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 04/24/2025

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 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.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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 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 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 pressure ulcer. Findings included:	F 686	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 Pake Nursing Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of	5/16/25

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

Electronically Signed | 05/13/2025

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F 686	Continued From page 1 Resident #1 was initially admitted to the facility on 6/24/2024 and readmitted to the facility on 12/13/2024 with diagnoses of a right femur fracture. A Progress Note written 12/13/2024 at 3:19 pm by Nurse #3 stated Resident #1 arrived at the facility with a right femur fracture with a cast in place. A significant change Minimum Data Set assessment dated 1/11/2025 indicated Resident #1 was severely cognitively impaired and required extensive assistance with bed mobility and transfers. The assessment further indicated Resident #1 had a stage 3 pressure ulcer. An Orthopedic Office Visit Note dated 1/15/2025, which was written by the Orthopedic Physician's Assistant, stated Resident #1's cast was removed, and an immobilizer was placed on her right leg to stabilize her right, distal femur fracture. The Office Visit Note further stated the immobilizer should be worn full-time, and Resident #1 should continue to be non-weight bearing to her right leg. A Nurse's Progress Note written 1/15/2025 at 5:18 pm by Nurse #5 indicated Resident #1 was seen by the Orthopedist and her cast was removed and an immobilizer was applied to her right lower extremity. The Nurse's Progress Note further indicated Resident #1 was to keep the brace on at all times and was non-weight bearing on her right lower extremity. A review of the Physician's Orders for 1/2025 revealed no order was written for Resident #1's skin assessments under the right leg immobilizer	F 686	Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Park Nursing and Rehabilitation Center reserves the right to 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 potential to be affected by this deficient practice. 100 % Skin Audits were performed and completed on residents to include immobilizers/splints on 4/29/2025 by Director of Nursing/Designee. No new areas of concerns were identified. Wound 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 the nursing staff to include the licensed nurses, certified nursing assistants, and Medication Aides regarding identifying and reporting skin concerns. On 4/24/25, the Staff Development Coordinator initiated education with the licensed nurses related to accurate and timely completion of skin assessments and care of immobilizers as scheduled. The education will be ongoing to include new hire and prn nursing staff to include	

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F 686	Continued From page 2 to be checked for redness or skin breakdown each shift. Resident #1's Treatment Administration Record was reviewed for 1/2025 and there was no documentation found for nursing assessments of the skin under Resident #1's right leg immobilizer each shift to check for redness or skin breakdown. On 2/19/2025 at 5:18 pm Nurse #1wrote a Nurse's Progress Note that stated Resident #1's immobilizer to her right thigh leg was removed and she had developed a stage 3 pressure ulcer to her right lateral, upper femur and a red area on her lateral right ankle. The Nurse's Progress Note further indicated a skin assessment was completed, the hospice nurse was notified, the Responsible Party was notified, and the Physician was notified of the resident's pressure ulcers. On 2/19/2025 at 12:41 pm a Wound Ulcer Flowsheet, completed by the Director of Nursing, indicated Resident #1 had a stage 3 pressure ulcer to her right, posterior thigh that measured 5 centimeters long by 3 centimeters wide. During an interview with Nurse #1 on 4/23/2025 at 1:28 pm she stated Resident #1 returned from the hospital on 12/13/2024 with a cast to her right leg due to a femur fracture. She stated Resident #1 had a cast to her right leg when she returned to the facility and the hospital discharge summary indicated she was not a candidate for surgical repair of the right femur fracture. Nurse #1 stated she returned to the Orthopedist on 1/15/2025 and the cast was removed, and an immobilizer was placed on her right leg that extended from the top of her thigh to her ankle. Nurse #1 stated she	F 686	licensed nurses, certified nursing assistants, and medication aides. Staff will not be able to work until the education is completed. The Director of Nursing/Designee will complete Skin and Immobilizer/Splint Audit Tool weekly x4 weeks and monthly x2 months to ensure that skin assessments and immobilizer/ splints are being checked to prevent skin breakdown. The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 months to review audit results to determine trends and/or follow up if needed.	

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was responsible for entering the orders from the Orthopedist Consult and failed to put orders into the system for Resident #1's skin to be checked under the immobilizer twice daily, on each shift for any skin breakdown under the immobilizer. She stated the Orthopedist's Nurse Practitioner had written the orders on the consultation that stated the immobilizer should be worn at all times and the staff thought they could not open the immobilizer and had not checked Resident #1's skin under the immobilizer. During a follow-up interview with Nurse #1 on 4/24/2025 at 12:46 pm she stated Resident #1 was complaining of pain to her right leg on 2/19/2025 and she asked Nurse Practitioner #1 if she could take the brace off Resident #1's leg and that was when she saw the pressure ulcers to her upper right thigh and right ankle. Nurse #1 stated the pressure ulcers were areas that had been against the hard areas on the immobilizer. Nurse #1 stated she asked Nurse Practitioner #1 to assess the wounds on Resident #1's right leg and she assessed her and ordered a soft brace to her right leg.

A Physician's Order dated 2/21/2025 indicated Resident #1 should have an immobilizer brace to her right lower extremity to stabilize fracture to right distal femur. The order stated only remove the brace for skin check and skin care every day and night shift.
The 2/2025 Treatment Administration Record (TAR) for Resident #1 indicated she should have the right lower extremity immobilizer brace in place to stabilize the right distal femur fracture and the immobilizer should only be removed to check her skin and skin care each shift beginning 2/21/2025.

A Wound Ulcer Flowsheet dated 2/26/2025 at

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1:53 pm, completed by Nurse #1, indicated Resident #1's stage 3 pressure ulcer to her right, posterior thigh measured 5 centimeters in length, 3.8 centimeters in width and .5 centimeters in depth, and the wound was improving.

On 3/6/2025 at 1:54 pm Nurse #1 completed a Wound Ulcer Flowsheet which indicated Resident #1's right, posterior thigh stage 3 pressure ulcer measured 5 centimeters long, 7 centimeters wide, and 0.5 centimeters deep. The Wound Ulcer Flowsheet did not indicate if the wound had improved.

Nurse #1 completed a Wound Ulcer Flowsheet on 3/18/2025 at 8:35 am which indicated Resident #1's right, posterior thigh stage 3 pressure ulcer was measured and was 3.2 centimeters long, 5.2 centimeters wide, and 0.5 centimeters in depth. The Wound Ulcer Flowsheet indicated Resident #1's right posterior thigh stage 3 pressure ulcer was improving.

On 3/18/2025 at 1:46 pm a Wound Ulcer Flowsheet completed by Nurse #1 indicated Resident #1 had a right, outer ankle unstageable area that measured 2 centimeters in length, 2 centimeters in width, and 0.1 centimeters in depth. The Wound Ulcer Flowsheet further indicated the wound bed had eschar and there was dried, yellow drainage.

Nurse #6 completed a Wound Ulcer Flowsheet on 3/24/2025 at 11:45 am and Resident #1's right, outer ankle wound continued to be unstageable and measured 2 centimeters long, 2 centimeters wide, and 0.1 centimeter deep. The Wound Ulcer Flowsheet did not indicate if the wound had improved.

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On 3/24/2025 at 5:10 pm the Director of Nursing completed a Wound Ulcer Flowsheet which indicated Resident #1's right, posterior thigh stage 3 pressure ulcer was improving and measured 2 centimeters long, 0.2 centimeters in width, and 0.3 centimeters in depth.
Nurse #1 completed a Wound Ulcer Flowsheet on 4/1/2025 at 2:55 pm and indicated Resident #1's right, outer ankle pressure wound was unstageable and measured 2.7 centimeters in length, 2 centimeters in width, and 0.4 centimeters in depth. The Wound Ulcer Flowsheet described the wound as having 25% slough tissue and 75% eschar tissue, but did not indicate if the wound had improved or declined.

A Wound Ulcer Flowsheet completed by Nurse #1 on 4/2/2025 at 3:27 pm indicated Resident #1's right, posterior thigh stage 3 pressure ulcer measured 3.3 centimeters in length, 6 centimeters in width, and 1 centimeter in depth and continued to improve.
On 4/8/2025 at 1:20 pm Nurse #5 wrote a Progress Note that stated Resident #1 had no acute distress and the hospice nurse had evaluated her but Resident #1's family requested the resident be sent to the emergency department. Resident #1 was discharged from the hospital to home at the Responsible Party's request with hospice services.

During a phone interview with the Responsible Party on 4/24/2025 at 3:46 pm she stated Resident #1had a cast on her right leg when she returned from the hospital on 12/13/2024. The Responsible Party stated Resident #1 had an Orthopedist follow-up appointment on 1/15/2025 and the Orthopedist removed the cast and placed

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an immobilizer on Resident #1's right leg. The Responsible Party stated no one opened the immobilizer and checked her skin until 2/19/2025 and she had developed pressure wounds on her thigh and ankle. The Responsible Party stated a nurse at the facility told her the nursing staff had failed to check Resident #1's skin under the immobilizer but she did not remember the Nurse's name.

An interview was conducted with Nurse Practitioner #1 on 4/24/2025 at 1:18 pm and she stated she assessed Resident #1 on 2/20/2025 after the pressure ulcers were found on her right upper thigh and right ankle. Nurse Practitioner #1 stated the wounds were caused by pressure of the immobilizer against Resident #1's leg and she was not aware until the pressure wounds were found that the nurses were not opening the immobilizer and checking Resident #1's right leg for any skin breakdown. Nurse Practitioner #1 stated there should have been at least daily routine checks of the skin under the immobilizer.

On 4/24/2025 at 3:02 pm the Orthopedist Nurse Practitioner was interviewed by phone, and she stated she did order Resident #1's immobilizer to be worn at all times but she did expect that the facility's Nursing staff would have known that the immobilizer should be opened at least daily and the skin checked for any redness or signs of skin breakdown.

The Director of Nursing (DON) was interviewed on 4/24/2025 at 2:03 pm and she stated Resident #1 readmitted to the facility on 12/13/2024 with a right femur fracture and she had a cast to her right leg. The DON further stated she went to an Orthopedist appointment on 1/15/2025 for a

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follow-up appointment and the cast was removed and an immobilizer was placed on Resident #1's right leg. The DON stated the order to check Resident #1's right leg for skin breakdown under the immobilizer was not put into place until 2/21/2025 after the pressure ulcers were found to her right upper femur and her ankle on 2/19/2025. The DON stated the nursing staff should have assessed Resident #1's skin under the immobilizer on her right leg every shift. The DON stated no one reported the pressure ulcers until 2/19/2025 and the areas were assessed as stage 3 pressure ulcers. The DON stated Resident #1 returned to the facility from the hospital on 12/13/2024 with orders for hospice care.

On 4/24/2025 at 1:46 pm the Administrator was interviewed by phone and stated he was aware of Resident #1 having pressure ulcers that developed under the immobilizer on his right leg. The Administrator stated the Orthopedist had ordered the immobilizer be left in place and he would not make an assumption about whether the facility's nursing staff should have opened the immobilizer to check Resident #1 for skin breakdown.

During an interview with the Physician on 4/23/2025 at 3:14 pm he stated Resident #1 returned to the facility with a cast on her right leg due to a fracture to her femur on 12/13/2024. The Physician stated Resident #1 returned from the hospital with a cast to her right leg and when she was seen for a follow-up with the Orthopedist, the Orthopedist ordered an immobilizer to her right leg and gave instructions for the immobilizer to be left on at all times. The Physician stated the nursing staff at the facility

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F 686	Continued From page 8 should have opened the immobilizer and checked Resident #1's skin at least daily. The Physician stated Resident #1's pressure ulcers were unavoidable due to her poor nutrition, decreased mobility and history of heart failure and dementia.	F 686		