STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Park Rehabilitation and Healthcare Center	**901 Halstead Boulevard , Elizabeth City, North Carolina, 27909**

(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
F0000	INITIAL COMMENTS A complaint investigation was conducted on 10/15/2025. Event ID # 1D9531-H1. The following intake was investigated 2637814. One of the four allegations resulted in a deficiency. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown.	F0000		
F0842 SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F0842		

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 reverse for further 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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F0842 SS = A	Continued from page 1 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F0842		

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F0842 SS = A	Continued from page 2 services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to document a description, actions taken, minor injuries, and notifications after a fall for 1 of 3 sampled residents reviewed for documentation after a fall (Resident #1). Findings included: Resident #1 was admitted to the facility on 8/18/2025 and discharged on 8/22/2025. A review of the medical record of Resident #1 revealed that neurological checks were documented as initiated on 8/22/2025 at 9:30 AM by Nurse #1. There was no documentation in the medical record of Resident #1 of the reason for the initiation of neurological checks on 8/22/2025. An interview was conducted with Nurse #1 on 10/15/2025 at 9:58 AM. Nurse #1 stated he did recall the events of the morning of 8/22/2025 and Resident #1. Nurse #1 began to explain the circumstances, the actions taken, injuries, and notifications made when Resident #1 had a fall on the morning of 8/22/2025. Nurse #1 requested to look in the electronic medical record to recall the accurate details of the fall and Resident #1. Initially Nurse #1 was unable to find any of his documentation regarding the fall Resident #1 had on 8/22/2025 but after several minutes was able to find an internal incident report on which all his documentation was made. Nurse #1 confirmed there was no nursing progress note regarding the fall in the medical record of Resident #1. The Director of Nursing (DON) provided an internal incident report on 10/15/2025 at 12:45 PM. Documentation on the internal incident report dated 8/22/2025 at 9:30 AM detailed the incident description, immediate action taken, minor injuries, and notification of family regarding an unattended/unwitnessed fall sustained by Resident #1. The bottom of the report stated, “Privileged and Confidential – Not part of the medical record – Do not copy.” The DON was interviewed on 10/15/2025 at 12:45 PM at the time of the provision of the internal incident report regarding Resident #1’s fall. The DON explained that the internal incident report was available to all	F0842		

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F0842 SS = A	Continued from page 3 the facility staff with access to the electronic medical record of Resident #1. The DON explained that Nurse #1 failed to click on something to include the description of the fall made in the incident report, into a nursing note. The DON said she would give a copy of the internal incident reports to anyone who requested them despite the label of privileged, confidential, and not a part of the medical record.	F0842		