PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391

A complaint investigation survey was conducted 4723/2025 (b) Skin Integrity \$483.25(b)(t) Pressure ulcers and on the complements assessment of a resident, the facility must ensure that: (i) A resident twith prossure ulcers under on the resident with professional standards of practice, to prevent pressure ulcers unders the rindividual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with professional standards of practice, to prevent new ulcers from developing. This REQUIREMENT, the not make the residence of the right thing was found on 21/912/025, and a pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer. Findings included: SIRRER ADDRESS, CITY, SIXTE, ZIP CODE 3315 FAUTH CHURCH ROAD NIDIAN TRAIL, NO 28079 Beach CHURCH CARGO NIDIAN TRAIL, NO 28079 FROM TO CRESS, CITY, SIXTE, ZIP CODE 3315 FAUTH CHURCH ROAD NIDIAN TRAIL, NO 28079 Beach CHURCH CARGO NIDIAN TRAIL, NO 28079 FROM TO CRESS, CITY, SIXTE, ZIP CODE 3315 FAUTH CHURCH ROAD NIDIAN TRAIL, NO 28079 FROM TICH CHURCH ROAD NIDIAN TRAIL, NO 28079 FROM NIDIAN TRAIL, NO 28079 FROM THE ACCH CORRECTION FROM DULL BY PREPAIR TO COMES, REFERENCED TO THE PROPOGRAM. FROM TH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X	(X3) DATE SURVEY COMPLETED	
INAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER (MA 10) (MA 10) REGILATORY OR LSC IDEMTIFYING INFORMATION) F 000 INITIAL COMMENTS A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUNI211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFK(s): 483.25(b)(1)(1)(0) \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable, and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This RECUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitione	345502			B. WING _			C 04/24/2025
FREETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) \$483.25(b)(3) Kin Integrity \$433.25(b)(1)(iii)(iii) \$483.25(b)(3) Frestwer ulcers. Based on the comprehensive assessment of a resident, the facility mate insure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident receives care, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #1 developed a stage 3 pressure ulcer to the right ankle on 3/18/25 the pressure ulcer to the right ankle and 3/18/25 the pressure ulcer to the right ankle and 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer. Endown of the present content of the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Pake Nursing Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies do			ABILITATION CENTER	•	3315 FAITH CHURCH ROAD	PCODE	
A complaint investigation survey was conducted 4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #1 developed a stage 3 pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer. Findings included:	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETION
4/23/2025 to 4/24/2025. Event ID PUM211. The following intake was investigated: NC00229210. 1 of 5 complaint allegations resulted in deficiency. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) \$483.25(b) Skin Integrity \$483.25(b) Skin Integrity \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers unders and does not develop pressure ulcers unders that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1 developed a stage 3 pressure ulcer to her right thigh which was found on 2/19/2025, and a pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer. F 686 5/16/25 F 686 5/16/25 F 686 5/16/25 F 686 5/16/25	F 000	INITIAL COMMENTS	3	FC	000		
F 686 SS=G CFR(s): 483.25(b) (1)(ii)(ii) §483.25(b) Skin Integrity §483.25(b) (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #1 developed a stage 3 pressure ulcer to her right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer. F 686 S168 S169 S168 S16625 S168 S16625 S168 S16625 S169		4/23/2025 to 4/24/20	25. Event ID PUM211. The				
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APODATORY DIRECTOR'S OR DROVIDED/SURDI IED DEDRECENTATIVE'S SIGNATURE		§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Orthopedic Nurse Practitioner, and Physician's interviews the facility failed to provide monitoring for skin breakdown under a leg immobilizer for 1 of 3 residents (Resident #1) reviewed for wound care. Resident #1 developed a stage 3 pressure ulcer to her right thigh which was found on 2/19/2025, and a pressure ulcer to the right ankle. On 3/18/25 the pressure ulcer to the right ankle was assessed as an unstageable pressure ulcer.			Center acknowledges resistatement of Deficiencies this Plan of Correction to the summary of findings correct and to maintain applicable rules and provof care of residents. The Correction is submitted a allegation of compliance. Nursing Rehabilitation Coto the Statement of Deficience.	ceipt of the s and proposes the extent that is factually compliance with visions of quality e Plan of as a written Lake Pake enter's response siencies does not	
	ABOBATORY	-	CLIDDLIED DEDDECENTATIVEIC CLORATURE	-	TITLE		(X6) DATE

Electronically Signed 05/13/2025

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
				С			
		345502	B. WING _			04/	24/2025
	ROVIDER OR SUPPLIER	ABILITATION CENTER		33 ⁻	REET ADDRESS, CITY, STATE, ZIP CODE 15 FAITH CHURCH ROAD DIAN TRAIL, NC 28079		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 686	6/24/2024 and readn 12/13/2024 with diag fracture. A Progress Note writh Nurse #3 stated Reswith a right femur france assessment dated 1/2 #1 was severely cogextensive assistance transfers. The assess Resident #1 had a standard fracture assistant, stated Resremoved, and an immoright leg to stabilize fracture. The Office immobilizer should bearing to her right leg to stabilize fracture. The Office immobilizer should bearing to her right leg to stabilizer fracture. The Office immobilizer should bearing to her right leg to stabilizer fracture. The Office immobilizer should bearing to her right leg to stabilizer fracture. The Office immobilizer should bearing to her right leg to stabilizer fracture. The Office immobilizer should bearing to her right leg to stabilizer fracture.	fally admitted to the facility on inited to the facility on innoses of a right femur. Iten 12/13/2024 at 3:19 pm by ident #1 arrived at the facility cture with a cast in place. Minimum Data Set //11/2025 indicated Resident initively impaired and required with bed mobility and sament further indicated rage 3 pressure ulcer. It Visit Note dated 1/15/2025, withe Orthopedic Physician's sident #1's cast was mobilizer was placed on her ner right, distal femur Visit Note further stated the e worn full-time, and continue to be non-weight reg. Note written 1/15/2025 at 5 indicated Resident #1 was dist and her cast was nobilizer was applied to her in The Nurse's Progress Note sident #1 was to keep the and was non-weight bearing	F	686	Deficiencies nor does it constitute an admission that any deficiency is accura Further, Lake Park Nursing and Rehabilitation Center reserves the right refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. Resident #1 was discharged from the facility on 04/08/25. All current residents have the potential be affected by this deficient practice. 100 % Skin Audits were performed and completed on residents to include immobilizers/splints on 4/29/2025 by Director of Nursing/Designee. No new areas of concerns were identified. Wo Ulcer Flowsheet were completed on 4/29/2025 for current residents with wounds. No newly identified wounds were identified. On 4/24/25, the Staff Development Coordinator initiated education with the nursing staff to include the licensed nurses, certified nursing assistants, and Medication Aides regarding identifying reporting skin concerns. On 4/24/25, the Staff Development Coordinator initiated education with the licensed nurses related to accurate and timely completion of skin assessments and care of immobilizers as scheduled.	to to und	
	revealed no order wa	as written for Resident #1's ader the right leg immobilizer			The education will be ongoing to includ new hire and prn nursing staff to includ		

` '		L' (IDENTIFICATION LINE DED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345502	B. WING			C 04/24/2025		
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			(X5)	
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 686	to be checked for red each shift. Resident #1's Treatm was reviewed for 1/20 documentation found the skin under Reside each shift to check fo breakdown. On 2/19/2025 at 5:18 Nurse's Progress Not immobilizer to her right and she had develope to her right lateral, up her lateral right ankle Note further indicated completed, the hospid Responsible Party was notified of the result of the right lateral right, post centimeters long by 3 During an interview was 1:28 pm she stated the hospital on 12/13/leg due to a femur fra #1 had a cast to her right fem she returned to the Othe cast was removed placed on her right legister.	ent Administration Record 025 and there was no for nursing assessments of ent #1's right leg immobilizer r redness or skin pm Nurse #1wrote a that stated Resident #1's thigh leg was removed ed a stage 3 pressure ulcer per femur and a red area on The Nurse's Progress a skin assessment was the nurse was notified, the as notified, and the Physician sident's pressure ulcers. 1 pm a Wound Ulcer d by the Director of Nursing, had a stage 3 pressure terior thigh that measured 5	F	686	licensed nurses, certified nursing assistants, and medication aides. Staff not be able to work until the education completed. The Director of Nursing/Designee will complete Skin and Immobilizer/Splint Audit Tool weekly x4 weeks and month x2 months to ensure that skin assessments and immobilizer/ splints a being checked to prevent skin breakdo The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 month to review audit results to determine treat and/or follow up if needed.	is are wn.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345502	B. WING _			C 4/24/2025	
NAME OF PROVIDER OR SUPPLIER LAKE PARK NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079	•	7/2-1/2023	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Orthopedist Cons the system for Re under the immobil for any skin break She stated the Or had written the or stated the immobil and the staff though immobilizer and his skin under the immobilizer and his skin under the immobilizer and his stated Residen to her right leg on Nurse Practitioner off Resident #1's Inthe pressure ulcer right ankle. Nurse were areas that he on the immobilize Nurse Practitioner Resident #1's right ordered a soft brack A Physician's Ord Resident #1 shou her right lower extright distal femur. The brace for skin and night shift. The 2/2025 Treatmost (TAR) for Resident the right lower extraplace to stabilize the skin and 2/21/2025.	or entering the orders from the ult and failed to put orders into sident #1's skin to be checked lizer twice daily, on each shift down under the immobilizer. thopedist's Nurse Practitioner ders on the consultation that lizer should be worn at all times ght they could not open the ad not checked Resident #1's mobilizer. During a follow-up se #1 on 4/24/2025 at 12:46 pm ent #1 was complaining of pain 2/19/2025 and she asked of #1 if she could take the brace leg and that was when she saw is to her upper right thigh and ent #1 stated the pressure ulcers and been against the hard areas of the entity in the assess the wounds on the leg and she assessed her and ce to her right leg. Ber dated 2/21/2025 indicated and have an immobilizer brace to the entity to stabilize fracture to the order stated only remove check and skin care every day ment Administration Record at #1 indicated she should have remity immobilizer brace in the right distal femur fracture er should only be removed to diskin care each shift beginning owsheet dated 2/26/2025 at	F	586			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING		C 04/24/2025	
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	U-1/2-1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE COMPLETION	
F 686	1:53 pm, completed Resident #1's stage posterior thigh meas 3.8 centimeters in w depth, and the wour On 3/6/2025 at 1:54 Wound Ulcer Flowsh #1's right, posterior measured 5 centime wide, and 0.5 centime Ulcer Flowsheet did improved. Nurse #1 completed on 3/18/2025 at 8:35 Resident #1's right, pressure ulcer was recentimeters long, 5.2 centimeters in depth Flowsheet indicated thigh stage 3 pressured thigh stage 3 pressured on 3/18/2025 at 1:4 Flowsheet complete Resident #1 had a riarea that measured centimeters in width depth. The Wound indicated the wound was dried, yellow draws dried, yellow draws dried, yellow draws dried, and 0.1 centimeters wide, and 0.1 centimeters wide, and 0.1 centimeters in wide, and 0.1 centimeters wide, and 0	by Nurse #1, indicated 3 pressure ulcer to her right, ured 5 centimeters in length, idth and .5 centimeters in d was improving. pm Nurse #1 completed a neet which indicated Resident high stage 3 pressure ulcer ters long, 7 centimeters neters deep. The Wound not indicate if the wound had a Wound Ulcer Flowsheet am which indicated costerior thigh stage 3 measured and was 3.2 centimeters wide, and 0.5 . The Wound Ulcer Resident #1's right posterior re ulcer was improving. 5 pm a Wound Ulcer d by Nurse #1 indicated ght, outer ankle unstageable 2 centimeters in length, 2 , and 0.1 centimeters in Ulcer Flowsheet further bed had eschar and there	F 68	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345502	B. WING		C 04/24/2025		
	ROVIDER OR SUPPLIER	HABILITATION CENTER	33	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
F 686	Continued From pa	age 5	F 686				
	completed a Woun indicated Resident stage 3 pressure u measured 2 centim width, and 0.3 cent Nurse #1 complete on 4/1/2025 at 2:55 #1's right, outer and unstageable and mlength, 2 centimeters in dept Flowsheet describes slough tissue and indicate if the wour A Wound Ulcer Flo on 4/2/2025 at 3:27 right, posterior thig measured 3.3 cent centimeters in widt and continued to in On 4/8/2025 at 1:2 Progress Note that acute distress and evaluated her but F the resident be sendepartment. Reside the hospital to hom request with hospic During a phone into Party on 4/24/2025 Resident #1had a creturned from the hesponsible Party Orthopedist follow-	d a Wound Ulcer Flowsheet o pm and indicated Resident kle pressure wound was leasured 2.7 centimeters in ors in width, and 0.4 ch. The Wound Ulcer led the wound as having 25% of 5% eschar tissue, but did not ord had improved or declined. Where the completed by Nurse #1 of pm indicated Resident #1's of h stage 3 pressure ulcer of imeters in length, 6 of h, and 1 centimeter in depth of prove. Of pm Nurse #5 wrote a stated Resident #1 had no of the hospice nurse had of Resident #1's family requested of the to the emergency of the Responsible Party's					

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)4/24/2025	
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		4/24/2023	
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F 686	Responsible Party simmobilizer and che and she had develo thigh and ankle. The nurse at the facility to failed to check Resimmobilizer but she Nurse's name. An interview was concentrated she assessed after the pressure of upper thigh and right stated the wounds with the immobilizer again was not aware untile found that the nurse immobilizer and che for any skin breakdo stated there should routine checks of the On 4/24/2025 at 3:00 Practitioner was intestated she did order be worn at all times facility's Nursing state immobilizer should the skin checked for breakdown. The Director of Nurson 4/24/2025 at 2:03 #1 readmitted to the right femur fracture right leg. The DON	esident #1's right leg. The tated no one opened the cked her skin until 2/19/2025 ped pressure wounds on her e Responsible Party stated a old her the nursing staff had dent #1's skin under the did not remember the	F 68	36			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345502	B. WING _				C / 24/2025	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		3315 FA	ADDRESS, CITY, STATE, ZIP CODE TH CHURCH ROAD TRAIL, NC 28079	1 04/	24/2023	
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F 686	follow-up appointme and an immobilizer wright leg. The DON Resident #1's right let the immobilizer was 2/21/2025 after the pher right upper femu 2/19/2025. The DOI should have assesse the immobilizer on h DON stated no one until 2/19/2025 and to stage 3 pressure ulcon Resident #1 returned hospital on 12/13/20 care.	nt and the cast was removed was placed on Resident #1's stated the order to check eg for skin breakdown under not put into place until pressure ulcers were found to r and her ankle on N stated the nursing staff ed Resident #1's skin under er right leg every shift. The reported the pressure ulcers he areas were assessed as ers. The DON stated to the facility from the 24 with orders for hospice	F	586				
	interviewed by phone Resident #1 having pleveloped under the The Administrator strongered the immobility would not make an a facility's nursing staff immobilizer to check breakdown. During an interview of 4/23/2025 at 3:14 properties to the facility due to a fracture to he The Physician states the hospital with a care of the properties of the properti	immobilizer on his right leg. ated the Orthopedist had zer be left in place and he assumption about whether the f should have opened the Resident #1 for skin with the Physician on in he stated Resident #1 y with a cast on her right leg her femur on 12/13/2024. d Resident #1 returned from last to her right leg and when						
	for the immobilizer to							

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		345502	B. WING _			C 04/24/2025
	ROVIDER OR SUPPLIER RK NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3315 FAITH CHURCH ROAD INDIAN TRAIL, NC 28079)ODE	0 112 112020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 686	should have opened Resident #1's skin at stated Resident #1's unavoidable due to h	the immobilizer and checked least daily. The Physician	F	586		