STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbotts Creek Center	877 Hill Everhart Road Lexington, NC 27295

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) vents in 2 of 6 on the upper 100 hall. This deficient practice affected 2 of 6 residents reviewed for comfortable, clean, and homelike environment (Resident #46 and Resident #54).The findings included:a. An observation was conducted of Resident #46's room on 1/4/26 at 10:00 AM. The PTAC unit was noted to have dark brown spots that covered every vent slat of the unit. The room was occupied, and the PTAC was running at the time of the observation.b. An observation was conducted of Resident #54's room on 1/4/26 at 12:55 PM. The PTAC unit was noted to have a dark brown substance caked in the corners of every vent slat of the unit. The room was occupied, and the PTAC was running at the time of the observation.On 1/6/26 at 3:00 PM an observation of Resident #46's and Resident #54's room was conducted during a round with the Maintenance Director. He explained the Maintenance Department was responsible for cleaning the vents and filters of the PTAC units every 2 months. The Maintenance Director stated the last time he cleaned the PTAC units was October 2025. The Maintenance Director stated he was the only person who worked in the department and was behind in cleaning the PTAC units for December.The Housekeeping Manager was interviewed on 1/7/26 at 9:27 AM. He stated the Housekeeping Department was responsible for wiping down the top and front of the PTAC units when they clean the residents' rooms, but housekeeping does not have the required tools to clean the vents on the units. According to the Housekeeping Director, it was the responsibility of Maintenance to clean the vents of the PTAC units.On 1/7/26 at 1:44 PM the Administrator was interviewed and stated it was the responsibility of the Maintenance Director to ensure the PTAC units were kept clean. She stated maintenance should follow the every 2 month scheduled plan to clean the units.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with staff, the Nurse Practitioner, and the Medical Director, the facility failed to obtain a physician's order for supplemental oxygen use for 1 of 1 resident reviewed for respiratory care (Resident #23).Findings included:Resident #23 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD).A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. She was not coded as using supplemental oxygen.The active orders reviewed for Resident #23 did not include one for supplemental oxygen use.A review of the nurse's progress notes dated 12/28/25 revealed she assessed Resident #23 to have shortness of breath and reported it to the Medical Director for the resident to be assessed. A review of the progress notes revealed a written statement by the Nurse Practitioner during her assessment dated [DATE] to continue oxygen for Resident #23; however, there was no order written for supplemental oxygen use.An observation of Resident #23 on 1/4/26 at 10:02 AM revealed she was receiving supplemental oxygen by nasal cannula at a rate of 2 liters per minute (L/min), as indicated on the gauge of the bedside oxygen concentrator. Subsequent observations on 1/5/26 at 11:15 AM and on 1/6/26 at 10:15 AM revealed she continued to receive supplemental oxygen at a rate of 2 L/min by nasal cannula.Resident #23 was interviewed on 1/4/26 at 10:02 AM and stated she was placed on oxygen a few days ago when she had trouble breathing.An interview with Nurse #2 on 1/6/26 at 10:33 AM revealed that Resident #23 had an order for supplemental oxygen when she originally entered the facility a long time ago but was eventually weaned from it. Nurse #2 explained that Resident #23 had increased coughing and shortness of breath a week ago and was assessed by the Medical Director. She indicated she thought the Medical Director ordered supplemental oxygen for the resident at that time. However, Nurse #2 was unable to find an order for oxygen use in the medical record. On 1/6/26 at 10:53 AM, an interview was conducted with the Medical Director, who stated he assessed Resident #23 on 12/28/25 and noted she had increased wheezing and looked weaker than usual, but her oxygen saturation level was 95% on room air. He indicated he ordered nebulizer treatments and a steroid for the resident, but he did not order supplemental oxygen. The Medical Director stated he reviewed Resident #23's medical record later that evening and noted the resident was documented as receiving supplemental oxygen in the nurse's progress notes. He stated the resident should have had an order for administering supplemental oxygen before it was initiated. However, he indicated the resident was not at risk for any adverse outcome due to oxygen use at 2 L/min. The Nurse Practitioner (NP) was interviewed on 1/7/26 at 10:55 AM and stated that when she assessed Resident #23 on 12/31/25, the resident was already receiving supplemental oxygen at 2 L/min by nasal cannula. The NP indicated she wrote in her progress note to continue oxygen use since the resident was benefiting from it and a review of the resident's oxygen saturation level revealed she registered 93% on 2 L/min of supplemental oxygen. The NP explained she did not review the resident's orders and did not notice there was no order for oxygen use. According to the NP, the nurse should have obtained an order for supplemental oxygen use before applying it. On 1/7/26 at 1:47 PM, the Director of Nursing (DON) was interviewed and stated Resident #23 did have an order for oxygen use in the past, but it was discontinued. The DON indicated that if the resident needed supplemental oxygen again, staff should have obtained an order before applying it.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, observations, and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff scheduled for licensed and unlicensed nursing staff for 28 out of 30 days reviewed (12/6/25 to 1/2/26). The facility also failed to ensure the resident census was present on the daily nurse staffing sheets for 2 of 3 days reviewed (1/3/26 and 1/4/26). The findings included: 1) A review of the facility's daily posting for nursing staff for the past 30 days as compared to the daily staffing schedule included an inaccurate total of nursing staff worked, which included the following: a. The nursing schedule for 12/6/25 indicated that one (1) Medication Aide (MA) worked 7:00 AM to 7:30 PM. The daily posted nurse staffing sheet for 12/6/25 documented that One (1) MA worked 3:00 PM to 11:30. b. The nursing schedule for 12/7/25 indicated that one (1) MA worked from 7:00 AM to 7:30 PM. The daily posted nurse staffing sheet for 12/7/25 documented that one (1) MA worked 3:00 PM to 11:30 PM. c. The nursing schedule for 12/8/25 indicated that 3 Licensed Practical Nurses (LPNs) worked from 3:00 PM to 7:30 PM, 1 LPN worked from 7:00 PM to 7:30 AM and 3 Nurse Aides (NAs) worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/8/25 documented that one (1) LPN worked from 3:00 PM to 7:30 PM, no LPN worked 7:00 PM to 7:30 AM and 5 NAs worked 11:00 PM to 7:00 AM. d. The nursing schedule for 12/9/25 indicated that 4 NAs worked 7:00 AM to 3:00 PM. The daily posted nurse staffing sheet for 12/9/25 documented that 6 NAs worked from 7:00 AM to 3:00 PM. e. The nursing schedule for 12/10/25 indicated that 3 LPNs worked from 7:00 AM to 3:00 PM, 3 LPNs worked from 3:00 PM to 7:30 PM, one (1) Registered Nurse (RN) worked 7:00 PM to 7:30 AM, one (1) LPN worked 7:00 PM to 7:30 AM, 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/10/25 documented that one (1) LPN worked 7:00 AM to 3:00 PM, no LPN worked 3:00 PM to 7:30 PM, no RN worked 7:00 PM to 7:30 AM and 2 NAs worked 11:00 PM to 7:00 AM. f. The nursing schedule for 12/11/25 indicated that 4 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, one (1) RN worked 7:00 PM to 7:30 AM and one (1) LPN worked 7:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/11/25 documented that 6 NAs worked 7:00 AM to 3:00 PM, 6 NAs worked 3:00 PM to 11:00 PM, no RN worked 7:00 PM to 7:30 AM and 2 LPNs worked 7:00 PM to 7:30 AM. g. The nursing schedule for 12/12/25 indicated that 2 LPNs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, no MA worked that day, and one (1) LPN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/12/25 documented that 3 LPNs worked 7:00 AM to 3:00 PM, 6 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM and 3 LPNs worked 11:00 PM to 7:30 AM. h. The nursing schedule for 12/13/25 indicated that 2 LPNs worked 3:00 PM to 11:00 PM, no MA worked any shift, 2 LPNs worked 11:00 PM to 7:30 AM, one (1) RN worked 11:00 PM to 7:30 AM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/13/25 documented 3 LPNs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 4 LPNs worked 11:00 PM to 7:30 AM, 3 RNs worked 11:00 PM to 7:30 AM and 6 NAs worked 11:00 PM to 7:00 AM. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	i. The nursing schedule for 12/14/25 indicated that 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 4 NAs worked from 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM, one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/14/25 documented 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 7 NAs worked 11:00 PM to 7:00 AM, 3 LPNs worked 11:00 PM to 7:30 AM and 3 RNs worked 11:00 PM to 7:30 AM. j. The nursing schedule for 12/15/25 indicated that 2 LPNs worked 7:00 AM to 3:00 PM, 4 NAs worked the 3:00 PM to 11:00 PM shift, one (1) LPN worked 3:00 PM to 11:00 PM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/15/25 documented 4 LPNs worked 7:00 AM 3:00 PM, 8 NAs worked 3:00 PM to 11:00 PM, 2 LPNs worked 3:00 PM to 11:00 PM, and no RN worked 11:00 PM to 7:30 AM. k. The nursing schedule for 12/16/25 indicated that 5 NAs worked 3:00 PM to 11:00 PM, one (1) RN worked 7:00 PM to 11:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/16/25 documented 2 NAs worked 3:00 PM to 11:00 PM, no RN worked 7:00 PM to 11:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, no LPN worked 11:00 PM to 7:30 AM and no RN worked 11:00 PM to 7:30 AM. l. The nursing schedule for 12/17/25 indicated that 6 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/17/25 documented 8 NAs 7:00 AM to 3:00 PM, one (1) NA worked 3:00 PM to 11:00 PM, no MA worked 3:00 PM to 11:30 PM, and 2 NAs worked 11:00 PM to 7:00 AM. m. The nursing schedule for 12/18/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 1 RN worked 3:00 PM to 11:30 PM, one (1) RN worked 7:00 PM to 7:30 AM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/18/25 documented 8 NAs worked from 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, no RN worked 3:00 PM to 11:30 PM, no RN worked 7:00 PM to 7:30 AM and 2 NAs worked 11:00 PM to 7:00 AM. n. The nursing schedule for 12/19/25 indicated 5 NAs worked 7:00 AM to 3:00 PM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/19/25 documented 4 NAs worked 7:00 AM to 3:00 PM and 2 RNs worked 11:00 PM to 7:30 AM. o. The nursing schedule for 12/20/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, 3 LPNs worked 3:00 PM 11:00 PM, no MA worked any shift, and 2 LPNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/20/25 documented 4 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 3:00 PM to 11:00 PM, 4 LPNs worked 3:00 PM 11:00 PM, one (1) MA 3:00 PM to 11:30 PM, and 3 LPNs worked 11:00 PM to 7:30 AM. p. The nursing schedule for 12/21/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, and 2 LPNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/21/25 documented 4 NAs worked from 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 3 LPNs worked from 11:00 PM to 7:30 AM. q. The nursing schedule for 12/22/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, 2 LPNs worked 7:00 AM to 3:00 PM, 2 RNs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, and 3 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/22/25 documented 3 NAs worked 7:00 AM to 3:00 PM, 4 LPNs worked 7:00 AM to 3:00 PM, no RNs worked 7:00 AM to 3:00 PM, one (1) NA worked (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	3:00 PM to 11:00 PM, and 2 NA worked 11:00 PM to 7:00 AM. r. The nursing schedule for 12/23/25 indicated 6 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, no LPNs worked 11:00 PM to 7:30 AM and 2 RNs worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/23/25 documented 5 NAs worked 7:00 AM to 3:00 PM, one (1) NA worked 3:00 PM to 11:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM. s. The nursing schedule for 12/24/25 indicated one (1) RN worked 7:00 AM to 3:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/24/25 documented no RN worked 7:00 AM to 3:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. t. The nursing schedule for 12/25/25 indicated 5 NAs worked 3:00 PM to 11:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/25/25 documented 4 NAs worked 3:00 PM to 11:00 PM and 5 NAs worked 11:00 PM to 7:00 AM. u. The nursing schedule for 12/26/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, one (1) LPN worked 7:00 AM to 3:00 PM, 4 NAs worked 3:00 PM to 11:00 PM and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/26/25 documented 4 NAs worked 7:00 AM to 3:00 PM, 2 LPNs worked 7:00 AM to 3:00 PM, 2 NAs worked 3:00 PM to 11:00 PM and 3 NAs worked 11:00 PM to 7:00 AM. v. The nursing schedule for 12/27/25 indicated 5 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/27/25 documented 4 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM and 3 NAs worked 11:00 PM to 7:00 AM. w. The nursing schedule for 12/28/25 indicated 5 NAs worked 7:00 AM to 3:00 PM, no MA worked any shift, and 4 NAs worked 11:00 PM to 7:00 AM. The daily posted nurse staffing sheet for 12/28/25 documented 6 NAs worked 7:00 AM to 3:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, and 3 NAs worked 11:00 PM to 7:00 AM. x. The nursing schedule for 12/29/25 indicated 6 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, and 2 RNs worked from11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/29/25 documented 5 NAs worked from 7:00 AM to 3:00 PM, 6 NAs worked 11:00 PM to 7:00 AM, and no RNs worked from 11:00 PM to 7:30 AM. y. The nursing schedule for 12/30/25 indicated 4 NAs worked 7:00 AM to 3:00 PM, 4 NAs worked 11:00 PM to 7:00 AM, one (1) LPN worked 11:00 PM to 7:30 AM and one (1) RN worked 11:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 12/30/25 documented 5 NAs worked 7:00 AM to 3:00 PM, 3 NAs worked 11:00 PM to 7:00 AM, no LPN worked 11:00 PM to 7:30 AM and no RN worked 11:00 PM to 7:30 AM. z. The nursing schedule for 12/31/25 indicated 5 NAs worked 7:00 AM to 3:00 PM and 4 NAs worked 3:00 PM to 11:00 PM. The daily posted nurse staffing sheet for 12/31/25 documented 7 NAs worked 7:00 AM to 3:00 PM and 2 NAs worked 3:00 PM to 11:00 PM. aa. The nursing schedule for 1/1/26 indicated 3 LPNs worked the 7:00 AM to 3:00 PM shift, 5 NAs worked the 3:00 PM to 11:00 PM shift, one (1) RN worked 3:00 PM to 11:30 PM and one (1) RN worked 7:00 PM to 7:30 AM. The daily posted nurse staffing sheet for 1/1/26 documented 4 LPNs worked the 7:00 AM to 3:00 PM shift, 4 NAs worked the 3:00 PM to 11:00 PM shift, no RN worked 3:00 PM to 11:30 PM and (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	no RN worked 7:00 PM to 7:30 AM. bb. The nursing schedule for 1/2/26 indicated 5 NAs worked 7:00 AM to 3:00 PM, one (1) LPN worked the 7:00 AM to 3:00 PM shift, 4 NAs worked 3:00 PM to 11:00 PM, no MA worked any shift, 4 NAs worked 11:00 PM to 7:00 AM and 2 LPNs worked the 11:00 PM to 7:30 AM shift. The daily posted nurse staffing sheet for 1/2/26 documented 6 NAs worked 7:00 AM to 3:00 PM, 3 LPNs worked the 7:00 AM to 3:00 PM shift, 2 NAs worked 3:00 PM to 11:00 PM, one (1) MA worked 3:00 PM to 11:30 PM, 2 NAs worked 11:00 PM to 7:00 AM and one (1) LPN worked the 11:00 PM to 7:30 AM shift. On 1/6/26 at 9:36 AM, an interview occurred with the Scheduling Manager. She was able to review the staffing schedule and daily postings and verified the number of staff working from 12/6/25 to 1/2/26 did not match. She explained the facility had recently gone to a new payroll/scheduling system and stated the system was pulling staff for the daily postings from a data report rather than the actual working schedule. She stated she didn't know how to edit in the system to reflect the actual number of staff that worked in a day. The Administrator was interviewed on 1/7/26 at 11:03 AM. The staffing schedule and daily postings were reviewed, which did not match for the actual staff that worked on a certain day. She confirmed that the facility recently began using a new payroll/scheduling system and there was not a way for the Scheduling Manager to edit the daily postings to reflect the correct number of staff that had worked. She had reached out to the company that manages the system several times but has been unsuccessful in getting feedback. The Administrator added that the daily staff schedule posting and the staffing schedule should match for the number of staff worked on any given shift. 2) An observation was made in the lobby of the facility on 1/4/26 at 9:45 AM. A review of the facility's daily posting for nursing staff for 1/3/26 revealed no resident census number for the 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM or 11:00 PM to 7:00 AM shifts. Additionally, the daily posting for the 7:00 AM to 3:00 PM shift on 1/4/26 demonstrated no resident census number. The Weekend Supervisor was interviewed on 1/5/26 at 1:15 PM. She reported the Staff Scheduler was responsible for completing the staff posting sheets for all days of the week. The Staff Scheduler was interviewed on 1/05/26 at 1:21 PM. She reviewed the daily nursing staff postings and noted that they did not include a resident census for the weekend dates of 1/3/26 and 1/4/26. She stated that she does not work on the weekends and completed the daily nursing staff postings on Monday when she returned to work. She stated that there was not a staff member assigned to complete the daily staff postings on the weekends. The Scheduler stated she was responsible for all the daily staffing sheets for the week, Sunday through Saturday. She stated that when she completed them on Friday, 1/2/26, her plan was to finish completing the resident census for 1/3/26 and 1/4/26 when she returned to work on Monday, 1/5/26. The Administrator was interviewed on 1/07/26 at 1:12 PM and stated she expected the resident census to be present on the daily nursing staff posting as required. The Administrator stated the weekend supervisor should have filled in the census on the posting and was not aware this was not being done.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with the Medical Director and staff, the facility failed to hold blood pressure medication as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Residents #2 and #3). The findings included: 1) Resident #2 was admitted to the facility on [DATE] with diagnoses that included hypertension. An admission Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #2 had severe cognitive impairment. Review of Resident #2's physician orders included an order dated 11/10/25 for Metoprolol (a medication for high blood pressure) 25 milligrams (mg) one tablet by mouth one time a day for hypertension. Hold for heart rate less than 60 or systolic blood pressure (the top number in the blood pressure reading) less than 100 or diastolic blood pressure (the bottom number in the blood pressure reading) less than 60. The December 2025 Medication Administration Record (MAR) was reviewed and revealed Resident #2 had received Metoprolol despite the heart rate below 60 on the following dates:12/13/25 heart rate was 52 administered by Nurse #3.12/14/25 heart rate was 52 administered by Nurse #3.12/16/25 heart rate was 53 administered by Nurse #4.12/18/25 heart rate was 55 administered by Nurse #5.12/20/25 heart rate was 59 administered by Nurse #4. On 1/6/26 at 8:47 AM, an interview occurred with the Medical Director. He reviewed Resident #2's medical record to include the December 2025 MAR and stated there were no negative outcomes from receiving Metoprolol outside the ordered parameter, however he would expect the nursing staff to follow the orders for the Metoprolol parameter as written. Nurse #5 was interviewed on 1/6/26 at 1:00 PM. Resident #2's December 2025 MAR was reviewed with her, and she verified that Metoprolol was administered on 12/18/25 despite the heart rate being below 60 when it should have been held and stated it was an oversight. Nurse #4 was interviewed via the phone on 1/6/26 at 1:56 PM. Resident #2's December 2025 MAR was reviewed with her and she verified that she had administered medications to Resident #2 on 12/16/25 and 12/20/25. She was unable to state why the Metoprolol was administered outside the parameter on 12/16/25 and 12/20/25, other than to say it was an oversight and the medication should have been held. Attempts to contact Nurse #3 were made without success. An interview was conducted with the Director of Nursing on 1/7/26 at 10:55 AM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold the medication. 2) Resident #3 was admitted to the facility on [DATE] with diagnoses that included hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #3 was cognitively intact. Review of Resident #3's physician orders included an order dated 12/18/25 for Metoprolol (a medication for high blood pressure) 50 milligrams (mg) one tablet by mouth three times a day for hypertension. Hold for heart rate less than 60 or systolic blood pressure (the top number in the blood pressure reading) less than 100 or diastolic blood pressure (the bottom number in the blood pressure reading) less than 60. The January 2026 Medication Administration Record (MAR) was reviewed and revealed Resident #3 had received Metoprolol despite the systolic blood pressure below 100 on 1/2/26 at the 1:00 PM dose, the systolic blood pressure was 97 and was administered by Nurse #6.1/2/26 at the 9:00 PM dose, the systolic blood pressure was 97 and was administered by Nurse #7. On 1/6/26 at 8:47 AM, an interview occurred with the Medical Director. He reviewed Resident #3's medical record, to include the January 2026 MAR, and stated there were no negative outcomes from receiving Metoprolol outside the ordered parameter, however he would expect the nursing staff to follow the orders for the Metoprolol parameter as written. Nurse #6 was interviewed on 1/6/26 at 12:08 PM. Resident #3's January 2026 MAR was reviewed with him, and he verified that Metoprolol was administered on 1/2/26 at 1:00 PM, despite the systolic blood pressure being below 100 when it should have been held and stated it was an oversight. Attempts to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbotts Creek Center	877 Hill Everhart Road Lexington, NC 27295

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contact Nurse #7 were made without success. An interview was conducted with the Director of Nursing on 1/7/26 at 10:55 AM and stated she expected the nursing staff to follow physician orders including blood pressure medications with parameters to hold the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. Building B. Wing	01/07/2026

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, the facility failed to store and secure a controlled medication that required refrigeration within a separately locked, permanently affixed box within the medication room refrigerator. This deficient practice was for 1 of 2 medication storage rooms reviewed (103 Medication Storage Room).The findings included:An observation and interview were conducted on 01/04/26 at 10:35 AM of the 103 medication storage room refrigerator with Nurse #1. The observation revealed a 30 ml (milliliter) bottle of liquid lorazepam (a benzodiazepine) 2 mg (milligram) /ml located in the refrigerator door. Nurse #1 stated staff did not have a key to the lock box inside of the refrigerator and there was not a lock for the refrigerator door. Nurse #1 explained she was unsure why there was no key for the lock box within the refrigerator and it had been that way for a long time. Nurse #1 confirmed the lorazepam should have been secured within the medication storage refrigerator inside the affixed lock box. An interview was conducted on 01/06/26 at 11:27 AM with the Director of Nursing (DON). She stated she was unaware nurses did not have a key to the internal lock box in the medication refrigerator. She explained the controlled medications, including lorazepam, were to be stored in the secured lock box affixed within the refrigerator.An interview was conducted on 01/06/26 at 3:57 PM with the Administrator. She indicated she was unaware staff could not access the internal lock box in the medication refrigerator. She expected controlled medications that required refrigeration to be stored in the secured lock box affixed to the inside of the refrigerator.