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	10/13/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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

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	10/13/2025

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 0658 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 observation, record review, and interviews with staff, Nurse Practitioner, Pharmacist, and Physician the facility failed to ensure a nurse accurately measured a liquid narcotic medication per professional standards of practice resulting in a wrong administration dose. This was for 1 of 3 residents whose medications were reviewed (Resident #1). The findings included:Resident # 1 was admitted to the facility on [DATE]. Review of a hospital discharge summary revealed that prior to Resident # 1's facility residency he had been hospitalized from [DATE] to 9/2/25. The resident was diagnosed with pulmonary nodules, a large chest mass with evidence of metastatic disease to multiple areas in his bones along with enlarged lymph nodes. Additionally, Resident # 1 had diagnoses of heart failure with a decreased ejection fraction (percent of blood flow the heart pumps with each heart beat), chronic obstructive pulmonary disease, anxiety disorder, schizophrenia, hypertension, and seizure disorder. Resident # 1's admission weight on 9/2/25 registered 256. 6 pounds.Resident # 1's admission Minimum Data Set assessment, dated 9/9/25, coded Resident # 1 as cognitively intact with occasional pain.Review of Nurse Practitioner (NP) # 1's progress note, dated 9/17/25, revealed the following information. The resident had chosen not to receive any treatment for his metastatic lung cancer. He had chosen not to be hospitalized or to be resuscitated. He was becoming more lethargic and more hypoxic, and there had been a decline in his meal intake.Review of physician orders revealed an order, dated 9/24/25 at 11:42 AM, for Morphine Sulfate (concentrate) solution 20 mg (milligrams)/ML (Milliliter) Give 5 mg by mouth every 2 hours as needed for end of life care/restlessness, labored breathing for 10 days comfort measures.Review of Resident # 1's Medication Administration Record (MAR) revealed the 9/24/25 Morphine order was transcribed onto the MAR without any directions that .25 ml would equate to the ordered 5 mg.Nurse Manager # 1 and Nurse # 2 were interviewed together on 10/10/25 at 3:12 PM. Nurse # 2 routinely cared for Resident # 1 and Nurse Manager # 1 was the resident's care manager. Nurse # 2 reported the following information. Resident # 1 was ordered to have oxygen and nebulizer treatments. He was noncompliant and would take the oxygen off or remove the nebulizer treatments. After being at the facility for approximately three weeks he began to decline, and they had trouble keeping his oxygen levels up because he would remove his oxygen. Nurse Manager # 1 reported that the resident, who had mental illness and anxiety, would take his oxygen off and then he would not be able to get his breath. This further increased his anxiety, which in turn made it harder for him to breathe. He would then cry out he could not breathe as if panicking. He had been prescribed Morphine which helped him become calmer, slow his respirations, and raise his oxygen saturations as part of his comfort care in the end of life. Nurse # 2 further reported that after three weeks of being at the facility, Resident # 1 would sleep almost the entire shift at times, and this was not correlated to the morphine. At times he would do this even when the morphine was not administered.On 10/1/25 a significant change MDS assessment was completed. Resident # 1 was coded on this assessment as being moderately cognitively impaired and as having frequent pain during the assessment period.Review of Resident # 1's Controlled Substance Receipt/Count Sheet revealed on 10/3/25 at 2:30 AM Nurse # 1 signed out 1 milliliter of Morphine from Resident # 1's supply. According to the Controlled Substance Receipt/Count Sheet, there were 20 milligrams of Morphine per one milliliter. This indicated that Nurse # 1 signed out 20 milligrams of Morphine rather than the prescribed 5 mg of Morphine. On 10/3/25 at 3:03 AM Nurse # 1 documented on Resident # 1's MAR (Medication Administration Record) the administration of the Morphine beside of the order which noted the dosage should have been 5 milligrams.On 10/10/25 at 1:39 PM an attempt was made to interview Nurse # 1 and she could not be reached for interview.Nurse Aide (NA) # 1 was assigned to care for Resident # 1 on the night shift which began on 10/2/25. NA # 1 was interviewed on 10/13/25 at 1:23 PM and reported the following information. Nurse # 1 had informed her that she had made a medication error and given the resident too much morphine. Nurse # 1 went to call the physician. Nurse # 1 had instructed her (NA # 1) to take the resident's respirations and oxygen saturation every ten minutes, and she had done so and checked on him throughout the night. She also did full vitals every four hours. Nurse # 1 also checked on him. Resident # 1 was still alert after the error until around 5:00 AM. He had not slept in a long time prior to the error being made and then around 5:00 AM he started to rest and seemed really relaxed at that point. His respirations were at his baseline at the end of her shift.Review of nursing notes revealed an entry on 10/3/25 at 6:00 AM noting Resident # 1 was sleeping and was responsive to tactile stimuli. His vitals were 101/67, heart rate 115

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	10/13/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview the facility failed to ensure a resident's medical record was complete regarding medication orders given by a Nurse Practitioner and documentation of the administration of medications. This was for 1 of 3 of three sampled residents whose medications were reviewed (Resident # 1). The findings included: Resident # 1 was admitted to the facility on [DATE] with a diagnosis of metastatic lung cancer disease.Review of a Nurse Practitioner's (NP) progress note for the date of 10/3/25 revealed the NP had ordered some medications when the resident was not responding. According to the NP's note she ordered two doses of Narcan and one dose of Lasix which were administered to the resident.Review of Resident # 1's orders revealed these orders were never entered into the resident's electronic record. Review of Resident # 1's MAR (Medication Administration Record) revealed no documentation when these medications were given. They did not appear on the MAR. Review of the facility's emergency medication supply sign out records revealed Narcan was removed from the supply on 10/3/25 at 9:32 AM and 12:16 PM for Resident # 1. Lasix was removed from the emergency supply for Resident # 1 on 10/3/25 at 9:37 AM. Nurse # 5 was interviewed on 10/13/25 at 1:06 PM and reported the following information. There had been multiple nurses in the room with the Nurse Practitioner on 10/3/25 when the NP gave orders for the first dose of Narcan and the Lasix. This included Nurse Manager # 1, Nurse # 3, Nurse # 4, and herself (Nurse #5). The NP did not direct the order to any particular nurse, and it was not clear that she (the NP) did not enter the order in herself. Nurse # 4 had removed the Narcan and the Lasix from the backup supply and she (Nurse # 5) had administered Narcan and Lasix at the time these had been removed from the emergency supply. She had not documented the administration on the MAR.Nurse # 3 was interviewed on 10/13/25 at 1:10 PM and reported the following information. The NP had given the order for a second dose of Narcan on 10/3/25 around 12:30 PM. She had removed the Narcan from the backup supply and administered it per the verbal order. She had not documented the order on the MAR. When entering orders into the electronic medical record system, the system had choices of different medications and different forms in which the medications were supplied. She had tried to enter the order in the facility's electronic medical record system, but she could not find the correct form of Narcan in the electronic record as a choice. Therefore, the order was not entered into the resident's electronic record, and it never appeared on the MAR. Therefore, she had not documented the administration, but she did administer it.According to interviews with the Administrator on 10/10/25 at 5:00 PM and again on 10/13/25 at 12:59 PM the Resident's record should have reflected the orders and administration times of the Narcan and Lasix.