STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Center for Nursing and Rehabilitation	279 Brian Center Drive Lexington, NC 27292

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to ensure the Nursing Assistant (NA) and/or Medication Aide requested a nurse to assess a Resident who experienced a drop in oxygen saturation on room air to a level of 68 percent where a normal oxygen saturation ranges from 95-100 percent in healthy individuals but may be 90-100 percent in individuals with known respiratory conditions. The deficient practice occurred in 1 of 1 resident investigated for quality of life (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease with hemodialysis three times per week, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, obstructive sleep apnea, hypertension, bipolar disorder and anxiety disorder. Review of hospital records revealed Resident #1 was hospitalized from [DATE] through 12/17/25. A chest x-ray obtained on 12/13/25 revealed pulmonary interstitial edema (fluid in the lung tissues which can occur in the setting of respiratory acidosis or renal failure). Hospital records also indicated Resident #1 had a NSTEMI (NSTEMI stands for non-ST elevation myocardial infarction and occurs when an area of the heart does not get enough oxygen) on 12/14/25, which was likely due to demand ischemia (a sudden inability for the heart muscle to get enough oxygen) secondary to her respiratory acidosis and sepsis, workup revealed no further cardiac concern and no additional follow up was indicated. Discharge diagnoses included sepsis (a blood infection) resulting from a suspected direct inoculation of her dialysis fistula during hemodialysis, respiratory acidosis (a condition where the blood becomes too acidic rendering breathing difficult and which can result in a respiratory emergency if untreated) and acute respiratory failure (a respiratory emergency where the lungs are unable to oxygenate the body). Hospital records indicated Resident #1 declined the use of special positive pressure breathing machines that would have assisted with her respiratory acidosis and breathing, but her mental status remained stable. Hospital progress notes further indicated Resident #1 exhibited normal breathing effort and was oxygenating well on 2 liters of oxygen via nasal canula. Hospital records further indicated comprehensive work up and treatment courses by kidney specialists and infectious disease specialists and Resident #1 was discharged back to the facility in stable condition.Review of Resident #1's comprehensive care plan revised on 12/21/25 included focus areas for chronic obstructive pulmonary disease, chronic respiratory failure, obstructive sleep apnea and pneumonia. Ongoing goals included keeping oxygen saturation levels above 90 percent, maintaining normal breathing pattern as evidenced by normal respirations, normal skin color and maintaining a regular respiratory rate and pattern. Interventions for Resident #1's respiratory care plan included: Monitoring for signs and symptoms of respiratory distress and reporting to the physician any increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis or cough; Monitoring for pleuritic pain, accessory muscle usage or skin color changes to blue or grey; Monitoring, document and/or reporting abnormal breathing patterns to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing or nasal flaring; Positioning resident with proper body alignment for optimal breathing pattern and providing relaxation training as appropriate to help normalize breathing patterns (for example, biofeedback, imagery, progressive muscle relaxation).A provider note dated 1/12/26 revealed Resident #1 had been hospitalized again from 12/27/25 through 1/2/26 for influenza and pneumonia following a chest x-ray showing right upper lung infiltrates (fluid in the lung). Resident #1 was started on antibiotic therapy and had since returned to the facility on said antibiotics. Records also indicated Resident #1 had a newer diagnosis of thrombocytopenia (a condition in which the blood does not have enough platelets which hinders blood clotting) which the provider was aware of and Resident #1 was being monitored for. A 1/8/26 re-entry Minimum Data Set (MDS) assessment revealed Resident #1 had moderate cognitive impairment. Diagnoses included COPD, obstructive sleep apnea, respiratory failure and pneumonia.Review of Resident #1's vital sign records from 1/2/26 through 1/13/26 revealed vital signs within Resident #1's baseline. Resident #1's oxygen saturation levels ranged from 90 percent to 96 percent. Some oxygen saturation readings were noted to be on room air and some were noted to be with Resident #1 wearing oxygen, in no discernable pattern. Vital sign readings were documented once daily at differing times of day. Review of Resident #1's vital sign readings on 1/14/26 revealed a respiratory count of 18 breaths per minute (normal range is 16-20 breaths per minute) at 5:30 PM. At 7:56 PM, remaining vital signs entered revealed a blood pressure of 176/98 (within Resident's baseline), a heart rate of 80 beats per minute (normal range is 60-100 beats per minute), a temperature of 97.7 degrees Fahrenheit (normal range is are 97.0-99.0 degrees Fahrenheit) and An oxygen saturation level of 68 percent on room air (normal range is 90-100 percent in individuals with known respiratory conditions). The 7:56 PM vital signs were entered by Nurse Aide #1. On 1/21/26 at 2:06 PM, an interview was conducted with Nurse Aide (NA) #1. NA #1 confirmed she worked from 6:00 PM on 1/14/26 until 6:00 AM on 1/15/26. NA #1 said at around 8:00 PM on 1/14/26, as she prepared to take Resident #1's vitals, the Medication Aide told her Resident #1 had been taking off her oxygen and the Medication Aide had already been in the room back and forth checking on her. NA #1 said Resident #1 could get anxious and she tended to yell out a lot, sometimes she could get confused but not always. NA #1 said Resident #1 liked to have company and was not as anxious when staff could stay in her room and talk with her more. NA #1 said when she entered Resident #1's room at around 8:00 PM, Resident #1 did not have her oxygen on and was yelling out and said she was anxious about her health issues and what was going to happen to her. NA #1 said she took Resident #1's vitals and her oxygen saturation level was 68 percent without her oxygen on. NA #1 said she notified the Medication Aide who was just outside the door and the Medication Aide came in immediately to assist. NA #1 said she helped Resident #1 put her oxygen back on and rechecked her oxygen level, which went back up to 91 or 92 percent after a few minutes. NA #1 said the Medication Aide also re-checked the Resident's oxygen saturation level with a manual oximeter (a hand-held machine used to check oxygen saturation levels) and her oxygen level was 92 percent with her oxygen on. NA #1 said she did not remember how much oxygen Resident #1 was on but she stayed with Resident #1 and talked with her and then Resident #1 became calmer. NA #1 said it took about 10 minutes for Resident #1 to become calmer and her oxygen level to come back up. NA #1 said Resident #1 otherwise looked normal, she didn't look pale or blue or anything. NA #1 said before Resident #1 went to the hospital the last time, she had oxygen if she needed it, and she had needed it more since she had come back. NA #1 stated every time she had taken care of Resident #1 since her last return from the hospital; she was always wearing her oxygen.An interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Medication Aide was conducted on 1/21/26 at 2:23 PM. The Medication Aide confirmed she worked from 6:00 PM on 1/14/26 to 6:00 AM on 1/15/26. The Medication Aide said Resident #1 had been yelling a lot that night, which was rather normal for her. The Medication Aide said Resident #1 had been removing her oxygen and at times would throw it down onto the floor. The Medication Aide indicated Resident #1 had used oxygen before, but she had needed it more since coming back from the hospital after being treated for the flu and pneumonia, the Resident #1 didn't seem like she had gotten used to wearing it more. The Medication Aide said she went in back and forth numerous times during her medication pass to keep checking on Resident #1 and re-educate the Resident about her oxygen and to replace her oxygen tubing. The Medication Aide said Resident #1 was confused sometimes. The Medication Aide said about 8:00 PM, NA #1 called her into Resident #1's room because she had gotten a low oxygen saturation level in the 60s. The Medication Aide said when she entered the room, NA #1 had already replaced Resident #1's oxygen and said the oxygen level was coming back up. The Medication Aide said she also checked Resident #1's oxygen with her manual oximeter and the reading was 91 or 92 percent with her oxygen on. The Medication Aide said she did not remember how much oxygen Resident #1 had on. The Medication Aide said Resident #1 had calmed down with them in the room with her. The Medication Aide said NA #1 also re-checked her vital signs and they were normal around 8:30 PM. The Medication Aide said she administered a scheduled breathing treatment to Resident #1 during that time as well. The Medication Aide said Nurse #1, who was Resident #1 primary nurse that night, was on a different hall passing medications for other residents at that time. The Medication Aide said she went back and forth and checked Resident #1 with her manual oximeter numerous times and everything seemed fine. The Medication Aide said Resident #1 looked pretty normal, she was not pale, her lips did not appear cyanotic (a blue or purple discoloration of the skin caused by low oxygen), her oxygen saturation at that time was 91or 92 percent with her oxygen on and she seemed calmer so she finished her medication pass and checked Resident #1 again right before 10:00 PM. The Medication Aide stated when she saw Nurse #1 shortly before 10:00 PM, she notified Nurse #1 of Resident #1's low saturation level and that the Resident seemed stable ever since and asked her to keep an eye on her. On 1/22/26 at 11:59 AM, a follow up interview with the Medication Aide was conducted. The Medication Aide said she last checked on Resident #1 at 9:56 PM right before she notified Nurse #1 of the low oxygen saturation. The Medication Aide said she spoke with Resident #1 at that time, and the Resident was calmer and appeared to be doing ok with her oxygen on. The Medication Aide said Resident #1's oxygen was about 92 percent right before 10:00 PM with her oxygen and she did not re-check complete vital signs. On 1/21/26 at 12:48 PM, an interview with Nurse #1 was conducted. Nurse #1 confirmed she was the primary nurse for Resident #1 on the evening of 1/14/26 from 6:00 PM to 6:00 AM on 1/15/26. Nurse #1 said that Resident #1 seemed her normal self when she started her shift at 6:00 PM and had rounded on Resident #1 and assessed her at the start of her shift. Nurse #1 said Resident #1 frequently yelled and called out which she was doing that evening as was usual for her and nothing seemed out of the ordinary. Nurse #1 stated she saw the Medication Aide had been in and out of Resident #1's room to help Resident #1 with her oxygen because the Resident kept removing her oxygen tubing but her readings were ok then. Nurse #1 said Resident #1 had oxygen before but since she had returned from the hospital about a week prior, she had been wearing it most of the time but would frequently remove it. Nurse #1 said at about 9:30 PM, she passed by Resident #1's room to visualize her and she was still awake and calling out but seemed calmer than before. Nurse #1 stated she did not go in to Resident #1's room at that time but visualized that she was awake and proceeded to administer medications to 2 of her other residents that were on her other hall and so she did not know about the low reading for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a little while longer. Nurse #1 stated just before 10:00 PM, she was notified by the Medication Aide that Resident #1's oxygen saturation level had dropped to 68 percent on room air at about 8:00 PM but the oxygen saturation had gone back up to normal levels with her oxygen on. Nurse #1 indicated the Medication Aide told her she had checked on the Resident numerous times, had given her a breathing treatment and the Resident had since been calmer with normal vital signs. Nurse #1 said because the Medication Aide told her she had just checked on Resident #1 and the Resident was doing ok, she (Nurse #1) finished her current medication task and then made her way down to her other hall to Resident #1's room. On 1/22/26 at 11:48 AM, a follow up interview with Nurse #1 was conducted. Nurse #1 said if she had been notified earlier of the low oxygen saturation, she would not have done anything different because her Medication Aide had already checked the resident, re-applied the oxygen and the Resident had been doing better by the time she was notified. Nurse #1 said she would have done the exact same thing the Medication Aide had done. On 1/21/26 at 3:15 PM, an interview with the Medical Director was conducted. The Medical Director said Resident #1 had been very sick with her existing comorbidities and was recently being monitored for thrombocytopenia (a condition in which the blood does not have enough platelets which hinders blood clotting). The Medical Director said Resident #1 had had several recent hospitalizations and was most recently diagnosed with influenza and pneumonia. The Medical Director said the oxygen need for Resident #1 was on an as needed basis. The Medical Director said he was not aware that Resident #1 had desaturated (low blood oxygen saturation) to 68 percent on room air and would have expected the Resident to be checked at that time and to be notified of a new oxygen desaturation level. An interview with the Assistant Director of Nursing (ADON) was conducted on 1/21/26 at 3:30 PM. The ADON said if a resident experienced a changed in condition, staff would be expected to assess the resident and if initial corrective measures taken by nursing were successful, they were not required or expected to immediately notify the on call provider at night. An interview with the Administrator was conducted on 1/22/26 at 11:30 AM. The Administrator said when a resident experienced a change of condition, he would expect the nursing staff to assess a resident and notify the provider if need be, but if initial corrective measures by nursing staff were successful, nursing staff would not necessarily need to notify the provider immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to obtain a physician order for oxygen therapy for 1 of 1 resident reviewed for respiratory care (Resident #1). Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including end stage renal disease with hemodialysis three times per week, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, obstructive sleep apnea, hypertension, bipolar disorder and anxiety disorder. Review of hospital records revealed Resident #1 was hospitalized from [DATE] through 12/17/25. Discharge diagnoses included sepsis (a blood infection) resulting from a suspected direct inoculation of her dialysis fistula during hemodialysis, respiratory acidosis (a condition where the blood becomes too acidic rendering breathing difficult and which can result in a respiratory emergency if untreated) and acute respiratory failure (a respiratory emergency where the lungs are unable to oxygenate the body). Hospital records indicated Resident #1 declined the use of special positive pressure breathing machines that would have assisted with her respiratory acidosis and breathing, but her mental status remained stable. Hospital progress notes further indicated Resident #1 exhibited normal breathing effort and was oxygenating well on 2 liters of oxygen via nasal canula. Resident #1 was discharged back to the facility in stable condition. Review of the medical record revealed no order for oxygen therapy for Resident #1. Review of Resident #1's comprehensive care plan revised on 12/21/25 included focus areas for chronic obstructive pulmonary disease, chronic respiratory failure, obstructive sleep apnea and pneumonia. Ongoing goals included keeping oxygen saturation levels above 90 percent, maintaining normal breathing pattern as evidenced by normal respirations, normal skin color and maintaining a regular respiratory rate and pattern. Interventions for Resident #1's respiratory care plan included: Monitoring for signs and symptoms of respiratory distress and reporting to the physician any increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis or cough. A provider note dated 1/12/26 revealed Resident #1 had been hospitalized again from 12/27/25 through 1/2/26 for influenza and pneumonia following a chest x-ray showing right upper lung infiltrates (fluid in the lung). Resident #1 was started on antibiotic therapy had since returned to the facility on said antibiotics. The provider note indicated Resident had a newer diagnosis of thrombocytopenia (a condition in which the blood does not have enough platelets which hinders blood clotting) which the provider was aware of and Resident #1 was being monitored for. The provider further summarized Resident #1's vital signs from the dates of 1/8/26 through 1/12/26 (excepting 1/9/26 where there was no entry listed) which showed on 1/8/26 the Resident's oxygen saturation was 96 percent on oxygen, on 1/10/26 the Resident's oxygen saturation was 96 on oxygen, on 1/11/26 the Resident's oxygen was 95 on oxygen and on 1/12/26 the Resident's oxygen saturation was 95 with oxygen. A 1/8/26 re-entry Minimum Data Set (MDS) assessment revealed Resident #1 had moderate cognitive impairment, noted respiratory diagnoses of COPD, obstructive sleep apnea, respiratory failure and pneumonia but no coding for oxygen use.On 1/21/26 at 2:06 PM, an interview was conducted with Nurse Aide (NA) #1. NA #1 confirmed she was the NA for Resident #1 on the evening of 1/14/26. NA #1 said when she entered Resident #1's room at around 8:00 PM to take vital signs, Resident #1 did not have her oxygen on. NA #1 said she took Resident #1's vitals and her oxygen saturation level was 68 percent without her oxygen on. NA #1 said she notified the Medication Aide who was just outside the door and the Medication Aide came in immediately to assist. NA #1 said she helped Resident #1 put her oxygen back on and rechecked her oxygen level, which went back up to 91 or 92 percent after a few minutes. NA #1 said she did not remember how much oxygen Resident #1 was on. NA #1 said before Resident #1 went (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the hospital the last time, she had oxygen if she needed it, and she had needed it more since she had come back. NA #1 stated every time she had taken care of Resident #1 since her last return from the hospital; she was always wearing her oxygen. An interview with the Medication Aide was conducted on 1/21/26 at 2:23 PM. The Medication Aide confirmed she was the Medication Aide on Resident #1's hall on the evening of 1/14/26. The Medication Aide reported Resident #1 had been removing her oxygen and at times would throw it down onto the floor. The Medication Aide indicated Resident #1 had used oxygen before, but she had needed it more since coming back from the hospital after being treated for the flu and pneumonia. The Medication Aide stated that she did not remember how much oxygen Resident #1 had on. On 1/21/26 at 12:48 PM, an interview with Nurse #1 was conducted. Nurse #1 confirmed she was the primary nurse for Resident #1 on the evening of 1/14/26 from 6:00 PM to 6:00 AM on 1/15/26. Nurse #1 stated she saw the Medication Aide had been in and out of Resident #1's room to help Resident #1 with her oxygen because the Resident kept removing her oxygen tubing, but her readings were ok then. Nurse #1 said Resident #1 had used oxygen before but since she had returned from the hospital about a week prior, she had been wearing it most of the time but would frequently remove it. Nurse #1 said at about 9:30 PM, she passed by Resident #1's room to visualize her and she was still awake and her oxygen was on. Nurse #1 stated she did not remember how much oxygen Resident #1 was using.On 1/21/26 at 3:15 PM, an interview with the Medical Director was conducted. The Medical Director said Resident #1 had been very sick with her existing comorbidities and was recently being monitored for thrombocytopenia (a condition in which the blood does not have enough platelets which hinders blood clotting). The Medical Director said Resident #1 had had several recent hospitalizations and was most recently diagnosed with influenza and pneumonia. The Medical Director said the oxygen need for Resident #1 was on an as needed basis.