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 11/03/2023

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

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F 000	INITIAL COMMENTS A complaint investigation survey was on conducted 11/1/23 through 11/3/23. The following intakes were investigated: NC00209229 and NC00209521. One (1) of 8 allegations resulted in a deficiency. Event ID# F20Z11.	F 000		
F 689 SS=G	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 record review, staff interviews, and family interview the facility failed to provide supervision to prevent accidents for a resident with a known history of falls, when Resident #1 was left unattended in the common area and had an unwitnessed fall. This occurred for 1 of 1 resident reviewed for accidents and resulted in the resident going to the hospital to receive 7 stitches to his face (Resident #1). The findings included: Resident #1 was admitted to the facility on 5/18/23 with diagnoses that included Parkinson's disease, lack of coordination, recurrent falls, dementia, and anxiety. A significant change Minimum Data Set for Resident #1 dated 8/15/23 revealed he was	F 689	Lake Park Nursing and Rehabilitation 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 Rehabilitations 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 reserves the right to refute any of the deficiencies	11/27/23

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

Electronically Signed | 11/21/2023

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F 689	Continued From page 1 cognitively impaired. He had a short- and long-term memory problem in addition to inattention and disorganized thinking. Resident #1 required moderate assistance for transfers and mobility. In addition, Resident #1 had 2 falls with no injury since the last MDS assessment. Resident #1's care plan revised on 10/23/23 revealed he was at risk for falls characterized by a history of falls/actual falls and injury, related to Parkinson's disease. The interventions included keep bed in lowest position as tolerated, keep fall mat on the floor when resident is in bed. Toilet resident frequently and as needed, observe and intervene for factors causing falls, keep commonly used items in reach, keep environment free of clutter. Ensure the anti-slip mat and cushion are positioned properly in the wheelchair. Ensure report is given to next staff 1:1 (1 staff member to care for 1 resident that requires extra supervision for safety) every shift, to help prevent falls and impulsiveness. Educate on the importance of being in reach of the resident as he is impulsive. Ensure that constant supervision is in place for safety. Resident #1 also required assistance with Activities of Daily Living/ Personal care. The interventions included provide 1 person guidance and extensive physical assistance with transfers. Provide 1-person extensive physical assistance with bed mobility and ambulate with handheld contact guard assistance. During an interview on 11/3/23 at 8:40 AM NA #1 revealed she was working on 10/21/23, 7a-7p shift as Resident #1's 1:1. During the evening shift change she brought Resident #1 to the common area. NA #1 further revealed NA #2 was going to be the 1:1 for Resident #1 from 7p-7a	F 689	through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. F689 Free of Accident Hazards/ Supervision/ Devices 1. On 10/21/2023 Resident #1 had a fall. Resident was sent to the Emergency Room for further evaluation, due to having a laceration above his eye. 2. On 11/20/2023 and 11/21/2023 Unit Manger #1, Unit Manger #2, Director of Rehab, and the Administrator completed a review of current residents' fall interventions to ensure the interventions are updated. On 11/21/2023 the Director of Nursing and Nurse Managers completed an audit of incident reports from the last 30 days, to ensure appropriate interventions were put in place and the care plan was updated. Any findings were corrected by the Director of Nursing or Unit Manager. 3. On 11/17/2023 Staff Development Coordinator (SDC) initiated education with all nursing staff to include agency nursing staff regarding following fall interventions and where to find them. Education will be completed by 11/24/2023. Employees who have not received this education after 11/24/2023 will be educated prior to working their next shift. Fall prevention and interventions will be included in the orientation process for new hires, agency and contract nursing staff. 4. The Director of Nursing/Assistant	

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F 689	Continued From page 2 shift. When NA #2 arrived, she wanted to put her things away. NA #1 decided to walk with NA #2 to put her things away and give her shift report while they were walking. NA #1 recalled NA #2 asking staff in the common area to watch Resident #1. She also recalled someone answered "ok" when NA #2 said watch Resident #1. NA #1 did not know which staff member said "ok". She stated there were multiple staff members in the common area. After she reported to NA#2 she left the facility. NA #1 explained report is usually given while standing next to Resident #1. She further explained Resident #1 had poor impulse control and often stood up quickly and would fall if someone was not close to him. NA #1 indicated the reason report wasn't given in the presence of Resident #1 was NA #2 wanted to put her things away and there were multiple staff members in the common area to watch Resident #1. During an interview on 11/2/23 at 12:12 PM NA#2 revealed she was assigned as the 1:1 sitter for Resident #1 on 10/21/23 7 PM shift. She stated when she came in for her shift, herself, and NA #1 both went to the clock in room and left Resident #1 sitting in his wheelchair in the common area near the piano. NA #2 stated she was going to clock in and put her things away, she was unsure why NA #1 went to the clock in room. When she returned the resident had fallen. She indicated she thought they asked someone to watch Resident #1 as they walked away, but she could not recall who. She further indicated she was aware Resident #1 needed a staff member close for safety. She stated, "He will jump up quickly, he can move fast". A statement written by Medication Aide (MA) #1 on 10/22/23 revealed on 10/21/23 during the	F 689	Director of Nursing/Nurse Managers will randomly audit six residents per week for 4 weeks to ensure that appropriate fall interventions are in place. Then four residents a week for 2 weeks. The Cardinal Interdisciplinary Fall Audit Tool will be used to monitor. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. The Administrator is responsible for sustained compliance. 5. Alleged date of compliance is 11/27/2023	

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evening shift change she recalled Sitter #1 bringing Resident #1 to the common area near the piano. MA #1 was counting the cart with the oncoming nurse, she did not recall her name, when they heard a loud sound, turned around, and observed Resident #1 on the floor. Other staff members were in the area, and she saw Nurse Aide (NA)#2 walking up the hall.

During an interview on 11/3/23 at 10:40 AM MA #1 revealed she was working on 10/21/23, 7a-7p shift and NA #1 was the 1:1 for Resident #1. During the evening shift change MA #1 was counting the cart with the oncoming nurse. She recalled NA #1 bringing Resident #1 to the common area in his wheelchair. NA #1 told MA #1 she was about to leave. MA #1 also recalled while counting the cart she could hear NA #1 and NA #2 talking in the common area. She then heard NA #2 say she was going to put her things away, watch him. MA #1 was unsure who NA #2 was speaking to, her back was turned, still counting the cart. MA #1 revealed she heard Resident #1 fall, when she saw him, he was on the floor. A nurse and an NA went to help the resident. MA #1 stated she saw NA #2 coming back to the common area and NA #2 said, I can't believe y'all let him fall.

An interview on 11/3/23 at 12:40 PM with NA #7 revealed she was working on 10/21/23 7p-7a shift. She was in the common area at the time of Resident #1's fall, but she was talking to another NA and her back was turned to the resident. She turned around when she heard a noise. Resident #1 was on the floor and had an injury above his right eye. She stated staff was assisting the resident after his fall. NA #7 revealed Resident #1 often tries to get up very quickly, sometimes

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every few seconds. Staff must be right next to him to prevent him from falling. She did not recall anyone asking her to watch Resident #1.

During an interview on 11/3/23 at 10:18 AM NA #4 revealed she was working 10/21/23 and was in the common area when Resident #1 fell. She stated she saw the NAs that were his 1:1's giving report in the common area, then the oncoming NA for Resident #1 went to put her things away. NA #4 explained she was in the common area talking to another NA and their backs were turned to Resident #1, she heard him fall but did not see him fall. When she looked at him, he was on the floor and the nurses in the area went to Resident #1 and began caring for him and treating his injury. NA #4 stated she had never cared for Resident #1 and on that day, no one asked her to watch him, she also did not recall if the NAs asked anyone else to watch him.

A statement written by Nurse #3 on 10/21/23 revealed she did not witness Resident #1's fall. She last observed the resident at 7:00 PM sitting in his wheelchair.

Multiple unsuccessful attempts were made to contact Nurse #3.

A nurse note dated 10/21/23 at 8:05 PM by Nurse #1 read in part: The writer was not present during the incident and was not providing care to Resident #1 on that day. The writer heard a loud noise that came from the common area. Upon arriving to the common area, Resident #1 was observed in the wheelchair with bleeding from the right side of his head. A laceration was noted to the right side of his head. The writer began neuro checks and contacted the provider and the

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resident was sent to the hospital.

A statement written by Nurse #1 on 10/22/23 revealed at the time of Resident #1's fall on 10/21/23 she was in the nurse station area and did not witness the fall. The last time she observed the resident he was seated in the common area with his sitter. She heard a loud noise from the common area. In the common area she observed Resident #1 sitting in his wheelchair with a laceration to the right side of his head. She assisted with his care and sent him to the hospital.

An interview was conducted with Nurse #1 on 11/2/23 at 12:53 PM. Nurse #1 revealed she worked on 10/21/23, 7 AM shift. She was not assigned as the nurse for Resident #1. During the evening shift change around 7PM she was in the nurses' station, preparing to leave the facility when she heard the resident fall. She went to the common area and observed the resident sitting in his wheelchair with blood dripping from the right side of his head. She stated there were multiple staff members in the area, but no one witnessed Resident #1's fall. Nurse #1 stayed and helped staff with the resident. She explained she called the provider; the oncoming nurse, Nurse #3, called the family. After emergency medical services arrived, she left the facility. Nurse #1 explained that NAs should give report in the presence of Resident #1, he needed 1:1 supervision. The NA always needed to be close to him. Nurse #1 indicated Resident #1 could get up from a seated position quickly but was very unsteady on his feet and would fall once in a standing position.

Hospital records for Resident #1 dated 10/21/23

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revealed Resident #1 was brought to the emergency department after an unwitnessed fall from his wheelchair causing a right facial laceration. Resident #1 received 7 stitches to repair the laceration. He also received a scan of his head a cervical spine, that were both negative. Resident #1 was then sent back to the facility.

An observation of Resident #1 was made on 11/1/23 at 1:30 PM. He was in his room seated in his wheelchair slightly reclined. He was awake and dressed, the resident had a healing area with sutures above his right eye. There was a family friend sitting with the resident.

An interview was conducted with Resident #1's family on 11/2/23 at 9:19 AM. Resident #1's family revealed he was admitted to the facility in May 2023 after having some falls at home. He initially received therapy, but he continues to have falls. He tries but cannot stand unassisted. Family further revealed the facility provided a 1:1 sitter for the resident 24/7 to keep the resident safe. The sitter was a facility staff member, usually a nurse aide. The only time there was no 1:1 was when family or friends visited.

During an interview on 11/3/23 at 1:39 PM NA #8 revealed she worked on 10/21/23 7a-7p shift. She did not witness Resident #1 fall; she had already clocked out and left. She stated the last time she saw him he was seated in his wheelchair near the piano in the common area. She further stated his 1:1 NA was with him at that time.

During an interview on 11/2/23 at 11:46 AM Nurse Aide (NA) #3 revealed she worked on 10/21/23 7

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PM shift. She stated she did not witness Resident #1's fall, she had started passing ice to the residents assigned to her.

An interview on 11/3/23 at 10:29 AM with NA #5 revealed she was working on 10/21/23 when Resident #1 fell, but she did not see the fall. She stated she was at the time clock when the fall occurred. As she walked back through the facility, she saw Resident #1 seated in his wheelchair in the common area. She explained he had an injury to his head that the nurses were treating.

During an interview on 11/3/23 at 11:00 AM Nurse #2 revealed she worked on 10/21/23 7p-7a shift. She stated she did not witness Resident #1 fall, she was clocking in. She did hear the fall, and as she entered the common area, she saw Resident #1 was on the floor. Nurse #2 stated Resident #1 was surrounded by multiple staff members that were helping him.

During an interview on 11/3/23 at 12:35 PM NA #6 revealed she worked on 10/21/23 7a-7p shift. NA #6 stated she did not witness Resident #1's fall. She was in the charting room and heard a "boom", she ran to the common area and saw Resident #1 on the floor. She revealed there were many staff in the area assisting the resident. Resident #1 had bleeding from his head. NA #6 explained Resident #1 was quick when he moved, if you were his 1:1, you needed to always sit right next to him.

During an interview with on 11/2/23 at 4:06 PM the Director of Nursing revealed Resident #1 has had multiple falls related to his disease process, he had Parkinson's and was impulsive. The

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facility had put multiple fall interventions in place for the resident including a 1:1 NA. The resident had a 1:1 NA because he would stand up quickly and then fall. Staff needed to be in reach of the resident, he could not be left alone. The DON further revealed on 10/21/23 Resident #1 had a fall in the common area during the 7 PM shift change. NA #1 was assigned as the 1:1 during the 7a-7p shift. Close to shift change Resident #1 was taken to the common area by NA #1. She stated there were staff in the area but not face to face with the resident and he had a fall. The DON indicated NA #1 had left to go home and she was unsure where NA #2 was at the time of the fall. Staff treated Resident #1's injuries and he was sent to the hospital. In the hospital he received sutures and returned to the facility the same night. The DON explained the NAs should report in the presence of Resident #1, "hand off should be a tag in, tag out situation". She indicated if the resident was not left unattended, his fall could have been prevented. The DON stated although there were staff in the area, all staff denied seeing Resident #1 fall, and no staff recalled being asked to watch Resident #1.