STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Creek Health and Rehabilitation Center	5201 Clarks Fork Drive NW Raleigh, NC 27616

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and Physician, the facility failed to consult with the physician when a resident was unable to swallow his medications. This was for 1 of 3 sampled residents reviewed for medical care during acute illness (Resident # 1).The findings included:Resident # 1 was admitted to the facility on [DATE] after being hospitalized for altered mental status which was partially attributed to multifocal stroke (a stroke affecting multiple areas of the brain). According to the 2/20/26 hospital Discharge summary, dated [DATE], the resident also had additional diagnoses of multiple myeloma (cancer of the bone marrow plasma cells), atrial fibrillation, chronic pain, and depression.On 2/20/26 at 5:58 PM, Nurse # 1 documented Resident # 1 was admitted to the facility at 5:45 PM and was alert but confused.On 2/20/26 the following medication orders were entered into Resident # 1's record:Calcium 600 + D3 Plus minerals tablet by mouth every day.Cyanocobalamin tablet 1000 micrograms every day (A form of B12).Pantoprazole Sodium Delayed Release 40 mg every day (used for gastroesophageal reflux disease).Apixaban 5 mg every twelve hours for atrial fibrillation (Apixaban is an anticoagulant used to prevent clot formation which can occur with atrial fibrillation when blood pools in the heart). On 2/20/26 Resident # 1's physician documented he saw Resident # 1 and in addition to having a history of stroke, the physician noted the resident had a history of dysphagia.Review of Resident # 1's February 2026 Medication Administration Record (MAR) revealed Resident # 1's medications were initialed as administered on 2/21/26 as ordered.Medication Aide # 1, who initialed she administered morning medications on 2/21/26, was interviewed on 2/25/26 at 5:02 PM and reported she had crushed Resident # 1's medications, placed them in applesauce, and the resident took them without difficulty.Nurse # 3, who initialed she administered evening medications on 2/21/26, was interviewed on 2/25/26 at 1:25 PM and reported the resident took his medications without problems. Nurse # 3 did not specify if the resident took the medications whole or crushed.On 2/22/26 Nurse # 2 documented on the February 2026 MAR that Resident # 1's Calcium, Cyanocobalamin, Pantoprazole and Apixaban were not administered at 9:00 AM when they were scheduled to have been administered.On 2/22/26 at 7:52 PM, Nurse # 2 documented in a progress note that Resident # 1 had refused all his medications due to difficulty swallowing.Nurse # 2 was interviewed on 2/26/26 at 9:05 AM and reported the following information. She had cared for Resident # 1 from 7:00 AM to 7:00 PM on 2/22/26. In the morning, Resident # 1 could not take his medication. Resident # 1's RP (Responsible Party) was present that morning and Resident # 1 drank from a straw for the RP. The RP also pointed to an empty blue bowl and reported Resident # 1 had eaten some dry cereal. She (Nurse # 2) tried to give him his medication, but he would hold the water in his mouth and not swallow. The water seemed to pool in his mouth. The RP wanted her (Nurse # 2) to try giving the medications in applesauce and she also tried that, but he held the applesauce in his cheek and would not swallow. She spent a long time at the bedside talking to the RP and trying to see if the resident would swallow, but he would not. Eventually, they (she and the RP) turned his head, and she (the nurse) wiped the medications out of his mouth, and he spit also to remove them. She was not sure if it was a behavioral issue or if he just could not swallow. Nurse #2 indicated she held his medication all (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day and she did not call the provider and consult with the provider about the missed medications or swallowing difficulty.Review of Resident # 1's February 2026 MAR revealed Resident # 1's evening medications were initialed as given. One of the medications administered on the evening of 2/22/26 was the resident's evening dose of Apixaban.On 2/25/26 at 8:37 PM Nurse # 4, who had initialed the administration of evening medications on 2/22/26, was interviewed and reported the following information. She crushed the resident's medications and gave them in applesauce. It took some time to get him to swallow the medications, but she went slow and he was able to swallow the medications. She also gave him sips of water which he was able to drink.On 2/23/26 (Monday) Unit Manager # 1 made a late entry notation at 10:10 AM in Resident # 1's medical record noting Resident # 1 appeared restless, was not eating, drinking or taking his morning medications. The physician had been consulted and an order obtained on 2/23/26 to transfer the resident to the hospital.The DON (Director of Nursing) was not available for interview during the survey.The facility's corporate Nurse Consultant was interviewed on 2/26/26 at 3:45 PM regarding whether the physician should be notified if a resident could not swallow medications and reported that the physician should have been contacted on 2/22/26 about the missed medications.On 3/3/26 at 11:28 PM, Resident # 1's physician was interviewed and reported the staff should have consulted him when the resident could not swallow his medications. The physician reported that the resident was not harmed by the facility's failure to call him. The Physician reported he reviewed an EKG (Electrocardiogram) which was completed the following day on 2/23/26 for Resident # 1 and the resident had a normal heart rhythm. The physician reported it was his opinion that one dose of a missed anticoagulant had not led to further problems with atrial fibrillation or stroke. The physician also reported the resident had both dementia and a history of strokes and it was anticipated that he might wax and wane at times.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Nurse Practitioner (NP), and contracted lab company, the facility failed to ensure labs to check the resident's medical condition following a hospitalization stay within the last month were completed as ordered by the provider. This was for 1 of 3 sampled residents reviewed for medical care following acute illness (Resident #4).The findings included:Record review revealed Resident # 4 was initially admitted to the facility on [DATE]. Resident # 4 had diagnoses of chronic kidney disease, diabetes, anemia, polyneuropathy, and congestive heart failure. Review of Resident # 4's record revealed she was most recently readmitted to the facility on [DATE] after a hospitalization and followed by a health care group who provided primary oversight and care for medical issues in addition to the resident's physician.On 2/16/26 Resident # 4 had an annual Minimum Data Set assessment completed noting she was cognitively intact.On 2/20/26 the NP documented a clinic note noting that she had received a call from a nurse who reported Resident # 4 was short of breath without hypoxia (low levels of oxygen in the body's tissues) and had a feeling of abdominal fullness. She was functionally at her baseline. Medication changes were made and labs were ordered.A review of orders, which were entered in the resident's record on 2/20/26, included: CBC (complete blood count) with differentialBMP (basic metabolic panel) BNP/NT proBNP (B-type Natriuretic Peptide which measures hormones released by the heart when stressed) During an interview on 2/27/26 at 11:17 AM with Resident # 4's NP the NP reported the lab work had been ordered to help plan Resident # 4's care, monitor the resident's kidney function, anemia, and risk for infection. She had expected the lab work to be completed the next routine blood draw after she ordered it on 2/20/26. The Risk Manager for the facility's lab company was interviewed on 2/26/26 at 3:29 PM and again on 3/2/26 at 2:25 PM and reported the following information. The lab company provided routine lab services six days per week. The only day they did not provide routine lab drawings was on Sunday morning. For an order that was given on a Friday (such as for Resident # 4's 2/20/26 order) the lab phlebotomist should have drawn it on Saturday morning if the requisition was in the book for it to be drawn. The phlebotomist arrived sometime after midnight on lab days and drew blood in the early morning hours. There was one notation which was entered by the Unit Manager on 2/24/26 at 8:59 AM noting the labs were unable to be obtained. The NP was notified and the labs would be done the next lab draw. Resident # 4 was interviewed on 2/25/26 at 9:05 AM and reported the following. She had recently returned from the hospital due to a new diagnosis of congestive heart failure. She was dealing with being more short of breath and was very tired. While hospitalized she had required blood and they were supposed to have drawn labs recently, but they had not been done. One of the nurses told her that she had refused the blood work on the morning of 2/24/26 when she was asleep. She may have done so in her sleep but did not recall. The next morning (2/25/26) one of the nurses had told her that she was glad they got her blood work done. She had looked at her arms, saw no cotton balls to indicate she had a lab stick, and did not recall a blood draw in the early morning hours. During a follow up interview with Resident # 4 on 2/26/26 at 2:15 PM, Resident # 4 reported she still had no lab work drawn. Resident # 4's Unit Manager (Unit Manager # 2) was interviewed on 2/26/26 at 2:25 PM and reported on the morning of 2/24/26 the phlebotomist had noted she was not able to obtain the labs. On the morning of 2/25/26 the phlebotomist had signed off she had drawn the blood work, and they thought it had been done. The Phlebotomist was not available for interview during the investigation. During the interviews with the Risk Manager for the facility's lab company on 2/26/26 at 3:29 PM and again on 3/2/26 at 2:25 PM the Risk Manager further reported the following information. If a phlebotomist was unable to draw blood from a resident two days in a row, then the phlebotomist was to notify a nurse and also notify their lead team phlebotomist so a second phlebotomist could go out. The phlebotomist, who was designated for Resident # 4's facility, was not available for interview. She (the Lab Company's Risk (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager) was not sure why the blood had not been drawn and the phlebotomist who had been responsible for drawing the labs could not be interviewed by her at the current time. When the phlebotomist was at the facility it was the procedure that the phlebotomist checked the facility's lab book which had requisitions under a tab for the date they were due. There was also a lab sheet at the front of each day's lab requisitions. The phlebotomist was to sign that she had drawn the labs on the lab sheet. During the interview on 2/26/26 at 3:29 PM the Lab Risk Manager reported the lab would get the blood work done that day (2/26/26). On 3/2/26 the Administrator provided copies of lab sheets/logs which had been left for the phlebotomist. A review of a lab tracking form dated 2/21/26 (Saturday) revealed Resident # 4's name appeared on the form with her room number along with other residents listed on the form/log which needed labs collected. Resident # 4's name and room number were the only information on the form about Resident # 4. There was no notation by Resident # 4's name noting Resident # 4 had refused or the phlebotomist had been unable to draw the labs. The phlebotomist had initialed at the top of the form under the date of 2/21/26. Review of a lab tracking form dated 2/24/26 (Tuesday) revealed Resident # 4's room number, name, and labs to be drawn were listed along with other residents on the log who had scheduled labs for that morning (2/24/26). There was one notation which read, unable by Resident # 4's name and no further explanation. The lab phlebotomist signed her initials and the date of 2/24/26 at the top of this form. On 2/25/25 (Wednesday) Resident # 4's name and labs to be drawn again appeared on the lab tracking form with the Phlebotomist's initials at the top of the page. There was no notation that the resident had refused or the labs were not drawn. During a follow-up interview with Resident # 4's Unit Manager (Unit Manager # 2) on 3/2/26 at 3:00 PM the Unit Manager reported the following information. When the phlebotomist signs at the top of the page and makes no notation that the labs were not done by their name, then this indicates that the labs were done. The labs had not been done prior to 2/26/26. Residents, who were under the care of the provider's group, were visited daily by a nurse within the provider's group. Each day when the labs did not come back the facility had alerted this nurse who in turn alerted the NP about the delay. The Director of Nursing was not available for interview during the survey. The Administrator and the Nurse Consultant were interviewed on 3/3/26 at 3:58 PM and reported the following information. The Administrator reported that he expected labs to be done timely and did not offer a timeframe he considered to be timely. He pointed out that the facility lab sheets indicated the labs were done excluding on one date on which the resident refused. The Nurse Consultant reported that the clinical team reviewed labs daily to make sure they were done, and this had been being done for Resident # 4. By their system which required the phlebotomist to put her initials at the top of the lab sheets, it was indicated to them that the labs had been drawn on 2/21/26 and 2/25/25. If the resident had refused or the phlebotomist could not draw the blood for a reason, there should have been a notation by her name. According to the Nurse Consultant, each day the NP had been notified. During the interview with Resident # 4's NP on 2/27/26 at 11:17 AM, the NP reported when the labs, which were ordered on 2/20/26, were completed on 2/26/26, they were stable and the resident had not been harmed in any way by the delay in obtaining the labs.