporate Wound care nurse conducted in-service with Treatment nurses and Director of Nursing (DON) on care plan revision on 11/5/19. Audit of care plans of resident with wounds was conducted by the treatment nurse on 11.21.19. A total of 3 residents needed care plan revisions and care plans were updated to reflect current treatments. New wounds will be reported in Cardinal IDT 5x a week and treatment nurse will revise care plans as needed. C. Monitoring procedure for implementing plan of correction. MDS nurse or designee will review 4 care plans of residents with wounds weekly x 4 weeks for proper care plan revision. Then biweekly x 1 month, then monthly x 3 months on care plan audit tool. All finding will be brought to QAPI monthly for review and implementation of changes in process if needed.	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 26 offloaded with pillows and began application of bunny boots when the order occurred on 10/26/19. Nurse #1 explained either the MDS Coordinator or the wound nurse updated and revised the care plan. Interview with the MDS Coordinator on 10/31/19 at 3:18 PM revealed the wound nurse should update and review Resident #58's care plan. The MDS Coordinator explained unit nurses held responsibility for care plan updates and revisions. During an interview with Nurse #2, wound nurse, on 10/31/19 at 3:29 PM revealed she began the wound nurse position on 10/28/19. Nurse #2 explained she thought the wound nurse updated and revised the care plan but did not know the former wound nurse's role in care plan revisions. Telephone interview with Nurse #5 on 11/01/19 at 10:18 AM revealed she shared wound treatment responsibility with Nurse #4 until 10/25/19. Nurse #5 explained Nurse #4 updated and revised the care plan since Nurse #4 was a Registered Nurse. Nurse #4 was not available for interview. Interview with the Director of Nursing (DON) on 11/01/19 at 4:00 PM revealed the wound nurses should communicate changes in care plan interventions to the MDS Coordinator. The DON reported the MDS Coordinator should update and revise Resident #58's care plan. The DON added the care plan revision process was currently under review.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		11/29/19

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 658	Continued From page 27 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician's order to implement dose reduction for 1 of 5 sampled residents reviewed for unnecessary medication. (Resident #64). Finding included: Resident #64 was admitted to the facility on 06/23/18 with diagnoses included Alzheimer's disease, depression, muscle weakness, and insomnia. Review of the most recent Minimum Data Set (MDS) dated 09/23/19 revealed Resident #64 was coded with severe impairment in cognition and required extensive staff assistance for most of her activities of daily living (ADL) included bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS indicated Resident #64 had fallen one time with injury since admission and was receiving antidepressant daily during the 7-day look back period. Review of care plan for falls that was last revised on 09/27/19 revealed Resident #64 was at risk for falls related to cognitive impairment and unsteady gait. Interventions included evaluation of effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage or elimination of medications, monitoring	F 658	A. The plan of correcting the specific deficiency On 11/1/2019 resident # 64 was assessed by Director of Nursing with no negative findings related to medication error. On 9/17/2019 the medication order was reviewed by Pharmacy Consultant and a recommendation was issued. On 9/25/2019 the Nurse Practitioner reviewed the pharmacy recommendation to decrease dosage and she declined changes at that time. B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Between 11/19/19 and 11/27/2019 the Director of Nursing and the Resident Care Coordinator audited pharmacy recommendations for the month of October for any orders not transcribed. No negative findings. On 11/27/2019 the Director of Nursing began an in-service with all administrative nurses on the transcription of pharmacy recommendations with physician orders,	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 28 of potential medication side effects that might increase the risk of falls, and review of fall potential, possible causative and contributing factors. Review of physician's order revealed Trazodone 50 milligram (mg) half tablets by mouth at bed time for insomnia was ordered for Resident #64 on 05/17/19. Review of Consultant Pharmacist's (CP) recommendation to Physician dated 06/10/19 revealed the CP had recommended to reduce the dose of Trazodone from 25 mg to 12.5 mg once daily at bed time to help decrease fall potential. The Physician agreed and signed the recommendation on 06/24/19. Review of Medication Administration Record (MAR) revealed Resident #64 had been receiving Trazodone 25 mg once daily at bed time as ordered since 05/17/19 except from 08/22/19 through 08/26/19 when she was hospitalized. Review of incident report dated 08/21/19 revealed Resident #64 had an unwitnessed fall at around 1:00 AM. She was hospitalized and later X-ray confirmed she had suffered hip fracture. An interview was conducted on 11/01/19 at 9:26 AM with the Director of Nursing (DON). She acknowledged that the dose reduction for Resident #64's Trazodone was approved and signed by the physician, but it was not implemented as ordered. The DON stated she did not know how the system worked in the past as she had just assumed the position for about 2 months. She added the former DON was ultimately responsible to implement physician's	F 658	to prevent medication errors. In-service will be completed by 11/29/2019. These in-services were added to the orientation for newly hired administrative nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit pharmacy recommendations weekly x 12 weeks to ensure all pharmacy recommendations with physician orders have been transcribed and are being carried out as ordered. This audit will be documented on the medication error audit tool. The monthly quality improvement (QAPI) committee will review the results of the MAR audit tools for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The DON and/or ADON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive quality improvement performance improvement (QAPI) committee for further recommendations and oversight.	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 658	Continued From page 29 orders after CP's recommendation was accepted by the physician. According to the current protocol, the DON stated after the physician agreed to CP's recommendation, she would forward the Unit Manager (UM) a copy of Physician's decisions and the UM was responsible to implement the order. It was her expectation for all the physician orders to be implemented accurately and in timely manner. A phone interview was attempted on 11/01/19 at 10:39 AM with the former DON. A voice mail message was left but not return phone calls were received from her. A phone interview was conducted on 11/01/19 at 11:44 AM with the Physician. He stated when the CP recommended a dose reduction for Trazodone in June, he agreed to try the gradual dose reduction and monitor Resident #64's reactions to the dose reduction. He did not know that the order was not implemented. The Physician stated 25 mg of Trazodone was a very low dose used just for sedation at night and it should not increase the risk of falls. He denied Resident #64's falls in August was related to continuous receiving of Trazodone 25 mg at bed time as she was receiving such a low dose at that time. The Physician stated it was his expectation for all the physician orders to be implemented accurately and in timely manner.	F 658	.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		11/29/19

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 30 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff and nurse practitioner interviews, and record review, the facility failed to change a pressure ulcer dressing as ordered (medi-honey and a foam dressing) for 1 of 3 sampled residents who required pressure ulcer dressings (Resident #58). The findings included: Resident #58 was admitted to the facility on 09/04/19 with diagnoses which included end stage Alzheimer's Disease. Resident #58's admission Minimum Data Set (MDS) dated 09/10/19 revealed an assessment of severely impaired cognition. The MDS indicated Resident #58 was always incontinent of bladder and bowel with no pressure ulcers. Resident #58's care plan dated 09/11/19 revealed interventions to prevent pressure ulcers included incontinent care, provision of assistance with repositioning and turning and pressure relieving devices. The care plan contained an undated addition of unstageable pressure ulcer under the problem section of the care plan. There were no revised goals or additional interventions	F 686	A. The plan of correcting the specific deficiency Resident # 58□s left hip wound was assessed on 10/31/19 by Treatment LPN; assessment entered into medical record on 11/1/19. Wound had no exudate and showed no signs or symptoms of infection. B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 11/8/19 the wound nurse audited residents with pressure ulcers to ensure 1. Dressing was in place, 2. Dressing in place was corrected per physician order. Audit revealed that wounds were treated as ordered. On 11/27/19 the Director of Nursing started an in-service with licensed nurses, including agency, on wound care. This in-service included treatment must be applied per physician order. This in-service will be completed by	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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 686	Continued From page 31 documented. A skin treatment note dated 09/23/19 revealed presence of an unstageable pressure ulcer on Resident #58's left hip. The pressure ulcer was cleansed with normal saline with application of a foam dressing. Resident #58's family member and the Nurse Practitioner (NP) received notification. The NP's order dated 09/24/19 revealed direction to cleanse Resident #58's left hip open area with normal saline, apply medi-honey and cover with a foam dressing every 3 days and when needed. Resident #58's electronic treatment records revealed Nurse # 3 documented application of medi-honey and foam dressing on 10/30/19 at 10:58 PM to Resident #58's left hip. Observation on 10/31/19 at 9:16 am revealed a gauze dressing on Resident #58's left hip. Nurse #2, the wound nurse, removed the gauze dressing which uncovered a pressure ulcer on Resident #58's left hip which measured 1 centimeter in diameter. The pressure ulcer was approximately 0.1 cm deep and without odor or discharge. Nurse #2 cleansed the pressure ulcer with normal saline, applied medi-honey and covered the area with a foam dressing. Interview with Nurse #2 on 10/31/19 at 9:25 AM revealed she began the wound nurse position on 10/28/19. Nurse #2 confirmed the dressing removed from Resident #58's left hip was not the ordered dressing. During a telephone interview with Nurse #3 on 10/31/19 at 12:35 PM, Nurse #3 explained she	F 686	11/29/2019. This in-service is included for their orientation of newly hired licensed nurses, including agency. C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, and or unit manager will audit all pressure ulcers weekly x 12 weeks to ensure that 1. Dressing is in place, and 2. Treatment in place is correct per physician order. This audit will be documented on the wound audit tool. The monthly QI committee will review the results of the fall and MDS audit tools monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 686	Continued From page 32 worked at the facility through a temporary agency. Nurse #3 explained she could not find the supplies for Resident #58's dressing so cleansed the area with normal saline and applied a dry gauze dressing. Nurse #3 reported she asked another nurse for information regarding the location of Resident #58's pressure sore supplies but that nurse did not know. Nurse #3 could not remember the nurse's name. Interview with the NP on 10/31/19 at 11:04 AM revealed she expected staff to change Resident #58's left hip dressing as ordered. The NP explained although the pressure ulcer was unavoidable due to Resident #58's poor nutritional state and end-stage condition, the extra protection of a foam dressing was needed. Interview with the Director of Nursing (DON) on 10/31/19 at 2:28 PM revealed staff should change Resident #58's pressure ulcer dressing as ordered. The DON explained Nurse #3 received orientation prior to assignment which included location of treatment supplies.	F 686		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident, staff and physician interviews, and record review, the facility failed to administer Xarelto (a medication used to prevent blood clots) as ordered to 1 of 11 sampled residents who received a medication review (Resident #192).	F 760	A. The plan of correcting the specific deficiency On 11/27/2019 the Nurse Practitioner assessed resident #192. No negative findings related to Xarelto.	11/29/19

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	345502	A. BUILDING _____ B. WING _____	C 11/01/2019

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F 760	Continued From page 33 The findings included: Resident #192 was admitted to the facility on 10/22/19 with diagnoses which included pulmonary fibrosis, diabetes mellitus type 2, congestive heart failure and long-term use of anticoagulants. Review of Resident 192's hospital discharge summary dated 10/22/19 revealed Resident #192 should continue to receive Xarelto 15 milligrams daily for history of venous thromboembolism. Review of Resident #192's admission orders revealed there was no direction to administer Xarelto. The admission orders were transcribed by Nurse #6. Review of an admission nursing note dated 10/22/19 revealed Resident #192 was alert and "verbally responsible." Review of a physician's note dated 10/23/19 revealed Resident #192 received admission as a hospice respite stay resident with continuance of hospice medications. The physician documented Resident #192 was disoriented to time but aware of person and place. Review of a Nurse Practitioner's note dated 10/24/19 revealed Resident #192 received anticoagulation therapy. Review of Resident 192's October 2019 electronic Medication Administration Record (eMAR) revealed there was no documentation of Xarelto administration. Xarelto was not listed on the eMAR.	F 760	On 11/1/2019 the Director of Nursing notified the attending physician of the medication error on resident # 192. No new orders given. B. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 11/25/2019 the DON audited new admissions for the past 14 days to ensure medications were transcribed correctly. No negative findings. On 11/27/2019 the DON started an in-service with licensed nurses, including agency, on medication administration including transcription of orders on new admissions. This in-service will be completed by 11/29/2019. This in-service was added to the orientation for newly hired licensed nurses, including agency. C. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, assistant director of nursing, unit manager, and/or staff facilitator will audit each new admissions to ensure orders were transcribed correctly weekly x 12 weeks. This audit will be documented on the MAR audit tool. The monthly quality improvement (QAPI) committee will review the results of the	

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F 760	Continued From page 34 Interview with Resident #192 on 10/29/19 at 10:10 AM revealed he relied on facility staff for medication administration. Resident #192 explained he took a blood thinning medication for the "past several years." Interview with Nurse #1 on 11/01/19 at 9:31 AM revealed the physician confirmed Resident 192's admission medication orders upon admission on 10/22/19. Nurse #1 reviewed Resident #192's electronic record and reported Resident #192 should receive the Xarelto since the physician confirmed the admission hospital discharge medications without change. The nurse who confirmed Resident #192's admission orders, Nurse #6, was not available for interview. Interview with the Director of Nursing (DON) on 11/01/19 at 1:23 PM revealed Resident #192 should have received the Xarelto as ordered. The DON explained the hospital discharge summary medications were confirmed and considered orders. During a telephone interview with Resident #192's physician on 11/01/19 at 11:29 AM, the Physician reported Xarelto was ordered for Resident #192. The physician explained the medication orders on the discharge summary were confirmed and thought Resident #192 received the Xarelto as ordered. The physician reported the omission of Xarelto for 9 days would not harm Resident #192. The physician reported replacement of the Xarelto with an aspirin was under consideration due to Resident #192's recent history of multiple falls.	F 760	MAR audit tools for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QAPI committee to the quarterly executive quality improvement performance improvement (QAPI) committee for further recommendations and oversight.	

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