STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Creek Health and Rehabilitation Center	**5201 Clarks Fork Drive NW , Raleigh, North Carolina, 27616**

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/9/26 through 2/12/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E2FAC-H1.	E0000		02/24/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/9/26 through 2/12/26. Event ID#1E2FAC-H1. The following intakes were investigated 2704108, 2699144, 2692411, 2683927, 2673667, 2648797 and 2648081. 2 of the 15 complaint allegations resulted in deficiency.	F0000		02/24/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F. 550 1. Corrective action for the residents found to have been affected by the deficient practice: Residents #72 and #106 still reside in the facility. Resident #72 was immediately treated with dignity while being assisted with feeding. Resident #106 had her clothing items returned from laundry immediately on 2/9/2026. 2. Corrective action for other residents having the potential to be affected by the same deficient practice: All residents that require assistance with feeding have the potential to be affected.	03/10/2026

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 reverse for further 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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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with resident, responsible party, and staff, the facility failed to treat residents with dignity and respect when Nurse Aide #1 was watching a video on her cell phone while assisting Resident #72 with eating and Resident #106's clothes were not provided to her for a 3 day period after they were sent to the laundry resulting in the resident having to wear a hospital gown, feeling "annoyed", and causing her not to leave her room. A reasonable person would expect Resident #72's caregiver to be focused on them during the provision of care. This deficient practice affected 2 of 4 residents reviewed for dignity (Resident #72 and Resident #106). Findings included: 1. Resident #72 was admitted to the facility on 6/21/24. Her active diagnoses included cognitive communication deficit and muscle weakness. Resident #72's quarterly Minimum Data Set (MDS) assessment dated 11/24/25 revealed she was assessed as severely cognitively impaired, required supervision or touching assistance with eating, was able to make herself understood, and she understood others. During observation on 2/11/26 at 9:12 AM Nurse Aide #1 was observed assisting Resident #72 with her breakfast. The nurse aide was sitting next to Resident #72 at the head of the bed with the bedside table in front of her. The bedside table was perpendicular to the resident's	F0550	Continued from page 1 On 2/13/2026, the Assistant Director of Nursing (ADON) and the Unit Managers reviewed all residents that are assisted with feeding to ensure that the nurse aides are not on their cell phones while feeding a resident. There were no dignity issues noted. On 2/13/2026 the Housekeeping Manager reviewed the laundry schedule to ensure all residents' laundry was done and returned per schedule. 3. Systemic changes made to ensure that the deficient practice will not recur: On 2/13/2026, the Staff Development Coordinator (SDC) initiated education for all licensed nurses and nurse aides on dignity and respect when assisting with feeding residents, to include no cell phone use during feeding. On 2/13/2026 the Housekeeping Manager initiated education to housekeeping and laundry staff on returning laundry timely per the schedule. All education will be completed by 2/28/2026. Any staff that has not completed the education by 2/28/26 will be educated prior to the start of the next scheduled shift. Any new hires in the nursing department and housekeeping/laundry department will be educated as indicated above by the SDC and Housekeeping Manager respectively during orientation before they are allowed to work. 4. Plans to monitor its performance to make sure that solutions are sustained: The Administrator introduced an observation tool on 2/27/26 to be utilized by the Unit Managers to observe residents who are assisted with feeding to ensure the staff member is not on their cell phone during feeding. The tool will be utilized daily for 5 days and weekly for 4 weeks and then monthly for 3 months or until compliance is maintained. A different observation tool for laundry was introduced by the Administrator on 2/27/2026 to monitor the laundry schedule to ensure laundry is done and returned as scheduled. The tool will be utilized by the Housekeeping Manager and will be used weekly for 4 weeks and then monthly for 3 months or until compliance is maintained. Both tools will be reviewed by the Administrator and/or the Director of Nursing (DON) and /or ADON weekly for a month and, then monthly for 3	

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F0550 SS = D	Continued from page 2 bed, and a cell phone was observed on the bedside table, out of view of the resident. A video was playing on the cell phone with closed captioning on and no sound. Nurse Aide #1 was observed watching the video on her phone while she offered the resident bites of food. The nurse aide was glancing back and forth between the video on her phone and the resident. During an interview on 2/11/26 at 9:13 AM Nurse Aide #1 stated no one had indicated she could not watch a show on her phone while providing assistance to residents with their meals. She stated she was watching a series on vampires. During an interview on 2/12/26 at 10:15 AM Resident #72's Responsible Party (RP), he stated it was a disgrace that his family member would be provided assistance with her meal by a nurse aide whose attention was divided between the nurse aide's own entertainment and his mother's care. He stated that when a nurse aide was providing Resident #72 assistance, the nurse aide should be present and 100% involved with the care his family member needed because she was reliant on the other person to ensure her needs were met. He expressed that the nurse aide should not be focused on their own entertainment while assisting the resident. During an interview on 2/11/26 at 9:28 AM the Regional Director of Clinical Services stated she was not sure if Resident #72 was able to respond to the nurse aide or not. She was also unsure if watching a video while assisting a resident with a meal was a dignity concern, however she did prefer nurse aides engage with residents while assisting with meals. She concluded the facility did not have a policy regarding staff cell phone use. During an interview on 2/11/26 at 9:30 AM the Administrator stated he would not recommend nurse aides watch a show on their cell phone while providing assistance to a resident with their meals, however he would need to check their cell phone policy to know if a nurse aide would be able to watch a show while assisting residents with meals. He stated he was unsure if a nurse aide watching a show while assisting residents with meals would be a dignity concern but watching a video while assisting a resident with their meal would not be something he recommended. 2. Resident #106 was admitted to the facility on 01/23/26.	F0550	Continued from page 2 months until compliance is maintained. Any areas of non-compliance will be reported by the Administrator and/or DON to the Quality Assurance Performance Improvement Committee (QAPI) monthly or quarterly as needed for further recommendations to ensure compliance. 5. Date of Compliance: 3/10/2026	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F0550 SS = D	Continued from page 3 The Minimum Data Set admission assessment dated 01/30/26 revealed Resident #106 was cognitively intact and she demonstrated no behaviors. During an observation and interview on 02/09/26 at 11:15 AM with Resident #106, she was observed in her room wearing a hospital gown. Resident #106 reported that she had 4 house coats (a loose lightweight robe) that were brought to the laundry department on Friday 02/05/26. She stated the facility was responsible for doing her laundry and the laundry was picked up on Fridays and returned back to her clean on the same day. Resident #106 stated a nurse aide picked up her laundry on Friday morning on 02/05/26 and as of today (02/09/26) the laundry had not been returned. Resident #106 stated she had been in a hospital gown since Friday 02/05/26. Resident #106 stated she was “annoyed” that she could not get dressed and had to wear a hospital gown for 3 days. Resident #106 added that she was not comfortable leaving her room while wearing a hospital gown, so she had remained in her room since her clothes were taken to the laundry on 02/05/26. Resident #106 stated she only brought 4 house coats to the facility and she and had no other clothes to wear. During an observation and interview on 02/10/26 at 3:25 PM with Resident #106, she was observed wearing a house coat. She revealed the staff brought back her 4 house coats late in the afternoon on 02/09/26. An interview was conducted with Housekeeper #1 on 02/12/26 at 10:00 AM. Housekeeper #1 stated that she and Housekeeper #2 were assigned to collect the laundry for the 500 hall each Friday. Housekeeper #1 stated once she brought the laundry and linens to the laundry department on Fridays; the laundry staff would launder the 500 hall’s items and were supposed to return the clothing the same day. Housekeeper #1 stated the laundry was returned the same day on the 500 - hall because these residents were at the facility for rehabilitation services and they were discharged quicker than residents on other halls. Housekeeper #1 stated she did not work on Friday 02/05/26 so she did not pick up Resident #106’s laundry. An interview with the Housekeeping Director on 02/12/26 at 10:30 AM revealed she had picked up the laundry from Resident #106’s room on Friday 02/05/26 and returned the clean laundry the same day. The Housekeeping Director stated she returned the folded clothing items	F0550		

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F0550 SS = D	Continued from page 4 and left them in Resident #106’s room to be put away on 02/05/26. A follow-up interview was conducted with the Housekeeping Director on 02/12/26 at 12:32 PM. The Housekeeping Director stated she did not bring Resident #106’s clothes back to her room on Friday 02/05/26 like she had indicated in her previous interview. The Housekeeping Director stated she had confused Resident #106’s room with another room on the same hall. The Housekeeping Director stated she recalled staff coming to her on Saturday 02/06/26 looking for Resident #106’s clothes but they had not been laundered yet. She stated she worked all weekend in the laundry department due to being short staffed and got the laundry caught up. The Housekeeping Director stated there was usually one person assigned to the laundry room on day shift and one person on 2nd shift and that was enough staff to be able to keep up with the laundry. The Housekeeping Director stated she was familiar with the laundry process and on Fridays the 500-hall laundry would be picked up by the housekeeping department and washed and returned the same day. An interview was conducted with Nurse Aide #2 on 02/12/26 at 11:29 AM. Nurse Aide #2 stated she worked on Friday 02/05/26, Saturday 02/06/26, and Sunday 02/07/26. Nurse Aide #2 stated she brought Resident #106’s laundry to the laundry department on Friday 02/05/26. Nurse Aide #2 reported Resident #106 did not have any clothes to wear all weekend. Nurse Aide #2 stated Resident #106 got out of bed and did therapy over the weekend in her room, but the resident did not leave her room because she said she had no clothes to wear. Nurse Aide #2 stated Resident #106 did not have any of her own clothes to wear all weekend and she (Nurse Aide #2) went to the laundry department on Saturday 02/06/26 and Sunday 02/07/26 and the Housekeeping Director kept saying “we are working on it.” Nurse Aide #2 stated when she returned on Monday 02/09/26, Resident #106 still did not have her clothes and she (Nurse Aide #2) went to the laundry department on Monday afternoon and Resident #106’s 4 house coats were ready, so she brought them to Resident #106’s room. An interview was conducted with the Administrator on 02/12/26 at 3:45 PM. The Administrator stated he expected the laundry to be completed on the day it was scheduled. He reported that the laundry on Resident #106’s hall was scheduled to be done on Fridays. He	F0550		

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F0550 SS = D	Continued from page 5 indicated it should have been done that day so that Resident #106 had her own clothing to wear.	F0550		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a resident's Minimum Data Set (MDS) assessment for 2 of 30 MDS assessments reviewed (Resident #3, Resident #59). Findings included:	F0641	F. 641 1. Corrective action the resident found to have been affected by the deficient practice: Resident #3 no longer resides in the facility. Resident #59 still resides in the facility and the quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date of 11/05/2025 was modified by the MDS nurse on 2/13/2026. 2. Corrective action for other residents having the potential to be affected by the same deficient practice: Any resident that is on hospice services have the potential to be affected. On 2/13/26, the Regional Director of Clinical Reimbursement audited all residents on Hospice Services to ensure the Minimum Data Set (MDS) was coded accurately. There were no issues noted. Any resident who is receiving Ozempic injections have the potential to be affected. On 2/13/26, the Regional Director of Clinical Reimbursement audited all residents receiving Ozempic injections to ensure accurate coding of N0350A on the MDS. There were no issues noted. 3. Systemic changes made to ensure that the deficient practice will not recur: On 2/13/2026, education was initiated by the Regional Director of Clinical Reimbursement for the MDS nurses' regarding accurate coding of the MDS per the RAI manual related to resident's on hospice services and/or Ozempic injections. The education was completed by 2/24/2026. Any new hires in the MDS department will not be allowed to work until education indicated above has been completed. 4. Plans to monitor its performance to make sure that solutions are sustained: The Administrator introduced a monitoring tool on 2/13/2026 to be utilized by the Regional Director of Clinical Reimbursement or the DON/ADON to conduct an audit of 10 completed MDS assessments weekly for four weeks then monthly for two months for coding of N0350A on the MDS. The Results will be reported to	03/10/2026

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F0641 SS = D	Continued from page 6 1. Resident #3 was admitted to the facility on 1/16/26. Her active diagnoses included anemia, heart failure and diabetes mellitus. Review of Resident #3's Election of Benefits for Hospice dated 1/19/26 revealed she elected hospice and services were started for her on this date. Review of Resident #3's admission Minimum Data Set assessment dated 1/23/26 did not indicate she received hospice care. During an interview on 2/11/25 at 8:19 AM the MDS Coordinator stated he used the census report while completing the MDS assessment which had not been updated to reflect the hospice admission for Resident #3. The MDS Coordinator explained Resident #3's MDS assessment dated 1/23/26 did not capture her hospice status and it should have. During an interview on 2/11/25 at 9:34 AM the Administrator stated MDS assessments should accurately reflect resident's hospice status. 2. Resident #59 was admitted to the facility on 10/3/24 with a diagnosis of diabetes mellitus type 2 (DM 2). A physician's order for Resident #59 dated 10/31/25 revealed Ozempic (0.25 or 0.5 milligram (MG/DOSE) subcutaneous (beneath the skin) Solution Pen-injector 2 MG/1.5 milliliter (ML) (Semaglutide) Inject 0.5 mg subcutaneously one time a day every 7day(s) for DM2 0.5 mg once every week. Resident #59's medical record did not reveal any physician's orders for Resident #59 to receive insulin in October 2025 or November 2025. Resident #59's October 2025 and November 2025 Medication Administration Record (MAR) did not reveal any documentation indicating insulin was administered to Resident #59. Resident #59's November 2025 MAR revealed documentation indicating Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous Solution Pen-injector 2 MG/1.5ML (Semaglutide) Inject 0.5 mg subcutaneously was administered to her on 11/1/25 at 9:00 AM. Resident #59's quarterly Minimum Data Set (MDS) assessment dated 11/5/25 revealed Resident #59 received one insulin injection in the last 7 days. On 2/11/26 at 12:59 PM an interview with MDS Nurse #1 indicated she coded the Medications section of Resident #59's 11/5/25 MDS assessment to indicate Resident #59	F0641	Continued from page 6 the Quality Assurance Performance Improvement Committee (QAPI) for further recommendations or until substantial compliance is maintained. 5. Date of Compliance: 3/10/2026	

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F0641 SS = D	Continued from page 7 received one (1) insulin injection in the 7-day look-back period which included 10/30/25 through 11/5/25 because of the documentation on Resident #59's November 2025 MAR indicating Resident #59 received an Ozempic injection subcutaneously on 11/1/25. She reported that she thought because the medication was ordered for Resident #59's DM 2, it was to be coded as an insulin injection. On 2/11/26 at 1:08 PM an interview with the MDS Director revealed that although Ozempic was ordered for Resident #59's DM 2, it was not an insulin and should not be coded as insulin on MDS assessments. The facility's Director of Nursing was not present in the facility during the investigation and was unavailable for telephone interview. On 2/12/26 at 3:51 PM an interview with the Administrator indicated MDS assessments should be coded to accurately reflect the medication residents received.	F0641		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	F. 761 1. Corrective action the resident found to have been affected by the deficient practice: The medication cart was secured immediately after the deficiency practice was observed. 2. Corrective action for other residents having the potential to be affected by the same deficient practice: On 2/11/2026, the ADON and Unit Managers inspected all medication carts and ensured they were secured. 3. Systemic changes made to ensure that the deficient practice will not recur: On 2/13/2026, education was initiated by the Staff Development Coordinator for all licensed nurses including Nurse #3 and Medication Aides on securing medication carts. The education will be completed by 2/28/2026. Licensed nurses and/or Medication Aides who have not received education will not be allowed to work until education indicated above has been completed. All newly hired licensed nurses and/or Medication Aides will be education on securing medication carts during new hire orientation. 4. Plans to monitor its performance to make sure that	03/10/2026

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F0761 SS = D	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to secure a medication cart when the cart was left unattended for 1 of 4 medication carts observed for medication storage (500 Hall medication cart). Findings included: A continuous observation was conducted on 02/11/26 at 8:35 AM through 8:38 AM and revealed a medication cart on the 500 hall was left unattended and unsecured. The medication cart was noted to have 3 drawers containing prescription medications that were pulled open and medications were exposed. Additionally, the medication cart was noted to be unlocked with the keys hanging from the lock. The medication cart was facing the hallway and there were no staff or residents visible on the 500 - hall near or around the medication cart during the observation. Nurse #3 exited a resident's room and approached the unsecured cart. An interview was conducted with Nurse #3 on 02/11/26 at 8:38 AM when she returned to the medication cart. Nurse #3 stated she had her eyes on the cart the whole time. Nurse #3 then reported that she was assisting a resident to his room and did not have her eyes on the medication cart. Nurse #3 stated she knew the cart should not have been left unattended and unsecured with drawers' open and the keys left in the lock. Nurse #3 stated she was rushing and did not realize she left the drawers open or that she kept the key in the lock. An interview was conducted with the Administrator on 02/13/26 at 3:40 PM. The Administrator stated he expected his nursing staff to ensure the medications carts were secured at all times whenever the nursing staff stepped away from their cart. He stated it was important to keep the medications carts secured while unattended to prevent any residents or staff from taking medications from the cart who were not issued access to the medication cart.	F0761	Continued from page 8 solutions are sustained: The Administrator introduced an observation tool on 2/16/2026 to be utilized by Unit Managers to observe medication carts daily for a week and weekly for 3 weeks then monthly for 3 months. The Results will be reported to the Quality Assurance Performance improvement Committee (QAPI) for further recommendations as needed or until compliance is maintained. 5. Date of Compliance: 3/10/2026	