

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Lexington Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident, family, Medical Director, and staff, the facility failed to treat a resident in a dignified manner when staff filed legal guardianship of the resident without communicating with the resident or the resident's family and without having the resident evaluated or assessed to be deemed incompetent. Resident #1, with visible tears in her eyes, stated she felt the facility was trying to control her and take her rights away. This affected 1 of 1 resident reviewed for dignity and respect (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease, hypertension, anoxic brain damage, dependence of renal dialysis, cognitive communication deficit, and muscle weakness.Review of Resident #1's face sheet revealed the resident was her own responsible party (RP). The face sheet further revealed the resident had Family Member #1 and Family Member #2 listed as emergency contacts.A physician note completed by the Medical Director dated 07/26/26 noted Resident #1 had historically refused dialysis and medication but had shown variable willingness to reconsider when educated about their purpose. The note further revealed Resident #1's cognitive impairment rendered comprehension of her decisions doubtful, but Resident #1 had not been declared incompetent and family were not willing to force the issue.Resident #1's significant change Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and had no behavior or rejection of care. The MDS further revealed the resident was coded for dialysis.Review of Resident #1's active care plan (revised on 06/12/26) revealed the resident had behaviors of refusing medications and dialysis treatments due to denial of health conditions. The goal was that Resident #1's behaviors would not cause the resident distress. Interventions included administering medications as ordered and assign staff to the resident that were familiar or preferred.Review of Resident #1's active care plan (revised on 06/18/26) revealed the resident was expected to be at the facility on a short-term basis and return to the community. The goal was that Resident #1 would return to the community successfully when ready. Interventions included to coordinate with the physician regarding discharge plans as indicated, refer to community resources as indicated per resident and resident representative preference, and update discharge plans with the resident when needed.A physician note completed by the Medical Director dated 08/14/26 noted Family Member #1 had been involved in the resident's care and had been notified of the resident's refusal of hemodialysis treatments. Resident #1 believed she did not have chronic kidney disease and education had been provided. Resident #1 reported she wanted to speak with Family Member #2 (ex-husband) before making any decisions.Review of a court petition filed for guardianship of Resident #1 on 08/14/26 by the Social Worker revealed there was a pending court date for 09/23/26.An interview with the Social Worker (SW) on 08/17/26 at 1:00 PM indicated Resident #1 had some days that she was confused, but she was still able to make her own decisions. (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 0578 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, resident and law enforcement interviews, the facility failed to honor a resident's right to refuse treatment when the resident declined five hemodialysis (a life-sustaining procedure for kidney failure that uses a machine to filter waste, toxins, and excess fluids from the blood) treatments and the facility proceeded to file an involuntary commitment which deemed the resident a danger to herself. The resident reported once the local law enforcement officer had walked her out to the front entrance of the facility, the resident was asked to put her hands out and the officer placed handcuffs on both wrists in the front of her body and had her sit in the backseat of the police car. The resident stated she did not know what was happening as she had no previous experience with law enforcement. The resident expressed she was upset and aggravated but tried to remain calm and was cooperative and compliant with the officer's instructions. The resident stated she now felt she no longer had the right to refuse hemodialysis and was afraid local law enforcement would again be contacted by the facility if she did so. This deficient practice affected 1 of 3 residents reviewed for the resident's right to refuse treatment (Resident #101). The findings included: Resident #101 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD) with dependence on hemodialysis (a brand new diagnosis and treatment process for Resident #101) and a history of anoxic brain injury. Resident #101 was her own Responsible Party (RP). Resident #101 was [AGE] years old. Resident #101's care plan dated 3/9/2026 had a focus area for Resident #101 having an increased risk of complications due to the need for community hemodialysis for ESRD. Goals included Resident #101 would be free of complications from hemodialysis through the review period. Interventions included Resident #101 would receive community hemodialysis three times weekly, perform labs and diagnostics as ordered, and monitor for the signs and symptoms of complications related to ESRD including but not limited to fluid overload, hemorrhage, infection at the access site, hypotension, respiratory and/or cardiac distress and notify the provider as indicated. Resident #101's care plan had a focus area added on 6/10/2026 related to Resident #101 having behaviors of refusing medications and hemodialysis treatment due to denial of health conditions. Goals included Resident #101's behaviors would not cause her or other resident's distress through the next review period. Interventions included staff would administer medications as ordered, and assign staff members that are familiar or preferred by Resident #101 when possible. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #101 was moderately cognitively impaired. Resident #101 required minimum assistance with Activities of Daily Living (ADL). Resident #101 ambulated independently and self-propel independently in a wheelchair. Resident #101 was admitted to the facility after a hospital admission from 1/11/2026 to 3/8/2026 at which time hemodialysis was initiated due to an acute kidney injury/ESRD and Resident #101 required rehabilitation. A telephone interview with the community dialysis center Clinic Manager on 6/25/2026 at 10:55 AM indicated that prior to 6/10/2026, Resident #101 had refused hemodialysis on 5/30/2026, 6/2/2026, 6/4/2026, 6/6/2026 and 6/9/2026. A Nurse Practitioner (NP) note dated 6/10/2026 at 1:00 PM created by Nurse Practitioner #1 stated that Resident #101 continued to be noncompliant with her hemodialysis treatments and was scheduled to go on Tuesday, Thursday, and Saturday. Resident #101 was reminded that the hemodialysis access dressing needed to be changed and flushed as well. Resident #101 acknowledged understanding and stated she would attend the hemodialysis session on 6/11/2026 but then stated that after she had the dressing changed and (continued on next page)		

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F 0578 Level of Harm - Actual harm Residents Affected - Few	diagnosis list and medications several times and reviewed these with Resident #101. Nurse #1 stated that on 6/10/2026 Resident #101 refused to go to the hospital with EMS and EMS stated Resident #101 could not be transported against her will. Nurse #1 recalled the decision for IVC was made by the Administrator, NP and DON. The Nurse stated Resident #101 was at no time violent, aggressive, suicidal or homicidal on 6/10/2026. Nurse #1 stated on 6/11/2026 she learned Resident #101 had attended her scheduled hemodialysis appointment and Nurse #1 reported she had not spoken to anyone further including Resident #101 about the events on 6/10/2026. An Affidavit and Petition for Involuntary Commitment dated 6/10/2026 at 6:50 PM indicated that the petition was completed by the DON. The DON checked the box on the Affidavit and Petition for Involuntary Commitment for the prewritten choice indicating that Resident #101 had a mental illness and was dangerous to self or others or has a mental illness and is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness. The DON's sworn, handwritten statement stated on the petition that Resident #101 had an anoxic brain injury that rendered her to be incompetent of her decisions regarding her health. Resident #101 was refusing her hemodialysis and had for the last two weeks. Resident #101 believed she no longer needed hemodialysis and wanted bloodwork done. Resident #101 had a history of depression and was refusing lifesaving medications, hemodialysis and care. An interview with the Director of Nursing (DON) on 6/25/2026 at 9:51 AM indicated she initiated the IVC on 6/10/2026 as Resident #101 had an anoxic brain injury, had refused to go to hemodialysis and was denying her medical diagnosis of renal disease. The DON stated the decision to IVC Resident #101 was made by the Administrator, DON, NP and also the facility Nurse Consultant as Resident #101 had refused to go to the hospital with EMS for a medical evaluation. The DON revealed the facility was concerned that toxins had built up as Resident #101 had refused hemodialysis for about 2 weeks. The DON stated she left a message for Resident #101's emergency contact on 6/10/2026 to advise that Resident #101 was recommended to go to the hospital with EMS but refused so the facility had pursued IVC. The DON indicated she spoke with the emergency contact later to report the IVC had been completed. The DON stated that a resident's right to refuse treatment really depended on the resident and if that resident could make their own decisions. The DON revealed that at no time was Resident #101 considered to be suicidal, homicidal and displayed a calm demeanor throughout the day. The DON stated the facility did not reach out to the Regional Ombudsman regarding Resident #101 and the refusals of hemodialysis. A nursing note dated 6/10/2026 at 8:45 PM created by Nurse #2 indicated Resident #101 was picked up by the police and transferred to the emergency room. A telephone interview on 6/24/2026 at 5:28 PM with a local law enforcement Supervisor revealed the Magistrate's office contacted local law enforcement when IVC papers were filed to assist with transportation of the individual named in the petition. The Supervisor indicated the individual was usually behaviorally unstable, suicidal and/or homicidal. The law enforcement officer would only transport an individual in the police car if deemed medically stable and would call for EMS transport if the individual required medical attention/monitoring. The Supervisor reported law enforcement policy/procedure required the individual to be searched and handcuffed usually with hands in the front unless the person showed dangerous behavior which would require the hands to be handcuffed behind the individual's back. The Supervisor stated the individual would then ride in the cage in the back seat of the police car. The Supervisor went on to say that this procedure was followed to ensure the safety of the individual and the officer as the person had been deemed a danger to themselves or others by the Magistrate. The Supervisor indicated that the responding officer would not discuss the IVC with the individual named in the petition as the officer was not part of the assessment process and just present for safe transportation of the individual. The Supervisor (continued on next page)		

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F 0578 Level of Harm - Actual harm Residents Affected - Few	change in symptoms or any other concerns. A nursing note dated 6/10/2026 at 11:00 PM created by Nurse #2 stated Resident #101 returned, walking into the facility. ER paperwork was obtained. Resident #101 was in stable condition. An interview on 6/24/2026 at 4:15 PM with Resident #101 revealed she had refused hemodialysis treatments since the end of May 2026 until June 11, 2026. Resident #101 stated she had refused as she did not understand why she needed hemodialysis as she urinated normally. Resident #101 indicated she had requested the original hospital documents to review to better understand her medical condition as she had only been told by a hospital physician that hemodialysis was required or she would die. Resident #101 reported she had been attending hemodialysis since admission to the facility but began to have painful stomach cramping during treatments and felt like her throat was closing up. Resident #101 stated she was not sure that she had any kidney issues. Resident #101 stated she did not recall anyone discussing with her what she really wanted regarding her future care and treatment especially in the area of hemodialysis. Resident #101 revealed nursing staff seemed to become upset with her when she declined going to hemodialysis treatments. On 6/10/2026 in the evening, Resident #101 recalled a local law enforcement officer came to her room and asked her to walk out with him. Resident #101 indicated she complied and when she reached the front of the building she sat down on the bench at the front of the building. Resident #101 stated the police car was parked at the front of the building and initially the officer opened the front passenger door but then told her to stand up and hold out her hands. Resident #101 stated the officer handcuffed her hands in the front and told her to sit in the back of the police car. Resident #101 indicated she had asked the officer what was happening and where they were going but the officer did not answer her. Resident #101 recalled arriving at a building with a large emergency sign so she thought she was at the hospital. Resident #101 stated she waited in a room and a physician and nurse came into the room and her vital signs were taken. Resident #101 indicated she could not remember if the handcuffs were removed while she was in the room but knew the handcuffs had been taken off when she was moved to a stretcher in the hallway. Resident #101 revealed she thought blood work was taken and she stayed on the stretcher until it was time to return to the facility. Resident #101 recalled she saw the officer and physician talking and the physician came over to her and stated, All I can tell you is to please go to dialysis. At that point Resident #101 stated she left with the officer and returned to the facility. Resident #101 reported she did not recall speaking with staff when she returned until the next morning when breakfast was served and she got up to go to hemodialysis. Resident #101 stated during the interaction with the officer, she was upset and aggravated but tried to stay calm and cooperative. Resident #101 revealed that she had never had any interaction with law enforcement in the past but knew she had not been arrested that evening. Resident #101 indicated she now felt that she did not have the right to refuse her hemodialysis treatments as she was afraid the facility would contact local law enforcement again. Resident #101 stated she recalled a nurse had asked her to meet with staff regarding her care but could not remember the specific date. Resident #101 knew the request was after 6/10/2026. Resident #101 stated she did not want to talk with the facility staff about her care or condition as she did not trust them after the facility called local law enforcement on her. An interview on 6/25/2026 at 12:26 PM with the facility Discharge Planner #1 indicated psychology services were ordered on 3/8/2026 but Resident #101 declined the services. Discharge Planner #1 stated she was not part of the decision making process for the IVC for Resident #101. Discharge Planner #1 stated she had left one voice mail message for Resident #101's emergency contact regarding a discussion about guardianship but had never received a return call. Discharge Planner #1 indicated she could not recall the exact date of the call but knew it was before 6/10/2026. Discharge Planner #1 stated she met with Resident #101 once (continued on next page)		

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F 0578 Level of Harm - Actual harm Residents Affected - Few	she learned about the IVC. Discharge Planner #1 recalled Resident #101 expressed she was upset about the IVC as Resident #101 felt she should be able to decline hemodialysis, and make her own decisions. Discharge Planner #1 stated Resident #101 appeared to feel better after having the opportunity to verbalize her feelings with Discharge Planner #1. A telephone interview on 6/25/2026 at 1:35 PM with Resident #101's emergency contact revealed Resident #101 had, in the past, denied other medical diagnoses. The emergency contact reported she had received a voicemail from the facility on 6/10/2026 and had called back. The emergency contact indicated she knew Resident #101 had been sent to the hospital and the IVC had been done due to Resident #101 refusing hemodialysis and concerns that toxins were building up. The emergency contact indicated that she believed Resident #101 could make some decisions but was unsure if Resident #101 could make medical decisions. The emergency contact reported she had discussed the importance of hemodialysis and medications with Resident #101 while Resident #101 was hospitalized and more recently when Resident #101 began refusing hemodialysis in June 2026. The emergency contact stated that guardianship had not been discussed with her. The emergency contact indicated she had been invited to a care team meeting but she was working and could not be on her phone while at work. A telephone interview with the Medical Director on 6/25/2026 at 11:45 AM revealed he had not been advised that an IVC had been initiated for Resident #101 until the surveyor told him during the telephone interview. The Medical Director reported he was not included in the decision process for the IVC. The Medical Director stated the NP saw Resident #101 on a regular basis but did recall the last time he assessed Resident #101 on 6/9/2026, he believed Resident #101 demonstrated some cognitive impairment. The Medical Director reported he knew Resident #101 had refused some hemodialysis treatments but also knew that Resident #101 had not been legally declared incompetent. The Medical Director indicated he had no comment on Resident #101's current decision making capability but felt residents who were competent could refuse treatment. The Medical Director stated he thought the IVC was an attempt by the facility to address Resident #101's poor choices. The Medical Director stated the facility should have pursued guardianship with Resident #101's family. An interview with the Administrator on 6/25/2026 at 3:15 PM indicated the facility felt that Resident #101's refusal of hemodialysis and medications was becoming an emergent situation on 6/10/2026 due to the buildup of toxins. The Administrator revealed he had personally met with Resident #101 and explained the importance of hemodialysis but could not provide a specific date this was done. The Administrator stated he did not feel Resident #101 could make her own decisions due to the buildup of toxins from not receiving hemodialysis. The Administrator reported he did believe Resident #101 was a danger to herself when she refused hemodialysis treatments and had completed the IVC as Resident #101 refused to go to the hospital with EMS and they could not take her against her will. The Administrator stated that he was aware Resident #101 had travelled to and from the hospital in the police car and had talked with the responding law enforcement officer via telephone. The Administrator stated the officer had told him the IVC had been completely unnecessary for Resident #101. The Administrator stated that the facility did not reach out to the Regional Ombudsman prior to initiating the IVC. The Administrator stated Resident #101's cognition seemed better now that she had resumed hemodialysis treatments. The Administrator stated the facility attempted to have a care team meeting on 6/18/2026 but Resident #101 and the emergency contact did not attend.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to label and date food items stored for use, reseal dry goods that were left open to air, keep a gas range and oven clean of grime (ingrained dirt or filth accumulated on a surface) and grease build-up, and maintain a clean food preparation area. These practices occurred in 1 of 3 reach-in coolers (cooler #2), 1 of 1 dry goods storage room and had the potential to affect food served to residents. The findings included: An initial tour of the main kitchen occurred on 6/22/26 at 10:20 AM with the Dietary Manager. The following concerns were identified: a. Undated food items found in the reach-in cooler #2 included: - A large, prepared container of sliced fresh tomatoes, - A large, prepared container of sliced fresh onions. b. Leftover food items found in the dry storage area on 6/22/26 at 10:25 AM that were not resealed and left open to air and/or undated included: - A 35 ounce (oz.) bag of crisped rice cereal, - A 35 oz. bag of corn flakes cereal, - One 24 oz. open-to-air bag of strawberry gelatin in the original container without a date. c. Observations of the cooking equipment and the food preparation area on 6/22/26 at 10:35 AM included: - Visible grime and grease build-up present on four burners of the gas cooking range in the food preparation area, - Visible grease build-up and food particles present on the glass oven doors in the food preparation area, - Grease build-up and food crumbs were present in the tile grout in front of the cooking and food preparations areas. An interview with the Dietary Manager on 6/22/26 at 10:35 AM revealed she had just started as the Dietary Manager a few weeks ago and she stated kitchen staff were expected to clean the food preparation areas daily. She stated she was unsure of the deep cleaning schedule, but she had degreasing products which she planned to use on the grease build up in the food preparation areas. A second interview with the Dietary Manager occurred on 6/25/26 at 3:11 PM. She stated kitchen staff started using resealable storage bags for the opened cereal. An interview with the Administrator on 6/25/26 at 3:46 PM revealed he had the expectation that the kitchen would not have any grease build-up in the food preparation area and that staff would keep the equipment clean. He stated he had received a quote for repairing and replacing some of the tile and grout areas in the food cooking and preparation areas. The Administrator also stated he had the expectation that all food stored in the kitchen would be correctly stored and labeled.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and Responsible Party (RP), continuous radar-monitoring system representatives, and staff interviews, the facility failed to obtain written consent and educate the resident or Responsible Party for the use of a continuous radar-monitoring system mounted on the wall above the resident's bed for 1 of 2 sampled residents with a monitoring system (Resident #35). Findings included: Resident #35 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #35 was moderately cognitively impaired. An observation on 6/22/26 at 12:00 PM revealed Resident #35 had a small, white device with no lens or light mounted above her bed which was pointed directly at her bed. A review of the continuous radar-monitoring system's website revealed the mounted device continuously monitored vital signs and activity through clothing and bedding using radar-based sensors. Subtle skin movements from the patient's heartbeat were detected, measured, and tracked around the clock. The data was sent to a centralized dashboard, giving facility staff access to patient insights, analysis, and alerts. A telephone interview with continuous radar-monitoring company Representative #2 occurred on 7/1/26 at 11:12 AM. He stated the continuous radar-monitoring device in any resident's room would continuously collect data and was never physically turned off, but the data would not be monitored until the consent was signed. When asked by the State Surveyor how the monitoring company would know if a resident had moved in or out of a room, he replied that the monitoring service would rely on nursing documentation of a discharge, room change, etc. and as soon as that update was loaded, the data would be received. An interview with Resident #35 was attempted on 6/22/26 at 12:00 PM but was unsuccessful. An interview with Resident #35's Responsible Party (RP) on 6/22/26 at 12:00 PM revealed he was not aware of what the small, white device mounted to the wall was and noted it had been there since Resident #35 was admitted. He stated he thought it might be a camera and was not sure how he felt about a camera or other monitoring device being used in Resident #35's room. The RP stated he was not made aware of the device and did not recall receiving any education on the device or signing a consent form for its use when he signed Resident #35's admission paperwork. He stated he could not decide if he was ok with the use of the device as he was not aware of what it was monitoring. The RP noted he had not asked facility staff about the device. A request was made by the State Surveyor on 6/25/26 for the continuous radar-monitoring system written consent forms. On 6/26/26 the signed consent forms were reviewed and there were none present for Resident #35. A telephone interview with the Director of Nursing (DON) on 7/1/26 at 10:01 AM revealed she and the admission Director went through the consent forms requested by the State Surveyor on 6/25/26 and 6/26/26 and realized a consent form for Resident #35 was missing. A combined telephone interview with the Admissions Director and the Administrator on 7/1/26 at 10:44 AM revealed the Admissions Director did the admissions paperwork for Resident #35 when she moved into the facility. She stated the admission Assistant typically did the admission paperwork, but she was out on vacation, so she went through the paperwork with Resident #35's RP. She stated she missed the consent form and the education that accompanied the form when speaking to Resident #35's RP. The Administrator stated the continuous radar-monitoring device would not have been turned on in Resident #35's room until a consent had been signed for her. A telephone interview with continuous radar-monitoring device Representative #1 occurred on 6/29/26 at 1:20 PM. He stated the device in Resident #35's room used continuous radar technology and would monitor metrics such as heart rate and respirations on all residents. He indicated a team of clinicians offsite monitored the information tracked from the device. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Representative #1 stated the system interfaced with the facility's EMR and the offsite clinicians monitoring the data could view the EMR and would look for an action of the facility's nursing staff and if there was not a current action, it would send an alert through the system to the nursing staff to alert them to a problem with a resident. He stated the continuous radar-monitoring device did not use a receiver on any resident being monitored but instead took the data from the person in the bed. Representative #1 stated if someone else stepped in front of the monitor, the continuous radar-monitoring system would shut down and reestablish on the correct resident. He stated a daily risk report was formulated and sent to the administrative staff in the building every morning. The report is formulated by Artificial Intelligence (AI) algorithms as it started to pick up on and resident's habits such as getting up out of bed, turning, etc. Representative #1 stated education should occur when the consent forms were signed, and the company representatives did a lot of education with admissions staff so they could relay the information to the families and inform them the system is covered by Medicare and Medicaid in most states. Representative #1 stated if there was no consent, the company would not monitor that resident. A combined interview with the Nurse Consultant and the Administrator on 6/25/26 at 2:45 PM revealed all the company's facilities had the continuous radar-monitoring system in resident rooms and the device tracked things like respirations and resident movement. The Nurse Consultant stated the facility received a report each morning which included a list of residents who were most at risk. She was unable to explain what metrics were used or how the list was formulated. The Administrator stated all new residents or their RP's signed a consent form during the admission process with the Admissions Director or Admissions Assistant and were given education on the device. He stated all previous residents in the building were educated and consents were signed when the devices were installed.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening Resident Review (PASRR) was completed prior to admission to the facility for a resident with a diagnosis of a serious mental illness for 1 of 1 resident reviewed for PASRR (Resident #45). The findings included: A review of the medical record revealed a PASRR Level I was completed for Resident #45 on 9/15/22. The hospital Discharge summary dated [DATE] indicated Resident #45 was transferred to the emergency department (ED) from his home on [DATE] by law enforcement to be evaluated for involuntary commitment (IVC) due to suicidal ideations and aggressive behaviors. A psychiatric evaluation completed in the ED on 12/23/25 indicated Resident #45 had diagnoses including post-traumatic stress disorder (PTSD) and stroke with right sided weakness and was living with a family member. Resident #45 reported his living situation was stressful and he verbalized suicidal ideations in frustration during an argument with a family member which led to the IVC. Resident #45 denied wanting to hurt himself or others and had exhibited no acute psychiatric concerns or behaviors while being evaluated in the ED. Resident #45 was determined not to meet criteria for IVC but was admitted to the hospital on [DATE] for assistance with finding facility placement due to his uncertain housing situation. Resident #45's condition remained stable during the hospitalization, and he was discharged to the facility on [DATE] with orders to follow up with outpatient psychiatry services as needed. Resident #45 was admitted to the facility on [DATE] with diagnoses that included PTSD and adjustment disorder with mixed disturbance of emotions/conduct. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact, exhibited no behaviors or rejections of care, had active diagnoses including PTSD and adjustment disorder with mixed disturbance of emotions/conduct, and he was not receiving any psychotropic medications. The MDS indicated Resident #45 was not currently considered by the state Level II PASRR authority to have a serious mental illness or intellectual disability. During an interview with Discharge Planner #1 on 6/24/26 at 1:36 PM she revealed she assumed the responsibilities of the Former Social Worker at the end of February 2026 after Resident #45 was admitted to the facility. Discharge Planner #1 stated the hospital case managers usually completed a Level I PASRR for a resident prior to admission to the facility however she was responsible for reviewing the Level I PASRR screen in the North Carolina Medicaid Uniform Screening Tool (NC MUST-an internet-based application utilized to communicate and manage PASRR requests) to ensure the hospital submitted it during the most recent hospitalization and included the resident's active diagnoses of mental illness. She stated if she observed the Level I PASRR screen was not submitted recently or did not include the resident's active diagnoses of mental illness then she would complete a new Level I PASRR screen and submit it for review. She explained that but she was unsure if the Former Social Worker followed this procedure when Resident #45 was admitted to the facility. Discharge Planner #1 revealed if a Level I PASRR had not been completed for Resident #45 since 2022 then a new Level I PASRR screen including his active diagnoses of mental illness should have been completed and submitted for review. A phone interview conducted with the Former Social Worker on 6/25/26 at 2:07 PM revealed when a resident was admitted to the facility, she was responsible for reviewing the admission paperwork to ensure the resident had a PASRR number. The Former Social Worker indicated she did not complete or review the Level I PASSRs for newly admitted residents to ensure it was completed on a recent date prior to admission and included the resident's active diagnoses of mental illness. The Former Social Worker stated that Resident #45 had a PASRR number when he was admitted to the facility on (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] but she was unsure when the Level I PASRR screen was completed or if it included Resident #45's active diagnoses of mental illness. An interview conducted with the Administrator on 6/25/26 at 4:22 PM indicated the Former Social Worker was responsible for ensuring a Level I PASRR was completed for all residents prior to admission to the facility. He stated the hospital case managers typically completed the Level I PASRR however the facility was responsible for reviewing the Level I PASRR screen to ensure it included resident's active diagnoses of mental illness and was completed during their most recent hospitalization.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and Medical Director, Nurse Practitioner, staff and resident interviews the facility failed to provide the necessary assistance to obtain dental services for 1 of 2 residents reviewed for dental services (Resident #57).The findings included:Resident #57 was admitted to the facility on [DATE] with diagnoses that included dysphagia oral phase (difficulty chewing or moving food from the mouth to the throat) and protein calorie malnutrition.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #57 was cognitively intact and received a mechanically altered diet. Resident #57 was not coded for a swallowing disorder or any dental/oral concerns.Resident #45's physician orders revealed an order dated 3/18/26 for a regular pureed diet with thin liquids. The Medical Director note dated 6/09/26 revealed Resident #57 was seen for a routine visit and was monitored closely for weight loss due to a diagnosis of severe protein-calorie malnutrition. Resident #57 reported during the visit that she was receiving a pureed diet but did not like most of the meals and stated she could eat better if her teeth were better. A dental consult was ordered for Resident #57 to be evaluated for dentures.Resident #57's physician orders revealed an order dated 6/09/26 for a dental consult for dentures due to poor dentition and the order end date was 6/23/26. The quarterly MDS assessment dated [DATE] indicated Resident #57 did not have a weight loss of 5 percent or more in one month or 10 percent or more in six months.The Nurse Practitioner (NP) note dated 6/17/26 revealed monitoring continued of Resident #57's nutritional status due to a diagnosis of severe protein-calorie malnutrition and dental consult was pending. Resident #57 continued with a pureed diet and nutritional supplements three times a day, however, was refusing the supplements. Resident #57 was observed during visit with snack/drink at beside and her condition was stable. No new orders at this time.During an observation and interview with Resident #57 on 6/22/26 at 11:19 AM she was observed to have several missing teeth. Resident #57 indicated she was receiving a pureed diet due to difficulty chewing but did not like most of the pureed food and wanted to be evaluated for dentures. Resident #57 stated I would not need a pureed diet if I had teeth and could chew. Resident #57 indicated she did not recall their names, but since her admission to the facility she had notified several staff members she wanted a dental appointment, however nothing had been done. A phone interview conducted with the Medical Director on 6/26/26 at 10:09 AM revealed Resident #57 had poor dentition, difficulty chewing and was receiving a pureed diet. He stated Resident #57 reported she did not like most of the pureed food and requested a dental consultation for dentures. The Medical Director indicated he entered a dental consultation order for Resident #57 into the electronic medical record (EMR), but he did not recall the date or duration of the order. He revealed he usually set the duration of a consultation order for 7 to 14 days to give the nurses time to schedule the appointment and would expect the appointment to be scheduled before the order end date. During an interview with the NP on 6/24/26 at 10:15 AM she stated Resident #57 was admitted with a diagnosis of protein-calorie malnutrition and had difficulty maintaining her weight, but this was expected. The NP indicated Resident #57 had nutritional interventions in place and no significant weight loss at this time. The NP revealed there was a dental consult pending for Resident #57 but she was unsure as to why the consult was ordered. The NP revealed Resident #57 had not reported any concerns to her related to not liking the pureed diet or that she wanted to be evaluated for dentures. An interview with Nurse Aide (NA) #1 on 6/25/26 at 8:40 AM revealed she was the primary NA assigned to Resident #57 from 7:00 AM to 7:00 PM. NA #1 stated she did not recall the date but approximately 2 or 3 weeks ago Resident #57 requested to see the dentist because (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she did not like the pureed diet and wanted to get dentures. NA #1 revealed she notified Nurse #1 that Resident #57 requested to see the dentist. An interview conducted with Nurse #1 on 6/25/26 at 8:45 PM revealed she was the primary nurse assigned to Resident #57 from 7:00 AM to 7:00 PM but she did not recall NA #1 notifying her that Resident #57 requested to see the dental provider. Nurse #1 stated she would observe a new order for a resident in the EMR when she pulled up their order list to administer medications, but she did not recall seeing a new order for a dental consult for Resident #57's on her order list. Nurse #1 revealed if she was notified that resident requested to see the dental provider or they had a new order for a dental consult she would notify the Unit Manager or Discharge Planner #1. During a phone interview with the Unit Manager on 6/26/26 at 8:34 AM she revealed she was not aware that Resident #57 had a physician order for a dental consult. She indicated Nurse #1 should have notified her or Discharge Planner #1 that Resident #57 had an order for a dental consult. The Unit Manager revealed the dental provider was at the facility on 6/18/26 however Resident #57 was not seen during their visit. An interview was conducted with Discharge Planner #1 on 6/24/26 at 1:35 PM which indicated the facility had a dentist that visited the facility quarterly to provide dental services for the residents. Discharge Planner #1 revealed she was unaware that Resident #57 had requested to see the dental provider or that she had a physician order for a dental consult. Discharge Planner #1 stated the dental provider's last visit was on 6/18/26 however Resident #57 was not seen during their visit. An interview with the Administrator on 6/25/26 at 4:27 PM revealed when a resident requested dental services or the physician ordered a dental consult, Discharge Planner #1 should be notified by the nurse or Unit Manager to ensure the resident was placed on the dental providers list to receive services during their next scheduled visit at the facility.		