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 03/28/2023

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 A complaint investigation survey was conducted from 03/27/2023 through 03/28/2023. The following intake was investigated: NC00199984. 1 of the 1 complaint allegation did not result in deficiency . Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Non-compliance began on 03/22/2023. The facility came back in compliance effective 03/25/2023. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Physician interview, observation, and record review, the facility failed to provide incontinent care safely for a resident who required extensive staff assistance for 1 (Resident #1) of 3 residents reviewed for accidents. On 3/22/23 during incontinent care	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 04/04/2023

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 03/28/2023

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 689	Continued From page 1	F 689		

provided by Nursing Assistant (NA) #1, Resident #1 rolled off of the bed hitting her face on the nightstand and landing on the floor. Resident #1 sustained bruises to all extremities and the left side of her face, a laceration on left forehead 0.5 centimeters (cm) in length, multiple skin tears to her upper right arm, fractures of the left and right distal femurs (fracture of the thigh bone that occur just above the knee joint), a right lateral tibia plateau fracture (a break of the larger lower leg bone below the knee), and she suffered pain in her face and lower extremities.

The findings included:

Resident #1 was admitted on 08/05/2022 with cumulative diagnoses of osteoporosis and dementia.

The quarterly Minimum Data Set (MDS) dated 03/10/2023 indicated Resident #1 had moderate cognitive impairment, required extensive assistance of 1 with bed mobility, toileting, and personal hygiene. The MDS did not code the resident as having behavioral symptoms or refusal of care. The MDS indicated the resident was always incontinent of bladder and bowel.

Resident #1's care plan revised on 03/16/2023 indicated Resident # 1 had a focus of urinary incontinence related to: Physical immobility. The intervention included peri care after each incontinent episode. The care plan also indicated a focus area of the resident requiring assistance to maintain maximum function of self-sufficiency for transferring from one position to another and personal hygiene related to physical limitation.

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 03/28/2023

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 689	Continued From page 2	F 689		

The incident report completed by Director of Nursing (DON) dated 03/22/2023 revealed Resident #1 had a fall from bed while being changed by staff. The resident fell onto her side with eye pain and right knee pain. NA #1 stated while changing her, the resident began turning over onto the floor and she was unable to catch her. The resident's position on the floor was left lateral with her head resting on the floor with NA #1 by her side. Resident #1 had a moderate amount of bleeding from the laceration to her forehead and swelling to her left eye. Later during assessment, multiple skin tears were noted on resident's upper right arm and increased swelling to right knee.

The investigation of the incident dated 03/22/2023 completed by Director of Nursing (DON) revealed Nursing Assistant (NA)#1 entered Resident #1's room to provide incontinent care. NA #1 had turned and positioned the resident from side to side to remove soil brief and placed a new brief and disposable pads under the resident without difficulty. NA #1 left the resident lying on the left side in the center of the bed. Resident #1 remained safely in the center of bed for approximately 5 minutes before NA #1 returned to complete care. NA #1 resumed incontinent care. Resident #1 was still lying on the left side in center of bed with right leg crossed over her left leg and slightly in front of the resident. While NA #1 was attempting to place a clean brief under the resident, she noted the resident's right leg slid forward and off the edge of the bed. NA #1 grabbed the resident's right upper arm/shoulder but was unable to stop the resident's forward motion. Resident #1 began to roll off the bed landing onto the floor. Resident#1

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 03/28/2023

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 689	Continued From page 3	F 689		

was noted lying on her left side almost on her stomach and lying on her left arm with her feet toward the foot of the bed and her head toward the head of the bed resulting in multiple injuries. Resident#1 was immediately assessed by nursing staff and 911 notified. Resident #1 was transferred to the local hospital emergency room for further evaluation and treatment. Resident #1 was alert to self and verbal with staff at time of transfer.

Review of Nursing Assistant (NA)#1's statement dated 03/24/2023 revealed the NA #1 went in resident's room around 1:55 PM on 3/22/23 to check on Resident#1. The resident had stool present in her brief. She gathered supplies and moved the bed so she could stand between the bed and the wall to provide care. She rolled the resident from side to side to remove the brief. Resident#1 continued to have stool. NA #1 indicated she placed the resident in the center of the bed on her left side facing the door with an incontinent pad and brief underneath her. She lowered the bed and returned in 5-6 minutes. The resident was still on her left side. She raised the bed back up to about waist height. She had her left hand on the resident and cleaned her with her right hand and removed the dirty brief. She indicated as she was wiping, the resident said "ouch" when she wiped over the reddened area that had been there before. NA #1 looked up, the resident's right leg was crossed over her left leg and her leg had dipped off the bed a little and her whole body started to roll off the bed. She grabbed Resident #1's right shoulder where her hand had been placed on her shoulder. When Resident #1 rolled from bed, NA #1 ran around the bed and checked the resident. The resident

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 03/28/2023

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 689	Continued From page 4	F 689		

was laying on her left side, almost on her stomach. There was blood on her face and mouth. She placed a pillow under Resident #1's head and towel on her forehead. She went to doorway and yelled "code green" (a fall with an injury).

During the phone interview on 03/27/2023 at 12:44 PM, NA #1 reported that she was in the resident's room giving care on 03/22/2023. Resident#1 needed to be changed due to having a loose stool. NA #1stated the resident was lying on the left side facing the door and her left hand was holding the resident's shoulder. She indicated the resident's right leg was extended over the left leg. NA #1 stated when she positioned the incontinent pad under the resident, she observed the resident's right leg dipped off the bed then the resident slid down and fell to the floor. NA #1 indicated She was standing next to the wall when cleaning the resident, so she ran around the bed and went to the door and called "code green" which meant the resident fell with an injury. She indicated that the resident moved her leg when placing the incontinent pad underneath, her then she started rolling and she could not stop her from falling to the floor. She indicated she had been in serviced on how to properly turn and repositioned the residents at the facility.

Review of Nurse #2's witness statement dated 03/23/2023 revealed the nurse was the first to respond to the "code green" called by NA #1 for Resident #1. The nurse entered the room, the resident was already on the floor on her left side, lying on her left arm. Her head was tilted to the left. NA #1 who was her nurse aide was kneeling in front of her with a washcloth to her head,

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 03/28/2023

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 689	Continued From page 5	F 689		

covering a laceration. Resident #1's left eye was swollen and there was a laceration to forehead, bruising under her left eye and her mouth had a bloody top and bottom lip. The nurse was unable to tell if it was coming from inside her mouth or from the resident biting her lips. The nurse then went to NA #1 who stated she was "giving care and the resident weight shifted."

Nurse #2 was unavailable for an interview.

During an interview on 03/27/2023 at 11:02 AM, Nurse #1 who was assigned to Resident#1 reported on 03/22/2023 at approximately 2:15PM, she heard NA #1 yelling "code green" meaning a fall with an injury and heard "call 911." Nurse #1 reported that she got the paperwork together and called the resident's son. She then went to the resident's room and saw 2 staff members (Unit Manager (UM)#1 and UM#2) in the room applying a bandage to the resident's head. She saw the resident positioned on the floor on her back, right leg over her left, and a bruise under the left eye.

Review of Unit Manager (UM)#1's witness statement dated 03/23/2023 indicated she was in the hall helping another resident when she heard the "code green" announced. When she got to the room the resident was lying on her left side and was complaining of eye pain. NA #1 was kneeling on the floor holding pressure with a washcloth to the resident's head. NA #1 stated while changing the resident, the resident began turning over onto the floor and she was unable to catch her. Resident #1's head was resting on the floor with NA #1 by her side. Resident #1 had moderate amount of bleeding from a laceration to

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 03/28/2023

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 689	Continued From page 6	F 689		

her forehead and swelling to her left eye. During the assessment of Resident #1, multiple skin tears were noted on resident's upper right arm and increased swelling to her right knee. The resident was semi undressed, and brief was not fastened with noted stool. The bed was about waist height and the foot was raised 2-3 inches. The resident was able to state her name and that her eye hurt. The room had adequate lighting and the floor appeared dry and free of hazards. Nursing staff responded rapidly assessing the resident and obtaining vital signs of Blood Pressure (BP) 110/ Heart Rate (HR) 74, respiration 24, and Oxygen (O2) 89%. Resident #1 was placed on O2 via Nasal Cannula (NC) @ 2 Liters (L). The nursing staff completed the head-to-toe assessment and bandaged her head to stop the bleeding. Resident #1 was transferred into stretcher and care turned over to Emergency Medical Services (EMS).

During an interview on 03/27/2023 at 11:34 AM, UM #1 stated that she responded to a code green with everyone else. When she got to the resident's room, she observed the resident was lying on her left side, NA #1 was kneeling on the floor holding pressure with a washcloth to the resident's head. UM #1 reported she performed an assessment on the resident's cognition and the resident was able to state her name but did not know where she was. UM #1 reported that she assessed the resident, and she noticed the bleeding from a laceration to her forehead and swelling to right knee. She reported the resident indicated her head was hurting. UM #1 also indicated NA #1 stated to her that while she was changing the resident, she started rolling over and she could not stop the resident from falling to the floor.

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 03/28/2023

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 689	Continued From page 7	F 689		

Review of UM #2's witness statement dated 03/23/2023 indicated she entered Resident#1's room and noticed her lying on her left side with her right leg over her left leg. NA #1 was applying pressure to the resident's forehead using a washcloth. The resident had skin tears on her arm, but UM #1 indicated she could not remember which arm. After she assessed that the blood was coming from the deep laceration on her forehead, she took over from NA #1 and began applying pressure with the washcloth. She also cleaned the inside of the resident's mouth, but there was blood on her lips. She cleaned her forehead with additional gauze, then applied (elastic) wrap to the laceration and applied more pressure. She did not notice any abnormalities when assessing her pupils. She asked the resident her name, and she stated her name but stated she did not know where she was. She assessed her upper body while UM #1 assessed her bottom. She attempted to get a blood pressure reading on Resident #1's right arm unsuccessfully. She got a fluctuating pulse oximeter reading 86-89% while UM #1 was getting BP. Then EMS arrived in the room and asked EMS to confirm their oxygen saturation reading, which was 89-90%.

During an interview on 03/27/2023 at 12:01 PM, UM #2 stated on 03/22/2023 she heard code green, and she ran to Resident#1's room. She then observed the resident lying on the left side in front of her bed. NA #1 was down on the floor using a washcloth to apply pressure on the resident's forehead. UM #2 reported that she took over from NA #1 and started applying pressure with the washcloth. She also assessed the

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 03/28/2023

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 689	Continued From page 8	F 689		

resident's cognition. The resident stated her name but did not recall where she was. UM #2 reported that she applied the elastic band on the resident's laceration on her forehead to control the bleeding.

Review of the Emergency Room report dated 03/22/2023 revealed the resident was given fentanyl (a narcotic medication) for pain and was given fluids because she was hypotensive (low blood pressure). The resident sustained bruises on all extremities and the left side of her face. She complained of pain in her face and her right and left leg. There was a laceration on her left forehead 0.5 centimeters in length. The report indicated left and right distal fracture and a right lateral tibia plateau fracture. Facial and head Computed Tomography (CT) scans did not show any acute except for laceration on the left forehead.

During the phone interview with the Physician on 03/27/2023 at 2:10 PM, she stated the ER report indicated the resident had multiple fractures in lower extremities. The physician reported the resident had a history of a right tibia fracture and verified this was fractured again from the fall. The physician added the CT scan was done and it did not identify head injuries.

During an interview on 03/27/2023 at 3:30PM, the Director of Nursing (DON) indicated that NA #1's turning and repositioning skill checks had been done when she was hired and annually. The DON indicated NA #1 had no history of not following instructions in reference to turning and repositioning residents at the facility. She stated

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 03/28/2023

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 689	Continued From page 9	F 689		

when NA #1 was providing care to Resident#1, she rolled and fell from bed to floor due to the positioning of the resident's right leg which shifted during the care. The DON also added after the resident's fall incident, she educated all the NAs to ensure that residents were kept in center of bed and to maintain proper safety when turning and positioning residents at the facility.

During an interview on 03/27/2023 at 3:35 PM, the Administrator revealed that they had completed an investigation on how the resident fell from bed to the floor and they determined that the resident rolled due to the position of the resident's leg that shifted when NA #1 was providing incontinent care. She added that the NAs at the facility had been in serviced in keeping the resident in center of bed. The administrator also added the NAs had been in serviced in paying attention to resident safety when turning and repositioning residents when providing care. She indicated they also informed the NAs to report to the unit managers if they need more than 1 person to assist with turning and repositioning residents. The Administrator indicated the NAs have also been in serviced that while providing care to residents they needed to monitor residents' leg movements to prevent the residents from rolling from bed to the floor.

The Administrator and DON were notified of the Immediate Jeopardy on 03/27/2023 at 03:05 PM.

The corrective action for the past non-compliance dated 03/24/2023 was as follows:

"Address how corrective action will be accomplished for those residents found to have

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 03/28/2023

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 689	Continued From page 10	F 689		

been affected by the deficient practice.

Resident #1 is alert and oriented to self with a brief interview for mental status (BIMs) of 9 of 15 indicating resident cognition as moderately impaired. Resident #1 can verbalize needs. Diagnoses include Osteoporosis, Dementia, Anxiety, Hypertensive Heart Disease, blindness right eye, Major Depressive Disorder, Convulsions, Cardiomegaly (enlarge heart), Hypokalemia (low potassium which affects heart health), Hypomagnesemia (low magnesium which affect bones and leads to osteoporosis and heart disease), Psychosis, diabetes, and Anemia. Resident #1 has a history of a right tibial fracture with delayed/nonunion healing requiring the use of a bone stimulator to electronically stimulate bone growth and help heal broken. Resident #1 is receiving cholecalciferol (Vitamin D3, used to treat bone disorders), Calcium Citrate, Magnesium and Vitamin D for Osteoporosis and bone health. Resident #1's seizures are controlled with Keppra. Last Keppra level 3/16/23 was 62. Resident #1's fall risk assessments determined Resident #1 not to be at risk/or low risk for falls. It had been over a year since Resident #1's last fall. No previous falls while being assisted during care. Per Minimum Data Set Nurse (MDS) assessment 3/10/23 for bed mobility and toileting was extensive assistance of one person. Resident #1's height/weight is appropriate for her bed. On 3/22/23 at approximately 1:55pm Nursing Assistant (NA) #1 went in to check on Resident #1. Resident #1 had stool present in brief. NA #1 gathered supplies and moved the bed so NA #1 could stand between the bed and the wall to provide care. NA #1 rolled Resident #1 from side to side to remove brief and provide incontinent care.

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 03/28/2023

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 689	Continued From page 11	F 689		

Resident #1 was continuing to have bowel movement; it was very loose. NA #1 decided Resident #1 needed more time to have bowel movement and placed Resident #1 in the center of the bed. The resident was positioned on the left side facing the door with right leg positioned over the left leg and slightly forward with an incontinence pad and brief underneath the resident. NA #1 lowered the bed and left the room. The foot of the bed was slightly raised 2-3 inches. On 3/22/23 at approximately 2:00pm NA #1 entered Resident #1's room to complete incontinent care. The bed was close to the wall. Resident #1 continued to be lying on left side, brief and pad were underneath Resident #1, with right leg crossed over left leg and slightly forward. The foot of the bed was elevated 2-3 inches. NA #1 unlocked bed and angled away from wall (just enough to get behind bed), then locked bed. NA #1 raised bed to about waist height, then placed remote of bed close to the Resident #1's head on the right side. NA #1 placed left hand on Resident #1 just below her right shoulder and provided incontinent care to Resident #1 using the right hand. NA #1 pulled out and rolled soiled brief and placed a new rolled pad/brief under Resident #1 using right hand while left hand remained on right arm. NA #1 saw the movement of Resident #1's legs. NA #1 looked up and observed Resident #1's right leg dipped off the bed a little and the resident's whole body started to roll. Resident #1's right leg first went off the bed. NA #1 tried to grab Resident #1's right shoulder. Resident #1 continued to roll. Resident #1's side of her face hit her nightstand, then her right knee hit the ground first, then the left knee. Resident #1 landed on left side mostly on stomach. The bed remote, brief and incontinence pad had come off bed with Resident #1, and

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 03/28/2023

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 689	Continued From page 12	F 689		

Resident #1 was lying on the remote. Her brief was unfastened. NA #1 immediately ran around the bed; Resident #1 was on the left side almost on her stomach. Resident #1 had blood on her face. NA #1 placed a pillow under Resident #1's head, then went to doorway and called "code green". NA #1 returned to Resident #1's side and held a towel against her head over laceration. Nurse #1 responded and assessed Resident #1 and noted Resident #1 was lying on the left side of his left arm. Her head was toward the bedside table and feet toward bathroom door. Resident #1's head was tilted to the left. Resident #1's left eye was swollen with a laceration to the forehead, bruise under left eye, and bloody mouth (top and bottom lip). Nurse #1 was unable to tell if blood was coming from Resident #1's mouth or the resident biting her lips. NA #1 told Nurse #1 she was providing care and Resident #1's weight shifted. Nurse #1 then went to doorway and called to charge nurse to call 911. License Practical Nurse (LPN) notified 911 and then went to assist with incident. Therapy staff member responded to assist, retrieved blanket from bed and covered resident #1. Nurse #2 responded to the incident and assessed resident #1. Resident #1 had multiple skin tears noted on upper right arm and increased swelling to right knee. Resident #1 was semi undressed, and brief not fastened. Resident #1 was able to state her name and that her eye was hurting. The room had adequate lighting. Vital signs were obtained with no significant findings, except for O2 (oxygen) saturation (O2 sat) at 89%. Resident #1 was placed on O2 at 2 liters per minute (lpm), head to toe assessment was completed and a bandage placed on the resident's head to stop the bleeding. Nurse #3 came to assist. Nurse #3 took over to apply pressure to the head with washcloth

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 03/28/2023

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 689	Continued From page 13	F 689		

and cleaned inside Resident #1's mouth with gauze. Nurse #3 then cleaned the resident's forehead with gauze and secure dressing and applied additional pressure. Her pupils were assessed with no abnormalities. Nurse #3 asked Resident #1 her name and resident #1 was able to state her name. Resident #1 was not able to state where she was but was able to say in "Henderson". Nurse #3 assisted with head-to-toe assessment. Nurse #2 attempted to get Blood Pressure (BP) reading on right arm unsuccessfully. Pulse oximeter fluctuating between 86-89%. Nurse #4 and Director of Nursing responded and assisted with preparation for transfer. On 3/22/23 at approximately 2:25pm Emergency Medical Services (EMS) arrived, took over care and assessed resident #1. EMS confirmed O2 sat 86-89%. EMS staff placed draw sheet under Resident #1. Incontinent care was provided by facility staff and EMS prior to lifting resident #1 onto the gurney. On 3/22/23 at approximately 2:30pm EMS left facility with resident #1. Resident was alert to self and verbal with staff at time of transfer.

"Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 3/22/23, the Director of Nursing (DON) and unit managers completed an audit of all residents' positioning in bed. This audit was to identify any resident who was not positioned in the center of bed and away from the edge of bed following care. No concerns were identified during the audit.
On 3/22/23, DON initiated a Resident Care Audit on turning and positioning in bed with return demonstration to include NA #1. This audit was to

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 03/28/2023

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 689	Continued From page 14	F 689		

ensure staff used appropriate techniques with turning and positioning during care, to ensure that the resident is positioned in the center of bed during care and following care and that the NA monitored position in bed during care to include when placing brief/pad under resident to prevent falls. The Resident Care Audit with required return demonstration will be conducted with all nurses and nursing assistants by 3/24/2023. After 3/24/2023, any nurse or nursing assistant who has not completed the return demonstration will complete upon the next scheduled work shift. The DON and Unit Managers will immediately address all areas of concern identified during the audit to include education of staff and/or repositioning residents when indicated.

On 3/22/2023, the Unit Managers completed an audit of all residents to ensure the bed is the appropriate size for weight and stature. No concerns were identified during the audit.

On 3/23/2023, the Social Worker conducted interviews with all alert and oriented residents in the facility to identify any resident concerns related to turning and repositioning during care as well as appropriate bed size. No concerns were identified during the interviews.

"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 3/22/23, DON initiated an audit of all care guides for assistance required for bed mobility. This audit is to ensure care guides accurately reflect the number of staff required for turning and repositioning resident in bed for safety. Audit will be completed by 3/24/2023. Any areas of concern

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 03/28/2023

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 689	Continued From page 15	F 689		

identified during the audit will be immediately addressed by DON to include revision of the care guide as needed and education of staff.
On 3/23/2023, DON reviewed progress notes for the past 14 days. This audit is to identify any residents with acute change to ensure acute change was addressed and safety interventions were initiated when indicated. The DON addressed all concerns identified during the audit. Audit was completed by 3/24/23.

On 3/23/23, the Facility Consultant completed an audit of all incident reports from 2/1/2023 to 3/23/23. This audit is to identify any falls during care. There were no additional concerns identified.
On 3/22/2023, the DON and Staff Development Coordinator (SDC) initiated an in-service with all nurses and nursing assistants to include NA #1 regarding turning and re-positioning during care. Emphasis on procedure for turning and positioning resident when providing care, positioning resident in the center of the bed following care when turning and positioning to prevent falls/injury. In-service will be completed by 3/24/2023. After 3/24/2023, any nurse or nursing assistant that has not received the in-service will receive it prior to the next scheduled work shift. All newly hired nurses and nursing assistants will be in-service by the Staff Development Coordinator (SDC) during orientation regarding turning and positioning.

"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Resident care audits on turning and positioning will be completed by the Staff Development

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 03/28/2023

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 689	Continued From page 16	F 689		

Coordinator (SDC) and Unit Managers with 10% of NAs to include NA #1 weekly x 2 weeks, then 5 % of NA's weekly x 2 weeks to ensure correct turning and positioning techniques are used during resident care, that the resident is positioned center of bed during care and following care and that the NA monitored position in bed during care to include when placing brief/pad under resident to prevent falls. Any areas of concern identified during the audits will be immediately addressed by the SDC and/or Unit Managers to include repositioning of residents and staff re-training. The DON will review and initiate the Resident Care Audit Tool weekly x 4 weeks to ensure all areas of concern have been addressed.

The DON will forward the Resident Care Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 1 month. The QAPI Committee will meet monthly x 1 month and review the Resident Care Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

The date of compliance was 03/25/2023.

Onsite validation was completed on 03/27/2023 through staff interviews, observation, and record review. The review of the in-service training revealed the staff were educated on 03/22/2023 until 03/24/2023 to ensure that they kept residents in the center of bed when providing care. Also, staff were educated on turning and repositioning residents in bed to maintain safety. Staff were interviewed to validate in-services

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 03/28/2023

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 689	Continued From page 17	F 689		

completed on education provided to ensure that they kept residents in center of bed when providing care. No issues were identified. Observation was conducted on 03/27/2023 of staff completing care on resident while lying in the bed. The staff positioned and repositioned the resident appropriately. A review of care audits for turning and repositioning for staff was reviewed and it was revealed it was complete on 03/24/2023. Review of the completed resident questionnaire related to being turned and repositioned appropriately by staff dated 03/23/2023 and no concerns were identified. The care guide was updated for the residents who require extensive assistance with bed mobility verified and no issues identified. Review of progress notes for the previous 14 days was completed on 3/24/23 which identified residents with acute change and safety interventions were identified was verified and no concerns identified. The validation process verified the facility's date of compliance of 03/25/2023.