| C Q424220 SIMULE IN CONCENTER STREET ADDRESS, CITY, STATE, 2IP CODE LAKE PARK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2IP CODE MALE OF PROVIDERS PLAN OF CORRECTION (EACH CORRECTION Y OLLS DENTETING INFORMATION) DEFICIENCY STATE, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION Y OLLS DENTETING INFORMATION) DEFICIENCY OF CORRECTION (EACH CORRECTION Y OLLS DENTETING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION Y OLLS DENTETING INFORMATION) DEFICIENCY F 000 DEFICIENCY F 000 F 000 A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event 1D PUM211. The following intake was investigated: NC00229210. F 686 S/16/ SS=G CFR(s): 483.25(b)(1)(0)(I) S483.25(b)(1) Pressure ulcers. Based on the complemensive assessment of a resident, the facility must ensure that- topressional standards of practice, to prevent pressional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Lake Park Nursing and Rehabilitation Center acknowledpende the right ank | IND PLAN OF | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|-------------|---|---|--------|--|-------------------------------------|
| NAME OF PROVIDER OR SUPPLIER STREETADDRESS, CITY, STATE, 2P CODE LAKE PARK NURSING AND REHABILITATION CENTER STREETADDRESS, CITY, STATE, 2P CODE (MI)D FREEK SUMMARY STATEMENT OF DEPICIENCIES (FACH DEPICENCY MAY BEPRECEDED BY FULL (FACH COMPACED A CITO B HOLLO BE (FACH COMPACED A CITO | 345502 | | B. WING | | - | |
| LAKE PARK NURSING AND REHABILITATION CENTER SIM FAITH CHURCH ROAD INDIAN TRAIL, NC 28079. (MID) TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY ACTION HOULD BE CROSS-REFIRENCED TO THE APPROPRIATE DEFICIENCY) CM F 000 INITIAL COMMENTS F 000 A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. F 000 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=G F 686 5/16/ (843.25(b)(11) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (1) A resident neceives care, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that individual's clinical condition demonstrates that and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of seciedent (Resident #1) reviewed for wound care. Resident #1 (H) reviewed for wound care. Resident #1 (H) reviewed for wound care. Resident #1 (H) was found on 2/19/2025, and a pressure ulcer to the right anike. On 3/18/25 the pressure ulcer to the right anike. On 3/18/25 the pressure ulcer to the righ | NAME OF PF | OVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 04/24/2025 |
| LAKE PARK NURSING AND REHABILITION CENTER NDIAN TRAIL, NC 28079 (M1)0 PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG C PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S PLAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S HAY OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S AND CORRECTION (PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX TAG D PROVIDER'S AND CORRECTION (PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX PRETX TAG D PROVIDER'S AND CORRECTION (PRECULATIONY OR LSC DENTIFYING INFORMATION) D PRETX PRETX PRETX SECONTRACTIONY OF DEFICIENCY PRETX | | | | | | |
| PRETX TAG PRETX REGULATORY OR LSC DENTEYING INFORMATION) PRETX TAG CEAH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE COMING CROSS-REFERENCED TO THE APPROPRIATE F 000 INITIAL COMMENTS F 000 A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. F 000 1 of 5 complaint allegations resulted in deficiency. F 686 Sees CFR(s): 483.25(b)(1)(i)(ii) § 483.25(b)(1) Pressure Ulcers. F 686 Sased on the comprehensive assessment of a resident, the facility must ensure that. F 686 (i) A resident trevely care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Lake Park Nursing and Rehabilitation Center acknowledges receipt of the Statement of Declicencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of resident. The Plan of Correction is submitted as a written allegation of compliance. Lake Pake | LAKE PAR | K NURSING AND REHA | BILITATION CENTER | | | |
| A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers fundes of practice, to promote healing, prevent infection and prevent new ulcers for bot metals of practice, to promote healing, prevent infection and prevent new ulcers for bot metals of practice, to promote healing, prevent infection and prevent new ulcers for bot metals of practice, to promote healing, prevent infection and prevent new ulcers for bot metals of practice, to promote healing, prevent infection and prevent new ulcers for bot metals of practice, to promote nealing, prevent infection and prevent new ulcers for bot metals with a servicenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for sin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #11 developed a stage 3 pressure ulcer to her right thigh which was found on 2/19/2025, and a pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI | |
| 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686 SS=G CFR(s): 483.25(b)(1)(i)(ii) §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that. F 686 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers neecives and evelop pressure ulcers from developing. F fis REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Lake Park Nursing and Rehabilitation Center 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 to maintain compliance with a paticable rules and provisons of quality of care of residents. The Plan of the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable Lake Park Nursing and Rehabilitation Center 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 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 Parke | F 000 | INITIAL COMMENTS | | F 000 | | |
| F 686 Treatment/Svos to Prevent/Heal Pressure Ulcer F 686 5/16/ SS=G CFR(s): 483.25(b)(1)(i)(ii) \$ \$ § 483.25(b) Skin Integrity § 483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident actility must ensure that-professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Lake Park Nursing and Rehabilitation Center 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 to maintain compliance with applicable rules and provisions of quality of area of residents. The Plan of Correction is submitted as a writen allegation of compliance. Lake Pake | | 4/23/2025 to 4/24/202 | 25. Event ID PUM211. The | | | |
| §483.25(b)(1) Pressure ulcers.Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #1 developed a stage 3 pressure ulcer to the right thigh which was found on 2/19/2025, and a pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageableLake Park Nursing and Rehabilitation Center 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 to maintain compliance with a applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Pake | | Treatment/Svcs to Pr | event/Heal Pressure Ulcer | F 686 | | 5/16/25 |
| pressure ulcer. Nursing Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of | | §483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment with professional star promote healing, pre- new ulcers from deve This REQUIREMENT by: Based on record revi Practitioner, Orthoped Physician's interviews monitoring for skin bro immobilizer for 1 of 3 reviewed for wound c a stage 3 pressure ul- was found on 2/19/20 the right ankle. On 3/ the right ankle was as pressure ulcer. | re ulcers. whensive assessment of a hust ensure that- is care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent hdards of practice, to vent infection and prevent eloping. T is not met as evidenced we and staff, Nurse dic Nurse Practitioner, and is the facility failed to provide eakdown under a leg residents (Resident #1) are. Resident #1 developed cer to her right thigh which 125, and a pressure ulcer to (18/25 the pressure ulcer to | | Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent the the summary of findings is factually correct and to maintain compliance wit applicable rules and provisions of qual of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Pake Nursing Rehabilitation Center's respon to the Statement of Deficiencies does | es at th ity nse not |

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.

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | D: 06/03/2025 M APPROVED D. 0938-0391 |
|---|---|---|--------------------|--------------|---|--|---|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | · , | | CONSTRUCTION | COM | E SURVEY PLETED | |
| | | 345502 | B. WING | | | | C / 24/2025 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKE PAF | RK NURSING AND REHA | BILITATION CENTER | | | 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | Continued From page | e 1 | F | 686 | | | |
| | 6/24/2024 and readm 12/13/2024 with diagonal fracture. A Progress Note writt Nurse #3 stated Resi with a right femur fract A significant change I assessment dated 1/ #1 was severely cogne extensive assistance transfers. The assess Resident #1 had a sta An Orthopedic Office which was written by Assistant, stated Resi removed, and an immostilizer should be Resident #1 should co bearing to her right lee A Nurse's Progress N 5:18 pm by Nurse #5 seen by the Orthoped removed and an immostilizer should be Resident #1 should co bearing to her right lee A Nurse's Progress N 5:18 pm by Nurse #5 seen by the Orthoped removed and an immostilizer should be an imposed an imp | en 12/13/2024 at 3:19 pm by dent #1 arrived at the facility cture with a cast in place. Minimum Data Set 11/2025 indicated Resident nitively impaired and required with bed mobility and sment further indicated age 3 pressure ulcer. Visit Note dated 1/15/2025, the Orthopedic Physician's ident #1's cast was nobilizer was placed on her er right, distal femur Visit Note further stated the e worn full-time, and ontinue to be non-weight g. Note written 1/15/2025 at indicated Resident #1 was dist and her cast was obilizer was applied to her The Nurse's Progress Note ident #1 was to keep the and was non-weight bearing remity. | | | Deficiencies nor does it constitute an admission that any deficiency is accur Further, Lake Park Nursing and Rehabilitation Center reserves the rigi refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. Resident #1 was discharged from the facility on 04/08/25. All current residents have the potentia be affected by this deficient practice. 100 % Skin Audits were performed an completed on residents to include immobilizers/splints on 4/29/2025 by Director of Nursing/Designee. No new areas of concerns were identified. We Ulcer Flowsheet were completed on 4/29/2025 for current residents with wounds. No newly identified wounds were identified. On 4/24/25, the Staff Development Coordinator initiated education with th nursing staff to include the licensed nurses, certified nursing assistants, an Medication Aides regarding identifying reporting skin concerns. On 4/24/25, the Staff Development Coordinator initiated education with th nursing staff to include the licensed nurses, certified nursing assistants, an Medication Aides regarding identifying reporting skin concerns. On 4/24/25, the Staff Development Coordinator initiated education with th licensed nurses related to accurate ar timely completion of skin assessments and care of immobilizers as schedule | ht to Il to Id vound e nd g and s d. | |
| | | s written for Resident #1's der the right leg immobilizer | | | The education will be ongoing to inclu new hire and prn nursing staff to inclu | | |

Facility ID: 970828

If continuation sheet Page 2 of 9

| | DF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|--|--|
| | | 245500 | | | С |
| | | 345502 | B. WING | | 04/24/2025 |
| | ROVIDER OR SUPPLIER RK NURSING AND REHA | BILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION |
| F 686 | to be checked for red each shift. Resident #1's Treatm was reviewed for 1/20 documentation found the skin under Reside each shift to check for breakdown. On 2/19/2025 at 5:18 Nurse's Progress Not immobilizer to her rig and she had develop to her right lateral, up her lateral right ankle Note further indicated completed, the hospi Responsible Party wa was notified of the resident #7 ulcer to her right, pos centimeters long by 3 | Iness or skin breakdown Inent Administration Record 025 and there was no for nursing assessments of ent #1's right leg immobilizer or redness or skin a pm Nurse #1wrote a te that stated Resident #1's ht thigh leg was removed ed a stage 3 pressure ulcer oper femur and a red area on . The Nurse's Progress d a skin assessment was ce nurse was notified, the as notified, and the Physician sident's pressure ulcers. .1 pm a Wound Ulcer d by the Director of Nursing, 1 had a stage 3 pressure terior thigh that measured 5 | F 68 | licensed nurses, certified nursing assistants, and medication aides. In not be able to work until the education completed. The Director of Nursing/Designeer complete Skin and Immobilizer/Sp Audit Tool weekly x4 weeks and m x2 months to ensure that skin assessments and immobilizer/ split being checked to prevent skin breat. The Administrator is responsible for plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 m to review audit results to determine and/or follow up if needed. | tion is will lint onthly ints are akdown. or the of |
| | at 1:28 pm she stated the hospital on 12/13 leg due to a femur fra #1 had a cast to her r to the facility and the indicated she was no repair of the right fem she returned to the O the cast was removed placed on her right le | d Resident #1 returned from /2024 with a cast to her right acture. She stated Resident right leg when she returned hospital discharge summary t a candidate for surgical hur fracture. Nurse #1 stated orthopedist on 1/15/2025 and d, and an immobilizer was g that extended from the top kle. Nurse #1 stated she | | | |

If continuation sheet Page 3 of 9

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|-------|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPLI | E CONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING _ | | | PLETED |
| | | 345502 | B. WING | | | | C / 24/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | I | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 0 | |
| | | | | | 3315 FAITH CHURCH ROAD | | |
| | RK NURSING AND REHA | BILITATION CENTER | | 1 | INDIAN TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | Orthopedist Consult a the system for Reside under the immobilizer for any skin breakdow She stated the Orthop had written the orders stated the immobilizer and the staff thought immobilizer and had r skin under the immobi interview with Nurse # she stated Resident # to her right leg on 2/1 Nurse Practitioner #1 off Resident #1's leg a the pressure ulcers to right ankle. Nurse #1 were areas that had b on the immobilizer. N Nurse Practitioner #1 Resident #1's right leg ordered a soft brace to A Physician's Order d Resident #1 should have her right lower extrem right distal femur. The the brace for skin che and night shift. The 2/2025 Treatmen (TAR) for Resident #1 the right lower extrem place to stabilize the p and the immobilizer s check her skin and sk 2/21/2025. | ntering the orders from the and failed to put orders into ent #1's skin to be checked twice daily, on each shift yn under the immobilizer. bedist's Nurse Practitioner s on the consultation that r should be worn at all times they could not open the not checked Resident #1's ilizer. During a follow-up #1 on 4/24/2025 at 12:46 pm #1 was complaining of pain 9/2025 and she asked if she could take the brace and that was when she saw o her upper right thigh and stated the pressure ulcers been against the hard areas lurse #1 stated she asked to assess the wounds on g and she assessed her and | F | 686 | | | |

If continuation sheet Page 4 of 9

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345502 | B. WING | | | | C /24/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 3315 FAITH CHURCH ROAD | | |
| | RK NURSING AND REHA | BILITATION CENTER | | 1 | NDIAN TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | 1:53 pm, completed b Resident #1's stage 3 posterior thigh measu 3.8 centimeters in wid depth, and the wound On 3/6/2025 at 1:54 p Wound Ulcer Flowshee #1's right, posterior the measured 5 centimeter wide, and 0.5 centimeter Ulcer Flowsheet did n improved. Nurse #1 completed a on 3/18/2025 at 8:35 Resident #1's right, po pressure ulcer was m centimeters long, 5.2 centimeters in depth. Flowsheet indicated F thigh stage 3 pressure On 3/18/2025 at 1:46 Flowsheet completed Resident #1 had a rig area that measured 2 centimeters in width, depth. The Wound U indicated the wound to was dried, yellow drait Nurse #6 completed a on 3/24/2025 at 11:45 outer ankle wound co and measured 2 centimeters wide, and 0.1 centimeters | by Nurse #1, indicated a pressure ulcer to her right, irred 5 centimeters in length, ith and .5 centimeters in a was improving. by Nurse #1 completed a bet which indicated Resident igh stage 3 pressure ulcer ers long, 7 centimeters eters deep. The Wound not indicate if the wound had a Wound Ulcer Flowsheet am which indicated osterior thigh stage 3 easured and was 3.2 centimeters wide, and 0.5 The Wound Ulcer Resident #1's right posterior e ulcer was improving. pm a Wound Ulcer by Nurse #1 indicated ht, outer ankle unstageable centimeters in length, 2 and 0.1 centimeters in lcer Flowsheet further bed had eschar and there | F | 686 | | | |

Facility ID: 970828

If continuation sheet Page 5 of 9

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 06/03/2025 MAPPROVED D. 0938-0391 |
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| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ì í | | E CONSTRUCTION | (X3) DATE | |
| | | 345502 | B. WING | | | | C 24/2025 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 3315 FAITH CHURCH ROAD | | |
| | RK NURSING AND REHA | BILITATION CENTER | | I | NDIAN TRAIL, NC 28079 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFI | х | (EACH CORRECTIVE ACTION SHOULD B | E | COMPLETION |
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| | | | | | BEITGENCT | | |
| F 686 | Continued From page | • 5 | F | 686 | | | |
| | 1.0 | | | | | | |
| | | pm the Director of Nursing | | | | | |
| | | JIcer Flowsheet which | | | | | |
| | | 's right, posterior thigh | | | | | |
| | stage 3 pressure ulce | | | | | | |
| | width, and 0.3 centim | ers long, 0.2 centimeters in eters in denth | | | | | |
| | | a Wound Ulcer Flowsheet | | | | | |
| | | m and indicated Resident | | | | | |
| | #1's right, outer ankle | | | | | | |
| | | sured 2.7 centimeters in | | | | | |
| | length, 2 centimeters | | | | | | |
| | centimeters in depth. | | | | | | |
| | | the wound as having 25% | | | | | |
| | - | % eschar tissue, but did not | | | | | |
| | | had improved or declined. | | | | | |
| | A Wound Ulcer Flows | heet completed by Nurse #1 | | | | | |
| | | m indicated Resident #1's | | | | | |
| | right, posterior thigh s | stage 3 pressure ulcer | | | | | |
| | measured 3.3 centime | - | | | | | |
| | | and 1 centimeter in depth | | | | | |
| | and continued to impr | | | | | | |
| | On 4/8/2025 at 1:20 p | ated Resident #1 had no | | | | | |
| | acute distress and the | | | | | | |
| | | sident #1's family requested | | | | | |
| | the resident be sent to | | | | | | |
| | | t #1 was discharged from | | | | | |
| | - | at the Responsible Party's | | | | | |
| | request with hospice | | | | | | |
| | During a phone interv | view with the Responsible | | | | | |
| | Party on 4/24/2025 at | | | | | | |
| | - | st on her right leg when she | | | | | |
| | | pital on 12/13/2024. The | | | | | |
| | | ated Resident #1 had an | | | | | |
| | | appointment on 1/15/2025 | | | | | |
| | and the Orthopedist r | emoved the cast and placed | | | | | |

Facility ID: 970828

If continuation sheet Page 6 of 9

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
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| STATEMENT | | | (X3) DATE COMF | E SURVEY PLETED | | | |
| | | 345502 | B. WING | | | | C /24/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKE PA | RK NURSING AND REHA | BILITATION CENTER | | | 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 686 | an immobilizer on Re Responsible Party sta immobilizer and chec and she had develop thigh and ankle. The nurse at the facility to failed to check Reside immobilizer but she d Nurse's name. An interview was con Practitioner #1 on 4/2 stated she assessed after the pressure ulc upper thigh and right stated the wounds we the immobilizer again was not aware until th found that the nurses immobilizer and chec for any skin breakdow stated there should ha routine checks of the On 4/24/2025 at 3:02 Practitioner was inter stated she did order F be worn at all times b facility's Nursing staff immobilizer should be the skin checked for a breakdown. The Director of Nursin on 4/24/2025 at 2:03 #1 readmitted to the f right femur fracture an right leg. The DON fu | sident #1's right leg. The ated no one opened the ked her skin until 2/19/2025 ed pressure wounds on her Responsible Party stated a Id her the nursing staff had ent #1's skin under the id not remember the ducted with Nurse 4/2025 at 1:18 pm and she Resident #1 on 2/20/2025 ers were found on her right ankle. Nurse Practitioner #1 ere caused by pressure of st Resident #1's leg and she ne pressure wounds were | F | 686 | | | |

Facility ID: 970828

If continuation sheet Page 7 of 9

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOF | ED: 06/03/2025 RM APPROVED IO. 0938-0391 |
|--------------------------|--|--|---------------------|---|-----------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 345502 | B. WING | | 0, | C 4/24/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | I | s | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKE PAF | RK NURSING AND REHA | BILITATION CENTER | | 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 686 | and an immobilizer w right leg. The DON s Resident #1's right le the immobilizer was r 2/21/2025 after the p her right upper femur 2/19/2025. The DON should have assesse the immobilizer on he DON stated no one ru until 2/19/2025 and th stage 3 pressure ulce Resident #1 returned hospital on 12/13/202 care. On 4/24/2025 at 1:46 interviewed by phone Resident #1 having p developed under the The Administrator stato ordered the immobilize would not make an at facility's nursing staff immobilizer to check breakdown. During an interview w 4/23/2025 at 3:14 pm returned to the facility due to a fracture to he The Physician stated the hospital with a ca she was seen for a fo Orthopedist, the Orth immobilizer to her rig for the immobilizer to | tand the cast was removed as placed on Resident #1's tated the order to check g for skin breakdown under not put into place until ressure ulcers were found to and her ankle on I stated the nursing staff d Resident #1's skin under er right leg every shift. The eported the pressure ulcers he areas were assessed as ers. The DON stated to the facility from the 24 with orders for hospice for mythe Administrator was and stated he was aware of ressure ulcers that immobilizer on his right leg. the d the Orthopedist had ter be left in place and he ssumption about whether the should have opened the Resident #1 for skin with the Physician on he stated Resident #1 y with a cast on her right leg er femur on 12/13/2024. Resident #1 returned from st to her right leg and when ollow-up with the | F 686 | | | |

Facility ID: 970828

If continuation sheet Page 8 of 9

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|--------|---|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | STRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345502 | B. WING | | | | C / 24/2025 |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | STREET | TADDRESS, CITY, STATE, ZIP CODE | | |
| LAKE PA | RK NURSING AND REHA | BILITATION CENTER | | | AITH CHURCH ROAD N TRAIL, NC 28079 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 686 | should have opened to Resident #1's skin at stated Resident #1's unavoidable due to he | the immobilizer and checked least daily. The Physician | F | 586 | | | |

If continuation sheet Page 9 of 9