| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345541 | A. BUILDING ______ B. WING ______ | C 08/08/2023 |

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

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| E 000 | Initial Comments<br><br>An unannounced COVID-19 Focused Survey was conducted 08/08/23. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# FWCS11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 08/08/23. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and the Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. Event ID # FWCS11. The following intake was investigated NC00205097.<br><br>1 of the 9 complaint allegations resulted in a deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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. | F 550 | | 9/5/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/30/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 550 | Continued From page 1<br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #1).<br><br>The Findings included:<br><br>1. Resident #1 was admitted to the facility on 02/08/23 with diagnoses of hemiplegia and seizure disorder.<br><br>The quarterly Minimum Data Set (MDS) | F 550 | "Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.<br><br>Resident number 1 was provided incontinent care and skin assessment completed with no redness or open areas noted on 8/8/2023.<br><br>To identify like residents Social Worker or Designee conducted interviews with all | |

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| F 550 | Continued From page 2 | F 550 | | |

assessment dated 05/22/23 revealed that Resident #1 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period.

Resident #1 was interviewed in his room on 08/08/23 at 10:30 AM. During the interview he stated he often had to wait 40 minutes or longer on staff to answer his call light when he needed to be changed. Resident #1 stated he had just soiled his brief 5 minutes prior to the surveyor speaking with him and proceeded to press his call light to request assistance from staff. The call light was observed on outside of the resident's door at 10:40 AM.

An observation was conducted on 08/08/23 at 10:42 AM of Nurse Aide (NA) #1 came into Resident #1's room. She turned off his call light and asked the resident what he needed. Resident #1 stated, "I need to be changed". NA #1 then stated to the resident that she would tell his assigned NA that he needed to be changed and exited the room. Resident #1's call light was observed to be off. Resident #1 stated to the surveyor, "you see this happens all of the time, they will forget about me".

An interview was conducted with Nurse #1 on 08/08/23 at 11:15 AM. He stated the NAs on the hall were good about assisting residents to the restroom. The interview revealed that any NA could assist each resident, it did not have to be the staff member directly assigned to the resident. After stating to Nurse #1 what had been observed and Resident #1 needed to be changed Nurse #1 stated it was typical for a resident to

alert and oriented residents to ensure their needs were met and they were being treated with dignity and respect. Any areas identified were addressed immediately. This audit was completed on 8/8/23.
The Director of Nursing or Designee completed skin checks on residents who were not alert and oriented to ensure no redness or open areas noted. Any area identified were documented, treatment initiated and physician and family were notified immediately. This audit was completed on 8/8/2023.

To prevent this from happening again the Director of Nursing or designee will educate all staff on residents rights, including treating them with dignity and respect, ensure call lights are answered in a timely manner and resident□s needs are met. New hires will be educated upon hire. Agency will be educated prior to working their scheduled shift. This education was completed on 8/8/8023 and ongoing.

To monitor and maintain compliance the facility will conduct audits on 12 residents weekly for 12 weeks to ensure call bell response is timely, ensuring the resident□s needs are met and residents are being treated with dignity and respect. Results of the audit will be submitted to the Quality Assurance Performance Improvement committee by the Director of Nursing or designee for the next 3 months for further review and recommendations.

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| F 550 | Continued From page 3<br>wait on average 30-40 minutes for incontinence care. He stated the NAs on the hall must just be busy. Nurse #1 was then observed pulling medication from the medication cart and proceeding to the other end of the resident hall.<br><br>An ongoing observation was conducted on 08/08/23 from 10:49 AM until 11:30 AM of NA #1 walking by Resident #1's room but not reentering the room or looking for another NA to provide care for Resident #1. Resident #1 did not place his call light back on.<br><br>On 08/08/23 at 11:30 AM the surveyor went and informed the Director of Nursing (DON) that Resident #1 had notified NA #1 at 10:40 AM he had soiled his brief and had still not been changed by staff. The DON immediately went to NA #2 who was in a room with another resident and told her that Resident #1 needed assistance.<br><br>On 08/08/23 at 11:40 AM an observation was conducted of NA #2 providing incontinent care to Resident #1. While NA #2 was completing incontinent care it was noted Resident #1 had a small loose bowel movement and urinated in the brief. Resident #1's clothing was not soiled nor was the bed pad underneath him. No skin breakdown or redness was observed. Resident #1 was observed smiling, laughing, and joking with NA#2 stating, "she takes care of me". Resident #1 was not observed in any distress.<br><br>An interview conducted on 08/08/23 at 11:48 AM with NA #2 revealed NA#1 had never notified her that Resident #1 needed assistance. She stated she was assisting another resident with a shower and did not know until the Director of Nursing came and told her that the resident needed | F 550 | Date of completion 9/5/2023 | |

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| F 550 | Continued From page 4<br>assistance. She stated she was on the split hall meaning she had several residents from 3 different areas in the building and had to rely on assistance from other NAs to let her know if someone needed care. NA #2 stated it was frustrating when other staff members did not tell her when someone needed to be changed and turned off their call light. She stated she had provided Resident #1 with a shower around 8:30 AM and assisted him back to bed.<br><br>On 08/08/23 at 11:50 AM a follow up interview was conducted with Resident #1. During the interview he stated having to wait on assistance occurred at least once or twice daily in the facility. He stated it made him feel uncomfortable and forgotten about when he had to wait an hour for assistance to be changed. He stated he did not have any burning or pain on his bottom.<br><br>On 08/08/23 at 12:17 PM an interview was conducted with NA #1. During the interview she stated she was in the middle of assisting a resident when she walked by Resident #1's room and saw the call light on. She stated Resident #1 told her he needed to be changed. NA #1 then stated she left the room and walked past NA #2 and told her the resident needed to be changed. NA #1 stated she never went back into Resident #1's room to check and see if he had received assistance because she was caring for her assigned residents. She stated she couldn't remember if NA #2 had acknowledged her or responded when she told her. NA #1 stated she had been told by the Director of Nursing if she saw a call light on to go into the room and turn off the call light regardless of if you provide the care, and to let the assigned staff member know what the resident needed. She stated she would assist | F 550 | | |

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| F 550 | Continued From page 5 | F 550 | | |

other NAs if they needed a two person assist to get a resident out of bed but otherwise, she would let them know if a resident on their assignment needed incontinence care.

On 08/08/23 at 1:30 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she had told facility staff it was okay to turn the call light off as long as the staff member notified the assigned staff member a resident needed assistance. The DON stated NA #1 should have just changed Resident #1 herself when he told her he had soiled his brief. The interview revealed Nurse #1 could have also assisted Resident #1 with incontinence care. The DON stated Resident #1 should never feel like he had been forgotten about or have to wait an hour to be changed.

On 08/08/23 at 1:50 PM an interview was conducted with the Administrator. She stated NA #1 should have provided incontinence care for Resident #1 and not turned off his call light until care had been provided. She stated Resident #1 should not have had to wait an hour on incontinence care and that the facility had just completed an in-service to staff on the days prior discussing the topic.