PRINTED: 05/31/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3)	ODATE SURVEY COMPLETED
		345502	B. WING _			C 05/05/2023
	ROVIDER OR SUPPLIER RK NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000		
F 000	investigation survey through 05/05/23. T compliance with the	certification and complaint was conducted on 05/01/23 The facility was found in requirement CFR 483.73, dness. Event ID #6X5S11.	F	000		
	survey was conductor 05/05/23. Event ID# intakes were investion NC00189079, NC00 NC00195144, NC00 NC00199373, NC00	complaint investigation ed from 05/01/23 through £6X5S11. The following gated NC00188619, 1190076, NC00193362, 1197475, NC00198747, 1199673, and NC00200593.				
F 552 SS=D	Right to be Informed CFR(s): 483.10(c)(1 §483.10(c) Planning	and Implementing Care.	F 5	552		6/2/23
	participate in, his or §483.10(c)(1) The rilanguage that he or her total health statuhis or her medical co §483.10(c)(4) The riladvance, of the care of care giver or professions.	e right to be informed of, and her treatment, including: ght to be fully informed in she can understand of his or us, including but not limited to, ondition. ght to be informed, in to be furnished and the type essional that will furnish care.				
	professional, of the i care, of treatment ar treatment options ar	sician or other practitioner or risks and benefits of proposed nd treatment alternatives or nd to choose the alternative or				
ADODATODY	DIDECTOR'S OR DROVIDED	SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F		(X6) DATE

Electronically Signed 05/27/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 05/05/2023
NAME OF PE	ROVIDER OR SUPPLIER	1 2 2 2 2 2		STREET ADDRESS, CITY, STATE, ZIP CODE	03/03/2023
	10 7.12 2.11 0.11 00.11 2.12.11			3315 FAITH CHURCH ROAD	
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 552	Continued From page	e 1	F 55	2	
	option he or she prefi This REQUIREMENT by:	ers. Γ is not met as evidenced			
		ons, record review, staff interview, and Family		F552 483.10	
	-	failed to communicate and		Lake Park Nursing and Rehabilitatio	n l
		n a language the resident		Center acknowledges receipt of the	"
		1 of 1 resident whose		statement of deficiencies and propos	ses
		s Spanish (Resident #29).		this plan of correction to the extent t	
	The findings included	ł:		the summary of findings is factually correct and in order to maintain compliance with applicable rules and	4
	Resident #29 was ad	mitted to the facility on		provisions of quality of care of reside	
		es that included pain in the		The plan of correction is submitted a	
		ind infection related to an		written allegation of compliance.	
	artificial joint.			Lake Park Nursing and Rehabilitatio Center response to this statement of	
	A quarterly Minimum	Data Set (MDS) for		deficiencies does not denote agreen	
	Resident #29 dated 4	1/23/23 revealed Resident		with statement of deficiencies nor do	pes it
	#29 had moderate co	gnitive impairment with no		constitute an admission that any	
	behaviors.			deficiency is accurate. Further, Lake Nursing and Rehabilitation Center	Park
		sident #29 revealed Resident		reserves the right to refute any of the	e l
		o express emotion, listen		deficiencies through informal dispute	•
		n related to a hearing deficit		resolution, formal appeal procedure	
		. The interventions included		and/or any other administrative or le	gal
		ranslator, Resident #29 was		proceeding.	
		ly. Get the resident's			
		king and observe for and		During a recertification and complai	
	report any change in	cognition.		survey (5/1/2023 – 5/4/2023) at Lake	
	An observation was	made of Posidont #20 on		Nursing and Rehabilitation Center, to	
		made of Resident #29 on Resident #29 was sitting on		survey team observed Limited English Proficient (LEP) resident was not pro	
		oking through bags of		an acceptable means of communica	
		29 spoke to me in Spanish		an acceptable means of communica	uon.
		nands. Her roommate said		Address how the facility will con-	rect
	she only spoke Span			the deficiency as it relates to the	
	, -pss -pan			individual.	
	An interview was con	iducted on 5/1/23 at 5:25 PM		Resident #29 continues to reside at	the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C	
NAME OF D	DOVIDED OD SLIDDLIED	343302	B: Wiito	CTDEET ADDRESS CITY STATE ZID COD	•	05/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		3315 FAITH CHURCH ROAD			
		-		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 552	Continued From pag	e 2	F 55	52			
	used google translate #29 usually gestured During an interview of #3 revealed it was di Resident #29 becaus so she called the fan help translate. Nurse never used an interpolation puring an interview of Physician revealed the communicate with reprimary language was speak English. He in interpreter with this runderstood some barevealed the resident	Spanish only. She had not e with the resident. Resident her needs. on 5/1/23 at 5:30 PM Nurse fficult communicating with se she did not speak English, nily if needed and they would e #3 further revealed she has reter for Resident #29.		facility and continues to be LE On 5/23/2023 a Spanish Com Board was ordered and will be implemented upon arrival (5/2 On 5/25/2023 an Interpreter li obtained and posted in Reside room for use. 2. Address how the facility of protect residents in similar sitt On 5/23/2023 a 100% audit wordered by Department Helimited English proficiency (LE resident identified as a LEP reprovided a communication bo arrival from mail order (5/26/2 primary language. On 5/25/2023 a posting of the line and direction was posted identified LEP resident's room	amunication e 26/23). ne was ent #28's will act to uations. vas ads of EP). Any esident was ard upon 3) in his/her e Interpreter in the		
	with NA #4. She rev spoke Spanish and it with her. She report assigned to care for an NA that spoke that Resident #29. She stranslate with Reside app could not captur. She was unsure if the clearly or slowly enough 4 explained she couresident through the	A an interview was conducted ealed Resident #29 only was hard to communicate ed she was not usually Resident #29 but there was at was usually assigned to estated she had tried google ent #29 in the past, but the ewhat the resident said. The eresident did not speak ugh for the app to work. Now all dask a question to the google translate app, but the rethe resident's response.		3. Address what measures into place or systemic change ensure that the problem does On 5/23/2023 the Facility Coneducated facility department hupdated LEP communication interpreter line per state & fed guidelines and facility protoco education included any newly LEP resident to ensure accep communication is in place upon admission. On 5/24/23 the Director of Nunurse Unit Manager (UM), Standard Development Coordinator (SE assigned department head be education to facility/agency st	es made to not recur. esultant heads on the boards and deral il. This admitted table on day of rsing (DON), aff OC), and egan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C (05/2022
NAME OF D	ROVIDER OR SUPPLIER	04002		6.	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	/05/2023
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
LAKE PAF	RK NURSING AND R	EHABILITATION CENTER			315 FAITH CHURCH ROAD		
				II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 552	Continued From p	page 3	F 5	552			
	Resident #29. Sh	ne further explained she relied			communication boards and interpreter	· line	
		gesturing to identify her needs.			are in place per state & federal guideli		
	`	,			and facility protocol. This education w		
	During an intervie	w on 5/4/23 at 8:41 AM the			completed on 05/31/2023.		
	MDS Coordinator	revealed when completing			On 5/24/2023 the SDC added this		
	Resident #29's M	DS assessments they utilized			education to the new hire packet and		
	the NA that spoke	Spanish to help translate so			agency/contract staff packet.		
		ete the assessment. She stated					
		nes when they obtained			Beginning 6/1/2023 the SDC will mail		
	assistance from the family, but they mostly used				education to any Contracted		
	the NA who spoke	e Spanish.			Agency/Facility staff and medication a		
					that has not completed education on I		
		e interview on 5/4/23 at 10:17			communication boards and interpreter		
		's family revealed there was a			per state & federal guidelines and faci	lity	
		spoke Spanish at the facility			protocol.		
		inicate with Resident #29, but it			After 0/4/0000 0tt		
		sistent basis. They thought it			After 6/1/2023, no Contracted		
		e times a week. On the other			Agency/Facility Staff will be allowed to	,	
		It Resident #29 had trouble			work until he/she has completed education on LEP communication boa	rdo	
		er needs due to the language me sometimes they don't			and interpreter line per state & federal		
		hen she needs to go to the			guidelines and facility protocol.		
		Family stated Resident #29			guidelines and facility protocol.		
		ek and kept saying "COVID,			Beginning 6/2/2023 the DON, Treatmo	≥nt	
		mily was told by Resident #29			Nurse, UM, and/or assigned departme		
		ner in a different room and kept			head will complete monitoring of any I		
	•	it she did not understand what			resident to ensure he/she has a		
		e Family stated shortly after the			communication board, and the interpre	eter	
		t #29, a Nurse called and told			line posting is visibly located in the		
		dent tested positive for Covid			resident room per state & federal		
		ved to another room for			guidelines and facility protocol.		
		days later the resident called the			The DON, Treatment Nurse, UM, and	/or	
		old them she needed some			assigned department head will review		
		old room, but the staff did not			identified LEP residents twice weekly		
	understand what	she was saying. The family			months to ensure compliance of LEP		
		t to the facility to gather things			communication boards and interpreter	line	
	from Resident #29	9's old room and asked staff to			are in place per state & federal guideli	nes	
	give it to her. The	e Family stated they visit around			and facility protocol.		
	3 times a week, a	nd they try to meet as many of					

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F 552 Continued From page 4 the residents needs as possible while visiting. TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 552 Beginning 6/9/2023 the DON, and/or		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE			345502	B. WING			_
LAKE PARK NURSING AND REHABILITATION CENTER X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 552 Continued From page 4 The residents needs as possible while visiting. 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		3/03/2023
INDIAN TRAIL, NC 28079 INDIAN TRAIL, NC 28							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 552 Continued From page 4 the residents needs as possible while visiting. PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 552 Beginning 6/9/2023 the DON, and/or	LAKE PAR	RK NURSING AND REH	ABILITATION CENTER				
the residents needs as possible while visiting. Beginning 6/9/2023 the DON, and/or	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	FIX (EACH CORRECTIVE ACTION SHOUL G CROSS-REFERENCED TO THE APPROF		COMPLETION
	F 552	Continued From pag	ue 4	F 5	52		
They did not think Resident #29 could effectively communicate with staff. Staff rarely called the family to translate for Resident #29, they only called if there was a dire need." They further stated the resident had never used an interpreter to their knowledge. During an interview on 5/4/23 at 11:34 AM Nurse #4 revealed she uses the google translate app to ask Resident #29 yes or no questions. She stated she could also ask the NA that spoke Spanish to translate Resident #29's needs and stated that NA work 3 days per week. An interview was conducted with the Director of Rehab on 5/4/23 at 3:05 PM. The Director of Rehab on 5/4/23 at 0:05 PM. The Director of Rehab not passing and was provided a communication board to express her needs. She stated that with the communication board Resident #29 could only express her basic needs such as eat, drink, pain, and bathroom. She further stated there was a Spanish speaking staff member that helped with translation. During an interview on 5/4/23 at 3:37 PM Nurse #5 revealed it was difficult to communicate with Resident #29, she did a lot of pointing to express her needs. She stated she never used any type of interpreter services for Resident #29, and she has never seen her communication board. An interview was conducted with the Unit Manager (UM) on 5/4/23 at 3:44 PM. The UM revealed she used gesturing to communicate with Resident #29. Staff could also use google translate, her communication board or call her	F 552	the residents needs They did not think Ricommunicate with st family to translate fo called if there was a stated the resident h to their knowledge. During an interview of #4 revealed she use ask Resident #29 ye stated she could also Spanish to translate stated that NA work An interview was con Rehab on 5/4/23 at 3 Rehab revealed Res speaking and was pi board to express her the communication to only express her bas pain, and bathroom. a Spanish speaking with translation. During an interview of #5 revealed it was d Resident #29, she di her needs. She stat of interpreter service has never seen her of An interview was con Manager (UM) on 5/ revealed she used g Resident #29. Staff	as possible while visiting. esident #29 could effectively aff. Staff rarely called the r Resident #29, "they only dire need." They further ad never used an interpreter on 5/4/23 at 11:34 AM Nurse s the google translate app to s or no questions. She o ask the NA that spoke Resident #29's needs and 3 days per week. Inducted with the Director of sident #29 was Spanish rovided a communication r needs. She stated that with board Resident #29 could sic needs such as eat, drink, She further stated there was staff member that helped on 5/4/23 at 3:37 PM Nurse ifficult to communicate with id a lot of pointing to express ed she never used any type es for Resident #29, and she communication board. Inducted with the Unit 4/23 at 3:44 PM. The UM esturing to communicate with could also use google	F 5:	Beginning 6/9/2023 the DON assigned department head w findings of the monitoring: LE ensure he/she has a commun board, and the interpreter line visibly located in the resident state & federal guidelines and protocol to the members of the Intradisciplinary Team once w months to ensure compliance for further recommendations up as needed for continued continuing for 3 months, 2023 and/or assigned department is report the findings of the mon resident to ensure he/she has communication board, and the line posting is visibly located resident room per state & fed guidelines and facility protocothe members of QUALITY AS AND IMPROVEMENT PERFORM (QAPI)) Committee meeting. Committee will review this more report for further recommendation to determine the frequency of the continued Q Improvement (QI) monitoring compliance is maintained.	ill report the EP resident to nication e posting is room per d facility ne Cardinal weekly x3 e and review and/or follow compliance. will monitor its at solutions 2023 and 3 the DON, head will nitoring: LEP is a le interpreter in the leral of monthly to SSURANCE ORMANCE The QAPI conitoring ations or nued need and/or uality to ensure	

Facility ID: 970828

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345502	B. WING				C (05/2023
	ROVIDER OR SUPPLIER	ABILITATION CENTER	•	3:	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565 SS=B	Nursing (DON) and the 5/4/23 at 4:41 PM. The 4/29 used gesturing at the expression has been care planning and the facility an interpreter line for aware that it was not know where the phore Consultant stated she facility and participate in resident/Family Groce CFR(s): 483.10(f)(5) (Section 1) The facility must person who is approximated that person who is approximated and participate in resident group or family group and the facility must person who is approximated as a providing assistance requests that result ficity. The facility must resident or family group and the facility must resident or family group and the result for the facility must resident or family group and the facility must resident and family group and the facility must resident and family group and the facility and family and family and family	with Resident #29. Inducted with the Director of the Facility Consultant on the DON revealed Resident and her communication board is. They also utilized an NA The DON stated she had the resident explained she when, but she implemented Resident #29. She was not being used and did not the was. The Facility the was not sure if Resident the interpreter line or if she and for it. The DON stated she had the resident #29. She was not being used and did not the was. The Facility the was not sure if Resident the interpreter line or if she and for it. The pand Response (i)-(iv)(6)(7) Stident has a right to organize ident groups in the facility. The rovide a resident or family with private space; and take the the approval of the group, different guests may attend the provide and the provide and the sinvitation. The provide a designated staff and who is responsible for and responding to written		552 565			6/2/23

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		OMPLETED
		345502	B. WING _			C 05/05/2023
	ROVIDER OR SUPPLIER	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	'	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 565	in the facility. (A) The facility must response and ration (B) This should not facility must implem request of the residual state o	issues of resident care and life It be able to demonstrate their hale for such response. be construed to mean that the hent as recommended every ent or family group. Besident has a right to groups. Besident has a right to have r other resident heet in the facility with the representative(s) of other lifty. Note in the facility with the representative (s) of other lifty. Solution to resident council secutive months. Council Minutes from hear (2/23, 3/1/23, and 4/5/23 was) Solution to complaints of cold be resident council minutes and 4/5/23).	F	F565 483.10 Lake Park Nursing and Rehabil Center acknowledges receipt of statement of deficiencies and put this plan of correction to the existence of the summary of findings is factor correct and in order to maintain compliance with applicable rule provisions of quality of care of a The plan of correction is submit written allegation of compliance Lake Park Nursing and Rehabil Center response to this statement deficiencies does not denote a with statement of deficiencies reconstitute an admission that an deficiency is accurate. Further, Nursing and Rehabilitation Center Response to the statement of deficiencies of the	of the proposes tent that ually n es and residents. tted as a e. litation ent of greement nor does it ny Lake Park or opens	
		on 5/2/23 at 4:22 PM the ndicated her standard practice		reserves the right to refute any deficiencies through informal di		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDI	_		,	С
		345502	B. WING				05/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2023
				33	315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	ABILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 565	Continued From page	e 7	F	565			
		nces voiced in resident			resolution, formal appeal procedure		
	council meetings was				and/or any other administrative or lega	I	
	_	eeting minutes form and			proceeding.		
	_	rator the form. She further					
	•	strator would assign the			During a recertification and complaint		
	grievances to the app	propriate department head,			survey (5/1/2023 – 5/4/2023) at Lake F	'ark	
	and she did not recei	ve resolutions to bring back			Nursing and Rehabilitation Center, the		
		il meetings. Therefore, cold			survey team reviewed Resident Counc	il	
			minutes for 5 months (12/7/22, 1/4/23,				
	_	ent Council meetings as new			2/22/23, 3/1/23, and 4/5/23). This revie		
		less with no resolutions. She			identified no resolution for cold food for		
	_	s implementing a better			resident council member complaint of	cold	
	l .	resolving Resident Council			food (12/7/22, 2/22/23, and 4/5/23).		
	issues.				1 Address how the facility will correct	\ 4	
	During an interview o	on 5/3/22 at 11:20 AM			Address how the facility will correct the deficiency as it relates to the	π	
	_	on 5/3/23 at 11:30 AM ed she was the Resident			individual.		
		nd that the facility did not act			On 5/5/2023 an audit of Resident Cour	ncil	
		to dietary although the			Meeting minutes for 6 months (11/2/23		
	Activities Director sub				12/7/22, 1/4/23, 2/22/23, 3/1/23, and	,	
	Administrator. She fu	rther revealed there had			4/5/23,) was reviewed by the Activities		
	been at least three a	dministrators in the past			Director and Licensed Nursing Home		
		oncerns were brought up in			Administrator (LNHA) to ensure any		
	the Resident Council	meeting and if the Dietary			Resident Council concerns not previou	sly	
	Manager was invited	to the meeting and			resolved, were addressed with an		
	attended, nothing wa	s done to resolve the issue.			acceptable resolution per state & feder	al	
					guidelines and facility protocol pertaini	ng	
	_	on 5/4/23 at 9:03 AM, the			to cold food.		
		M) indicated she had not					
		concerns through Resident			2. Address how the facility will act to		
	Council meetings for	the last few months.			protect residents in similar situations. On 5/5/2023 an audit of Resident Cour	ncil	
	During an interview o	on 5/4/23 at 5:31 PM, the			Meeting minutes for 6 months (11/2/23		
	_	DON) revealed she heard			12/7/22, 1/4/23, 2/22/23, 3/1/23, and	,	
		vere mentioned during			4/5/23,) was reviewed by the Activities		
		t never heard about a			Director and Licensed Nursing Home		
		er revealed she would bring			Administrator (LNHA) to ensure any		
		cerns to dietary if residents			Resident Council concerns not previou	sly	
	brought it to her atter				resolved, were addressed with an	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _		0,	C 5/05/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	00012025	
				3315 FAITH CHURCH ROAD			
LAKE PAI	RK NURSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 565	During a phone into the Social Worker for 2 years and cuneeded) for the factoreceived cold food March 2023, that we Council meetings a Department. She is hot and would sit to shortage, which we During a phone into Administrator #1 in Officer during the facility 3/14/23-to 4 being trained on orany grievances. During a phone into Administrator #2 in Officer during the facility 3/14/23 to 3/10/23 to 3/10/2	rerview on 5/4/23 at 4:05 PM, revealed she worked full time rrently worked PRN (as cility. She further revealed she grievances in February or were voiced during Resident and gave them to Dietary stated food carts left the kitchen on the hallways due to staffing	F	acceptable resolution guidelines and facility to cold food. Any Resconcerns pertaining to reviewed with Resider at the May 2023 Residenceting to ensure any concerns/grievances with an acceptable resimprovement. 3. Address what me into place or systemic ensure that the proble On 5/23/2023 the Face educated the Activity I Administrator on state guidelines and facility Resident Council concerns and acceptable education included resolution in the follow Council meeting. In acconsultant and Facilitied educated the remaining Heads on: Resident Concern/grievance proacceptable resolution. The solution is completed on 05/3 On 5/23/2023 the State Coordinator (SDC) and to the new hire packet agency/contract Deparallowed to work until heads of the completed education of the complete education of the compl	protocol pertaining sident Council cold food will be not Council members dent Council was resident Council passive been resolved solution of reasures will be put a changes made to em does not recurbility Consultant Director and Facility as a federal protocol on: cern/grievance ble resolution. This eviewing the wing Resident didition, the Facility by Administrator and Department council cocess and and artment Head packet. This education will and artment Head will be ne/she has		

PRINTED: 05/31/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 05/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0002		STREET ADDRESS, CITY, STATE, 2		05/05/2023	
				3315 FAITH CHURCH ROAD			
LAKE PAI	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE	DATE		
F 565	Continued From page	e 9	F 5	guidelines and facility p Resident Council conce process and acceptable Beginning 6/2/2023 the Administrator and Activi review Resident Counci Concerns/Grievances to Resident Council Conce have an acceptable res been reviewed in the Ri Meeting to ensure impri Activity Director will mo Council Concerns/Grievances to Resident Council Grievance and acceptable res week after Resident Co months to ensure comp Council concerns/grievances week after Resident Co months to ensure comp Council concerns/grievances and facility p Beginning 6/9/2023 Act report the findings of the Resident Council conce have been resolved with resolution of improvement federal guidelines and for the members of the Car Intradisciplinary Team in months to ensure comp for further recommenda up as needed for contin 4. Indicate how the far performance to make s are sustained. Beginning the month of	ern/grievance e resolution. Facility ity Director will ill o ensure all erns/Grievances colution and have esident Council ovement. The initor Resident vances to ensure ances/Concerns colution within 1 ouncil meeting fo oliance of Reside ances have been table resolution of ances have been table resolution of erns/grievances h an acceptable ent per state & facility protocol to rdinal monthly for 3 oliance and revie ations and/or follo aued compliance acility will monito ure that solution	e e e e e e e e e e e e e e e e e e e	

Facility ID: 970828

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE COMP	SURVEY LETED
							C
		345502	B. WING _			05/	05/2023
	ROVIDER OR SUPPLIER	BILITATION CENTER		3315 FA	T ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	will rep Reside have b resolut federa month ASSU PERF meetir this me recom for cor need a monite mainta		continuing for 3 months Activity Director will report the findings of this monitoring of Resident Council concerns/grievances have been resolved with an acceptable resolution of improvement per state & federal guidelines and facility protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI)) Committee meeting. The QAPI Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued monitoring to ensure compliance is maintained.		6/2/23		
SS=D	out activities of daily services to maintain gersonal and oral hyg. This REQUIREMENT by: Based on observation interviews and staff in provide nail care for 2 and #48) reviewed for (ADL). 1. Resident #5 was a 11/12/21 with diagnostic maintain services.	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ins, record review, resident atterviews the facility failed to 2 of 6 sampled residents (#5 or activities of daily living dmitted to the facility on ses that included anemia, se, dementia, and seizure		Lak Ce sta this the cor cor	ke Park Nursing and Rehabilitation enter acknowledges receipt of the atement of deficiencies and proposes s plan of correction to the extent that e summary of findings is factually rrect and in order to maintain mpliance with applicable rules and ovisions of quality of care of residents e plan of correction is submitted as a	S .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245502	B. WING				C
		345502	B. WING _			05/	05/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
I AKF PAF	K NURSING AND REH	ABILITATION CENTER		33	315 FAITH CHURCH ROAD		
_,		, is in the second seco		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	was cognitively intar assistance with bed toileting, and persor on locomotion and beating. A revised care plan Resident #5 require maintain or achieve functioning by proving hygiene/ grooming (perineum). A continuous observat 10:23 AM to 10:3 fingernails on both redges. The observat arm/ hand was contlong. Resident #5 reto cut his fingernails have nail clippers to A follow-up observarevealed Resident #	n Data Set (MDS) 2/10/23 indicated Resident #5 2t and required extensive mobility, transfers, dressing, hal hygiene; total dependence bathing; supervision with dated 12/23/22 revealed d assistance with ADLs to the highest level of ding total care for personal face, skin, hands, nails, and vation and interview on 5/1/23 0 AM revealed Resident #5's hands were long with jagged tion further revealed his left reacted and fingernails were exported he recently asked staff and was told they did not cut his nails. tion on 5/2/23 at 10 AM 65's fingernails on both hands	F6	577	written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this statement of deficiencies does not denote agreemer with statement of deficiencies nor does constitute an admission that any deficiency is accurate. Further, Lake Pa Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding. During a recertification and complaint survey (5/1/2023 – 5/4/2023) at Lake Pa Nursing and Rehabilitation Center, the survey team observed 2 of 6 residents nail care was not provided. 1. Address how the facility will correct the deficiency as it relates to the individual. Resident #5 continues to reside at the facility. Resident #5's nail care was corrected on 5/4/23.	s it ark I	
	remained long, jagged, and untrimmed. A review of bathing sheets and progress notes in the electronic medical record indicated Resident #5 had no refusals of nail care.				On 5/4/2023 Resident #5's nails were cleaned trimmed and filed to his satisfaction by assigned Certified Nursi Assistant (CNA).		
	Aide (NA) #1 indicate baths during the 7:0 nail care was usuall team, if they weren's She further indicate	on 5/3/23 at 12:17 PM, Nurse sed she normally provided bed 0 pm- 7:00 am shift and that y performed by the shower spulled to work on the floor. d that she had been assigned did not notice that his nails			Resident #480 no longer resides at the facility. 2. Address how the facility will act to protect residents in similar situations. On 5/3/2023 nursing staff were reminded by Director of Nursing (DON) and nurse unit manager (UM) to complete nail car	ed e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 5/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER		- -	STREET ADDRESS, CITY, STATE, ZIP C		5/05/2025	
				3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND RE	HABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From pa	age 12	F 6	77			
F 677	revealed he started 4/28/23 and was as provided ADL care nails needed to be nails because he defurther revealed he recall the nurse's in they needed to che office. 2. Resident #48 was 2/7/22 with diagnost artery disease and A quarterly Minimulassessment dated #48 had moderate required extensive toileting, and person with transfers, dress with eating. A continuous obset at 10:33 AM to 10:5 fingernails on both jagged with dark but Resident #48 furthestaff to cut his finger and had not refuse	needed care. on 5/2/23 at 4:03 PM, NA #2 d working at the facility on essigned to Resident #5. He to Resident #5, noticed his trimmed and did not trim his id not have a nail clipper. He e asked a nurse (unable to ame) for clippers and was told eck with the facility's corporate as admitted to the facility on eses that included coronary respiratory failure.	F 6	for all residents to include of and trimming. On 5/15/2023 a 100% audit completed by the special p Nursing Assistant (CNA) of care to ensure nail care for include cleaning, filing, and completed as each resident his/her satisfaction. 3. Address what measure into place or systemic charmensure that the problem do On 5/23/2023 the Facility Clean educated facility department care completed for resident assigned shower days and needed/requested per resident and facility expectation/proeducation included any new resident requiring/requesting performed by assigned nur 24 hours of admission to the resident satisfaction. On 5/24/23 the Director of nurse Unit Manager (UM), Development Coordinator (assigned nurse, and assigned began education to fastaff on nail care completed on his/her assigned showen needed/requested per residented.	it was roject Certified f resident nail rall residents to d trimming was at allowed to es will be put nges made to nes not recur. Consultant int heads on nail ts on his/her as dent I guidelines, tocol. This wly admitted ng nail care is rsing staff within ne facility per Nursing (DON), Staff (SDC), special ned department acility/agency d for residents r days and as		
	and splitting. A follow-up observe Unit Manager on 5 Resident #5 and #4	ation and interview with the /2/23 at 4:13 PM revealed 48's fingernails on both hands jagged edges as they were		satisfaction, state & federa and facility expectation/pro education included any neversident requiring/requesting performed by assigned nur 24 hours of admission to the	I guidelines, tocol. This wly admitted ng nail care is rsing staff within		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	C 05/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.0002	1 -		REET ADDRESS, CITY, STATE, ZIP CODE	05/	05/2023	
					5 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER			DIAN 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 SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page		F	677	resident satisfaction			
	the fingernails of both their nails were overgondered she nail care during ADL. During an interview w (DON) on 5/4/23 at 5 not aware nail care we care and expected the	The Unit Manager assessed a residents and determined grown and needed care. She expected her staff to provide care. With the Director of Nursing 125 PM revealed she was ras not provided during ADL is task to be routinely med weekly on shower days			resident satisfaction. This education will be completed on 05/31/2023. On 5/24/2023 the SDC added this education to the new hire packet and agency/contract nursing staff packet. Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility staff that has not completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines facility expectation/protocol to include a newly admitted resident requiring/requesting nail care is perform by assigned nursing staff within 24 hou of admission to the facility per resident satisfaction. After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines and facility expectation/proto to include any newly admitted resident requiring/requesting nail care is perform by assigned nursing staff within 24 hou of admission to the facility per resident satisfaction.	med urs ocol med urs		
					Beginning 6/2/2023 the Director of Nursing (DON), nurse Unit Manager (U Staff Development Coordinator (SDC),			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			05/0) 05/2023	
NAME OF P	ROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u> <u>_</u> E	<u> </u>	15/2023	
				3315 FAITH CHURCH ROAD				
LAKE PAI	RK NURSING AND REHA	ABILITATION CENTER		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	I .	(X5) COMPLETION DATE	
F 677	Continued From page	e 14	F	special assigned nurse, and as department head will complete of nail care completed for resid his/her assigned shower days needed/requested per residen satisfaction, state & federal gu and facility expectation/protoco. The DON, Treatment Nurse, Utreatment nurse, special assigned department hereview 6 random resident nails weekly x4 weeks, then 6 random nails weekly x8 weeks to ensu nail care is being as needed/reper resident satisfaction, state guidelines, and facility expectation/protocol. Beginning 6/9/2023 the DON, assigned department head will findings of the monitoring nail completed for residents on his assigned shower days and as needed/requested per residen satisfaction, state & federal gu and facility expectation/protocomembers of the Cardinal Intractem once weekly x3 months compliance and review for furt recommendations and/or follow needed for continued compliance. 4. Indicate how the facility we performance to make sure that are sustained. Beginning the month of June 2 continuing for 3 months, the Dassigned department head will findings of the monitoring: nail completed for residents on his	e monitoridents on and as at aidelines, ol. JM, aned nurse aead will as twice om reside are reside equested at and/or all report the care aidelines, ol to the disciplination to ensure ther wup as nice. Will monito at solution and/on, and/all report the care	e, ent ent int il		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 05/05/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	03/03/2023
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 697 SS=G	CFR(s): 483.25(k) §483.25(k) Pain Man The facility must ensign provided to residents consistent with profess the comprehensive pand the residents' go This REQUIREMENT by: Based on observation interviews, resident in interview the facility for a resident that wa pain. This occurred reviewed for pain. (Fresulted in Resident in the sident	agement. ure that pain management is who require such services, esional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced ns, record review, staff hterview, and Physician	F 69	assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines and facility expectation/protocol month to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will reventis monitoring report for further recommendations or follow up as need for continued compliance to determine need and/or frequency of the continue Quality Improvement (QI) monitoring the ensure compliance is maintained. 5. Date of completion 6/2/2023.	iew ded the d c c c c c c c c c c c c c c c c c c

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 5/05/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/03/2023
				3315 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REH	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	Continued From pag	e 16	F 69	7		
	The findings included Resident #310 was a 4/25/23 with diagnos osteoarthritis of the r replacement, right kr arthritis. A 5-day Minimum Da dated 4/27/23 reveal with no behaviors. F major joint surgery a care. She was expe constantly and was of A baseline care plan on 4/25/23 revealed actual acute and/or of interventions include presence of pain and residents' concerns. as ordered by the ph resident's need for pa appropriately. Docume	admitted to the facility on es that included ight knee, right knee nee pain, and rheumatoid at a Set for Resident #310 ed she was cognitively intact desident #310 had a recent and required skilled nursing riencing pain almost on a pain regimen. If or Resident #310 initiated she had the potential for chronic pain. The d acknowledging the discomfort and listen to the Administer pain medication ysician. Anticipate the ain relief and respond ment/report complaints and pain. Notify the physician if		written allegation of compliance Lake Park Nursing and Rehabili Center response to this stateme deficiencies does not denote ag with statement of deficiencies no constitute an admission that any deficiency is accurate. Further, I Nursing and Rehabilitation Cent reserves the right to refute any of deficiencies through informal dis resolution, formal appeal proced and/or any other administrative proceeding. During a recertification and con survey (5/1/2023 □ 5/4/2023) at Park Nursing and Rehabilitation the survey team reported that pa medication was not given as rec a resident. 1. Address how the facility will the deficiency as it relates to the individual. Resident #310 no longer resides facility.	tation ent of reement or does it / Lake Park er of the spute dure or legal nplaint Lake Center, ain quested to	
	4/26/23 read in part: admitted to the skille hospitalization for rig per orthopedist and scare because she is home, unable to condifficulty with persiste pain. Reviewed for hwill change her analog request to schedule	n progress note dated Resident #310 was being d nursing facility after ht total knee replacement subsequently needing skilled unable to care for herself at sistently bear weight and ent severe breakthrough her ongoing treatment: We gesic regimen per her her oxycodone at 20 mg e does suffer from chronic		2. Address how the facility will protect residents in similar situa On 5/25/2023 a 100% audit was completed by the Licensed Nurs Administrator (LNHA), Director (DON), Nursing Unit Managers assigned department heads throresident and/or staff interviews or pain, pain levels if reported/note and ensuring each resident has pain management in place and timely.	tions. Sing Home of Nursing (UM), and ough of resident ed pain, adequate	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SUR COMPLETE						
		345502	B. WING			C 05/05/2023
NAME OF PE	ROVIDER OR SUPPLIER	1 0.0002	 	STREET ADDRESS, CITY, STATE, ZIP CODE	ı	05/05/2023
IVAIVIL OI II	TOVIDER OR GOLF EIER			3315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		INDIAN TRAIL, NC 28079		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
F 697	Continued From pag	e 17	F 69	97		
	pain issues due to he	er rheumatoid arthritis and		Any resident with reported/note	d pain was	
	recent exacerbation	with ongoing treatment.		corrected through pain manage	ment	
				medication/intervention via pres	sent order	
	Review of Physician	orders for Resident #310		or licensed provider new order	to ensure	
	revealed:			resident has acceptable pain		
		ams(mg), give 2 tablets by urs for chronic pain 4/26/23.		management medication/interv	ention.	
	•	·		3. Address what measures w	ill be put	
	Review of the April 2	023 Medication		into place or systemic changes	made to	
	Administration Recor	d (MAR) for Resident #310		ensure that the problem does n	ot recur.	
		codone 20mg due to be		On 5/23/2023 the Facility Cons	ultant	
	given every 4 hours a	at 8 AM, 12 noon, 4 PM, 8		educated facility department he	ads on	
	PM, 12 midnight and	4 AM.		resident pain, pain levels if repo		
				pain, and ensuring each reside		
	During an interview of			adequate pain management in		
		led she had been in the		resident satisfaction, state & fee	deral	
	_	eek, she was in the facility for		guidelines, and facility		
		ırgery. Resident #310 stated		expectation/protocol. This educ		
		s did not bring her pain		included any newly admitted re		
		e requested it. She reported		requiring/requesting pain mana	-	
		She further stated after she		per resident acceptable pain ac		
		ne physician changed her		pain management medication/ii		
		as needed to scheduled		and state & federal guidelines,	and facility	
		y to ensure she received her		expectation/protocol.	. (DON)	
		Resident #310 revealed on		On 5/24/23 the Director of Nurs		
		23, she could not recall if it		nurse Unit Manager (UM), Staff		
	•	day, she requested her 8 PM		Development Coordinator (SDC	•	
	asked an NA to tell th	esident #310 explained she		special assigned nurse began of		
		ier pain was an eight out of		to facility/agency staff on ensur resident has adequate pain ma	-	
		the NA that the nurse was		in place per resident satisfactio	-	
	-	let her know. Resident #310		federal guidelines, and facility	ii, sidi e (X	
	•	t after about 30 minutes she		expectation/protocol. This educ	ation	
	-	it because the nurse had not		included any newly admitted re		
	_	her call light another time		requiring/requesting pain mana		
		d to come to the nursing		per resident acceptable pain le	-	
	_	0 stated when her friend		state & federal guidelines, and		
		her pain was ten out of ten,		expectation/protocol.		
		charts" and she was in the		This education will be complete	ed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C 05/2022	
NAME OF DE	ROVIDER OR SUPPLIER	040002	1	-	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	05/2023	
NAIVIE OF PI	ROVIDER OR SUPPLIER							
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER			315 FAITH CHURCH ROAD			
				II	NDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	Continued From pag	ge 18	F 6	697				
	bed crying. She ser	nt her friend to find a nurse			05/31/2023.			
		ain medication. Resident			On 5/24/2023 the SDC added this			
		urse brought her pain			education to the new hire packet and			
		0:30 or 10 PM. She thought			agency/contract nursing staff packet.			
	she waited more that				agency/community cam passes			
		not the first time her pain			Beginning 6/1/2023 the SDC will mail			
		Resident #310 stated she			education to any Contracted			
	kept track of the time				Agency/Facility nursing staff that has n	ot		
		·			completed education on ensuring each			
	During an interview	on 5/2/23 at 3:32 PM NA #4			resident has adequate pain manageme	ent		
	revealed she worked	d on the hall where Resident			in place per resident satisfaction, state			
	#310 resided on Sur	nday 4/30/23. She further			federal guidelines, and facility			
		busy on that day and she			expectation/protocol.			
	could not recall if Re	sident #310 asked her to tell						
	the nurse she neede	ed pain medication. NA #4			After 6/1/2023, no Contracted			
	stated that Resident	#310 resided on the rehab			Agency/Facility Staff will be allowed to			
	unit. Residents on t	he rehab unit frequently			work until he/she has completed			
	requested pain med	ication. She further stated			education on ensuring each resident ha			
		ed her to tell the nurse they			adequate pain management in place p	er		
	needed something,	she told the nurse.			resident satisfaction, state & federal			
					guidelines, and facility			
		nducted on 5/3/23 at 12:05			expectation/protocol.			
	,	led she was the nurse on the						
		#310 resided on Sunday			Beginning 6/2/2023 the Director of			
		intil 11 PM. She recalled that			Nursing (DON), nurse Unit Manager (L			
		d for her pain medication			Staff Development Coordinator (SDC),	ĺ		
		ening, but she did not			special assigned nurse, and assigned			
		e it was not due until 8 PM. It			department head will complete monitor			
		e and she was going to pass			of ensuring each resident has adequat			
		g nurse. Nurse #2 explained			pain management in place per residen			
		nging day, they were short			satisfaction, state & federal guidelines,	ĺ		
		ly an NA and herself working			and facility expectation/protocol.	ſ		
		nething residents. She			The DON, Treatment Nurse, UM,	10		
		n 7PM until 7 AM, but she			treatment nurse, special assigned nurs	€,		
	_	I until 7PM on 4/30/23			and/or assigned department head will	 V		
		was short staffed and there over that shift. Nurse #2			review 6 random residents twice weekl	•		
		lowed to give medications an			x4 weeks, then 6 random resident nails weekly x8 weeks to ensure ensuring earth			
		our after and they would be			resident has adequate pain manageme			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		PLETED
		345502	B. WING				C 05/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00/2020
LAKEDAE	DE NUIDEING AND DEUA	DII ITATION CENTED		3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		IN	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 697	Continued From page	e 19	F	697			
F 697	considered on time. requested pain medica and Nurse #2 expects nurse at that time. Sit pass on Resident #3 to the oncoming nurse came, "she was a no covered the shift until find another nurse to revealed she did not the time she notified to show and got her and had forgotten about for pain medication. remembered the resimedication, there was running up to the cart #310 was in her bed medication. Nurse #3 Resident #310's room she was in her bed on around 9:30 PM when She said her medication the facility was frequently was frequently was frequently to the staffing situation the facility was frequently was not medication when she medication was initial changed her medicat times so she would not physician further revenues continuing to have medication as scheduled.	when Resident #310 cation it was around 7 PM ed to be relieved by another the stated she was going to 10's pain medication request the but that nurse never call no show". She 11 PM until the facility could relieve her. Nurse #2 plan to stay until 11 PM, by the facility about the no call night started she was behind out Resident #310's request She stated when she dent needed pain s a friend of Resident #310 telling her that Resident crying and needed her pain 2 stated when she went to in to give the pain medication rying. She thought it was in she gave the medication. ion being late was the result in that day. Nurse #2 stated ently short staffed. In 5/3/23 at 2:50 PM the esident #310 mentioned to receiving her pain requested it. Her pain ty ordered as needed; he ion to be given at scheduled ot have to request it. The ealed he was not aware she we trouble getting her uled. The Physician stated o administer residents their	F	697	in place per resident satisfaction, state federal guidelines, and facility expectation/protocol. This monitoring was be conducted through resident/staff interviews and/or reviewing resident Electronic Medication Administration Record (EMAR). Beginning 6/9/2023 the DON, and/or assigned department head will report the findings of the monitoring: ensuring earesident has adequate pain management in place per resident satisfaction, state federal guidelines, and facility expectation/protocol to the members of the Cardinal Intradisciplinary Team one weekly x3 months to ensure compliance and review for further recommendation and/or follow up as needed for continuous compliance. 4. Indicate how the facility will monitor performance to make sure that solution are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON will report the findings of the monitoring: ensuring each resident has adequate paranagement in place per resident satisfaction, state & federal guidelines, and facility expectation/protocol month to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will revithis monitoring report for further recommendations or follow up as need for continued compliance to determine	will he ach ent & f ce ce is ed or its ns I pain	
	medication was initial changed her medicat times so she would n Physician further revewas continuing to have medication as schedule expected nurses to	lly ordered as needed; he ion to be given at scheduled ot have to request it. The ealed he was not aware she ve trouble getting her uled. The Physician stated o administer residents their			and facility expectation/protocol month to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will revithis monitoring report for further recommendations or follow up as need	iew led the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345502	B. WING _				C 05/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	05/2025
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER			815 FAITH CHURCH ROAD		
				IN	IDIAN TRAIL, NC 28079		I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	÷ 20	F	697			
	Nursing (DON) and the 5/4/23 at 4:41 PM. The expected the resident medications timely an revealed she believed #310 's pain medicat staffing challenges the weekend of 4/29/23, multiple call outs on the have caused Resident behind.	is to receive their pain and as ordered. She further if the issue with Resident ion was related to the e facility experienced on the The DON stated there were that weekend and this may at #310's nurse to get			Quality Improvement (QI) monitoring to ensure compliance is maintained. 5. Date of completion 6/2/2023.	1	
F 725	Sufficient Nursing Sta		F 7	725			6/2/23
SS=G	the appropriate comp provide nursing and resident safety and at practicable physical, resident assessments and considering the nediagnoses of the faciliaccordance with the fat §483.70(e). §483.35(a)(1) The faciliactordance with the fat sufficient numbers types of personnel on nursing care to all resident care plans: (i) Except when waive this section, licensed	Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure stain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care sumber, acuity and sity's resident population in acility assessment required cility must provide services of each of the following a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING		C 05/05/2023	
NAME OF PR	ROVIDER OR SUPPLIER	1 111		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD	03/03/2023	
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 725	Continued From page	e 21	F 72	5		
F /25	§483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation interviews, and reside failed to have sufficie residents received paragraph (Resident #310). The findings included This citation is cross B.) F697: Based on a staff interviews, residinterview the facility of scheduled pain media for a resident that was pain. This occurred reviewed for pain (Resident abeing "off the charts" pain. During an interview of #4 revealed staffing with the days they had two medical unit it was the when they had two to unit, she did a lot of "help the NAs pass ar with feeding, and ans stated she knew all the couldn't get done and	twhen waived under section, the facility must nurse to serve as a charge of duty. I is not met as evidenced ons, record review, staff tent interviews the facility nurse staffing to ensure ain medication when needed. It referenced to F697 Observations, record review, tent interview, and Physician ailed to administer cation after it was requested as experiencing ten out of ten for one of four residents esident #310). This failure #310 experiencing her pain and crying related to her on 5/3/23 at 11:34 AM Nurse was bad at the facility and on the or three NAs on the rrible. She stated on days of three NAs on the medical juggling", she would try to and pick up meal trays, assist swer call lights. She further the baths and showers diresidents didn't always get	F 72	F725 483.35 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and propose this plan of correction to the extent the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of resider The plan of correction is submitted as written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this statement of deficiencies does not denote agreeme with statement of deficiencies nor doe constitute an admission that any deficiency is accurate. Further, Lake I Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or leg proceeding. During a recertification and complain survey (5/1/2023 – 5/4/2023) at Lake Nursing and Rehabilitation Center, the survey team observed there was not adequate nursing staff in the facility to	es at ats. a ent es it Park al	
	changed timely when She explained she tri	they were short staffed. ed to help the best she be a nurse too. Nurse #4		provide 1 of 1 resident pain medication was given timely resulting in reported level of 10 of 10.	n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C
NAME OF D	DOVIDED OD CUDDUED	343302	B: Wiite		TREET ADDRESS SITV STATE ZID SODE	05/	05/2023
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	RK NURSING AND REHA	ABILITATION CENTER			315 FAITH CHURCH ROAD		
				I	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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	e 22	F 7	725			
	revealed because of	the staffing issues she often					
		de care to the residents and			1. Address how the facility will correct	ct .	
		on pass would be late.			the deficiency as it relates to the individual.		
	An interview was con	ducted with Nurse #2 on			A.) The facility continues to hire staff a	and	
	5/3/23 at 12:05 PM.	Nurse #2 revealed staffing			renew contracts of agency licensed		
	was "not so great" at	the facility. She worked on			nursing staff to ensure adequate nursir	ıg	
	the Rehabilitation Uni	it (Rehab unit) and there was			staff is present in the facility to provide		
		nab unit for 23 residents.			adequate care/administer pain		
		o pass medications and			medications to all residents.		
		sidents on the unit that			B.) Resident #310 no longer resides a	ıt	
	•	ions because they've had			the facility.		
		er stated it was a lot for one					
		ealed she worked the past			2. Address how the facility will act to		
		and the facility was very short			protect residents in similar situations.		
		revealed on Sunday 4/30/23 M until 7 PM and she was			A.) On 5/9/2023 the Lake Park Nursin	g	
					and Rehabilitation Center employed a	70	
	_	r on the Rehab unit until 9 e and did not arrive until			Work Force Facilitator (WFF) to manage licensed nursing staff to ensure adequate		
	9AM. Nurse #2 expla				staff is in attendance on a 24-hour bas		
	-	AM she answered call lights			to provide nursing staff to meet all	13	
		t trays. She could not start			resident requests/needs/medication		
		until the NA came in, and			administration on a 24-hour basis as pe	er	
		ne two of them, she helped			state & federal guidelines and facility	J1	
	_	dents. She stated because			expectation/protocol.		
	_	ed, she was behind on her			Any reported staff shortage will be		
	-	nd it was difficult to get			immediately corrected by calling other		
	caught up.	3			licensed staff to work to cover the		
					licensed nursing staff shortage.		
	During an interview o	n 5/3/23 at 3:49 PM the			B.) On 5/25/2023 a 100% audit was		
	Scheduler revealed th	he facility was cutting back a			completed by the Licensed Nursing Ho	me	
		so staffing was a little more			Administrator (LNHA), Director of Nurs	-	
		vere currently hiring facility			(DON), Nursing Unit Managers (UM), a	and	
		iring staff was not an issue,			assigned department heads through		
		ne facility would hire a NA,			resident and/or staff interviews of resid		
	_	w shifts and then not return.			pain, pain levels if reported/noted pain,		
		I she was aware that the			and ensuring each resident has adequ		
	_	fed the weekend of 4/29/23. I a NA walk out and the two			pain management in place and is giver timely. This audit included the facility	1	

PRINTED: 05/31/2023 FORM APPROVED OMB NO. 0938-0391

		COME	E SURVEY PLETED				
		345502	B. WING _			1	C / 05/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				3	315 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER		II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 725	Continued From pag	ge 23	F 7	725			
F 725	remaining NAs had a She further stated the for the NAs to provid were four NAs on the have up to 20 resides shift. The Schedule was short staffed, shifty to get staff to concalled schedule pop vacancies, they offer and she would call a staff they could send enough staff, she, and (DON) would help of DON and Unit Mana 4/30/23 to help when the word and there were about with that number of two nurses and two it was only herself and explained she would trays and call lights a her medication pass meds". A telephone interview Administrator #1 on revealed when she we experiencing staffing getting worse. She in the she was a staff they could be she would tray and call lights a her medication pass meds".	and something residents each. That was too many residents are for. Even when there are Medical Unit, they could ants and that was a lot for day or explained when the facility he would make phone calls to me in. She also used an apposition where staff can see ared bonuses for extra shifts, agencies to see if they had at. If they could not get and the Director of Nursing and the Unit. She stated the ager came in on Sunday and the facility was short staffed. The sworking on the rehab unit at 25 residents. She stated aresidents they should have the NAs. On that day she stated and the NA. Nurse #5 I help the NA with residents, and it slowed her down with the was conducted with 5/4/23 at 12:44 PM. She was at the facility, they were go challenges and it was stated the facility was cutting	F 7	725	being staff adequately to ensure all resident requests/needs/medication administration are being met on a 24-h basis as per state & federal guidelines and facility expectation/protocol. Any resident with reported/noted pain of corrected through pain management medication/intervention via present or or licensed provider new order to ensure resident has acceptable pain management medication/intervention. 3. Address what measures will be purint place or systemic changes made to ensure that the problem does not recure the problem does not recure that the problem does not recure the problem does not re	was ler re it o c. ant nent ur	
	staff. When they hir they would cut an ac Administrator #1 rev 4/29/23 the facility w	staff as they hired facility ed a facility staff member, gency staff member. ealed on the weekend of vas very short staffed and on came in to help, but they			education to the new hire packet and agency/contract nursing staff packet. B.) On 5/23/2023 the Facility Consultated educated facility department heads on resident pain, pain levels if reported/no		

Facility ID: 970828

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	C 05/2023
	ROVIDER OR SUPPLIER			33	TREET ADDRESS, CITY, STATE, ZIP CODE 315 FAITH CHURCH ROAD NDIAN TRAIL, NC 28079	1 03/	03/2023
(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 SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Consultant on 5/4/23 staffing was an issue increase their staff. The mouth, advertising, a stated they recently high shown up for orientatic better, they continued facility was short staff offered hourly incention.	with the DON and the Facility at 4:41 PM DON revealed and the facility was trying to They had been using word of and offering bonuses. She nired 11 but only had four ion. Until the staffing was at to use agency. If the fed, they called around, and wes for extra shifts. The buraged staff to make the g situation until it gets better.	F	725	pain, and ensuring each resident has adequate pain management in place president satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resider requests/needs/medication administrat per state & federal guidelines, and facil expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervent and state & federal guidelines, and facil expectation/protocol. On 5/24/23 the Director of Nursing (DC nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency staff on ensuring resident pain, pain levels if reported/no pain, and ensuring each resident has adequate pain management in place president satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administrat per state & federal guidelines, and facil expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervent and state & federal guidelines, and facil expectation/protocol. This education will be completed on 05/31/2023. On 5/24/2023 the SDC added this education to the new hire packet and	nt ion lity e tion ility DN), on ted er nt ion lity e tion	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _				05/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	03/2023
LAKE DAI	NA NUIDOINO AND DEUA	DILITATION CENTED		33	15 FAITH CHURCH ROAD		
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	÷ 25	F 7	725	agency/contract nursing staff packet. Beginning 6/1/2023 the SDC will mail education to any Contracted Agency/Facility nursing staff that has n completed education on ensuring resid pain, pain levels if reported/noted pain, and ensuring each resident has adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administrate per state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting pain management per resident acceptable pain acceptable pain management medication/intervent and state & federal guidelines, and facility expectation/protocol. After 6/1/2023, no Contracted Agency/Facility Staff will be allowed to work until he/she has completed education on ensuring resident pain, and ensuring acceptable pain adequate pain management in place per resident satisfaction and ensuring the facility has adequate nursing staff is present in the facility to meet all resident requests/needs/medication administrate per state & federal guidelines, and facility to meet all resident requests/needs/medication administrate per state & federal guidelines, and facility requests/needs/medication administrate per state & federal guidelines, and facility requests/needs/medication administrate per state & federal guidelines, and facility requests/needs/medication administrate per state & federal guidelines, and facility requested and resident requiring/requesting pain management per resident acceptable pain acceptable	ent ate t s ion iity e ain ring s ion iity	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			OATE SURVEY OMPLETED
		345502	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 PREFIX TAG F 725 Bey Full PREFIX TAG F 725 Beginning 5/24/2023 the Directe Nursing (DON), nurse Unit Man Staff Development Coordinator special assigned nurse, and Wf complete monitoring of ensuring pain, pain levels if reported/note and ensuring each resident has pain management in place per is satisfaction and ensuring the fa adequate nursing staff is preser facility to meet all resident requests/needs/medication adm per state & federal guidelines, a expectation/protocol. This educ included any newly admitted res expectation/protocol. The Administrator, DON, UM, a will review staffing grid daily to adequate nursing staff is preser facility to meet all resident requests/needs/medication adm per state & federal guidelines, a expectation/protocol. The Administrator, DON, UM, a will review staffing grid daily to adequate nursing staff is preser facility to meet all resident requests/needs/medication adm per state & federal guidelines, a expectation/protocol. This educ included any newly admitted res	С		
		345502	B. WING _			05/05/2023
NAME OF P	ROVIDER OR SUPPLIER			, , ,		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
F 725	Continued From page	÷ 26	F 7.	pain management medication/interand state & federal guidelines, and expectation/protocol. Beginning 5/24/2023 the Director of Nursing (DON), nurse Unit Manag Staff Development Coordinator (S special assigned nurse, and WFF complete monitoring of ensuring repain, pain levels if reported/noted and ensuring each resident has ac pain management in place per ressatisfaction and ensuring the facility adequate nursing staff is present in facility to meet all resident requests/needs/medication adminiper state & federal guidelines, and expectation/protocol. This education included any newly admitted residing requiring/requesting pain management medication/interand state & federal guidelines, and expectation/protocol. The Administrator, DON, UM, and, will review staffing grid daily to ensadequate nursing staff is present in	of er (UM), DC), will esident coain, lequate ident cy has not the stration facility on ent ment otable evention decility on the stration facility on the stration facility on ent ment otable evention dent ment otable evention dent ment otable evention	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345502	B. WING		C 05/05/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	05/05/2023
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F 725	Continued From page	e 27	F 72	Beginning 5/24/2023 the Administration DON, and/or WFF will report the firm of the monitoring: ensuring adequation nursing staff is present in the facility meet all resident requests/needs/medication administ per state & federal guidelines, and expectation/protocol. This education included any newly admitted resident requiring/requesting pain management medication/inter and state & federal guidelines, and expectation/protocol. to the members of the Cardinal Intradisciplinary Team daily (Monda Friday {weekends will be reported of Friday}) x3 months to ensure compand review for further recommendation and/or follow up as needed for concompliance. 4. Indicate how the facility will management medication administration of the monitoring and performance to make sure that solution are sustained. Beginning the month of June 2023 continuing for 3 months, the DON at WFF will report the findings of the monitoring: adequate nursing staff present in the facility to meet all resident acceptable pain acceptable pain management medication administration and state & federal guidelines, and expectation/protocol. This education included any newly admitted resident equiring/requesting pain management medication/inter and state & federal guidelines, and expectation/protocol.	andings ate by to stration facility on ent nent otable evention I facility ay — on oliance ations tinued onitor its utions and and/or is sident stration facility on ent nent otable evention

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345502	B. WING			C 05/05/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, 2 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ZIP CODE	05/05/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		
F 725	Continued From pag	e 28	F7	monthly to the member ASSURANCE AND IMF PERFORMANCE (QAF meeting. The QAPI Corthis monitoring report for recommendations or for continued compliant need and/or frequency Quality Improvement (Censure compliance is multiple). Date of completion	PROVEMENT PI) Committee mmittee will revie or further llow up as neede ce to determine of of the continued QI) monitoring to naintained.	ed the

STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION 3	(X3) DA	ATE SURVEY OMPLETED
		345502	B. WING			C 05/05/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		3010012020
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	e 29	F 72	25		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
		345502	B. WING			C 05/05/2023
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	· · · · · ·	33,00,2020
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AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345502	B. WING _			C 05/05/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	<u> </u>	03/03/2023
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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X	3) DATE SURVEY COMPLETED
		345502	B. WING _			C 05/05/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/03/2023
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		3315 FAITH CHURCH ROAD		
			INDIAN TRAIL, NC 28079			
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/03/2023	
				3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	ODE	00/00	5/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
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NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 35 STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE F 725 Continued From page 35 F 725	STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/03/2023	
I VKE DVE	RK NURSING AND REHA	RII ITATION CENTER		3315 FAITH CHURCH ROAD			
LAKE PAR	KK NOKSING AND KEHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
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	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079				
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AND DUAN OF CODDECTION DENTIFICATION NUMBER.			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/05/2023	
I AKF PAR	RK NURSING AND REHA	BII ITATION CENTER		3315 FAITH CHURCH ROAD			
LAKE I A	TO TO THE THE	DIETIATION GENTER		INDIAN TRAIL, NC 28079			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
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F 725	Continued From page	e 46	F 72				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		G 05/05/2023 STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079				
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F 725	Continued From page	ge 47	F 7	25				

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	F 725	Continued From page	ge 48	F 72	5				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079				
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345502	B. WING			C 05/05/2023
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		03/03/2023
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 725	Continued From pag	ge 50	F 72	25		
	The findings include	d:				
	This citation is cross	referenced to F697				
	interviews, resident interview the facility scheduled pain med for a resident that w pain. This occurred reviewed for pain (R resulted in Resident	servations, record review, staff interview, and Physician failed to administer lication after it was requested as experiencing ten out of ten d for one of four residents tesident #310). This failure #310 experiencing her pain and crying related to her				
	#4 revealed staffing the days they had two on the medical unit days when there we medical unit, she did try to help the NAs passist with feeding, further stated she kn couldn't get done ar changed timely whe She explained she to could, but she had to revealed because on helped the NAs proving the medical unit.	on 5/3/23 at 11:34 AM Nurse was bad at the facility and on wo or three Nurse Aides (NA) at was terrible. She stated on the two to three NAs on the dialot of "juggling", she would bass and pick up meal trays, and answer call lights. She new all the baths and showers and residents didn't always get in they were short staffed. They were short staffed. They were short staffed to help the best she to be a nurse too. Nurse #4 of the staffing issues she often wide care to the residents and tion pass would be late.				
	5/3/23 at 12:05 PM. was "not so great" a the Rehabilitation U one nurse on the Re	nducted with Nurse #2 on Nurse #2 revealed staffing It the facility. She worked on nit (Rehab unit) and there was whab unit for 23 residents. It to pass medications and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	33/03/2023
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 725	needed pain med surgeries. She fu nurse. Nurse #2 weekend of 4/29/staffed. She furth she worked from the only staff mer AM. The NA was 9AM. Nurse #2 e between 7 AM an and passed breal her medication pabecause it was ju turn and change it they were short s medication passed caught up. During an intervie Scheduler reveal little on agency stof a struggle. The staff. She indicate but retention was they would work a The Scheduler st facility was short. The Scheduler ex short staffed, she to get staff to con called schedule p vacancies, they of	of residents on the unit that lications because they've had urther stated it was a lot for one revealed she worked the past 23 and the facility was very short her revealed on Sunday 4/30/23 7 AM until 7 PM and she was imber on the Rehab unit until 9 is late and did not arrive until explained on that morning and 9 AM she answered call lights of ast trays. She could not start ass until the NA came in, and st the two of them, she helped residents. She stated because taffed, she was behind on her as and it was difficult to get aw on 5/3/23 at 3:49 PM the ed the facility was cutting back a taff, so staffing was a little more ey were currently hiring facility ed hiring staff was not an issue, The facility would hire a NA, a few shifts and then not return, ated she was aware that the staffed the weekend of 4/29/23. Aplained when the facility was a would make phone calls to try ne in. She also used an app out of the control of t	F 7	725		
	and she would ca staff they could so enough staff, she (DON) would help DON and Unit Ma	and the Director of Nursing on the unit. She stated the anager came in on Sunday hen the facility was short staffed.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			1	05/2023
	ROVIDER OR SUPPLIER	BILITATION CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 815 FAITH CHURCH ROAD IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	e 52	F	725			
	#5 revealed she was and there were about with that number of retwo nurses and two Nit was only herself an explained she would trays and call lights a her medication passemeds". A telephone interview Administrator #1 on Strevealed when she wexperiencing staffing getting worse. She some of the agency staff. When they hire they would cut an agradministrator #1 reve 4/29/23 the facility was Sunday 4/30/23 she were still short. During an interview we Consultant on 5/4/23	help the NA with residents, and it slowed her down with ses. "It makes me behind with was conducted with 6/4/23 at 12:44 PM. She has at the facility, they were challenges and it was tated the facility was cutting staff as they hired facility at a facility staff member, ealed on the weekend of has very short staffed and on came in to help, but they with the DON and the Facility at 4:41 PM DON revealed					
	staffing was an issue increase their staff. mouth, advertising, a stated they recently high shown up for orientat better, they continued facility was short staff offered hourly incention DON stated she encountered their staff.	and the facility was trying to They had been using word of nd offering bonuses. She nired 11 but only four had ion. Until the staffing was do to use agency. If the fed, they called around, and wes for extra shifts. The buraged staff to make the gosituation until it gets better.					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	05/05/2023	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 761 F 761 SS=E	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In according feeder and laws, the fact biologicals in locked temperature controls personnel to have accessive storage of controlled the Comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed quantity stored is minute to the package drug distributed and the Comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the package drug distributed and the comprehensive IC Control Act of 1976 a abuse, except when the comprehensive IC Control Act of 1976 a abuse, except when the comprehensive IC Control Act of 1976 a abuse, except when the comprehensive IC Control Act of 1976 a abuse, except when the comprehensive IC Control Act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse, except when the control act of 1976 a abuse,	of Drugs and Biologicals as used in the facility must be with currently accepted as, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and dility must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit atton systems in which the simal and a missing dose can in, staff interviews and accility failed to remove	F 76	11		
	opened eye medicati	on for 4 of 6 medications g medication storage checks 00 hall, and 700 hall).		statement of deficiencies and proporthis plan of correction to the extent the summary of findings is factually correct and in order to maintain compliance with applicable rules ar	that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING		I	С	
	100 (1050 00 01 100) (50		B. WING _		•	05/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
LAKE PA	RK NURSING AND R	EHABILITATION CENTER		3315 FAITH CHURCH ROAD			
				INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 761	Continued From p	page 54	F 7				
	Latanoprost eye of should be stored to 46° F and prote Latanoprost could up to 77° F up to a. A medication sto 05/02/23 at 3:18 F cart in the present Latanoprost 0.000 01/20/23 was four ready to be used. from the pharmace During an intervieus:28 PM, Nurse # expired a year fro 01/11/24. She did Latanoprost eye of the pharmace of the	torage audit was conducted on PM for the 600-hall medication ce of Nurse #1. One bottle of 5% eye drop opened on nd in the medication cart and The eye drop was dispensed		provisions of quality of care The plan of correction is sub- written allegation of complia Lake Park Nursing and Reh Center response to this state deficiencies does not denote with statement of deficiencies constitute an admission that deficiency is accurate. Furth Nursing and Rehabilitation of reserves the right to refute a deficiencies through informat resolution, formal appeal pro- and/or any other administrat proceeding. During a recertification and survey (5/1/2023	omitted as a noce. abilitation ement of e agreement es nor does it any user, Lake Park Center any of the al dispute ocedure tive or legal complaint 3) at Lake tition Center, xpired and		
	b. During a medic on 05/02/23 at 3:4 presence of Medi of Latanoprost 0.0 date was found in to be used. The la would be expired An interview was PM. MA #1 explaid 400-hall medication acknowledged that when it was open	ration storage check conducted 17 PM for 400-hall in the cation Aide (MA) #1, one bottle 205% eye drop without opening the medication cart and ready abel indicated the eye drop 6 weeks after it was opened. conducted on 05/02/23 at 3:54 ned she had not worked with on cart for long time. She at the eye drop should be dated ed and discarded after 6 weeks. Olain why the eye drop was not		1. Address how the facility the deficiency as it relates to individual. On 5/2/2023 an audit of all r carts was conducted by the nursing (DON) and nurse Ur (UM). Any noted expired an undated medications were r replaced from these medica accordance to manufacturer and facility protocol. 2. Address how the facility protect residents in similar s On 5/2/2023 an audit of all r carts was conducted by DO	nedication Director of nit Manager nd/or opened emoved and tion carts in substitutions will act to ituations. medication		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING				C
NAME OF D	DOVIDED OD SUDDUED	343302	1 2:		TREET ADDRESS CITY STATE ZID CODE	05/	05/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKE PAR	K NURSING AND RE	HABILITATION CENTER			315 FAITH CHURCH ROAD		
				II	NDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From pa	age 55	F	761			
	2. Review of manu	ıfacturer's package insert for			Any noted expired and/or open undated	d	
		and Admelog indicated			medications were removed and replace		
	_	ould be stored in refrigerator at			from these medication carts in		
	•	expiration and kept away from			accordance with manufacturer□s		
		nt. Once these insulins were			guidelines and facility protocol.		
	opened, it could be	e stored at room temperature					
		frigerated up to 28 days.			3. Address what measures will be pu	t	
					into place or systemic changes made to	o	
	a. A subsequent m	nedication storage audit was			ensure that the problem does not recur	·.	
	conducted on 05/0	2/23 at 4:59 PM for the			On 5/2/2023 the Director of Nursing		
	200-hall medicatio	n cart in the presence of Nurse			(DON), nurse Unit Manager (UM), Staf	f	
	#2. One vial of Lar	ntus 100 unit/milliliter (ml)			Development Coordinator (SDC), and		
	insulin opened on	03/27/23 and one vial of			special assigned nurse began education	n	
	Novolog 100 unit/r	nl insulin opened on 03/01/23			to facility/agency nurses and medicatio	n	
	were found in the	medication cart under room			aides on removing and replacing as		
	temperature and re	eady to be used.			indicated, expired and/or opened unda		
					medications and dating medications wh		
		v conducted on 05/02/23 at			the medication is opened in accordanc	е	
		2 explained one of the nurses			with manufacturer□s guidelines and		
		might have opened another			facility protocol. This education will be		
		tten to discard the expired one			completed on 05/31/2023.		
		cart. She stated both insulins			On 5/22/2023 the SDC added this		
		ed after they were opened and			education to the new hire packet and		
	stored under room	temperature for 28 days.			agency/contract nurse and medication		
					aide packet.		
		orage check was conducted on			Beginning 6/1/2023 the SDC will mail	ĺ	
		M for the 700-hall medication			education to any Contracted		
		e of Nurse #3. One vial of			Agency/Facility nurse and medication a	aide	
		ml insulin opened on 03/31/23			that has not completed education of		
		nedication cart under room			removing and replacing as indicated,		
	temperature and re	eady to be used.			expired and/or opened undated		
	Am imtermiter				medications and dating medications wh		
		conducted on 05/02/23 at 5:28			the medication is opened in accordanc	е	
		ed she was not the only nurse			with manufacturer □s guidelines and	ĺ	
		dication cart. It was hard for her			facility protocol.	ĺ	
		e expiration date of insulin if			After 6/1/2023, no Contracted	ĺ	
		ot do their part. She			Agency/Facility Nursing Staff will be	ĺ	
	•	t the insulin should be			allowed to work until he/she has		
	uiscarded after it n	ad been opened and stored in			completed education on removing and		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345502	B. WING			l	05/2023
	ROVIDER OR SUPPLIER	ABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			50.2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Nursing (DON) on 05 stated nurses and M. their respective medi medications at least expectation for the fa expired medication a according to manufacturing an interview v 05/04/23 at 4:38 PM, staff to follow facility's	r 28 days. Inducted with the Director of 6/02/23 at 5:54 PM. She As were instructed to check cation cart for expired once every night. It was her incility to remain free of nd store all medications cturer's guidelines. With the Administrator on the expected all the nursing is policy and procedure for and store all medications	F	761	replacing as indicated, expired and/or opened undated medications and datin medications when the medication is opened in accordance with manufacturer squidelines and facility protocol. Beginning 5/2/2023 the DON, Treatme Nurse, UM, and/or assigned special project nurse will complete monitoring each medication cart to ensure compliance of removing and replacing indicated, expired and/or opened undated medications and dating medications with manufacturer squidelines and facility protocol. The DON, Treatment Nurse, UC, and/or assigned special project nurse will review each facility medication cart once weekly x3 monthstensure compliance of removing and replacing as indicated, expired and/or opened undated medications and datin medications when the medication is opened in accordance with manufacturer squidelines and facility protocol. Beginning 6/9/2023 the DON, Treatmen Nurse, UM, and/or assigned special project nurse will report the findings of monitoring: removing and replacing as indicated, expired and/or opened undated medications and facility protocol. Beginning 6-9/2023 the DON, Treatmen Nurse, UM, and/or assigned special project nurse will report the findings of monitoring: removing and replacing as indicated, expired and/or opened undated medications and dating medications with medication is opened in accordance with medication is opened in accordance with manufacturer squidelines and facility protocol to the members of the Cardinal Intradisciplinary Team once weekly x3 months to ensure compliance weekly x3 months to ensure compliance	nt of as ted nen e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			l	C 05/2023
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 761	Continued From page	÷ 57	F7	761	and review for further recommendation and/or follow up as needed for continue compliance. 4. Indicate how the facility will monitor performance to make sure that solution are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON will report the findings of the monitoring: removing and replacing as indicated, expired and/or opened undated medications and dating medications with emedication is opened in accordance with manufacturer suidelines and facility protocol monthly to of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The QAPI Committee will revithis monitoring report for further recommendations or follow up as need for continued compliance to determine need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.	ed or its ns nen e ew ed the	
F 867 SS=D	monitoring. A facility must establication policies and procedure collections systems, adverse event monitorial procedure.	e)(g)(2)(i)(ii) eedback, data systems and sh and implement written	F	367	5. Date of completion 6/2/2023.		6/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345502	B. WING _		0:	C 5/05/2023	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		770072020	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	systems to obtain an from direct care staff resident representation information will be used are high risk, high voopportunities for impossible systems to identify, conformation from all donot limited to the facing 483.70(e) and including the used to development, monitodevelopment, monitodevelopment, monitodevelopment, monitodevelopment, monitodevelopment, including the method systematically identification and track performance implementing those and track performance.	maintenance of effective d use of feedback and input on the staff, residents, and wes, including how such sed to identify problems that lume, or problem-prone, and rovement. maintenance of effective collect, and use data and departments, including but lity assessment required at ding how such information op and monitor performance of development, monitoring, formance indicators, ology and frequency for such wring, and evaluation. adverse event monitoring, so by which the facility will y, report, track, investigate, a and information relating to be facility, including how the lata to develop activities to ents. systematic analysis and cility must take actions e improvement and, after actions, measure its success,	F8	967			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 05/05/2023	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZII 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	P CODE	00.00.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	determine underlying impacting larger syste (ii) How they will deve will be designed to ef level to prevent qualit safety problems; and (iii) How the facility w of its performance imensure that improven §483.75(e) Program §483.75(e) (1) The factor performance improve high-risk, high-volumic consider the incidence of problems in those outcomes, resident stresident choice, and §483.75(e)(2) Performactivities must track in resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As partimprovement activitied distinct performance number and frequency conducted by the fact and complexity of the	cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems ty of care, quality of life, or ill monitor the effectiveness provement activities to nents are sustained. activities. cility must set priorities for its ement activities that focus on e, or problem-prone areas; i.e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement medical errors and adverse yze their causes, and a actions and mechanisms and learning throughout the stof their performance is, the facility must conduct improvement projects. The ey of improvement projects illity must reflect the scope of facility's services and	F	367			
	avaliable resources, a	as reflected in the facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	345502	B. WING		C 05/05/2023	
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079		
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
collection and analysis (c) and (d) of this section §483.75(g) Quality ass §483.75(g)(2) The qual assurance committee regoverning body, or destructioning as a govern activities, including imperogram required under (e) of this section. The (ii) Develop and implementation to correct identificii) Regularly review are data collected under the resulting from drug regestavailable data to make This REQUIREMENT by: Based on observations record review, the facilic Performance Improvem failed to maintain implementation to correct identification of the intervention control of the intervention control of the intervention of the intervention control of the intervention	at §483.70(e). must include at least focuses on high risk or dentified through the data described in paragraphs on. essment and assurance. lity assessment and reports to the facility's signated person(s) ning body regarding its elementation of the QAPI er paragraphs (a) through committee must: ment appropriate plans of fied quality deficiencies; and analyze data, including the QAPI program and data imen reviews, and act on improvements. is not met as evidenced s, staff interviews and ity's Quality Assurance and then (QAPI) committee the emented procedures and the for Activities of Daily or Dependent Residents, are during the complaint 2/21/22, and on the and complaint investigation continued failure of the real surveys of recording facility's inability to	F 86	F867 483.75 Lake Park Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and propose this plan of correction to the extent th the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of resider The plan of correction is submitted as written allegation of compliance. Lake Park Nursing and Rehabilitation Center response to this statement of	es at nts.	

AND PLAN OF CORRECTION IDENTIFICATION NUMB		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 05/05/2023		
NAME OF PROVIDER OR SUPPLIER				ST	FREET ADDRESS, CITY, STATE, ZIP CODE	05	0/05/2023	
LAKE PARK NURSING AND REHABILITATION CENTER					115 FAITH CHURCH ROAD			
					IDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMPLETION			
F 867 Continued From pag		e 61	F 8	367				
	Findings included:				deficiencies does not denote agreeme	nt		
This tag is cross re		renced to:			with statement of deficiencies nor does constitute an admission that any deficiency is accurate. Further, Lake P	s it		
	F 677: Based on obs	ervations, record review,			Nursing and Rehabilitation Center			
	resident interviews ar	nd staff interviews the facility			reserves the right to refute any of the			
	failed to provide nail	care for 2 of 6 sampled			deficiencies through informal dispute			
		8) reviewed for Activities of			resolution, formal appeal procedure			
	Daily Living (ADL).			and/or any other administrative or lega proceeding.	l			
	During the complaint investigation survey of							
	2/21/22 the facility failed to provide incontinence				During a recertification and complaint)l.		
	care to a resident causing the resident to soak through a brief, pad and onto bed linen for 1 of 3				survey (5/1/2023 – 5/4/2023) at Lake F			
	residents reviewed for				Nursing and Rehabilitation Center, the survey team observed facility's Quality			
	residents reviewed it	of ADL care.			Assurance and Performance			
	During a phone inter	view on 5/4/23 at 1:14 PM,			Improvement (QAPI)committee failed t	0		
		ed she was unaware that the			maintain implemented procedures and			
		iciency related to ADL care			monitor the interventions for Activities			
	_	tigation survey in March			Daily Living Care Provided for Depend			
	-	#1 stated that during the time			Residents, which were put into place			
		rator, she facilitated QAPI			during the complaint investigation surv	ey		
		ded all the department			of2/21/22, and on the current	-		
	managers, the Nurse	Consultant and Physician.			recertification and complaint investigat	investigation		
	She stated during the	ese meetings the agenda			survey of 5/5/23. The continued failure			
		related to agency nursing			the facility during two federal surveys of	ıf		
		tient care and that agency			record showed a pattern of the facility's	3		
		l re-education. Monitoring			inability to sustain an effective QAPI			
	included room rounds				program.			
		lated to patient care. Any						
		uring the room rounds were			Address how the facility will correct	at .		
		inistrator stated that she			the deficiency as it relates to the			
		concerns related to ADL care aff not providing patient care.			individual. Resident #5 continues to reside at the			
					facility. Resident #5's nail care was			
		Nurse Consultant on 5/4/23			corrected on 5/4/23.			
		she attributed continued			On 5/4/2023 Resident #5's nails were			
		are to a lack of Director of			cleaned trimmed and filed to his	ina		
	ivursing (DON) overs	ight resulting from repeated			satisfaction by assigned Certified Nurs	лg		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED C 05/05/2023	
	345502 B. WING						
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	03/2023
					815 FAITH CHURCH ROAD		
LAKE PAF	RK NURSING AND REHA	BILITATION CENTER		IN	IDIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	F 867 Continued From page 62 DON turnover in the last year. The Nurse Consultant stated the lack of DON oversight attributed to a lack of management of nursing care and implementation of policies and procedures.		F8	367	Assistant (CNA). Resident #480 no longer resides at the facility. 2. Address how the facility will act to protect residents in similar situations. On 5/3/2023 nursing staff were reminded.	ed	
					by Director of Nursing (DON) and nursular unit manager (UM) to complete nail cale for all residents to include cleaning, filing and trimming. On 5/15/2023 a 100% audit was completed by the special project Certific Nursing Assistant (CNA) of resident nate are to ensure nail care for all residents include cleaning, filing, and trimming we completed as each resident allowed to his/her satisfaction.	re ng, ied il s to	
					3. Address what measures will be purinto place or systemic changes made to ensure that the problem does not recur On 5/23/2023 the Facility Consultant educated facility department heads on care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol. This education included any newly admitted resident requiring/requesting nail care performed by assigned nursing staff wi 24 hours of admission to the facility per resident satisfaction. On 5/24/23 the Director of Nursing (DC nurse Unit Manager (UM), Staff Development Coordinator (SDC), speciassigned nurse, and assigned department.	o nail r is thin r DN),	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345502 B. WING			C 05/05/2023				
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	CODE	1 00/0	0/2020	
				3315 FAITH CHURCH ROAD				
LAKE PAI	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA	HOULD BE COMPLETION		
F 867	Continued From page	÷ 63	F8	head began education to fa staff on nail care completed on his/her assigned showed needed/requested per residuation, state & federal and facility expectation/proveducation included any new resident requiring/requesting performed by assigned nur 24 hours of admission to the resident satisfaction. This education will be comedos/31/2023. On 5/24/2023 the SDC addeducation to the new hire pagency/contract nursing staff that here is the state of t	d for residen er days and a dent al guidelines, otocol. This why admitted ng nail care i rsing staff with the facility per upleted on ded this packet and the facility as not all care in his/her all guidelines a dent all guidelines a dent all guidelines are is performitation and per resident atted a allowed to pleted npleted for ned shower ested per	and any med		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 03/	03/2023	
				3315 FAITH CHURCH ROAD				
LAKE PAR	RK NURSING AND REHA	BILITATION CENTER		INDIAN TRAIL, NC 28079				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BI THE APPROPRIA	SHOULD BE COMPLETION		
F 867	Continued From page	e 64	F8	guidelines and facility expeto include any newly admitted include any newly admitted passigned nursing staff work of admission to the facility pastisfaction. Beginning 6/2/2023 the Dirn Nursing (DON), nurse United Staff Development Coordinated special assigned nurse, and department head will comport of nail care completed for remaining the properties of the Cardinal facility expectation/proording the properties of the Cardinal Interest of th	ted resident are is perform vithin 24 hour per resident ector of Manager (Unator (SDC), dassigned elete monitor esidents on ays and as dent guidelines, tocol. e, UM, esigned nurs and mails twice endom reside d/requested exate & federal ex	ned lirs IM), ing e, ent ent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345502 B. WING			C 05/05/2023				
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	05/	05/2023	
					15 FAITH CHURCH ROAD			
LAKE PAR	RK NURSING AND REH	ABILITATION CENTER			DIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 867	Continued From page	ge 65	F8	367	needed for continued compliance. 4. Indicate how the facility will monitor performance to make sure that solution are sustained. Beginning the month of June 2023 and continuing for 3 months, the DON, and assigned department head will report the findings of the monitoring: nail care completed for residents on his/her assigned shower days and as needed/requested per resident satisfaction, state & federal guidelines, and facility expectation/protocol monthly to the members of QUALITY ASSURANCE AND IMPROVEMENT PERFORMANCE (QAPI) Committee meeting. The Facility Consultant/Corporate Clinical Director and/or Regional Vice President of Operations will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings, to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director review the minutes, and the Performan Improvement Plans once a month for 3 months. The QAPI Committee will review this monitoring report for further recommendations or follow up as need for continued compliance to determine need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.	dy dy dy dy de de de de de de		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	(X3) DATE SURVEY COMPLETED	
						С	
		345502	B. WING _		0:	5/05/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAVEDAD	RK NURSING AND REHA	ADII ITATION CENTED		3315 FAITH CHURCH ROAD			
LANE PAR	KK NUKSING AND KENA	ABILITATION CENTER		INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	