STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health & Rehab Center	13825 Hunton Lane Huntersville, NC 28078

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with resident and staff, the facility failed to maintain a clean shower room for 2 of 3 shower rooms observed. The facility also failed to maintain a wheelchair in good repair for 1 of 4 residents reviewed for mobility devices (Resident #99). The findings included: 1.a. An observation conducted on 12/10/25 at 10:14 AM of the 100-hall shower room with the Environmental Service Manager revealed a black/gray substance covering the tile floor of the resident shower stall. The black/gray substance covered the surface area in the middle of the shower stall near the shower drain and extended up the right side of the shower wall leading to the shower control knobs. The black/gray substance was also observed in the cracks of the shower tile lining the shower stall. b. An observation and interview conducted on 12/10/25 at 10:25 AM of the 300-hall shower room with the Environmental Service Manager revealed a black/gray substance lining the cracks of the shower stall and around the middle shower drain. During an interview conducted at the time of the observation on 12/10/25 at 10:25 AM the Environmental Service Manager stated he had a total of five housekeeping staff members working in the facility from 7:00 AM until 6:30 PM. He stated it was the responsibility of the housekeeping staff member to clean the shower room on the assigned hall. The interview revealed he had experienced a call out and that he was assigned to the 100-hall shower room. He stated Housekeeping Staff Member #1 was assigned to the 300-hall shower room. The housekeeping staff were responsible for mopping the shower rooms daily and wiping down all hardware. The Environmental Service Manager stated he monitored the resident shower rooms daily for cleanliness; however, he had failed to monitor the shower rooms. He stated he had not been in the 100-hall shower room on 12/10/25 but had planned on cleaning it as part of his assignment. On 12/10/25 at 10:30 AM, an interview was conducted with Housekeeping Staff Member #1. During the interview, she stated she was assigned to the 300-hall shower room. She stated she cleaned the shower room daily and knew about the black/gray substance in the shower room; however, she did not have a cleaner that would remove the substance. A second observation was conducted of the 100-hall shower room on 12/10/25 at 10:48 AM. During the observation, the Environmental Service Manager was observed cleaning the 100-hall shower room, and the black/gray substance was easily removed using the daily cleaner located on all housekeeping carts. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on 12/10/25 at 10:55 AM with the Environmental Service Manager. During the interview, he stated Housekeeping Staff Member #1 was under the impression she could not remove the substance with the standard cleaner located on her housekeeping cart. However, that was what he used to clean the 100-hall shower room and was able to remove all of the substance from the tile. He stated the shower rooms should have been cleaned daily and that if Housekeeping Staff Member #1 had an issue, it should have been reported to him. On 12/10/25 at 1:57 PM, an interview was conducted with the Administrator. During the interview, she stated all shower rooms should be cleaned on a daily basis and inspected as necessary. 2. Resident #99 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #99 with intact cognition and his primary mobility devices were wheelchair and walker. Review of weekly skin assessment from 11/11/25 through 12/09/25 revealed Resident #99's skin was intact. During an observation conducted on 12/08/25 at 11:45 AM, Resident #99 was seen sitting in his wheelchair next to the bed in his room. The plastic vinyl covers of his bilateral armrests for the wheelchair were in disrepair with multiple torn spots, ripped edges, and cracked lines along the edges. Resident #99 was seen wearing a short-sleeved shirt and both of his arms were contacting with the torn and ripped armrests during the observation. An interview was conducted with Resident #99 on 12/08/25 at 11:47 AM. He stated the vinyl cover of his bilateral armrests for the wheelchair had been torn and ripped since he was admitted to the facility around 1. 5 months ago. He added it caused itchiness and irritation to his bilateral arms at times. He indicated he used the wheelchair frequently and wanted the torn and ripped armrests to be fixed as soon as possible. During a joint observation conducted on 12/09/25 at 10:54 AM with Nurse #1 and Nurse Aide (NA) #1 in Resident #99's room, the plastic vinyl covers of bilateral armrests for Resident #99's wheelchair remained in disrepair. Nurse #1 assessed the skin condition of Resident #99's bilateral arms immediately and reported his skin was intact without any redness, rashes or open areas. A joint interview was conducted on 12/09/25 at 11:01 AM with Nurse #1 and NA #1. Both nursing staff stated they noticed the torn and ripped armrests of Resident #99's wheelchair but were unable to explain why they did not report the repair need to the maintenance staff. Both nursing staff acknowledged that the bilateral armrests of Resident #99's wheelchair were in disrepair and needed to be fixed immediately. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 12/10/25 at 1:35 PM, the Assistant Maintenance Manager stated the Maintenance Manager was on leave and he currently oversaw facility maintenance. He identified repair needs mainly by work orders filed by nursing staff or through verbal notification. The Assistant Maintenance Manager indicated he typically did not check repair needs for residents' wheelchairs but expected nursing or rehabilitation staff to file a work order if they identified any repair needs. He acknowledged that Resident #99's torn and ripped armrests needed to be fixed immediately to avoid any skin issues. He further stated he checked work order logs located at each nurse station at least twice daily. He stated it was the responsibility of all staff to remain attentive to residents' mobility devices and report repair needs in a timely manner to ensure they were in good repair all the times. An interview was conducted on 12/10/25 at 3:21 PM with the Director of Nursing. She expected all the staff, including housekeepers and management staff to be more attentive to residents' repair needs and reported the findings to maintenance department in a timely manner. It was her expectation for all the mobility devices including wheelchairs to be in good repair all the time. During an interview conducted on 12/11/25 at 1:24 PM, the Administrator expected all the staff to report repair needs through the work order logs located at each nursing station or by verbal notification to ensure the maintenance staff could address the identified issues in a timely manner. It was her expectation for all the mobility devices to be in good repair all the time.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to accurately complete a comprehensive assessment in the area of diagnoses for 1 of 22 resident assessments reviewed (Resident #10). The findings included:Resident #10 was admitted to the facility on [DATE]. Resident #10's diagnoses included congestive heart failure, end stage renal disease, atrial fibrillation (an abnormal heart rhythm), and hypertensive heart and chronic kidney disease with heart failure and stage 5 chronic kidney disease. A review of Resident #10's physician's orders revealed the following orders dated 11/18 25: - Midodrine (a medication used to treat low blood pressure) 5 mg by mouth three times daily.- Metoprolol (a beta blocker medication that treats congestive heart failure and atrial fibrillation) 25 mg by mouth daily. A care plan was initiated 11/18/25 for cardiovascular risk due to diagnosis of congestive heart failure (CHF) and the use of oxygen. The stated goal was Resident #10 would not exhibit respiratory distress through the review period. Interventions included administering medication as ordered, assessment to monitor for edema, elevation of edematous areas, and to monitor weight. An admission Minimum Data Set (MDS) completed on 11/24/25 was reviewed and heart failure was not coded as a diagnosis on the MDS. An interview with the MDS Coordinator was conducted on 12/10/25 at 2:26 PM. The MDS Coordinator stated that Resident #10 had a diagnosis of congestive heart failure. She stated that usually if a resident was not receiving any treatment, medication, or have any major symptoms of a diagnosis, it does not need to be coded on the MDS. The MDS Coordinator reviewed Resident #10's diagnoses and provider notes and stated it had been coded incorrectly. An interview with the Director of Nursing (DON) was conducted on 12/11/2025 at 10:25 AM. The DON stated that all MDS should be coded correctly for relevant diagnoses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to store ammonium lactate lotion (prescription-strength lotion), antifungal powder, and betadine solution (topical antiseptic solution) in a locked cart. These items were found unsecured on a resident's bedside table. This occurred for 1 of 5 residents reviewed for medication storage (Resident #64). Additionally, the facility failed to date one opened bottle of Latanoprost after it was opened and failed to store one bottle of Latanoprost in accordance with manufacturer's storage guidelines for 1 of 5 medication carts (600 Hall). The findings included: 1. Resident #64 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and hidradenitis suppurativa (skin condition that causes chronic rashes and infections). Resident #64's quarterly Minimum Data Set, dated [DATE] coded Resident #64 with severe cognitive impairment. The MDS did not code the resident for ski problems or rashes. Resident #64's physician orders for December 2025 found no orders for the ammonium lactate lotion, antifungal powder, and betadine solution. Review of Resident #64's Medication Administration Record and Treatment Administration Record for December 2025 revealed the antifungal powder, ammonium lactate lotion, and betadine solution were not listed. On 12/8/25 at 11:10 AM, prescription medications were observed on Resident #64's bedside table. The bedside table contained an opened bottle of ammonium lactate 12% moisturizing lotion prescribed by an outside provider. The lotion contained a discard by date of 3/24/25. The beside table also contained an opened bottle of antifungal powder that was prescribed to another resident and an opened bottle of betadine solution. On 12/8/25 at 11:19 AM, Resident #64's assigned Nurse #2 was interviewed. Nurse #2 confirmed Resident #64 did not have an order for the antifungal powder, prescription-strength lotion, or betadine solution. She said Resident #64 did not have any treatment orders and she did not know why the items were on Resident #64's bedside table. Nurse #2 stated she had not yet given Resident #64 his medications and had not seen the antifungal powder, prescription-strength lotion, or betadine solution at his bedside. The nurse stated Resident #64 could not self-administer the antifungal powder, prescription-strength lotion, or betadine solution and they should be stored in the nurse's cart. Nurse #2 added the prescription lotion was probably brought to the resident from a family member without notifying a nurse. Nurse #2 removed the antifungal powder, prescription-strength lotion, or betadine solution from Resident #64's room. On 12/10/25 at 4:44 PM the Wound Nurse was interviewed. She stated the antifungal powder, prescription-strength lotion, or betadine solution should be kept locked in a cart and not left at bedside. The Wound Nurse stated Resident #64 did not have an active order for wound treatment and did not know why the resident had treatment supplies in his room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/25 at 11:43 AM, the Director of Nursing stated the antifungal powder, prescription-strength lotion, or betadine solution should not be left at the bedside unless the resident had an order for self-administration of medications. Resident #64 did not have an order for self-administration, and the antifungal powder, prescription-strength lotion, or betadine solution should have been locked in a nurses or treatment cart. The Director of Nursing did not know why the antifungal powder, prescription-strength lotion, or betadine solution were left at bedside or who had brought them into the room. 2. A review of the manufacturer's package inserts for Latanoprost ophthalmic solution indicated that an unopened bottle must be stored under refrigeration at 36 degrees to 46 degrees Fahrenheit (F). Once a bottle of Latanoprost ophthalmic solution was opened for use, it could be stored at room temperature up to 77 degrees F for up to 6 weeks. During a medication storage audit conducted on 12/09/25 at 4:01 PM in the presence of Nurse #2, one unopened bottle of Latanoprost 0.005% eye drop stored at room temperature was found in the medication cart for 600 Hall. A review of the label on the bottle revealed its manufacturer's expiration date would be 12/2027. At the same time, one bottle of opened Latanoprost 0.005% eye drop was found in the same medication cart without an opened date and was available for use. An interview was conducted with Nurse #2 on 12/09/25 at 4:03 PM. She did not know how long the opened Latanoprost found in the medication cart for 600 Hall had been used and stored at room temperature. She explained that she just took over the medication cart and did not have time to check all the medications in the cart for proper storage yet. In addition, she did not know how long the unopened Latanoprost had been stored in the medication cart at room temperature. She stated that Latanoprost eye drops should be stored in the refrigerator when it was received from the pharmacy. Once it was opened, it should be dated and stored at room temperature for up to 42 days. During an interview conducted on 12/09/25 at 4:09 PM, Nurse #1 stated she was the nurse who worked the previous shift with medication cart for 600 Hall and explained she had just received the unopened Latanoprost from the pharmacy less than 1 hour ago. She stored the eye drop in the medication cart for the time being and planned to place it in the refrigerator later. She did not know who had opened the Latanoprost eye drops without putting an opening date and did not know how long it had been opened and stored at room temperature. She stated the opened Latanoprost should be dated once it was opened and stored in the medication cart at room temperature thereafter. An interview was conducted with the Director of Nursing (DON) on 12/09/25 at 4:14 PM. She stated it was her expectation for nursing staff to follow the facility's medication storage policy and procedure, and manufacturer's guidelines to date Latanoprost eye drops once it was opened and stored the unopened Latanoprost in the refrigerator until it was ready to be used. During an interview conducted on 12/10/25 at 11:24 AM, the Administrator stated it was her expectation for all the nursing staff to follow manufacturer's guidelines and the facility's medication storage policy and procedure when receiving and storing medication, including Latanoprost eye drops.

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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. Based on observations and interviews, the facility failed to clean a circulatory fan cover in the walk-in refrigerator and prevent condensation from forming and dripping onto stored food, which resulted in water standing on the floor of the walk-in refrigerator. This issue was identified for 1 of 3 refrigerators (walk-in) observed in the kitchen. The deficient practice had the potential to affect food served to some of the 103 residents residing in the facility. The findings included:On 12/8/25 at 9:48 AM, an observation of the walk-in refrigerator was conducted with the Dietary Manager. The circulatory fan cover contained a thick build-up of gray/brown debris that was crumbly to touch and covered the entire fan cover. Condensation droplets were observed on the bottom of the circulatory fan and drops of condensation had fallen onto a covered container of sliced tomatoes stored directly under the circulatory fan. Additionally, standing water, brown in color, was present on the floor beneath the fan.On 12/8/25 at 9:54 AM the Dietary Manager stated she was not aware of the debris on the fan covers and would report it to maintenance. She also stated the condensation, and dripping water had not occurred prior to this day. She added the floor would be mopped. The Dietary Manager confirmed water should not drip onto stored food, and the affected food container was removed. The Dietary Manager stated she cleaned the walk-in refrigerator after each food delivery on Monday, and it was last cleaned on 12/1/25.On 12/10/25 at 11:55 AM, a follow up observation revealed the walk-in fan cover remained unchanged.On 12/10/25 at 12:38 PM, Dietary Manager reported a refrigerator company had been contacted on 12/8/25. A repair technician inspected the fan the same day and stated the fan cover would be cleaned by the company. The technician also ordered parts to repair the walk-in refrigerator door so it would close automatically, as prolonged door openings caused the condensation issue. The Dietary Manager stated the refrigerator company would clean the fan covers when notified.On 12/11/25 at 1:44 PM, the Administrator stated routine cleaning of the walk-in refrigerator cover should have been done. Additionally, she stated the condensation in the walk-in refrigerator should have been reported for repair to prevent dripping on stored food.