STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345502	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Park Nursing and Rehabilitation Center	3315 Faith Church Road Indian Trail, NC 28079

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observations, record review, interviews with a resident and staff, the facility failed to provide larger portions per physician order to a resident at risk for weight loss due to a history of weight loss (Resident #73). The findings included: Resident #73 admitted to the facility on [DATE]. Diagnoses included Alzheimer's dementia, mild cognitive impairment, hyperlipidemia, and hypertension. Review of his medical record revealed Resident #73's monthly weight was assessed on 4/4/24 as 187.4 pounds. Review of his medical record revealed Resident #73's monthly weight was assessed on 5/10/24 as 180.6 pounds, approximately a seven-pound weight loss or approximately 3.7% weight loss in a month. A 5/16/24 Interdisciplinary Team progress note recorded Resident #73 was discussed for weight loss, decreased food intake, and disengagement with meals. A physician order was written to decrease the morning dose of Depakote (a mood stabilizer) to promote alertness and encourage food intake. Review of the medical record revealed a 7/3/24 physician order that recorded to provide 4 ounces of a high calorie nutritional supplement twice a day with breakfast and lunch. A nutrition care plan revised 7/12/24 documented Resident #73 at risk for nutritional decline due to weight loss related to a decline in intake. Interventions included to provide an appetite stimulant, high calorie supplements, encourage consumption of meals and provide a regular diet with double portions as ordered. Review of his medical record revealed Resident #73's monthly weight was assessed on 7/16/24 as 183.6 pounds. Review of his medical record revealed Resident #73's monthly weight was assessed on 8/7/24 as 178.6 pounds, a five-pound weight loss or 2.7% weight loss in a month and approximately 4.8% weight loss in four months. (continued on next page)

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.

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/2/24 quarterly Minimum Data Set assessment indicated Resident #73 had clear speech, adequate vision, adequate hearing, usually understood by others, usually understood others, severely impaired cognition, and fed himself after staff set-up assistance with meals. Review of his medical record revealed Resident #73's monthly weight was assessed on 10/21/24 as 178.4 pounds or approximately 4.8% weight loss in six months. Review of the facility's Diet Order Report dated 10/21/24 recorded Resident #73 received a regular diet with larger portions, milk, and a peanut butter sandwich with each meal. Resident #73 was observed on 10/22/24 at 9:05 AM and 10/23/24 at 9:18 AM in his room, feeding himself breakfast. During each observation, he received a 4-ounce bowl of grits. The breakfast meal tray card recorded a diet order for larger portions. Resident #73 did not receive larger portions of grits for breakfast on 10/22/24 or 10/23/24. During each observation, Resident #73 was asked if he would like to receive a larger portion of grits, and he responded yes and stated that grits were the best part of his breakfast. During a 10/23/24 12:00 PM interview with the Physician, he stated that Resident #73 required encouragement to eat because his nutritional status had declined due to his worsening dementia. The Registered Dietitian (RD) was interviewed on 10/23/24 at 2:57 PM and stated that Resident #73 received an appetite stimulant, milk, and a peanut butter sandwich with each meal, a high calorie nutritional supplement twice a day and double portions for nutritional support due to his history of weight loss and dementia. She stated that in the last six months, Resident #73 had some weight loss, but had not experienced significant weight changes. The RD stated that residents with diet orders for larger/double portions should receive larger/double portions of vegetables, starches and meats. The RD stated that Resident #73 should have received an 8-ounce portion of grits for breakfast on 10/22/24 and 10/23/24 per his diet order. The Certified Dietary Manager (CDM) was interviewed on 10/23/24 at 4:00 PM. The CDM stated that a resident with a diet order for larger/double portions should receive larger/double portions of meats, starches, and vegetables. She stated that a 4-ounce portion of grits was the standard portion, but that Resident #73 should have received an 8-ounce portion of grits for breakfast from the dietary staff. The CDM stated that it was an oversight that Resident #73 did not receive a double portion of grits on 10/22/24 and 10/23/24 and that the terminology on the tray cards would be changed from larger portions to double portions so that dietary staff would provide the correct portion. The Interim Director of Nursing stated on 10/24/24 at 12:22 PM that residents should receive the portion size of foods as ordered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37281 Based on a breakfast meal test tray observation, minutes from Resident Council meetings, a Resident Council meeting, resident and staff interviews, the facility failed to provide food that was palatable and had an appetizing temperature for 8 of 8 residents reviewed for palatable foods (Resident #5, Resident #1, Resident #88, Resident # 77, Resident # 76, Resident #95, Resident #63, and Resident # 34). The findings included: Resident #95 was interviewed on 10/21/24 at 10:43 AM and he reported he was on a regular diet with ground meat. The resident was not happy with the breakfast meat and it had no taste. Resident #63 was interviewed on 10/21/24 at 11:28 AM and when asked about the food in general, he reported the food looks like [expletive] and tastes like it, too. Resident Council Meeting minutes for 12/6/23, 1/10/24, 2/8/24, 6/12/24, and 7/10/24 identified issues with food and coffee temperatures, food texture, and flavor. During the Resident Council meeting on 10/22/24 at 1:30 PM, 6 of 6 residents in attendance (Resident#1, #49, #88, #77, #5, and #76) identified ongoing issues with cold coffee and tough meat. The residents also noted the microwave was broken and they did not have coffee available at any time they wanted. A breakfast test tray was requested on 10/23/24 at 8:05 AM. The plate was placed on an insulating bottom and had an insulating cover. The tray left the kitchen at 8:17 AM on an open cart. The coffee had a plastic lid over the cup and was in a plastic cup. The cart arrived at the 400/500 halls at 8:19 AM. Staff delivered the breakfast meal to residents on the 400/500 halls from 8:20 AM until 8:30 AM. During the observation of staff delivering resident trays, a staff member lifted the insulated lid on the test tray and then replaced it askew. The DM noted the lid was not on the test tray plate correctly and she replaced it. The test tray was sampled with the Dietary Manager (DM) at 8:32 AM. When the DM removed the insulated cover from the plate of food, no steam was noted to rise off the food. No steam came from the cup of coffee and the temperature was tepid to taste. The fried eggs were cool to the touch and taste, the pancakes were cool to the touch and were not warm, and the sausage links were cool to the touch and were not warm. The DM agreed the food temperature was not warm and reported she thought it was because the insulated lid had not been placed on the plate of food correctly, which allowed the heat to escape. The DM reported she expected food to be delivered covered correctly with the insulated lid to prevent loss of temperature. Resident #5 was interviewed 10/23/24 after the breakfast tray sample, and she reported that her breakfast was not good; I don't like the eggs, the coffee was barely warm, and the pancakes were cold. Resident #34 10/23/24 was interviewed after the breakfast tray sample, and she reported her breakfast was awful. Resident #34 was noted to have eaten approximately 10% of her meal and she had replaced the cover over her plate. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM was interviewed on 10/24/24 at 2:15 PM and she explained she was surprised by the results of the test tray and felt that breakfast was the best meal of the day with the residents feeling pleased with that meal. The DM reported the staff performed test trays for palatability and temperature, and she attended Resident Council meetings to talk about food preferences and food issues. The DM reported she ate at least one meal per day at the facility and they did test trays routinely but was unable to provide information for when the last test tray had been completed. The DM reported she had responded to the Resident Council concerns by changing the coffee vendor, offering flavored creamers for coffee, having more staff pass out the trays so the trays did not sit for a long time, and providing education to the kitchen staff for complaints of over-cooked foods. The Administrator was interviewed on 10/24/24 at 2:05 PM and he reported he expected the food to be served at the correct temperature and to be palatable.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37281 Based on observations and staff interviews, the facility failed to dry metal pans before being stacked, clean 1 of 3 ice machines in 1 of 3 nourishment rooms (medical unit), and store dry goods off the floor. These failures had the potential to affect food served to residents. The findings included: a. The kitchen was toured on 10/21/24 at 9:28 AM with the Dietary Manager (DM). During the observation, the storage rack for metal pans was observed and 3 metal pans were noted to be stacked wet. Water was noted to drip down the sides of the pain when the pans were separated, and the interior of the pans felt wet. When asked, the DM reported the metal pans should have been air dried completely before stacking. The DM asked [NAME] #1 who stacked the pans and [NAME] #1 reported she did not know who stacked the pans while they were still wet. b. The medical unit nourishment room was observed on 10/24/24 at 9:50 AM with the DM. The ice machine was observed to have wet, slimy, black material along the seal of the ice machine door. The DM explained the Maintenance Director was responsible for cleaning the ice machines. The ice machine was observed with the Maintenance Director on 10/24/24 at 10:06 AM. The Maintenance Director explained he cleaned all ice machines once per month and he had cleaned the ice machine on the medical unit on 9/28/24. The Maintenance Director was able to rub the wet, slimy, black material off the seal and he stated it was mildew. c. The storage shed was observed on 10/24/24 with the DM at 9:56 AM. The storage shed was cluttered with boxed medical records, decorations, resident possessions, and dry food goods. There was not a clear path to the stored dry goods and the DM had to move things out of the way to get back to the stored dry goods. The DM reported the facility used the shed to store extra water and dry goods, and the emergency supplies of food were kept in the shed. Gallon jugs of water were noted to sit directly on the floor of the shed, and several were noted to be tipped over on their sides and appeared to be partially filled with water. A back support pillow was observed on top of the gallon jugs of water. The pillow was noted to have some yellow stains and was slightly dusty. A pallet of rolled oats was noted to be tipped over on its side and laying on the floor of the shed. The DM reported she had not been in the storage shed for a while, and the water and rolled oats should not have been directly on the floor. The DM reported the shed got very hot in the summer and this caused the water jugs to expand, which might cause the jugs to leak. The DM was interviewed on 10/24/24 at 2:15 PM and she reported she explained she had interviewed [NAME] #1 after the kitchen observation on 10/21/24 and [NAME] #1 reported she had stacked the metal pans with wet hands, and that's why the pans were stacked wet. The DM explained it had been a while since she had been in the storage shed to look at the food storage and she was not aware that it was cluttered with resident possessions, medical records, and decorations. The DM reported she expected all dry goods to be stored off the floor and the food storage area to be tidy and organized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 10/24/24 at 2:05 PM. He reported the metal pans should be allowed to dry completely before they were stacked. The Administrator reported the ice machine had the potential to grow mildew because it was used often, and it was in a warm room and all ice machines should be checked for mildew growth. The Administrator reported the storage shed should be organized and the food stored off the floor of the shed.