	-	ID HUMAN SERVICES			F	ORM APPROVED		
		MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		OATE SURVEY COMPLETED		
			A. BUILDING			с		
		345419	B. WING			04/29/2025		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (04/29/2025		
				17 CORNELIA DRIVE	5052			
LEXINGTO	ON HEALTH CARE CENT	ER		LEXINGTON, NC 27292				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID			(X5) COMPLETION		
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		DATE		
				DEFICIEN	CY)			
E 000	Initial Comments		E 00	00				
	An unannounced rec	ertification and complaint						
		was conducted on 4/13/25						
		veyors returned to the						
		nvestigate new complaint						
		ived aditional information on exit date was changed to						
	,	vas found in compliance with						
	the requirement CFR	•						
	Preparedness. Even							
F 000	INITIAL COMMENTS	6	F 00	00				
	A reportification and	complaint investigation						
		d from 4/13/25 through						
	-	eturned to the facility on						
		e new complaint allegations,						
		l information on 4/29/25.						
		te was changed to 4/29/25.						
	Event ID# 03M511.							
	The following intakes	were investigated						
		226065, NC00227729,						
	NC00223959, NC002	229129, and NC00229248.						
		allegations resulted in						
F 561	deficiency. Self-Determination		F 56	31		5/27/25		
SS=D	CFR(s): 483.10(f)(1)-	(3)(8)	1.50			5/2/725		
	§483.10(f) Self-deteri							
		right to and the facility must						
		e resident self-determination						
		sident choice, including but ts specified in paragraphs (f)						
	(1) through (11) of thi							
	., .,							
		ident has a right to choose						
	activities, schedules ((including sleeping and						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE		(X6) DATE		
Electroni	cally Signed					05/21/2025		

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.

					FORM	APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
	345419	B. WING				C 29/2025
ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ON HEALTH CARE CENT	ER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspects facility that are signified §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other activities facility. §483.10(f)(8) The res participate in other activities facility. This REQUIREMENT by: Based on observation resident and staff inte allow residents who w smokers to smoke ince individual preference (Resident #8 and #24) The findings included Review of the Facility read, in part: "patients evaluated using the s admission and as need supervision. The patients policy and sign the Patients Acknowledgement for Safety Screen, a patie	care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to tivities, including social, nity activities that do not ts of other residents in the is not met as evidenced ms, record review, and rviews, the facility failed to vere assessed to be safe dependently per their for 2 of 3 residents 9) reviewed for smoking. : Smoking Acknowledgement s who wish to smoke will be moking safety screen upon eded to determine need for ent must also agree to the atient Smoking im based on the Smoking ent may smoke in	F	561	The facility sets forth the following pla correction to remain in compliance with federal and state regulations. The faci- has taken or will take the actions set for in the plan of correction. The following plan of correction constitutes the faciliti allegation of compliance. All deficienc cited have been or will be corrected by date or dates indicated. F-561 Resident Rights / Exercise Righ 1. Facility failed to allow residents wi were assessed to be safe smokers to smoke independently per their individu preference. Resident #249 is no longe the facility. Resident #8 remains at the	n all lity orth y s ies r the ts no al r at	
	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DN HEALTH CARE CENT SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect: facility that are signified §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res with members of the of community activities to facility. S483.10(f)(8) The res participate in other activities to facility. This REQUIREMENT by: Based on observation resident and staff inter allow residents who was smokers to smoke into individual preference (Resident #8 and #24 The findings included Review of the Facility read, in part: "patients evaluated using the patients admission and as new supervision. The patients policy and sign the Patients patients policy and sign the Patients policy and sign the Patients policy and sign the Patients patients policy and sign the Patients policy an	FORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345419 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	SPOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MUL A BUILD 345419 B. WING ROVIDER OR SUPPLIER B. WING CON HEALTH CARE CENTER IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFICATION Continued From page 1 F waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. \$483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. \$483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. \$483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to allow residents who were assessed to be safe smokers to smoke independently per their individual preference for 2 of 3 residents (Resident #8 and #249) reviewed for smoking. The findings included: Review of the Facility Smoking Acknowled	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 345419 B. WING ROVIDER OR SUPPLIER DN HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to allow residents who were assessed to be safe smokers to smoke independently per their individual preference for 2 o 3 residents (Resident #8 and #249) reviewed for smoking. The findings included: Review of the Facility Smoking Acknowledgement read, in part: "patients who wish to smoke will be	SFOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (x1) PROVIDERNUPPLICEQUA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345419 STREET ADDRESS, CITY, STATE, ZIP CODE TO CORRELIA DRIVE LEXINGTON, NC 27322 STREET ADDRESS, CITY, STATE, ZIP CODE DN HEALTH CARE CENTER TO CORRELIA DRIVE LEXINGTON, NC 27322 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION MOULD B CROSS REFERENCE TO THE APPROPRIM DEFICIENCY) Continued From page 1 F 561 waking times), health care and providers of health care services consistent with his or her infer in the facility. F 561 \$483.10(f)(2) The resident has a right to interact with members of the community and participate in community activities, including social, religious, and community and participate in community activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. The facility sets forth the following pla correction to remain in compliance with federal and state regulations. The facility plan of correction. The following plan of correct	MENT OF HEALTH AND HUMAN SERVICES FORMER SFOR MEDICARE & MEDICALD SERVICES OMB NC PERCENCIS (X) PROVERSUPPLENCUA IDENTIFICATION NUMBER 345419 E.WING 345419 E.WING CONTERCION CONSUMPLIES STREET ADDRESS, CITY, STATE, ZP CODE 17 CORNELLA DRIVE LEXINGTON, NC 27232 SIMMARY STATEMENT OF DEPICENCIES CONTINUE FOR SUPPLIES SIMMARY STATEMENT OF DEPICENCIES EXAMPLE STREET ADDRESS, CITY, STATE, ZP CODE 17 CORNELLA DRIVE LEXINGTON, NC 27232 SIMMARY STATEMENT OF DEPICENCIES EXAMPLE STREET ADDRESS, CITY, STATE, ZP CODE 17 CORNELLA DRIVE LEXINGTON, NC 27232 SIMMARY STATEMENT OF DEPICENCIES SIMMARY STATEMENT IN OF AN AND STATE SIMMARY STATEMENT IN THE SIGNAL SAS3.10(f)(3) The resident has a right to instract SIMMARY STATEMENT Is not met as evidenced by: Based on observations, record review, and resident and stati interviews, the facility failed to allow resident and stati interviews, the facility failed to sinterfer with the rights of Cher residents in the facility. The findings included: The findings included: Review of the Facility Smoking Acknowledgement read, in part. The SIGUIREMENT is not met as evidenced by: Based on observations, record review, and resident and stati interviews, the facility failed to allow resident and stati interviews, the facilit

Facility ID: 923306

	-	ID HUMAN SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345419	B. WING _			C 04/29/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				17	7 CORNELIA DRIVE		
LEXINGIC	ON HEALTH CARE CENT	ER		L	EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	3/18/25 was reviewed listed as 8:30 AM, 111 5:30 PM, and 8:00 PM members go with resi designated smoking a in proper clothing and place. No adjustment times." a. Resident #8 was au 11/27/24. A Patient Smoking Ad 12/2/24 was signed b The admission Minim assessment dated 12 #8 was cognitively int tobacco. Review of Resident # a smoking assessment determined Resident she could smoke uns A care plan initiated of recent revised date of Resident #8 preferred included the goal Resi safely through the rev interventions included the facility smoking po smoking assessments Resident #8 was inter	e for the facility dated d. Times for smoking were 100 AM, 1:30 PM, 3:30 PM, A. The form read "Staff dents out back to areas. Ensure the resident is a has shoes or foot pedals in s will be made to these dmitted to the facility eknowledgement form dated y Resident #8. um Data Set (MDS) /4/24 documented Resident act, and she did not use 8's medical record revealed nt dated 3/10/25 that #8 was a safe smoker and upervised. on 12/9/24 and the most n 3/13/25 documented a to smoke cigarettes, and sident #8 would smoke riew period. The d educating Resident #8 on olicy and conducting s as needed. rviewed on 4/15/25 at 1:39	F	561	 All current residents who were assessed as a safe smoker at risk. 100 of smokers audited. Residents reassessed. All identified independent smokers per assessment and care pla with BIMS of > 13 informed of allowand to smoke without a schedule. All staff educated by the Staff Development Coordinator (SDC) regarding smokers□ rights. Education completed 05/18/25. Any staff not receiving education by 5/27/2025 will receive education prior to the start of th shift. Future employees to be trained during orientation by the Staff Development Coordinator or designee annually and as needed. Unit Managers or Designee will observe independent smokers 5X per week for four weeks, then 3X per week four weeks, then once for one month. The results of these audits will be reviewed at the Quarterly QA meeting for further problem resolution if needed beam of compliance 05/27/25 	n ce neir c for X1	
		rviewed on 4/15/25 at 1:39 orted while she was glad					

If continuation sheet Page 3 of 44

	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMF	PLETED
		345419	B. WING				C 29/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	29/2029
	ON HEALTH CARE CENT	FR			17 CORNELIA DRIVE		
					LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	• 3	F	56 [.]	1		
	she was able to smok to be able to go out to wanted. She explaine	e at the facility, she wanted					
	During an interview w #2 on 4/16/25 at 9:52	rith Nursing Assistant (NA) AM, she reported Resident utside to smoke frequently.					
		ducted with NA #1 on and she reported Resident ne was not able to go out to					
		ewed on 4/16/25 at 10:44 AM sident #8 became anxious if out to smoke.					
	b. Resident #249 was 4/7/25.	admitted to the facility					
	A Patient Smoking Ac 4/7/25 was signed by	knowledgement form dated Resident #249.					
	revealed the smoking	Il record for Resident #249 assessment dated 4/7/25 t #249 was a safe smoker upervised.					
	#249 preferred to smo a goal he would smol period. The interventi	I/7/25 documented Resident oke cigarettes and included ke safely through the review ons included educating him g policy and conducting a as needed.					
	The admission MDS of Resident #249 was co	dated 4/14/25 documented ognitively intact. The					

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUR COMPLET	
		345419	B. WING				_ 29/2025
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			I7 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 561	8:25 AM. Resident #2 for someone to open to the smoking area. frustrated he had to we smoke and had to we him out to the smokin reported he had been was able to determine cigarette and waiting upsetting to him. The Director of Nursir on 4/16/25 at 1:04 PM facility had been non- residents who wanted outside and smoking steep hill of the drivey and back by the dump places. The DON rep- those smoking behav decided to allow smolt the rear of the building staff supervision. The smoking times had be residents, and they se reported Resident #24 frustration over not be smoking times. The Administrator wa 1:32 PM. The Administ	In progress and not o use. terviewed on 4/16/25 at 249 reported he was looking the door so he could go out He reported he was vait for certain times to it for a staff member to take g area. Resident #249 smoking for 50+ years, he e when he wanted to have a for the smoking times was of the smoking times was a for the smoking times was on the porch, down the vay that led to the street, osters, to name a few orted the facility felt that iors were unsafe and king in a designated area at g at certain times and with DON explained that the ecome a social activity for eemed to enjoy it. The DON are Resident #8 wanted to whenever she wanted but	F	561			
	1:32 PM. The Adminis was previously smoke	strator explained the facility					

If continuation sheet Page 5 of 44

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345419	B. WING _			C 04/29/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E	
LEXINGTO	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)		(X5) COMPLETION DATE			
F 565 SS=D	going outside to smok Administrator explained team did not feel this and they decided to in smoking for all resided times they would offer Administrator explained develop a system that opportunity to smoke providing them with sa The Administrator was residents who were at smokers were required designated times with Resident/Family Grou CFR(s): 483.10(f)(5)(if §483.10(f)(5) The rest and participate in rest (i) The facility must pr group, if one exists, we reasonable steps, with to make residents and upcoming meetings in (ii) Staff, visitors, or of resident group or fam the respective group's (iii) The facility must pr person who is approv group and the facility providing assistance at requests that result from (iv) The facility must of resident or family grou the grievances and re groups concerning iss in the facility.	te, at various places. The ed that the interdisciplinary was safe for the residents inplement supervised ints, and determined the r smoking. The ed that the facility decided to t provided residents with the if they wished, while afety through supervision. Is unable to explain why the ssessed as independent ed to smoke at the supervision. Ip and Response)-(iv)(6)(7) ident has a right to organize dent groups in the facility. ovide a resident or family ith private space; and take in the approval of the group, d family members aware of in a timely manner. ther guests may attend ily group meetings only at is invitation. provide a designated staff ed by the resident or family and who is responsible for and responding to written		561		5/27/25

Facility ID: 923306

If continuation sheet Page 6 of 44

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345419	B. WING				C 29/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LEXINGT	ON HEALTH CARE CENT	ER		1 L				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE COM RENCED TO THE APPROPRIATE		
F 565	response and rational (B) This should not be facility must implement request of the resident §483.10(f)(6) The res- participate in family gr §483.10(f)(7) The res- family member(s) or co- representative(s) meet families or resident re- residents in the facility This REQUIREMENT by: Based on record revi- interviews, the facility that were reported in meetings for 4 of 6 m 12/18/2024, 1/29/202 Findings included: A review of the Reside indicated the resident 11/19/2024, 12/18/202 2/26/2025, during the that they received pot several times during the that they received pot	le for such response. a construed to mean that the nt as recommended every at or family group. ident has a right to roups. ident has a right to have other resident at in the facility with the opresentative(s) of other y. is not met as evidenced ew and staff and resident failed to resolve grievances the Resident Council onths (11/19/2024, 5 and 2/26/2025). ent Council Minutes s had complained on 24, 1/29/2025, and Resident Council meeting, tatoes and green beans the same week. onse/Resolution dated the facility's menu was orate office and the Dietary nenu could not be changed. ponse/Resolution also vere served three times a tatoes were served two	F	565	 F-565 Resident/Family Group Respon 1. Facility failed to resolve grievance that were reported in the Resident Courmeetings for 4 of 6 months. Unable to identify resident #15. 2. Menus were modified and repeat vegetables were replaced with substitu. The Registered dietician reviewed and accepted changes to menu 3. Activities staff and Administrator educated 05/16/25 regarding residents rights including resolution of grievance by the by the Staff Development Coordinator (SDC) regarding residents right to assemble and obtain resolution grievances. Facility Activities staff will conduct weekly focus meetings to obta concerns. The concerns are to be addressed by the Administrator designated staff member within 72 hou Any new activity staff or facility administrator will receive education du the orientation process. 4. The Activities Director or Designet 	s incil ites. s i to iin irs. ring		

Event ID:03M511

Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED	
		345419	B. WING				C 29/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	29/2025
				17	7 CORNELIA DRIVE		
LEXINGIC	ON HEALTH CARE CENT	ER		LI	EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	On 12/18/2024 the De Response/Resolution Administrator stated t residents' concerns to if any substitutions co On 1/29/2025 the Dep Response/Resolution stated the Dietary Ma corporate office to asl your request options to On 2/27/2025 the Dep Response/Resolution Administrator and sta Regional Director of O resident's concerns a availability of alternato On 3/26/2025 the Dep Response/Resolution stated the menu woul May or June of 2025. An interview was com Council on 4/15/2025 council members indic concerns that the sam repeatedly. Resident multiple times in the p were being served the and dinner several tim continued to be an iss residents were served multiple times a week respond to the concern	epartmental form updated by the hey continued to report the o the Dietary Manager to see ould be made. Dartmental form was updated and nager would contact the k about substitutions and at for residents. Dartmental form was updated by the ted she emailed the Senior Operations regarding the nd asked about the e options. Dartmental form was updated and d change for the season in ducted with the Resident at 3:20 pm during which the cated they had brought up ne foods were being served #15 stated they shared past six months that they e same food items for lunch nes a week, but they d the same things, and it sue. Resident #15 stated d potatoes and green beans a and the facility did not rn and correct the issue.	F	565	 will audit/ record and resolve identified concerns 1X per week for eight weeks then once monthly. 5. Results of these audits will be reviewed at the Quarterly QA meeting for further problem resolution, if neede the monitoring will be conducted randomly. 6. Date of compliance 05/27/25 	X1	
	On 4/15/2025 at 3:49	pm the Activity Director was					

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED C
		345419	B. WING _		
NAME OF PI	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, S	•
LEXINGTO	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 2729	2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRE	I'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE COMPLETIC ENCED TO THE APPROPRIATE DATE DEFICIENCY) DATE
F 565 F 578 SS=D	written in the Residen Departmental Responsent to the Department concern. The Activity complaint about being items had been a con Administrator was not Administrator had cor dietary company and the menus in either M Activity Director states had taken so long for the mashed potatoes served so frequently. form for the complain green beans had bee and potatoes two time The Administrator was at 12:46 pm and states grievances during the on 11/19/2024, 12/18, 2/26/2025. She states Manager to replace th beans to make sure th with their meals. She reason the issue had the Dietary Manager I with substituting what	stated the concerns were at Council Minutes and a nse/Resolution form was nt Manager of the area of Director stated the g served the same food asistent problem and the tified of the concern, and the ntacted the contracted there was a plan to change lay 2025 or June 2025. The d she did not know why it something to be done about and green beans being She indicated the response t was dated 11/26/2024 and n served three times a week es a week. s interviewed on 4/16/2025 ed she was aware of the Resident Council Meetings /2024, 1/29/2025 and d she talked with the Dietary ne potatoes and green he residents were happy s stated she thought the taken so long was because had not been comfortable was on the menu. ntnue Trmnt;Formlte Adv Dir		565	5/27/25
	§483.10(c)(6) The rig	ht to request, refuse, and/or t, to participate in or refuse			

Facility ID: 923306

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 06/05/2025 ORM APPROVED NO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345419	B. WING				C 04/29/2025	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
LEXINGTO	ON HEALTH CARE CENT	ER						
	1				EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 578	Continued From page	a 0		578				
1 010	§483.10(c)(8) Nothin construed as the righ the provision of medi	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or		576				
	 Inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still 							
	legally responsible for requirements of this s (iv) If an adult individu time of admission and information or articula has executed an adv	r ensuring that the section are met. ual is incapacitated at the						
	individual's resident r with State law. (v) The facility is not provide this informati or she is able to rece Follow-up procedures the information to the	epresentative in accordance relieved of its obligation to on to the individual once he						
	by: Based on record rev facility failed to comp	「 is not met as evidenced iew and staff interviews, the letely fill out the Do Not orm for 1 of 2 residents			F-578 Request/Refuse/Dscntnu Formlte Adv Dir 1. Facility failed to completely			

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	FED: 06/05/2029 ORM APPROVED NO. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
		345419	B. WING			C 04/29/2025		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	N HEALTH CARE CENT	ED		17	7 CORNELIA DRIVE			
LEXINGIC	IN HEALTH CARE CENT	ER		L	EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 578	Continued From page	e 10	F	578				
	reviewed and Advance 30).	ced Directives (Resident #		570	Do Not Resuscitate (DNR) form for 1 residents reviewed and Advanced Directives. Resident #30 continues to			
		l: dmitted to the facility on # 30's diagnosis included			 reside at the facility. 2. All residents have the potential to affected. The DNR form for Resident was updated to reflect the correct coordinates and th	#30		
	hypertension, and co			status. Unit Manager audited 100% of DNR forms to ensure all were correct 3. Staff Development Coordinator	of			
	revealed Resident # 3	[#] 30's paper medical record 30's DNR form signed by the P) # 1 was not dated.			educated facility Nurse Practitioners (regarding the completion of the DNR forms. Education completed 05/17/25			
		[£] 30's Electronic Medical led a physician's order dated tatus DNR.			All new Nurse Practitioners will be educated during orientation by the Sta Development Coordinator or designed			
	An interview was con PM with Unit Manage revealed upon admis complete the DNR. U by stating the form w Practitioner (NP) to b scanned into the EMI kept at the nurse's sta Manager # 2 further s correspond with a ma match what was docu review of the form Ur date was missing from The Nurse Practitione on 4/16/2025 at 11:29 are usually dated bef sign. NP # 1 further s			 annually and as needed. The DON and/ or designee will a the DNR forms during daily clinical meetings. 5X per week for four weeks then 3X per week for four weeks, then weekly for one month. Results of these audits will be reviewed at the Quarterly QA meeting for further problem resolution, if need the monitoring will be conducted randomly. Date of compliance 05/27/25 	udit s, n			
	them.	with the date already on iducted with the Director of						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		IPLE CONSTRUCTION		SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578 F 580 SS=D	Nursing (DON) on 4/1 DON revealed the ad responsible for compl DON indicated inform checked during the tw after admission. The effective date. An interview was com Administrator on 4/16 Administrator on 4/16 Administrator reveale for signing and dating Administrator further may need additional t process. Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notified (i) A facility must imm consult with the reside	4/2025 at 1:13 PM. The missions nurse would be eting the DNR form. The ation on the form should be venty-four-hour chart check DNR form should have an appleted with the /2025 at 11:44 AM. The d NP # 1 was responsible the DNR form. The stated NP # 1 was new and raining or retraining of the jury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify,		578			5/27/25
	representative(s) whe (A) An accident involver results in injury and h physician intervention (B) A significant chan mental, or psychosocc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue	ving the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the					

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Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345419	B. WING				C 29/2025
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LEXINGTO	ON HEALTH CARE CENT	ER			I7 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	 (ii) When making notii (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must re update the address (re phone number of the representative(s). §483.10(g)(15) Admission to a composite dii §483.5) must disclose its physical configuration locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revia and staff interviews, to Nurse Practitioner (NIN Normalized Ratio (INI) 	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations f is not met as evidenced ew and Nurse Practitioner he facility failed to notify the P) after an International R) test (monitors the d-thinning medications) was ered for 1 of 1 resident ewed for monitoring ne.	F	580	F-580 Notify of Changes 1. Facility failed to notify the Nurse Practitioner (NP) after an International Normalized Ratio (INR) test (monitors effectiveness of blood-thinning medications) was not completed as ordered. Resident #255 no longer resident at the facility. 2. All residents have the potential to affected DON audited 100% of resider	des be	

Event ID:03M511

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		ID HUMAN SERVICES			FOF	RM APPROVED
STATEMENT O		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY MPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G	CON	
		345419	B. WING		04	C 4/29/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
				17 CORNELIA DRIVE		
LEXINGIC	ON HEALTH CARE CENT	ER		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Resident #255 was an 03/30/21 with diagnost fibrillation. Resident #255's phys revealed the resident warfarin sodium (antion tablet 2 milligram (mg bedtime related to un A progress note dated Nurse Practitioner (NI #225's INR was recert 4.0 that morning (norm further noted Resider held until 3/7/25. The #255's INR was to be to notify NP #1 of any Resident #255's phys order dated 03/07/25 INR on 03/07/25 and notice. Resident #255's MAR through 03/12/25 war to Resident #255. Fui #1 signed off on 03/0 completed on the resident midicated no results for #255 for the 03/07/25 A phone interview con	dmitted to the facility on ses which included atrial dician order dated 01/30/25 was ordered to receive a coagulant/blood thinner) oral (), give 1 tablet by mouth at specified atrial fibrillation. d 03/05/25 completed by P) #1 revealed Resident htly checked, and it was at mal range 2-3). It was nt #255's warfarin was to be note indicated Resident rechecked on 03/07/25 and bleeding or changes. dician orders revealed an to check Resident #255's hold Warfarin until further R revealed from 03/05/25 farin was not administered rther review revealed Nurse 7/25 that an INR was ident but there was no ult. and progress notes or an INR lab for Resident ordered INR.	F 58	 with PT/INR orders. No others during survey. Current licensed nurses weeducated by the Staff Developin Coordinator regarding obtaining as ordered and performing the of change in condition to the ME Education completed 05/17/25 Any licensed nurse not receiving education by 5/27/2025 will receive education prior to the start of the All newly hired nurses will be eduring orientation by the Staff Development Coordinator or deannually and as needed. The UM or designee will a orders and flowsheets during comorning meeting 5X per week weeks, then 3X per week for for then weekly for four weeks (on 5. Results of these audits will reviewed at the Quarterly QA in for further problem resolution, if the monitoring will be conducted randomly. Date of compliance 05/27/ 	vere ment ng PT/INR notification ID or NP. ng ceive neir shift. educated esignee udit the stinical for four bur weeks, ie month). Il be neeting X1 if needed ed	
	04/24/25 at 8:00 pm r	nducted with Nurse #1 on revealed on 03/07/25 she nt #255. Nurse #1 could not				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	06/05/2025 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	LETED
		345419	B. WING		_		C 29/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				17 CORNELIA DRIVE			
	ON HEALTH CARE CENT	ER		LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	BEAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	on that date but explation the resident's INR it was resident's INR it was resident's chart. Nurse was not in the resider complete it. A phone interview corrout/24/25 at 1:10 PM resident's INR number revealed on 03/05/25 rate of 4.0 and she was held and the INR to be The NP indicated Resider 1.3. The NP stated the negative outcome as INR was not checked nursing staff to follow and notification of any she was not notified to and would expect static completed as ordered. An interview conducter Nursing (DON) on 04/Resident #255 had or not being consistent. was being followed cliproviders. The DON si was not checked on 03/07/25.	bleted Resident #255's INR ined if she had completed yould have been in the e #1 stated if the INR result its' chart, then she did not hducted with NP #1 on revealed Resident #255's ed closely due to the rs fluctuating. NP #1 Resident #255 had an INR anted the resident's warfarin e rechecked on 03/07/25. sident #255 was checked on it #255 had an INR result of ere was no harm or a result of the resident's on 03/07/25 but expected through with orders given y changes. The NP indicated he lab was not completed ff to notify her if it was not l. ed with the Director of /24/25 at 3:00 PM revealed ingoing issues with her INR The DON further revealed it osely by the medical stated she was not aware it	F 58				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					MAPPROVE 0. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			PLETED		
		345419	B. WING				C 1 29/2025	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
LEXINGT	ON HEALTH CARE CENT	TER			7 CORNELIA DRIVE EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE	
F 580	the Administrator reve Resident #255's char documentation Resid check on 03/07/25. T revealed she expecte through with and beli from 03/07/25 to have	ealed she had reviewed t and could not find any lent #255 received an INR The Administrator further ed orders to be followed eved Resident #255's order e her INR checked was	F	580				
F 658 SS=D		eet Professional Standards (i)	F	658			5/27/25	
	The services provide as outlined by the com- must- (i) Meet professional This REQUIREMENT by: Based on observation interviews, the facility swallowed medication administration when the bedside for 1 of 5 medication administra The findings included Resident #2 was adm with diagnoses included heart failure. The quarterly Minimud dated 3/26/25 assess moderately cognitive	d or arranged by the facility, mprehensive care plan, standards of quality. Γ is not met as evidenced ons, record reviews, and staff γ failed to ensure a resident ns during medication Nurse #5 left medications at is residents observed for ation (Resident #2). d: hitted to the facility 12/19/24 ding diabetes and congestive um Data Set assessment sed Resident #2 to be ly impaired. ian orders for Resident #2			 F-658 Services Provided Meet Professional Standards 1. Facility failed to ensure a resident swallowed medications during medicat administration Resident #2 continues to reside at the facility. 2. All residents have the potential to affected. Nurse #5 pulled from the medcart and educated by the Director Nursing at the time of the event. 3. Staff Development Coordinator educated all nurses regarding the medication administration. Education completed 05/05/25. Any licensed nurse not receiving education by 5/27/2025 will receive education prior to the start of their shift All new nurses will be educated during orientation by the SDC or designee annually and as needed. 	ion o be of		

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Facility ID: 923306

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345419	B. WING _			04/2	C 29/2025
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	-	
LEXINGT	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE			
				LEXINGTON, NC 27	292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EACH COI	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	 Digoxin 125 microgr fibrillation at 9:00 AM Furosemide 20 millig blood pressure at 8:0 Nadolol 40 mg 1 tab at 9:00 AM Oxybutynin chloride bladder spasm at 8:00 Sennosides-docusa tablets daily for const Divalproex Sodium anxiety at 9:00 AM Metformin 500 mg 1 diabetes at 9:00 AM Metformin 500 mg 1 diabetes at 9:00 AM Methenamine Hippu urinary tract at 9:00 A Resident #2 was obse AM. A medication cu overbed table. Reside medications, and she what they were or wh Nurse #5 was asked to room and she arrived the medication on the exclaimed, "Oh, you of Resident #2 shook he take the medications. During the observation Nurse #5 was asked to left on the overbed ta that Resident #2 had and must have spit th she had an urgent ne had left the medication had not watched her st The medication admin 	ams 1 tablet daily for atrial grams (mg) 1 tablet daily for 0 AM let daily for blood pressure 5 mg 1 tablet daily for 0 AM te sodium 8.6 mg/50 mg 2 ipation at 9:00 AM 125 mg 1 tablet daily for tablet twice daily for rate 1 gram 1 tablet for M erved on 4/13/25 at 11:50 p with 9 pills was on her ent #2 was asked about the reported she did not know y they were on her table. to come to Resident #2's at 12:00 PM. When shown e overbed table, Nurse #5 didn't take your medication!" er head 'no' and refused to n on 4/13/25 at 12:00 PM, why the medications were ble and Nurse #5 reported put the pills in her mouth em out. Nurse #5 explained ed to use the bathroom and ns with Resident #2 and swallow the medications.	F	medication obs four weeks, the weeks, then we 5. Results of reviewed at the for further probl the monitoring by the Unit Ma	t designee will perform 5 ervations 5X per week f en 3X per week for four eekly for four weeks. these audits will be e Quarterly QA meeting 3 lem resolution, if needed will be conducted rando nager or designee. mpliance 05/27/25	for X1 d	

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F DEFICIENCIES	MEDICAID SERVICES				D. 0938-0391
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	345419	B. WING _			/29/2025
OVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
N HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 27292		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
been administered to The Director of Nursin on 4/13/25 at 12:40 P the medications shoul overbed table and Nu	Resident #2 at 10:11 AM. og (DON) was interviewed M. The DON reported that d not have been left on the rse #5 should have watched	F 6	58		
The DON was intervie 12:53 PM and she rep nurses to ensure the r medications by watch medications and not le The DON reported Nu physician of Resident	ewed again on 4/16/25 at ported she expected all residents were taking their ing them swallow the eaving pills at the bedside. urse #5 notified the #2's refusal to take the				
1:32 PM and she report urgently use the bathr administration to Resi pills for Resident #2 to reported she expected rights of medication are the residents swallow Free of Accident Haza	orted that Nurse #5 had to oom during the medication dent #2, and she left the o take. The Administrator d all nurses to follow the 6 dministration and to watch the medications. ards/Supervision/Devices	F 6	89		5/27/25
§483.25(d)(1) The res as free of accident hat §483.25(d)(2)Each res supervision and assist accidents. This REQUIREMENT	re that - ident environment remains zards as is possible; and sident receives adequate tance devices to prevent				
	NHEALTH CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page been administered to The Director of Nursir on 4/13/25 at 12:40 P the medications shoul overbed table and Nu her swallow the medica The DON was intervie 12:53 PM and she rep nurses to ensure the r medications by watch medications and not le The DON reported Nu physician of Resident medications on 4/13/2 The Administrator was 1:32 PM and she reported Nu physician of Resident medications on 4/13/2 The Administrator was 1:32 PM and she reported urgently use the bathr administration to Resi pills for Resident #2 to reported she expected rights of medication at the residents swallow Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d)(2)Each re- supervision and assis accidents.	DVIDER OR SUPPLIER NHEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 been administered to Resident #2 at 10: 11 AM. The Director of Nursing (DON) was interviewed on 4/13/25 at 12:40 PM. The DON reported that the medications should not have been left on the overbed table and Nurse #5 should have watched her swallow the medications. The DON was interviewed again on 4/16/25 at 12:53 PM and she reported she expected all nurses to ensure the residents were taking their medications by watching them swallow the medications and not leaving pills at the bedside. The DON reported Nurse #5 notified the physician of Resident #2's refusal to take the medications on 4/13/25. The Administrator was interviewed on 4/16/25 at 1:32 PM and she reported that Nurse #5 had to urgently use the bathroom during the medication administration to Resident #2, and she left the pills for Resident #2 to take. The Administrator reported she expected all nurses to follow the 6 rights of medication administration and to watch the residents swallow the medications. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d)(Accidents. The facility must ensure that - §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	345419 B. WING_ OVIDER OR SUPPLIER N HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 been administered to Resident #2 at 10:11 AM. The Director of Nursing (DON) was interviewed on 4/13/25 at 12:40 PM. The DON reported that the medications should not have been left on the overbed table and Nurse #5 should have watched her swallow the medications. The DON was interviewed again on 4/16/25 at 12:53 PM and she reported she expected all nurses to ensure the residents were taking their medications and not leaving pills at the bedside. The DON reported Nurse #5 notified the physician of Resident #2's refusal to take the medications on 4/13/25. The Administrator was interviewed on 4/16/25 at 1:32 PM and she reported that Nurse #5 had to urgently use the bathroom during the medication administration to Resident #2, and she left the pills for Resident #2 to take. The Administrator reported she expected all nurses to follow the 6 rights of medication administration and to watch the residents swallow the medications. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d)(1)(T) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent acciden	addition OWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE N HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SH REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX (EACH CORRECTIVE ACTION SH CROSS-HEPEREMEND TO THE PRINCIPS (EACH CORRECTIVE ACTION SH CROSS-HEPEREMEND SH THE RESIDENT SH (EACH CORRECTIVE ACTION SH (EACH CORRECTIVE ACT	JASS 19 B. WING Journal of the second secon

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Facility ID: 923306

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345419	B. WING				С
	ROVIDER OR SUPPLIER	545415	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	04	4/29/2025
NAME OF PI	ROVIDER OR SUPPLIER						
LEXINGTO	ON HEALTH CARE CENT	ER			7 CORNELIA DRIVE .EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From page	- 18	Í F	689			
		ns, record reviews and staff	1	009	F-689 Free of Accidents		
		e Practitioner interviews, the			Hazards/Supervision/Devices		
	•	te the necessary supervision			1. Facility failed to provide the ne	cessary	
		with known wandering			supervision to prevent a resident w	•	
		ing the room of another			known wandering behaviors from e		
	resident and attempti	-			the room of Resident 94. Resident	•	
	resident's (Resident #	#94's) belongings during the			continues to reside at the facility.		
	night for 1 of 3 reside	nts reviewed for accidents			Resident #94 no longer resides at t	he	
	(Resident #91).				facility.		
					2. Resident #91 has one on one		
	The findings included				while appropriate placement is beir located. Resident with BIMS of 13-	15 will	
		mitted to the facility on			be interviewed by facility social ser		
		es including metabolic			determine if they have any concern		
		ain dysfunction caused by			other residents coming into their ro		
		dy's metabolism, often due			Interviews will be completed by 5/2		
		ic illnesses), alcohol-induced major depressive disorder,			2. Staff Development Coordinato educated all staff regarding resider		
	and anxiety disorder.				behaviors who roam and may need		
					supervision. Education completed	•	
	A physician's order fo	or Resident #91 dated			05/17/25.		
		nzapine (an antipsychotic			Any staff not receiving education by	ý	
		ims (mg) every 8 hours for			5/27/2025 2ill receive education pri		
	severe alcohol abuse	e disorder with unspecified			the start of their shift.		
	mood disorder.				All new staff will be educated duri	•	
					orientation by the Staff Developme		
		d on 3/11/25 addressed			Coordinator or designee annually a	ind as	
		nt #91, including safety			needed.	aianaa	
		mbulating independently, ons, sitting on the floor, and			 The social services team or de will complete interviews to patients 	•	
		ns. Interventions included			BIMS 13-15 weekly to determine if		
		services and redirection of			residents are wandering to their roo		
		he exhibited behaviors.			This will be done weekly x4 then m x 2.		
	A Nurse Practitioner	(NP) note dated 3/15/25			4. Results of these audits will be		
		sident #91 had agitation, was			reviewed at the Quarterly QA meet	ina X1	
		date, and situation. Resident			for further problem resolution, if ne	-	
	-	be self-propelling in a			the monitoring will be conducted ra		
	wheelchair. The plan				by Unit Manager or designee.		

Facility ID: 923306

If continuation sheet Page 19 of 44

Instrummor perperiencies AND PLAN OF CORRECTION (X) IDENTIFICATION NUMBER: JUBENTIFICATION NUMBER: 345419 (X) MULTIPLE CONSTRUCTION A BUILDING (X) DATE SU A BUILDING (X) DATE SU COMPLEX STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELLA DRIVE LEXINGTON HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELLA DRIVE LEXINGTON NEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELLA DRIVE LEXINGTON, NC 27292 PRETX TAG SUMMARY STREMENT OF DEP/CIP/OSS (RCA) DEP/CIENCY MULTIPLE CONSTRUCTION CORRECTION (RCA) DEP/CIENCY MICE ADDRESS, CITY, STATE, ZIP CODE (RCA) DEP/CIENCY (RCA) DEP/CIENCY MICE ADDRESS, CITY, STATE, ZIP CODE (RCA) DEP/CIENCY (RCA) DEP/CIENCY MICE ADDRESS, CITY, STATE, ZIP CODE (RCA) DEP/CIENCY (RCA) DEP/CI			ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/05/2028 RM APPROVED IO. 0938-0391	
JA45419 B. WING Out200 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, ZIP CODE 17 CORRELLD BNIVE LEXINGTON. HEALTH CARE CENTER International Control of DeFiciencies 17 CORRELLD BNIVE LEXINGTON, NC 27292 PROVIDER OR SUPPLIER International Control of DeFiciencies 17 CORRECTION SHOULD BE 0 PROVIDER OR SUPPLIER International Control of DeFiciencies 10 PROVIDER OR SUPPLIER 12 PROVIDER OR SUPPLIER 12 12 CORRECTIVE ACTON SHOULD BE 0 0 12	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	· ,			(X3) DAT	E SURVEY IPLETED	
INVALE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2IP CODE LEXINGTON HEALTH CARE CENTER IT CORRELA DRIVE LEXINGTON, NC 27292 Image: Continued From page 19 Indicated medication adjustments to be made based on Resident #01's behavior, and staff continued to monitor her behavior and report changes. PROVE F 689 Continued From page 19 Indicated medication adjustments to be made based on Resident #01's behavior, and staff continued to monitor her behavior and report changes. F 689 A physician's order for Resident #01 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. F 689 The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #01 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #01 used a walker and wheelchair for mobility. Antipexpendition. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #01 used a walker and wheelchair for mobility. Antipexpendition medications were documented Resident #01 used a walker and wheelchair for mobility. Antipexpendition. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #01 had behaviors of aggression towards staff with splitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #01 had intermittent confusion during the assessment, and be had			345419	B. WING			C 04/29/2025		
LEXINGTON HEALTH CARE CENTER LEXINGTON, NC 27282 (%1) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENT WILST ER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH DEFICIENT WILST ER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENT WILST ER PRECEDED BY FULL DEFICIENCY) PREFIX (EACH DEFICIENT WILST ER PRECEDED BY FULL DEFICIENCY) PREFIX TAG PREFIX (EACH DEFICENCY WILST EACH DEFICIENCY) PREFIX (EACH DEFICENCY) PREFIX (EACH DEFICENCY) PREFIX (EACH DEFICIENCY)	NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
CM3 ID PHETX INC SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCY WIGT BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) ID PHETX TXG PROVIDERS PAN OF CORRECTION (EXCH DORRECTIVE ACTION SHOULD BE CROBS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 19 indicated medication adjustments to be made based on Resident #91's behavior, and staff continued to monitor her behavior and report changes. F 689 5. Date of compliance 05/27/25 A physician's order for Resident #91 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. F 689 5. Date of compliance 05/27/25 The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility. Antipsychotic medications were documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility. Antipsychotic medications were documented Resident #91 required Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #91 tab intermittent confusion during the assessment, and she had					17 (CORNELIA DRIVE			
Preferx TxG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TxG (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 19 indicated medication adjustments to be made based on Resident #91 behavior, and staff continued to monitor her behavior and report changes. F 689 5. Date of compliance 05/27/25 A physician's order for Resident #91 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. F 689 The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 did not reject care at the time of the assessment. The MDS documented Resident #91 equired substantial assistance of staff for rambulation. The MDS documented Resident #91 equired substantial assistance of rambility, and was dependent on staff for ambulation. The MDS documented Resident #91 required substantial assistance of staff for transiers, partial to moderate assistance for mobility, and was dependent on staff for ambulation The MDS documented Resident #91 required substantial assistance of aspecient #91 used a walker and wheelchair for mobility. Antipsychotic medications were documented as received on a routine basis. Impact the tare Assessment for the admission MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. Impact the tare Assessment, and she had	LEXINGIC	ON HEALTH CARE CENT	IER		LEX	KINGTON, NC 27292			
 Indicated medication adjustments to be made based on Resident #91's behavior, and staff continued to monitor her behavior and report changes. A physician's order for Resident #91 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance of mobility, and was dependent on staff for ambulation. The MDS documented Resident #91 readine basis. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #91 thad behaviors of agression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented the Resident #91 had behaviors and not following directions. 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETION DATE	
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based on Resident #91's behavior, and staff continued to monitor her behavior and report changes. A physician's order for Resident #91 dated 3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility, and was dependent on staff for ambulation. The MDS documented Resident #91 negative and wheelchair for mobility. And was dependent on staff for ambulation. The MDS documented as received on a routine basis. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented Resident #91 had intermittent confusion during the assessment, and she had	F 009			- F 6					
3/15/25 indicated Divalproex Sodium (an antiseizure medication that is also used for mood disorders) 250 mg every 12 hours for agitation. The admission Minimum Data Set (MDS) dated 3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 did not reject care at the time of the assessment. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility, and was dependent on staff for ambulation. The MDS documented Resident #91 used a walker and wheelchair for mobility. Antipsychotic medications were documented as received on a routine basis. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with splitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #91 had intermittent confusion during the assessment, and she had		based on Resident # continued to monitor	91's behavior, and staff			5. Date of compliance 05/27/25			
3/17/25 assessed Resident #91 to be severely cognitively impaired with hallucinations, delusions, and physical behaviors that impacted her care, activities, and social interactions. The MDS documented Resident #91 did not reject care at the time of the assessment. The MDS documented Resident #91 required substantial assistance of staff for transfers, partial to moderate assistance for mobility, and was dependent on staff for ambulation. The MDS documented Resident #91 used a walker and wheelchair for mobility. Antipsychotic medications were documented as received on a routine basis. The Care Area Assessment for the admission MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #91 had intermittent confusion during the assessment, and she had		3/15/25 indicated Div antiseizure medication	alproex Sodium (an on that is also used for mood						
MDS dated 3/17/25 documented Resident #91 had behaviors of aggression towards staff with spitting out medications and not following directions. A psychiatry NP initial consult note dated 3/19/25 documented that Resident #91 had intermittent confusion during the assessment, and she had		The admission Minim 3/17/25 assessed Re cognitively impaired v delusions, and physic her care, activities, a MDS documented Re care at the time of the documented Resider assistance of staff for moderate assistance dependent on staff for documented Resider wheelchair for mobility were documented as	hum Data Set (MDS) dated esident #91 to be severely with hallucinations, cal behaviors that impacted and social interactions. The esident #91 did not reject e assessment. The MDS at #91 required substantial r transfers, partial to for mobility, and was or ambulation. The MDS at #91 used a walker and ty. Antipsychotic medications received on a routine basis.						
anti-anxiety medication to be increased to three times per day, and staff to continue to monitor Resident #91 for changes in behavior.		MDS dated 3/17/25 c had behaviors of agg spitting out medication directions. A psychiatry NP initial documented that Res confusion during the been experiencing and anti-anxiety medication times per day, and st	documented Resident #91 pression towards staff with ons and not following al consult note dated 3/19/25 sident #91 had intermittent assessment, and she had nxiety. The note documented on to be increased to three aff to continue to monitor						
A physician note dated 3/19/25 documented		A physician note date	ed 3/19/25 documented						

Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	
		345419	B. WING				_ 29/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 .	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	repeating questions. A physician's order fo 3/19/25 indicated Dia for anxiety. A nursing note dated Resident #91 was ext picking at skin, restles biting, kicking, spitting stealing, delusions, his care. The note docum wandering into other in residents, and attemp note documented 2 m assistant (NA) were a Resident #91. A NP note dated 3/21 #91 was observed pathallway, wandering in rooms, and following The note documented easily redirected. A NP note dated 3/22 #91 was observed wathallway, attempting to residents' rooms. The #91 had a 1:1 sitter a redirected. The note of reported that Resider medications and had work was ordered, an note documented Resider	airment, with wandering and r Resident #91 dated zepam 5 mg 3 times per day 3/21/25 documented that hibiting behaviors: itching, ssness, agitation, hitting, g, cussing, racial slurs, allucinations, and refusing hented Resident #91 was resident rooms, touching biting to leave the facility. The urses, and 1 nursing ittempting to redirect /25 documented Resident cing up and down the and out of resident's visitors and staff members. d Resident #91 was not /25 documented Resident alking up and down the and out of resident's visitors and staff members. d Resident #91 was not	F	689			
	difficult to control due encephalopathy and l safety awareness.	to metabolic Resident #91 had poor					

Facility ID: 923306

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	
		345419	B. WING				29/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	21	F	689	h		
	behaviors was modifies sitter and noted the fa supervision. Unit Manager #1 was	dressed Resident #91's ed on 3/26/25 to add 1:1 amily was assisting with interviewed on 4/16/25 at ported the facility initiated a					
	1:1 sitter assigned to from 7:00 AM to 11:00 assigned sitter on 11:	Resident #91 on 3/26/25 D PM, but there had been no 00 PM to 7:00 AM shift. ined that all staff were					
	#91 was observed an	/25 documented Resident nbulating in the hall with a te documented Resident d restless.					
	report that Resident # restlessness and goin The note documented wandering with poor s documented a one-tir (antipsychotic medica emotional, and menta restlessness and requ evaluation. The note	sleep at night. The note ne dose of haloperidol ation used to treat nervous,					
	administration of halo behavior for Resident Resident #91 continu attempted to enter oth	3/30/25 documented the peridol without any effect on #91. The note documented ed to roam the halls and her resident rooms, and she staff when staff attempted to					

Facility ID: 923306

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	22	F	689			
	#91 remained restless The note documented	/25 documented Resident s and wandered the halls. d Resident #91 had poor span, and poor safety					
	3/31/25 documented	n by Nurse #1 and dated Resident #91 continued to reness and was taking other ems.					
	#91 was in the hallwa redirect. The note doo	25 documented Resident by, confused, and difficult to cumented Resident #91 in and out of other resident					
	Resident #91 had bee confusion and behavi attempts to elope and	e dated 4/2/25 documented en experiencing increased oral changes, including I sleep disturbances. The dication adjustments and					
	daily was increased to	bex Sodium 250 mg twice o 250 mg 3 times per day changed from 5 mg in the					
	#91 was ambulating i The note documented #91 was attempting to their hands when the	25 documented Resident n the hall with a 1:1 sitter. d staff reported Resident o bite staff and slapping at y attempted to redirect her.					
	A nursing note dated Resident #91 was ag	4/3/25 documented gressive and combative					

Facility ID: 923306

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345419	B. WING				C /29/2025
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page towards staff. A nursing note in Res written by Nurse #1 a documented Residen #94's room and atterr and glasses. The nurs Resident #94 yelling of The note documented Resident #94 and Re exit the room. A nursing note in Res written by Nurse #1 a documented Residen yelling "stop, stop, pu documented Residen yelling "stop, stop, pu documented when sta Resident #91 was not Resident #91 was not Resident #91 was rer assessment, small ind Resident #94's right f bruising. The skin wa denied pain. An interview was con 4/15/25 at 10:34 AM. working 11:00 PM to when Resident #91 w room and tried to take Nurse #1 described N supervise Resident #9	ident #91's medical record nd dated 4/4/25 at 3:40 AM t #91 entered Resident opted to take his cell phone se was alerted to this by out, "stop, put that down". I the items were returned to sident #91's medical record nd dated 4/4/25 at 3:40 AM t #94 was heard to be t that down." The note aff entered the room, ted to be standing beside h his cell phone and glasses e documented after noved from the room. Upon dentations on the back of hand were noted, without s intact and Resident #94 ducted with Nurse #1 on Nurse #1 reported she was 7:00 AM shift on 4/4/25 randered into Resident #94's e his cell phone and glasses. IA #4 had been assigned to		689	DEFICIENCY)		
	assistance and NA #4 asked Nurse #1 to he During the care, Nurs	resident called out for 4 went into the room and 1p her with the resident. e #1 reported she heard went out into the hall,					

Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	followed the yelling to she observed Resider Resident #94's bed w phone and glasses in Nurse #1 reported she grab Resident #94, at Resident #91 to leave and leave the room. NA #4 was interviewe 12:28 PM. NA #4 report to provide 1:1 care for but she was told to "k reported she worked at between halls and du wandered into Reside providing care to anot Resident #94 was inter 4/15/25 at 8:57 AM. If oriented person, place reported he very clear on 4/4/25 with Reside explained he was wol side of his bed on 4/4 when he fully awoke, #91, and she had his Resident #94 explained was confused and he and glasses away fro reported Resident #9 her fingernails presse described an indentat fingernail on the back not leave a mark or b Resident #91 was obs AM. She was walking	 Resident #94's room where nt #91 standing beside ith his (Resident #94's) cell her (Resident #91's) hands. e did not see Resident #91 nd she was able to redirect a the cell phone and glasses ed by phone on 4/16/25 at orted she was not assigned r Resident #91 on 4/4/25, eep an eye on her". NA #4 a "split" assignment ring the time Resident #91 ent #94's room, she was ther resident. erviewed by phone on Resident #94 was alert and e, time, situation and rly remembered the incident ent #91. Resident #94 ken up by someone at the /25 "about 3:00 AM", and he realized it was Resident cell phone and glasses. ed he knew Resident #91 grabbed to get his phone m her. Resident #94 1 grabbed at him and one of id into his skin. Resident #94 i grabbed at him and one of id into his skin. Resident #94 i grabbed at him and one of id into his skin afterwards. served on 4/14/25 at 9:47 in the hall with NA #3 and 	F	689			
	but she was told to "k reported she worked i between halls and du wandered into Reside providing care to anot Resident #94 was inte 4/15/25 at 8:57 AM. I oriented person, place reported he very clear on 4/4/25 with Reside explained he was wol side of his bed on 4/4 when he fully awoke, #91, and she had his Resident #94 explain was confused and he and glasses away fro reported Resident #9 her fingernails presse described an indentat fingernail on the back not leave a mark or b Resident #91 was obs AM. She was walking	eep an eye on her". NA #4 a "split" assignment ring the time Resident #91 ent #94's room, she was ther resident. erviewed by phone on Resident #94 was alert and e, time, situation and rly remembered the incident ent #91. Resident #94 ken up by someone at the /25 "about 3:00 AM", and he realized it was Resident cell phone and glasses. ed he knew Resident #91 grabbed to get his phone m her. Resident #94 1 grabbed at him and one of id into his skin. Resident #94 ition of Resident #91's of his right hand that did ruise his skin afterwards.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345419	B. WING				C 29/2025
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	to redirect Resident # conference room, but aside, came into the of down at the table and several minutes. NA # Resident #91 to leave she would not leave w made to interview Re unable to answer que An interview was con 4/14/25 at 9:47 AM. N assigned to provide 1 during the day shift (7 4/14/25. NA #3 explai up walking the halls for she was very difficult that Resident #91 wo something and would to see and pick up wf #3 explained she wou Resident #91 from tal belongings, but if she away from Resident # become agitated. The Psychiatric NP (N 4/16/25 at 9:28 AM. N the facility every mon Resident #91 on 4/2/2 Resident #94. NP #3 behaviors were difficult metabolic encephalog medication adjustmer has a 1:1 sitter during that she was adding a	ence table. NA #4 attempted 91 away from the Resident #91 pushed her conference room and sat spoke nonsensically for 43 attempted to redirect the conference room, but with NA #3. An attempt was sident #91, but she was sitons. ducted with NA #3 on IA #3 reported she was :1 care to Resident #91 ':00 AM to 3:00 PM) on ned Resident #91 had been or 4 hours at that point, and to redirect. NA #3 explained uid become very focused on not stop until she was able natever got her attention. NA ild attempt to redirect king other resident's tried to take the object 491, that caused her to NP #3) was interviewed on IP #3 explained she visited th and had last assessed 25, before the incident with explained Resident #91's ilt to control due to the bathy and multiple its had been made, as well the day. NP #3 explained a medication to start on ipefully help Resident #91	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/05/2025 APPROVED 0: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345419	B. WING		_		C 29/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 27292	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689 F 693 SS=D	the incident on 4/4/25 when she arrived at the rounds. On 4/16/25 Resident medication order was bedtime only. The Director of Nursin on 4/16/25 at 12:53 P the facility had been a #91 in a locked deme supervise her, but und assigned sitters from the depending on stat assigned on the 11:00 that was not the case explained that all staf supervising Resident residents, and she did could have been prev 91's persistent behav redirected. The Administrator wa 1:32 PM. The Administ facility was attempting Resident #91 in a fac her with 24 hours of s Administrator explained sitter during the day a adjusted to provide the the night shift from 11 Tube Feeding Mgmt/f CFR(s): 483.25(g)(4)	ported she was notified of this morning (4/16/25) he facility to perform her #91's Divalproex Sodium changed to 500 mg at mg (DON) was interviewed 'M. The DON explained that attempting to place Resident ntia facility that could better til that time, they had 7:00 AM until 11:00 PM, and ffing, a sitter could be 0 PM to 7:00 AM shift, but on 4/4/25. The DON f were responsible for #91, as well as other d not know if the incident rented because of Resident iors and difficulty with being s interviewed on 4/16/25 at strator explained that the g to find placement for ility better suited to provide supervision. The ed that the facility had 1:1 and staffing was being tat 1:1 supervision during :00 PM to 7:00 AM. Restore Eating Skills (5)	F 6				5/27/25
	§483.25(g)(4)-(5) Ent						

Facility ID: 923306

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEI					FORM APPROVED MB NO. 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	345419	B. WING _			C 04/29/2025
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
LEXINGTON HEALTH CARE CENTER			17 CORNELIA DRIVE		
LEXINGTON HEALTH CARE CENTER			LEXINGTON, NC 27292		
PRÉFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE	
F 693 Continued From page 27 (Includes naso-gastric an both percutaneous endoscopie enteral fluids). Based on comprehensive assessm ensure that a resident- §483.25(g)(4) A resident eat enough alone or with enteral methods unless th condition demonstrates th clinically indicated and cor resident; and §483.25(g)(5) A resident means receives the appri- services to restore, if pos- and to prevent complicati- including but not limited th diarrhea, vomiting, dehyca abnormalities, and nasal- This REQUIREMENT is by: Based on record review, interviews, the facility fail enteral feeding syringe w separated from the barre residents (Resident #79) feeding management. Th potential for bacterial gro Findings included: Resident #79 was admitta 3/24/2025 with diagnoses swallowing.	a d gastrostomy tubes, scopic gastrostomy and c jejunostomy, and a resident's ent, the facility must who has been able to assistance is not fed by he resident's clinical hat enteral feeding was onsented to by the who is fed by enteral opriate treatment and spible, oral eating skills ions of enteral feeding to aspiration pneumonia, dration, metabolic -pharyngeal ulcers. not met as evidenced pobservations, and staff ed to store a plastic <i>i</i> th the plunger d of the syringe for 1 of 3 reviewed for enteral his practice had the wth and contamination. ed to the facility on s of stroke and difficulty	F	 F-693 Tube feeding Mgm Eating Skills Facility failed to store feeding syringe with the p separated from the barrel for 1 of 3 residents (Resident #79 continues to facility. Resident #79 continues to facility. Resident #79 syringe and stored separately at t finding. The nurse who has syringe prior to storage re education on the appropria tube feeding syringe. All Nurses educated 	a plastic enter lunger of the syringe lent #79) ng manageme o reside at the was separate he time of the ad used the eccived late way to stor	nt. d

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) D	NO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	OMPLETED
		345419	B. WING			C 04/29/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		• = • : = • = •
LEXINGTO	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 693	Continued From page	e 28	F 693	3		
	medication administra should be checked ea flush of water should administration of medi a flush of 150 millilite and she should receive enteral feeding. An admission Minimu dated 4/1/2025 indica cognitively intact and her total calories and fluids per day by enter A review of Resident Administration Record received medications	#79's Medication d for 4/13/2025 revealed she , a 20 to 30 milliliter flush, r, and her residual feeding		 Development Coordinator real proper enteral feeding equiptient techniques. Education completechniques. Education completechniques. Education completechniques. Education completechniques. Education prior to the start of All new nursing staff will be during orientation by the State Development Coordinator or annually and as needed. 4. The UM or designee will monitor feeding tube care, existence and complete an aud week four weeks, then 3X perfour weeks, then weekly for f (one month). 5. Results of these audits week for the Quarterly QA for further problem resolution the monitoring will be conducted to the moni	ment storage leted ving will receive their shift. educated ff designee lobserve and quipment dit tool 5X per er week for four weeks will be a meeting X1 n, if needed	
	check the residual an stomach and flush he stored in a plastic bag pump pole. The plas cream-colored liquid the plunger was enga syringe. The syringe hanging from the feed On 4/13/2025 at 2:41 continued to have a c and the plunger was	m the plastic syringe used to nount of feeding in her er gastrotomy tube was g hanging from her feeding tic syringe had a in the tip of the syringe and aged in the barrel of the was stored in a plastic bag ding pump pole. pm the plastic syringe cream-colored liquid in the tip engaged in the barrel of the was stored in a plastic bag		the monitoring will be conductive randomly.6. Date of compliance 05/2		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345419	B. WING				C 29/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGT	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 693	pm and she stated sh Nurse #3 had checke Resident #79 her med 9:00 am. She stated with Nurse #3 when th and when Nurse #3 g medications around 9 she was not aware th removed from the bar the syringe to dry con when it was used to g medications. Nurse # syringe should be rins feeding should not hav from the barrel of the and the plunger, and placing them in the pl Resident #79's enter her medications throu this morning at 9:00 a During an interview w 4/15/2025 at 3:06 pm feeding Resident #79 the product sitting in t plunger engaged wou grow. She stated Res issues that would indi syringe being left with caused her any harm The Director of Nursin 4/16/2025 at 12:30 pr feeding syringe shoul removed, rinsed out a	e was training Nurse #3 and d the residual and gave dications this morning at she did not go into the room he residual was checked ave Resident #79 her :00 am. Nurse #2 stated e plunger should be rel of the syringe to allow hpletely after it was rinsed give Resident #79 her t2 stated she was aware the sed after each use and the ve been left in the syringe. was in training and was not ve separated the plunger syringe, rinsed the syringe allowed them to dry before astic bag after she checked al feeding residual and gave igh her gastrostomy tube im. ith Nurse Practitioner #1 on she stated the enteral received had sugar in it and he plastic syringe with the ild have caused bacteria to sident #79 had not had any cate the enteral feeding i feeding in the tip had	F	693			

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COM	E SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			7 CORNELIA DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 693	engaged. The Direct planned to re-educate On 4/16/2025 at 12:4 interviewed and state should have been tak	e 30 for of Nursing stated she e all the nursing staff. 2 pm the Administrator was ed the enteral feeding syringe ken apart and cleaned, en stored in the bag with the	F	693			
F 695 SS=E	plunger separate from Respiratory/Tracheos		F	695			5/27/25
	The facility must ensure needs respiratory car care and tracheal suc care, consistent with practice, the compre- care plan, the resider and 483.65 of this su This REQUIREMENT	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences,					
	interviews with staff, Practitioner, the facili oxygen at the rate or provide clean air intal concentrators for 1 of 2) post oxygen signs (Resident #10, Resid 3) change oxygen tut (Resident #10 and Re	ty failed to: 1) provide dered by the physician: ke filters on oxygen f 5 residents (Resident #79); for 3 of 5 residents ent #13, and Resident #33); bing for 2 of 5 residents esident #33); and 4) obtain oxygen delivery for 1 of 5			F-695 Respiratory/Tracheostomy Care and Suctioning 1. Facility failed to: 1) provide oxygen the rate ordered by the physician: prov clean air intake filters on oxygen concentrators for 1 of 5 residents (Resident #79); 2) post oxygen signs for of 5 residents (Resident #10, Resident #13, and Resident #33); 3) change oxygen tubing for 2 of 5 residents (Resident #10 and Resident #33); and obtain physician's order for oxygen delivery for 1 of 5 residents (Resident	n at ride or 3	
	Findings included:				#250) reviewed for respiratory care Resident #10, 33, 79, 250 continue to reside at the facility.		

Event ID: 03M511

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(V2) D	NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` ´	G	· · · ·	MPLETED
			A. BOILDING			С
		345419	B. WING			04/29/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				17 CORNELIA DRIVE		
LEXINGI	ON HEALTH CARE CENT	EK		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
			-			
F 695	Continued From page	e 31	F 69	95		
		admitted to the facility on		2. Resident # 79 oxyge		
	-	oses of respiratory failure,		corrected to the ordered		
	pneumonia, and strol	ke.		oxygen and trach resider		
	A Physician's Order of	lated 3/24/2025 indicated		audited, and concentrato flow rates filter cleanlines		
		receive 2 liters per minute		Identified issues correcte	-	
	oxygen by nasal can	•		3. Staff Development C		
				educated all nursing staff		
	An admission Minimu	ım Data Set assessment		oxygen tubing policy, pos		
	dated 4/1/2025 indica	ated Resident #79 was		rate/ flow as per orders a		
	cognitively intact and	required oxygen therapy.		cleaning of concentrator		
				Oxygen orders audited.		
		Concentrator Guide stated		immediately adjusted as		
		e cleaned at least once a		Oxygen signage posted a		
	week with warm wate	•		changed for residents. C		
		roughly with warm tap water filter should be completely		clerk and Floor Tech clea concentrator filters as pe		
		g. The guide also stated the		instructions. Education co		
		e oxygen concentrator		04/22/25 of nurses and c		
		th a damp cloth or sponge		staff. Any licensed nurse		
	with mild household of	cleaner and wiped dry		education by 5/27/2025 v	will be educated	
	weekly.			prior to the start of their s	•	
				nursing staff will be educ		
		5 am Resident #79 was		Development Coordinato	•	
		with the head of her bed		during orientation annual needed.	iy and as	
		79 had a tracheostomy with tracheostomy collar and		4. The UM or designee	will complete an	
	dressing in place. Th	-		audit tool for oxygen sett		
		and tracheostomy dressing		cleanliness of oxygen co		
	were clean with no st			per week four weeks, the		
	Resident #79's oxyge			for four weeks, then wee	kly for four	
		of dust covering the air		weeks.		
	intake filter.			5. Results of these aud		
		n = n = 0.4/4 E/2E at 40:44 DM		reviewed at the Quarterly		
		n on 04/15/25 at 12:44 PM		for further problem resolute		
	of Nurse #1 providing	dressing change the oxygen		the monitoring will be cor	lauclea	
		minute by tracheostomy		randomly. 6. Date of compliance	05/27/25	
	collar. Nurse #1 state				00/21/20	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGT	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 695	2 liters per minute by the order was written was set at 4 liters per she did not know why set higher than what y On 4/14/2025 at 1:05 conducted with Nurse thought the nurse that 7:00 am should clean she was not sure how be cleaned. Nurse # film of grey dust on th During an interview w Technician on 4/15/20 she cleaned the oxyg assigns the machine admitted, and she cha and either dusts them air gun. The Central she was not aware of instructions. Unit Manager #1 was 1:10 pm and she stat schedule for cleaning on a regular basis, bu daily by the nurse. During an interview w on 4/15/2025 at 3:06 staff should have follo written for oxygen at 2 Resident #79's oxyge oxygen needed to be Nurse Practitioner #1 Resident #79's oxyge minute to keep her ox	her tracheostomy collar and 3/24/2025 but her oxygen minute. Nurse #1 stated Resident #79's oxygen was was ordered. pm an interview was e #1, and she stated she t worked from 7:00 pm to the oxygen machines but y often the machine should 1 stated there was a 1/8-inch he oxygen concentrator filter. with the Central Supply 025 at 12:58 pm she stated en concentrator before she to a resident when they are ecks them once a month out or cleans them with an Supply Technician stated the manufacturer's interviewed on 4/15/2025 at ed she was not aware of a the oxygen concentrators at they should be checked with the Nurse Practitioner #1 pm she stated the nursing owed the order that was 2 liters per minute for in and notified her if the increased for any reason.	F	695	5		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 06/05/2025 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	
		345419	B. WING				C 29/2025
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				1	17 CORNELIA DRIVE		
LEXINGI	ON HEALTH CARE CENT	ER		1	LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page protocol for cleaning to The Director of Nursin 4/16/2025 at 12:30 pr concentrators should two weeks and the nu- when they change the the facility's policy sta should be cleaned ac manufacturer's guidel On 4/16/2024 at 12:42 interviewed and state should have been set ordered by the Physic should have been cleaned periodically per the m the oxygen concentra 2. a. Resident #10 was diagnoses of asthma, muscle weakness. A physician order for 1 03/21/25 read oxygen nasal canula every sh Review of Resident # Data Set (MDS) 03/28 was cognitively intact of oxygen. An observation condu AM revealed there was use found anywhere r Resident # 10's room observed wearing oxy	 a 33 the oxygen concentrators. and stated the oxygen be cleaned at least every urse should clean them a oxygen tubing. She stated ted the oxygen concentrator cording to the ines. 2 pm the Administrator was d Resident #79's oxygen at the level that was bian, and the concentrator aned as needed and anufacturer's guidelines for tor. as admitted on 03/21/25 with respiratory failure, and Resident #10 dated at 3 liters per minute via hift. 10's admission Minimum 8/25 revealed the resident and was coded for the use acted on 04/13/25 at 11:55 as no signage for oxygen hear the entrance of 		695	DEFICIENCY)		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			C
		345419	B. WING				_ 29/2025
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG F 695	Continued From page was observed in Resi An observation condu PM revealed there was use found anywhere r Resident # 10's room observed wearing oxy liters per minute (LPN was observed in Resi b. Resident #13 was a diagnoses of asthma, muscle weakness. A physician order for 1 04/01/25 read oxygen nasal canula every sh Review of Resident # revealed the resident was coded for the use An observation condu AM revealed there was use found anywhere r Resident #13's room. wearing oxygen via na minute (LPM). The ox observed in Resident	e 34 dent # 10's room. Incted on 04/14/24 at 12:50 as no signage for oxygen hear the entrance of . Resident #10 was /gen via nasal cannula at 3 1). The oxygen concentrator dent # 10's room. admitted on 04/02/25 with respiratory failure, and Resident #13 dated h at 3 liters per minute via hift. 13's significant change MDS was cognitively intact and e of oxygen. Incted on 04/13/25 at 11:55 as no signage for oxygen hear the entrance of Resident #13 was observed asal cannula at 3 liters per cygen concentrator was # 13's room.		695	DEFICIENCY)		
	PM revealed there wa use found anywhere r Resident # 13's room observed wearing oxy liters per minute (LPM was observed in Resi	. Resident #13 was /gen via nasal cannula at 3 1). The oxygen concentrator					

Facility ID: 923306

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345419	B. WING				C / 29/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 047	20,2020
					17 CORNELIA DRIVE		
LEXINGTO	ON HEALTH CARE CENT	ER			LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page diagnoses of asthma, failure, and muscle w A physician order for 02/28/25 read oxyger nasal canula every sh Review of Resident # 03/07/25 revealed the intact and was coded An observation condu AM revealed there wa use found anywhere in Resident #33's room. wearing oxygen via n minute (LPM). The ox observed in Resident An observation condu PM revealed there wa use found anywhere in Resident # 33's room observed in Resident An observation condu PM revealed there wa use found anywhere in Resident # 33's room observed in Resident An interview conducte #1 on 04/15/25 at 11: aware Resident #10, #33 had continuous of the residents did not foutside or inside their	e 35 hypertension, respiratory eakness. Resident #33 dated hat 2 liters per minute via hift. 33's admission MDS dated e resident was cognitively for the use of oxygen. Licted on 04/13/25 at 11:45 as no signage for oxygen hear the entrance of Resident #33 was observed asal cannula at 2 liters per kygen concentrator was # 33's room. Licted on 04/14/24 at 1:15 as no signage for oxygen hear the entrance of . Resident #33 was ygen via nasal cannula at 2 A). The oxygen concentrator		69			
	Nursing (DON) on 05 unit managers, house	ed with the Director of /15/25 at 3:45 PM revealed ekeeping supervisors, and ponsible for hanging signage					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345419	B. WING			C 04/29/2025		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
LEXINGTON HEALTH CARE CENTER					17 CORNELIA DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	 when a resident was she was not aware sigbut should have been policy. 3.a. Resident #10 wa diagnoses of asthma, muscle weakness. Review of Resident # Data Set (MDS) 03/20 was cognitively intact of oxygen. A physician order for 03/21/25 read oxyger nasal canula every she A physician order for read oxygen tubing cl Saturday during night An observation and ir 11:55 AM revealed Red ated 03/30/25. Resistaff had not recently like her nasal canula canula crust like substance. b. Resident #33 was a diagnoses of asthma, failure, and muscle weakness. 	on oxygen. The DON stated gnage had not been posted because it was facility s admitted on 03/21/25 with respiratory failure, and 10's admission Minimum B/25 revealed the resident and was coded for the use Resident #10 dated nat 3 liters per minute via hift. Resident #10 dated 3/22/25 hange weekly every s shift. terview on 04/13/25 at esident #10's tubing was dent #10 stated nursing changed her tubing and felt was dirty. Observation anula to be cloudy and with a admitted on 02/28/25 with hypertension, respiratory eakness. 33's admission MDS dated e resident was cognitively for the use of oxygen.	F	69	15			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345419	B. WING			0	4/29/2025
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	nasal canula every sh A physician order for read oxygen tubing cl Saturday during night An interview and obse Nurse #5 on 04/14/25 Resident #33's and R was dated 03/30/25 a two weeks. Nurse #5 should have been cha changed. A phone interview cor 04/16/25 at 10:30 AM worked evening shift #33 and Resident #10 she did not change of having enough suppli had voiced concerns management before s 04/06/25. A phone interview witt 11:30 AM revealed th #10 and Resident #33 stated he had not cha supplies or the shift b indicated night shift ca other priorities. An interview conducte Nursing (DON) on 04. Resident #10 and Resident #3	h at 2 liters per minute via hift. Resident #33 dated 3/21/25 hange weekly every a shift. ervation conducted with 5 at 1:15 PM revealed desident #10 oxygen tubing and had not been changed in indicated oxygen tubing anged and needed to be hducted with Nurse #6 on I revealed on 04/05/25 she and was assigned Resident 0. It was further revealed xygen tubing due to not es. Nurse #6 indicated she of lack of supplies to upper she left her shift on h Nurse #7 on 04/15/25 at ey were assigned Resident 3 on 04/12/25. Nurse #7 anged tubing due to lack of eing chaotic. Nurse #7 an be hectic and there are ed with the Director of /15/25 at 3:50 PM revealed sident #33 were on he DON stated she was not	F	695			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page 02/28/25 read oxyger nasal canula every sh A physician order for read oxygen tubing of Saturday during night An interview and obse Nurse #5 on 04/14/25 Resident #33's and R was dated 03/30/25 a two weeks. Nurse #5 should have been cha changed. A phone interview cor 04/16/25 at 10:30 AM worked evening shift #33 and Resident #10 she did not change op having enough suppli had voiced concerns management before s 04/06/25. A phone interview wit 11:30 AM revealed th #10 and Resident #33 stated he had not cha supplies or the shift b indicated night shift ca other priorities. An interview conducted Nursing (DON) on 04, Resident #10 and Resi continuous oxygen. T	ER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) a 37 h at 2 liters per minute via hift. Resident #33 dated 3/21/25 hange weekly every t shift. ervation conducted with 5 at 1:15 PM revealed tesident #10 oxygen tubing and had not been changed in indicated oxygen tubing anged and needed to be hducted with Nurse #6 on I revealed on 04/05/25 she and was assigned Resident D. It was further revealed xygen tubing due to not es. Nurse #6 indicated she of lack of supplies to upper she left her shift on h Nurse #7 on 04/15/25 at ey were assigned Resident 3 on 04/12/25. Nurse #7 anged tubing due to lack of eing chaotic. Nurse #7 an be hectic and there are ed with the Director of /15/25 at 3:50 PM revealed sident #33 were on the DON stated she was not oxygen tubing had not been	ID PREF TAG	IX	17 CORNELIA DRIVE LEXINGTON, NC 27292 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN D BE	(X COMP

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345419	B. WING				C 29/2025
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTON HEALTH CARE CENTER					17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	changed on 04/05/15 4. Resident #250 was 03/26/25 with diagnos weakness and hypert Review of Resident # 04/02/25 revealed the cognitively impaired a oxygen use. Review of Resident # plan or interventions f Review of Resident # revealed no orders in oxygen use. An observation was c 12:00 PM revealed Re her wheelchair with or minute. An observation was c 1:45 PM revealed Re wheelchair with oxyge minute. An interview conducted at 2:15 PM revealed s Resident #250 had st indicated she had bee at least a week. UM # been educated to ens when residents starte Resident #250 was se on 04/07/25 due to re	and 04/12/25. a admitted the facility on ses which included muscle ension. 250's admission MDS dated a resident was moderately and was not coded for 250's care plan revealed no for oxygen use. 250's physician orders place for continuous conducted on 04/13/25 at esident #250 sitting up in xygen running at 2 liters per conducted on 04/14/25 at sident #250 sitting up in her en running at 2 liters per ed with UM #1 on 04/15/25 she did not recall when arted on oxygen but en on continuous oxygen for 41 stated nursing staff had sure orders were initiated d oxygen. UM #1 indicated een by a Nurse Practitioner spiratory concerns and	F	695			
	Resident #250 was se	een by a Nurse Practitioner spiratory concerns and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345419	B. WING	C 04/29/2025	
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				17 CORNELIA DRIVE	
EXINGTO	ON HEALTH CARE CENT	ER		LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DAT
F 695	 Continued From page 39 A phone interview conducted with Nurse Practitioner (NP) #2 on 04/15/25 at 11:20 AM 		F 69	95	
	the facility and recalle NP #2 saw the reside breath and wheezing order oxygen becaus on oxygen when she already ordered. The should have had an o	ed in on 04/07/25 to assist ed assessing Resident #250. ent due to shortness of . The NP stated she did not e the resident was already arrived and thought it was NP indicated Resident #250 order put in for oxygen due to ontinuous oxygen for several			
F 757 SS=D	PM revealed NP #2 h on 04/07/25 due to re DON further revealed had been no oxygen #250. The DON indic determine when Resi oxygen, but nursing s an order if the NP fail Drug Regimen is Free	e from Unnecessary Drugs	F 75	57	5/27/25
	§483.45(d) Unnecess Each resident's drug				
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including y); or			
	§483.45(d)(2) For exe	cessive duration; or			
	§483.45(d)(3) Withou	t adequate monitoring; or			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345419	B. WING		0	C 4/29/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
				17 CORNELIA DRIVE			
LEXINGTO	ON HEALTH CARE CENT	ſER		LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 757	Continued From page use; or	e 40	F 7	57			
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this					
	by:	Γ is not met as evidenced iew and staff and Nurse		F-757 Drug Regimen is Unnecessary Drugs	s Free from		
	complete an Internati test as ordered by the	ional Normalized Ratio (INR) e physician for 1 of 1		1. Facility failed to co International Normalize	d Ratio (INR) test		
	anticoagulant medicii			as ordered by the phys resident (Resident # 25 monitoring anticoagular	5) reviewed for nt medicine.		
	The findings included	l:		Resident #255 no longe facility.	er resides at the		
	Resident #255 was a	dmitted to the facility on		2. Resident # 255 no	longer resides at		
	03/30/21 with diagno	ses which included atrial		the facility. Current res	-		
	fibrillation.			orders were audited on PT/INRs are up to date			
	Review of Resident #	255's quarterly Minimum		the provider.			
		d 02/22/25 revealed the		3. DON and all nurse	s educated by Staff		
	resident was coded f	or anticoagulant use.		Development Coordina obtaining PT/INR as pe			
		255's care plan created on		Education completed 0	5/17/25. Any		
		e was on anticoagulant		licensed nurse not rece	• •		
		Resident #255 would be to		5/27/2025 will receive e	•		
		ort or adverse reactions		the start of their shift.	•		
		ant use through the review		nurses will be educated			
		cluded complete labs as		by the Staff Developme			
		bnormal lab results to the		designee annually and			
	Medical Director (MD	<i>'</i>).		4. The UM or designed audit tool by reviewing			
	Review of Resident #	255's physician order dated		and the order listing for	the nast 24 hours		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/05/2025 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345419	B. WING				C / 29/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER			7 CORNELIA DRIVE EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	thinner) oral tablet 2 r by mouth at bedtime fibrillation. Review of an INR lab Resident #255's INR range 2.0 to 3.0). It w for 2 days and re-che 03/05/25. Review of Resident # Administration Review 03/03/25-03/05/25 wa as having been held of Review of INR lab da Resident #255's INR Review of a progress completed by Nurse F Resident #225's INR was at 4.0 that mornin was further noted Resi to be held until 3/7/25 Resident #255's INR 03/07/25 and to notify changes. Review of Resident # revealed an order dat Resident #255's INR Warfarin (anticoagula Review of Resident # 03/05/25- 03/12/25 w	dium(anticoagulant/blood milligram (mg), give 1 tablet related to unspecified atrial dated 03/03/25 revealed was at 3.54 (therapeutic as ordered to hold warfarin ck the INR level on 255's Medication w (MAR)revealed from arfarin 2mg was documented daily. ted 03/05/25 revealed was 4.0. note dated 03/05/25 Practitioner (NP) #1 revealed was recently checked, and it ng (normal range 2-3). It sident #255's warfarin was 5. The note indicated was to be rechecked on y NP #1 of any bleeding or 255's physician orders ted 03/07/25 to check on 03/07/25 and hold nt) until further notice. 255's MAR revealed from arfarin was not administered rther review revealed Nurse 7/25 that an INR was	F	757	that all PT/INR have been obtained a reviewed by provider for 5X per week weeks, then 3X per week for four wee then weekly for four weeks (1 month) 5. Results of these audits will be reviewed at the Quarterly QA meeting for further problem resolution, if need the monitoring will be conducted randomly. 6. Date of compliance 05/27/25	four eks, g X1	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/05/2025 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345419	B. WING		_		C 29/2025
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER		7 CORNELIA DRIVE EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	notes indicated no res ordered for Resident ; ordered INR. A phone interview cor 04/24/25 at 8:00 pm r	It. 255's labs and progress sults for an INR lab as #255 for the 03/07/25 nducted with Nurse #1 on evealed on 03/07/25 she	F 757				
	recall if she had comp on that date but expla the resident's INR it w resident's chart. Nurse	nt #255. Nurse #1 could not bleted Resident #255's INR ined if she had completed rould have been in the e #1 stated if the INR result its' chart, then she did not					
	Resident #255 was se PT/INR. The note furt was lying in bed, on re respiratory distress. T INR was checked and ordered for Resident = 2mg daily and rechec Resident #255 was ag	her revealed Resident #255 com air, alert, in no acute he note indicated Residents I her INR was a 1.3. It was #255 to continue Warfarin					
	Resident #255's INR v re-start 2 mg of Warfa the INR level on 03/12 Review of Resident #	255's MAR revealed dministered Warfarin 2 mg //17/25.					
	Resident #255's INR	was 2.18.					

Facility ID: 923306

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI					FORM	2: 06/05/2025 1 APPROVED 2: 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345419	B. WING		_	C 04/29/2025	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
LEXINGTON HEALTH CARE CENTER	R		17 CORNELIA DRIVE			
			LEXINGTON, NC 27292			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
rate of 4.0 and she wan held and the INR to be The NP indicated Resid 03/12/25 and Resident 1.3. The NP stated ther negative outcome as a INR was not checked o nursing staff to follow th and notification of any of An interview conducted Nursing (DON) on 04/24 Resident #255 had ong not being consistent. Th was being followed close providers. The DON stat was not checked on 03, nursing staff to follow of An interview conducted the Administrator revea Resident #255's chart a documentation Resider check on 03/07/25. The revealed she expected	lucted with NP #1 on vealed Resident #255's d closely due to the s fluctuating. NP #1 Resident #255 had an INR need the resident's warfarin rechecked on 03/07/25. dent #255 was checked on #255 had an INR result of re was no harm or result of the resident's in 03/07/25 but expected brough with orders given changes. I with the Director of 4/25 at 3:00 PM revealed poing issues with her INR he DON further revealed it sely by the medical ated she was not aware it /07/25 but expected rders. I on 04/28/25 at 1:00 PM led she had reviewed and could not find any in #255 received an INR e Administrator further orders to be followed red Resident #255's order	F 757				

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