

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345541	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Lakeside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13825 Hunton Lane Huntersville, NC 28078	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217</p> <p>Based on observation, record review, and interviews with resident and staff, the facility failed to ensure dependent residents could access the light switch located behind the bed for 1 of 1 resident reviewed for accommodation of needs (Resident #2).</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on [DATE].</p> <p>Review of Resident #2's medical record revealed she had stayed in room [ROOM NUMBER] since 08/16/23.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] coded Resident #2 with a moderately impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet did not occur for Resident #2 during the assessment period.</p> <p>During an observation conducted on 09/23/24 at 3:44 PM, the switch cord for the light fixture on the wall behind Resident #2's bed was approximately 5 feet from the floor and 6-7 feet from the bed. The switch cord was approximately 4 inches in length. Resident #2 was unable to reach the switch cord from the bed if needed.</p> <p>An interview was conducted with Resident #2 on 09/23/24 at 3:45 PM. Resident #2 stated she was bedbound and had been in this room for over a year. She could not recall when the switch cord broke. Resident #2 indicated she could not control the light fixture behind her bed as she could hardly stand up to reach the broken switch cord on the wall. She had to rely on nursing staff to control the light fixture and it was very inconvenient to her. Resident #2 wanted the maintenance staff to fix the switch cord to accommodate her needs as soon as possible.</p> <p>During an interview conducted on 09/23/24 at 3:57 PM, Nurse Aide (NA) #1 stated she noticed the switch cord for the light fixture behind Resident #2's bed was broken about 3 months ago. She notified the Maintenance Manager verbally on the same day. She did not know why it had not been fixed so far.</p> <p>Subsequent observations conducted on 09/24/24 at 11:38 AM revealed the switch cord for the light fixture behind Resident #2's bed remained inaccessible.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint observation conducted with Nurse #1 on 09/24/24 at 11:45 AM, the switch cord for the light fixture behind Resident #2's bed remained inaccessible from her bed. Nurse #1 acknowledged that the switch cord was broken, and it needed to be fixed immediately. She explained she was assigned to work in 700 halls at times and did not notice the switch cord was broken.</p> <p>An interview was conducted with Unit Manager #1 on 09/24/24 at 11:54 AM. She acknowledged that the switch cord for the light fixture behind Resident #2's bed was broken. It needed to be fixed immediately to ensure Resident #2 had full accessibility to the light fixture.</p> <p>During an interview conducted on 09/24/24 at 12:01 PM, the Maintenance Manager stated he walked through the entire facility at least once daily to identify repair needs. He did not notice the switch cord for Resident #2's light fixture behind her bed was broken and stated it was his oversight. In most cases, he depended on the staff to report repair needs by dropping the work orders in the boxes located in both nurse stations and by verbal notifications. He checked the work order boxes at least twice daily to ensure all repair needs were addressed in a timely manner.</p> <p>During an interview conducted on 09/26/24 at 8:56 AM, the Director of Nursing (DON) expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs.</p> <p>An interview was conducted with the Administrator on 09/25/24 at 4:33 PM. She expected nursing staff to pay attention to residents' home and report repair needs to the maintenance department in a timely manner. It was her expectation for all the dependent residents to have full accessibility and control of the light fixture behind the bed all the time.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51140</p> <p>Based on record review, observation and staff interviews the facility failed to follow a physician order to apply a splinting device for 1 of 2 residents (Resident #14) reviewed for range of motion.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on [DATE] with a diagnosis that included contracture to the left hand.</p> <p>Occupational Therapy (OT) discharge summary dated 11/02/2023 indicated recommendations that stated palm guard to left hand 8 hours to facilitate contracture management.</p> <p>On 09/25/2024 at 10:58 AM, an interview with the Director of Rehabilitation revealed on 11/2/2023 Occupational Therapy educated nursing how to don and doff the palm guard to the left hand of Resident #14.</p> <p>A physician order dated 04/04/2024 stated a palm guard should be applied to Resident #14's left hand every day for 8 hours as tolerated.</p> <p>A care plan dated 06/19/2024 revealed Resident #14 had limited physical mobility related to contracture, left-side hemiplegia, and history of stroke. The approaches included first shift Nursing Assistant (NA) to apply left palm guard for wear up to 8 hours as tolerated for contracture management, to monitor skin integrity and to notify nurse of any changes observed.</p> <p>Resident #14's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had moderate cognitive impairment and one upper extremity impairment.</p> <p>Observation of and interview with Resident #14 on 09/23/2024 at 11:08 AM revealed her left hand to be contracted as evidenced by her fingernails touched the palm of her left hand. The left hand was further observed in a tight fixed position. Resident #14 did not have a palm guard to her left hand. At an additional observation at 11:56 AM, the left hand was observed not to have a palm guard. The palm guard was not observed in Resident #14's room. Resident #14 was unable to answer if staff applied the palm guard.</p> <p>Observation of Resident #14 on 09/24/2024 at 9:11 AM revealed her left hand did not have a palm guard. Additional observation on 09/24/2024 at 2:15 PM showed Resident #14 was up in the wheelchair without the palm guard to the left hand.</p> <p>Upon observation on 09/25/2024 at 10:00 am, Resident #14 did not have a left palm guard in place on her left hand when she was lying in bed. At 3:40 PM on 09/25/2024, the resident was up in a wheelchair and was not wearing a left palm guard.</p> <p>During an interview on 09/24/24 at 10:45 AM, Resident #14's Representatives indicated they had not seen the palm guard on Resident #14's left hand for months.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the interview with the Director of Rehabilitation on 09/25/24 at 10:58 AM, she shared a referral for OT was made on 09/18/2024 for self-feeding and increased difficulty with contracture.</p> <p>On 09/25/24 at 11:12 AM, an interview took place with Occupational Therapist #1 who assessed Resident #14 on 09/25/2024. The Occupational Therapist stated the referral had not indicated Resident #14 refused to wear the left palm guard. Occupational Therapist #1 disclosed the palm guard was not on Resident #14 when she entered the room. Occupational Therapist #1 saw the palm guard in a white basket on Resident #14's side table. She stated that the contracture was not worse on 09/25/2024 compared to her 11/02/2023 assessment.</p> <p>Interview with NA #2 on 09/25/2024 at 2:50 PM indicated he was assigned to care for Resident #14 and had never seen Resident #14's left palm guard. NA #2 stated that if he saw a palm guard on the resident that he would ask about it.</p> <p>An interview with Nurse #2 on 09/25/2024 at 11:23 AM revealed NA's were to apply Resident #14's palm guard daily. She further indicated that she had not checked to ensure that NA's applied the palm guard as ordered.</p> <p>Upon interview with the Director of Nursing (DON) on 9/26/2024 at 11:00 AM, the DON revealed the nurse should have visually identified if a resident's contracture device was applied correctly. She further stated Resident #14's palm guard should have been applied according to physician order and OT recommendations.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>36217</p> <p>Based on observations, staff interviews and record reviews, the facility failed to date a bottle of eye medication after it was opened and failed to discard 2 bottle of expired eye medications from the medication cart as specified by manufacturer's guidelines for 2 of 5 medication carts observed during medication storage checks (100 hall and 700 hall medication carts).</p> <p>The findings included:</p> <p>a. The manufacturer's package inserts for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36 to 46 Fahrenheit (F) and protected from light. Once it was opened, Latanoprost could be stored at room temperature up to 77 F for up to six weeks.</p> <p>A medication storage audit was conducted on 09/24/24 at 2:46 PM for the 100 hall medication cart in the presence of Nurse #2. One opened bottle of Latanoprost 0.005% eye drops without an opened date was found in the medication cart at room temperature and available for use.</p> <p>An interview was conducted with Nurse #2 on 09/24/24 at 2:47 PM. She acknowledged that the bottle of Latanoprost eye drops was opened but did not know how long it had been stored in the medication cart. She was unsure how long Latanoprost could be stored under room temperature once it was opened.</p> <p>b. During a medication storage audit conducted on 09/24/24 at 3:01 PM for the 700 hall medication cart in the presence of Nurse #1, two opened bottles of Latanoprost 0.005% with opened date of 08/01/24 and 08/03/24 respectively were found in the medication cart and available for use.</p> <p>An interview was conducted with Nurse #1 on 09/24/24 at 3:01 PM. Nurse #1 stated both bottles of latanoprost should be discarded after they were opened and stored under room temperature for over 30 days. Nurse #1 explained she did not work in 700 hall on regular basis and most of her shifts were day shift. Nurse #1 further stated the eye drop was scheduled to be administered by nurses working night shift.</p> <p>During an interview conducted on 09/24/24 at 3:19 AM, Unit Manager #1 stated all 3 bottles of Latanoprost eye drops needed to be discard. She indicated all the nurses were instructed to check each medication for expiration before administration. In addition, as one of the Unit Managers, she checked each medication cart in her area at least once weekly and stated it was her oversight. She added many nursing staff were still unclear about the storage guidelines for Latanoprost, and they needed to be re-educated as soon as possible.</p> <p>During an interview conducted on 09/26/24 at 8:56 AM, the Director of Nursing (DON) stated it was her expectation for the nurses to remove all the expired medications from the medication cart according to manufacturer's expiration date and date the eye drops once it had been opened.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Administrator on 09/25/24 at 4:33 PM. She expected nurses to date latanoprost eye drops once it was opened and remove all expired medications from the medication carts. It was her expectation for the Unit Managers to check each medication cart at least once weekly to ensure the facility was free of expired medications.</p>