STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Health Care Center	17 Cornelia 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, family member, neighbor and staff interviews, the facility failed to protect a resident's right to be free from exploitation. In [DATE], Nurse Aide (NA) #1 told Resident #1 that her landlord raised the rent at her apartment and she was going to be evicted. Resident #1 reported that NA #1 asked to live in his personal home and being a goodhearted trusting person, he was considering letting NA #1 and her friend house-sit his personal home while he was at the facility. NA #1 asked the resident if she could look at his house and he informed her where the keys were located. NA #1 went to the resident's home and due to being unable to find the keys she went to Resident #1's neighbor's home to request a key at which time the neighbor did not give her the key preventing NA #1 from entering the home and having access to all of Resident #1's personal belongings. The deficient practice occurred for 1 of 3 residents reviewed for abuse, neglect and/or misappropriation of property/exploitation (Resident #1). Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included depression and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was moderately cognitively impaired and was receiving antidepressant medication and opioid medication (pain medication). Psychological Provider #1 notes dated [DATE] recorded Resident #1 had a major depressive disorder and anxiety with ongoing grief and a cognitive communication disorder but Resident #1 was able to express needs and communicate effectively.In an interview with Nurse Manager #1 on [DATE] at 2:58 pm, she recalled Resident #1's Family Member and a friend (Resident #1's neighbor) came to the facility in [DATE] and informed her that NA #1 had taken advantage of Resident #1 by asking Resident #1 if she (NA #1) could move into his personal house. She stated she escorted the family member and friend to the former Administrator's office. She stated although she never discussed the incident with Resident #1, she was able to obtain permission from Resident #1 to review his cellular phone and identified NA #1's phone number from a text that was sent to Resident #1. Nurse Manager #1 was unable to recall the date of the text and stated NA #1 was suspended and never worked at the facility after Resident #1's family member and neighbor came to the facility. An initial allegation report dated [DATE] at 2:13 pm was completed by the former Administrator and faxed to the State Agency alleging misappropriation of Resident #1's property on [DATE]. The initial report recorded the facility became aware of the incident on [DATE] at 10:45am. Details of the allegation stated NA #1 convinced Resident #1 to allow her to stay/live in his personal house while he was at the nursing facility. NA #1 went to Resident #1's neighbor's home to obtain a key to Resident #1's personal house who refused to give NA #1 a key to Resident #1's personal house. On [DATE], Resident #1's neighbor and family member reported NA #1 attempted to exploit Resident #1 to become a squatter in Resident #1's personal house. Resident #1's family member, who was financial proxy and health power of attorney for Resident #1, stated Resident #1 was easily manipulated and coerced into agreements of helping others. NA #1 was suspended pending investigation of the allegation on [DATE]. The facility notified the local law enforcement on [DATE] at 12:41 pm of the allegation.The facility's investigation report signed by the former Administrator on [DATE] was faxed to the State Agency on [DATE]. The investigation report recorded that Resident #1 agreed initially and then changed his mind and denied allowing NA #1 to stay/live in his personal house. The investigation report further stated Resident #1 was not mentally able to discern the ramifications of the action of NA #1 living in his personal house and family reported Resident #1 was easily manipulated and coerced into agreements to help others. NA #1 was suspended pending investigation and terminated on [DATE]. The termination was noted to not be related to the allegation. The allegation was not substantiated. In an interview with Resident #1 on [DATE] at 3:12 pm, he explained he had not seen his personal home in the last eight months due to repeated hospitalizations and rehabilitation at the facility. He stated NA #1 worked part-time at the facility and had been assigned to his hall. He explained it was in the mid of [DATE] when he and NA #1 were in the dining room talking at a table and NA #1 mentioned how her landlord had raised the rent and she was being evicted out of her living quarters. Resident #1 stated NA #1 asked to go live at his personal home and being the goodhearted trusting person that he was, he was considering letting NA #1 and her friend house-sit his personal home while he was at the facility. He stated NA #1 asked to go look at his house and he told her where the key was kept to his personal house. Resident #1 stated he had a love for people and a big house, and his wife had died while he and his wife were both hospitalized . Resident #1 stated he changed his mind after talking to other employees and learning that NA #1 had a

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to report an allegation misappropriation of property/exploitation to Adult Protective Services (APS) for 1 of 3 residents reviewed for abuse, misappropriation of property and/or exploitation (Resident #1).Findings included:The Facility's Reporting Requirements/Investigations policy statement dated effective 2/5/2023 indicated the Administrator will immediately notify the adult protective services agency for any incident of patient abuse, mistreatment, neglect or misappropriation of personal property or other reasonable suspicion of a crime. Resident #1 was admitted to the facility on [DATE].An initial allegation report dated 7/10/2025 at 2:13 pm was completed by the former Administrator and faxed to the State Agency alleging misappropriation of Resident #1's property on 7/9/2025. The initial report recorded the facility became aware of the incident on 7/10/2025 at 10:45am. Details of the allegation stated NA #1 convinced Resident #1 to allow her to stay/live in his personal house while he was at the nursing facility. NA #1 went to Resident #1's neighbor's home to obtain a key to Resident #1's personal house who refused to give NA #1 a key to Resident #1's personal house. On 7/10/2025, Resident #1's neighbor and family member reported NA #1 attempted to exploit Resident #1 to become a squatter in Resident #1's personal house. Resident #1's family member, who was financial proxy and health power of attorney for Resident #1, stated Resident #1 was easily manipulated and coerced into agreements of helping others. NA #1 was suspended pending investigation of the allegation on 7/10/2025. The facility report indicated notification of the allegation was made to local law enforcement on 7/10/2025 at 12:41 pm. There was no documentation that APS was notified of the allegation of misappropriation of property and/or exploitation.The facility's investigation report signed by the former Administrator on 7/16/2025 was faxed to the State Agency on 7/17/2025. There was no documentation that APS was notified of the allegation of misappropriation of property and/or exploitation.In a phone interview with the former Administrator on 8/27/2025 at 4:44pm, she stated she could not recall if APS was notified of the allegation related to misappropriation of property/exploitation for Resident #1. She explained that usually the Social Worker electronically notified APS of abuse, misappropriation or property and/or exploitation allegations.In an interview with the Social Worker on 8/28/2025 at 5:47 pm, she explained since starting at the facility in May 2025, she was responsible for notifying APS for incidents of residents leaving against medical advice and exploitation of funds. She stated the former Administrator would have to let her know when there were allegations of misappropriation of property and/or exploitation to report to APS. She stated she was not informed by the former Administrator of the allegation of misappropriation of property and/or exploitation for Resident #1 and therefore, she had not notified APS of the allegation.In a follow up phone interview with the former Administrator on 9/4/2025 at 12:00 pm, she stated per the facility's policy, the local adult protective agency should be notified of allegations of misappropriation of property and/or exploitation. She explained she had no recall of informing the Social Worker of the allegation of misappropriation of property and/or exploitation for Resident #1 and the local adult protective agency was not notified. In an interview with the Administrator, Regional Clinical Consultant and Director of Nursing on 8/28/2025 at 5:50 pm, they stated the facility did not have a plan of correction that was completed for reporting an allegation of misappropriation of property and/or exploitation for Resident #1.