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	01/22/2026

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 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns voiced by residents during Resident Council meetings for 3 of 4 months reviewed (November 2025, December 2025, and January 2026).Review of the Resident Council meeting minutes for October 2025, November 2025, December 2025, and January 2026, revealed the following:a. The Resident Council minutes dated 10/08/25, revealed, under New Business, resident concerns regarding lack of available linen, towels, and washcloths.b. The Resident Council minutes dated 11/5/2025 revealed concerns regarding housekeeping staff not removing trash and failing to clean residents' bathrooms and bedrooms. There was no follow up information documented regarding the facility's response to address the concerns noted in the October 2025 meeting. c. The Resident Council minutes dated 12/5/2025 revealed concerns that housekeeping staff were leaving excessive water on the floor after mopping and not adequately cleaning bathrooms. There was no follow up information documented regarding the facility's response to address the concerns noted in the November 2025 meeting. d. The Resident Council minutes dated 1/8/2026 revealed concerns that beds were not being made, bathrooms were not being properly cleaned, and excessive water was left on the floor after mopping. There was no follow up information documented regarding the facility's response to address the concerns noted in the December 2025 meeting.A Resident Council group interview was conducted on 1/21/2026 at 1:30 PM. During the interview, Residents #1, #70, #73, #79, #88, #95, and #99, who attended Resident Council meetings regularly, all stated they felt facility staff did not really address their concerns or suggestions because the only response they typically received from staff, if they received one at all, was we are working on it, we are short staffed, or we don't have a housekeeping manager and some of the issues continued to happen. Resident #1, who was the Resident Council President, added housekeeping concerns, including trash left in rooms, bathrooms not properly cleaned, and laundry issues had been on-going. The Residents all agreed they wanted to know they were being heard and receive feedback from the administration on the efforts that had been made or attempted to resolve their concerns and/or suggestions.In an interview conducted on 01/21/2026 at 2:36 PM, the Activities Assistant stated she was aware of housekeeping concerns but was not aware that resident grievances related to housekeeping had not been addressed by the Housekeeping Manager. The Activities Assistant reported that department managers typically attended Resident Council meetings but had not attended in the past three months. The Activities Assistant stated that the former Activities Director maintained the grievances from Resident Council and was no longer employed at the facility. The Activities Assistant reported that written grievances were not consistently completed when concerns were voiced during Resident Council meetings. She indicated that issues were discussed, however, grievance forms were not initiated or documented for those concerns. The Activities Assistant also stated grievances were currently handled verbally and discussed during morning meetings. The Activities Assistant reported she informed the Administrator of the housekeeping concerns in November of 2025 (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 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	and was instructed to follow up with the Housekeeping Manager once hired. The Activities Assistant indicated that the facility had since hired a new Housekeeping Manager and she planned to make him aware of the concerns. In an interview conducted on 01/22/2026 at 8:43 AM, the Housekeeping Manager, who had been employed at the facility for one month, reported he was not aware of the housekeeping concerns identified during Resident Council meetings.In an interview conducted on 01/22/2026 at 1:52 PM, the Director of Nursing (DON) stated her role in Resident Council was to address concerns related to nursing services and to follow up with the Administrator to ensure grievances were completed and resolved. The DON stated she was not aware of the concern that residents' beds were not being made by staff.In an interview conducted on 01/22/2026 at 3:20 PM. the Administrator stated he did not participate in Resident Council meetings and was unaware of the housekeeping issues raised by residents. The Administrator stated there was currently no Activities Director in place and stated he was not aware that staff were not utilizing the grievance forms for Resident Council concerns.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, resident, and Physician interviews, the facility failed to ensure advance directive information was consistent throughout the medical record for 1 of 4 residents reviewed for advance directives (Resident #84). The findings included: Resident # 84 was readmitted to the facility on [DATE]. Review of the Advance Directives binder located at the nursing station revealed a yellow Do Not Resuscitate (DNR) sticker on the outside Resident #84's binder (Binders with yellow stickers were used by nursing staff to identify Residents who have elected DNR status). Further review of the binder revealed Resident #84 had a Medical Orders for Scope of Treatment (MOST) form dated 03/09/2022 that was signed by the resident and the physician. The MOST form instructed to Attempt to Resuscitate (Full Code). Review of Resident #84's electronic health record (EHR) revealed an active Physician order dated 3/20/24 signed by the Physician that stated Do Not Resuscitate (DNR). Review of Resident #84's EHR revealed the Advance Directive was documented under the Demographics tab and under Physician Orders. The code status entered in the EHR was DNR. Resident #84's annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 was cognitively intact. Resident #84's advance directive care plan dated 12/16/2025 revealed the Resident's code status to be DNR. An interview with Resident #84 on 01/21/2026 at 11:14 AM revealed that Resident #84 remembered a staff member speaking with him at a previous time regarding his code status. Resident #84 was unable to recall the time frame or name of the staff member. The resident stated he made his wishes known to be Full Code. Resident #84 stated he did not inform anyone that he wished to be a DNR and did not recall signing paperwork for his code status. Interview with the MDS Nurse on 01/21/2026 at 12:16 PM revealed that upon admission, an admission Nurse was responsible for documenting the Resident's code status. The MDS Nurse explained that if a resident wished to change their code status, nursing staff would notify the physician to obtain a new order, and the change would be discussed during the daily morning clinical meeting. The MDS Nurse stated Resident #84 was a DNR per physician order. The MDS Nurse stated she was responsible for updating the care plan. She further stated she was unable to identify why Resident #84's code status had not been updated. The MDS Nurse also stated the Social Worker discussed code status during care plan meetings. Interview with Social Worker on 01/21/2026 at 2:54 PM revealed that code status was verified upon admission and discussed during baseline care plan meetings. The Social Worker reported that a code status audit had been conducted four months prior due to inconsistencies identified about a year earlier involving a resident's code status. The Social Worker stated the most recent care plan meeting for Resident #84 was held on 10/01/2025 and reported that code status was discussed during that meeting and Resident #84 remained a DNR. Attendees at the care plan meeting included the Social Worker, nursing staff, and Resident #84. When asked about the current discrepancy in Resident #84's code status, the Social Worker stated the Resident may not have fully understood the meaning of code status. The Social Worker further stated Resident #84 was cognitively able to express his wishes regarding code status. The Social Worker stated the MOST form had not been updated to reflect Resident #84's expressed wishes and acknowledged it was an error, stating she was unsure how the discrepancy in the Resident's code status was missed given her recent audit of all Residents. The Social Worker indicated that the Physician was responsible for correcting and signing the MOST form and acknowledged that the MOST form was not updated because it was overlooked by the Physician and Nursing staff. Review of progress notes and care plan meeting notes dated 10/01/2025 revealed no documentation that code status was discussed during the care plan meeting. In an interview conducted with the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician on 01/21/2026 at 3:13 PM. The Physician stated he was responsible for writing advance directive orders for the facility. The Physician reported staff were required to notify him of any changes related to a Resident's code status. When asked about the discrepancy in Resident #84's documented code status, the Physician stated that in 2024 the resident was hospitalized and returned to the facility documented as Do Not Resuscitate (DNR). The Physician stated Resident #84 was cognitively intact and capable of making his own medical decisions. The Physician acknowledged the discrepancy had been overlooked and indicated that Resident #84 code status was not accurate in the EHR, Resident #84's code status binder, or Physicians DNR orders. On 01/22/2026 at 3:13 PM, the Physician stated he met with Resident #84 on 01/21/2026 to discuss the resident's code status. The Physician provided evidence of an updated advance directive in the EHR and in the facility's code status binder, which reflected Resident #84 code status as Full Code. In an interview conducted with the Director of Nursing (DON) on 01/22/2026 at 12:25 PM, the DON stated that upon admission, a resident's code status was established, entered into the electronic medical record under physician orders, placed in the Advance Directives binder if the Resident was designated as DNR, and incorporated into the comprehensive care plan. The DON reported that if a resident elected hospice services or was sent to the hospital, the code status should be reviewed to ensure it remained accurate and up to date. The DON stated that if a resident wished to change their code status at any time, the resident could notify nursing staff or the Social Worker. Regarding the inaccurate code status for Resident #84, the DON stated she did not know how the discrepancy occurred. The DON further stated the discrepancy may have occurred prior to her employment at the facility. The DON indicated she was part of the audit conducted by the Social Worker regarding Residents' code statuses. The DON provided no information regarding the recent audit of Residents' code statuses. The DON further stated that Resident #83's code status should have been consistently and accurately documented in the Advance Directives binder, the EHR, and in physician orders. In an interview conducted with the Administrator on 01/22/2026 at 3:43 PM, the Administrator reported that Resident #84 returned to the facility from the hospital with documentation reflecting DNR status. When asked about the discrepancy between the MOST form, which indicated Full Code and the facility's Physician's orders reflecting DNR status, the Administrator stated he was not aware of the inconsistency.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 2 residents reviewed for respiratory care (Resident #60).? The findings included: Resident #60 was readmitted on [DATE]. Her diagnoses included atrial fibrillation, congestive heart failure, and shortness of breath. A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 was moderately cognitively impaired and received oxygen therapy. Resident #60 had a physician order dated 11/19/24 indicated the administration of oxygen via nasal cannula at 2 liters per minute continuously to keep oxygen saturation levels above 90%. The order had no expiration date and was ordered as indefinite. Resident #60's current care plan dated 11/25/25 indicated Resident #60 was at risk for ineffective breathing pattern related to congestive heart failure and shortness of breath. Interventions included administering oxygen via nasal cannula as ordered. The Medication Administration Record (MAR) included an order for oxygen at 2 liters via nasal cannula to keep oxygen saturation levels above 90% every day and night shift for shortness of breath. The order start date was 11/19/2024. The MAR schedule included Oxygen at 2 liters via nasal cannula to keep oxygen above 90% every day and night shift for shortness of breath. There were two 12-hour blocks for each day of the month for staff to confirm the flow rate every twelve hours. One block was marked 12H which represented Day shift, and the second block was marked 12HR which represented Night shift. A review of January 2026 MAR revealed staff documented the flow rate at 2 liters per minute twice each day on 1/20/26, 1/21/26, and 1/22/26. The MAR review for 1/20/26 and 1/21/26 revealed Nurse #3 documented that the oxygen was set at 2 liters per minute for the Day shift both days.? The MAR review for 1/22/26 revealed Nurse #1 documented that the oxygen was set at 2 liters per minute for Day shift. During observation on 1/20/26 at 10:52 AM Resident #60 was observed with the oxygen nasal cannula in place. Resident #60's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. During observation on 1/21/26 at 9:00 AM Resident #60 was observed with the oxygen nasal cannula in place. Resident #60's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level.? An interview was conducted with Nurse #3 on 01/21/26 at 9:31 AM. Nurse #3 did not answer questions specific to oxygen orders of Resident #60 but stated she would review the MAR for any medications or treatments. Nurse #3 indicated she followed what was listed on the MAR. Nurse #3 excused herself to complete her medication pass. Nurse #3 was not available for a follow-up interview during the survey. During observation on 1/22/26 at 10:07 AM Resident #60 was observed with the oxygen nasal cannula in place. Resident #60's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. Resident #60's oxygen regulator verified, with Nurse #1 present, to be set at 3 liters per minute. An interview was conducted on 1/22/26 at 10:10 AM with Nurse #1 who was assigned to administer medication, treatments, and provide care for Resident #60 on 1/22/26 during the day shift (7:00 AM - 7:00 PM). Nurse #1 stated Resident #60 had a physician order for oxygen at 2 liters per minute via nasal cannula.?He said he checked the yes radio button in the MAR that the oxygen was set at 2 liters per minute. Nurse #1 reported they were trained to visually check the oxygen flow rate. Nurse #1 further explained he usually checked?when he went to the room to administer medication, but he had not checked it earlier when he was in Resident #60's room and administered her morning medications. Nurse #1 reported the settings needed to be corrected and he would need to report to his Unit Manager. An interview was conducted with the Unit Manager #1 on 1/22/26 at 10:20 AM. She stated oxygen should be delivered at the rate ordered by the provider. Unit Manager #1 stated the nurse was expected to visually confirm (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the rate of oxygen before they signed in the MAR that the oxygen was set at the provider ordered flow rate. An interview was conducted on 1/22/26 at 1:30 PM with the Nurse Practitioner (NP). She stated she expected nurses to ensure oxygen was set at the ordered rate and if they needed to titrate the oxygen rate, she expected nurses to call the provider to request adjustment to the oxygen rate. She stated the increased oxygen rate was not harmful to the Resident with her listed diagnoses. An interview was conducted on 1/22/26 at 2:48 PM with the Assistant Director of Nursing (ADON). She stated the nurses should administer oxygen at the provider ordered rate. She reported that the oxygen order details were located in the electronic medical record and the MAR. She stated they should have notified the provider immediately if they needed to change the oxygen rate. The ADON stated she expected nurses to follow provider orders or notify the provider if they thought changes were indicated. An interview was conducted on 1/22/26 at 3:25 PM with the Director of Nursing (DON). She stated Nurse #1 should have verified that Resident #60's oxygen regulator was set at the physician ordered rate. The DON explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. The DON stated nurses should verify oxygen rates when they assumed the residents' care. She stated when administering medications the nurses should visually confirm the rate of administration before they entered confirmation in the MAR that oxygen was administered at the provider ordered rate. During an interview on 1/22/26 at 4:00 PM with the Administrator, he stated he expected nurses to monitor the oxygen setting to ensure that it was set at the rate ordered by the provider.