

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Perry Creek Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with resident, responsible party, and staff, the facility failed to treat residents with dignity and respect when Nurse Aide #1 was watching a video on her cell phone while assisting Resident #72 with eating and Resident #106's clothes were not provided to her for a 3 day period after they were sent to the laundry resulting in the resident having to wear a hospital gown, feeling annoyed, and causing her not to leave her room. A reasonable person would expect Resident #72's caregiver to be focused on them during the provision of care. This deficient practice affected 2 of 4 residents reviewed for dignity (Resident #72 and Resident #106). Findings included:</p> <p>1. Resident #72 was admitted to the facility on [DATE]. Her active diagnoses included cognitive communication deficit and muscle weakness.</p> <p>Resident #72's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was assessed as severely cognitively impaired, required supervision or touching assistance with eating, was able to make herself understood, and she understood others.</p> <p>During observation on 2/11/26 at 9:12 AM Nurse Aide #1 was observed assisting Resident #72 with her breakfast. The nurse aide was sitting next to Resident #72 at the head of the bed with the bedside table in front of her. The bedside table was perpendicular to the resident's bed, and a cell phone was observed on the bedside table, out of view of the resident. A video was playing on the cell phone with closed captioning on and no sound. Nurse Aide #1 was observed watching the video on her phone while she offered the resident bites of food. The nurse aide was glancing back and forth between the video on her phone and the resident.</p> <p>During an interview on 2/11/26 at 9:13 AM Nurse Aide #1 stated no one had indicated she could not watch a show on her phone while providing assistance to residents with their meals. She stated she was watching a series on vampires.</p> <p>During an interview on 2/12/26 at 10:15 AM Resident #72's Responsible Party (RP), he stated it was a disgrace that his family member would be provided assistance with her meal by a nurse aide whose attention was divided between the nurse aide's own entertainment and his mother's care. He stated that when a nurse aide was providing Resident #72 assistance, the nurse aide should be present and 100% involved with the care his family member needed because she was reliant on the other person to ensure her needs were met. He expressed that the nurse aide should not be focused on their own entertainment while assisting the resident.</p> <p>During an interview on 2/11/26 at 9:28 AM the Regional Director of Clinical Services stated she was (continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not sure if Resident #72 was able to respond to the nurse aide or not. She was also unsure if watching a video while assisting a resident with a meal was a dignity concern, however she did prefer nurse aides engage with residents while assisting with meals. She concluded the facility did not have a policy regarding staff cell phone use.</p> <p>During an interview on 2/11/26 at 9:30 AM the Administrator stated he would not recommend nurse aides watch a show on their cell phone while providing assistance to a resident with their meals, however he would need to check their cell phone policy to know if a nurse aide would be able to watch a show while assisting residents with meals. He stated he was unsure if a nurse aide watching a show while assisting residents with meals would be a dignity concern but watching a video while assisting a resident with their meal would not be something he recommended.</p> <p>2. Resident #106 was admitted to the facility on [DATE].</p> <p>The Minimum Data Set admission assessment dated [DATE] revealed Resident #106 was cognitively intact and she demonstrated no behaviors.</p> <p>During an observation and interview on 02/09/26 at 11:15 AM with Resident #106, she was observed in her room wearing a hospital gown. Resident #106 reported that she had 4 house coats (a loose lightweight robe) that were brought to the laundry department on Friday 02/05/26. She stated the facility was responsible for doing her laundry and the laundry was picked up on Fridays and returned back to her clean on the same day. Resident #106 stated a nurse aide picked up her laundry on Friday morning on 02/05/26 and as of today (02/09/26) the laundry had not been returned. Resident #106 stated she had been in a hospital gown since Friday 02/05/26. Resident #106 stated she was annoyed that she could not get dressed and had to wear a hospital gown for 3 days. Resident #106 added that she was not comfortable leaving her room while wearing a hospital gown, so she had remained in her room since her clothes were taken to the laundry on 02/05/26. Resident #106 stated she only brought 4 house coats to the facility and she and had no other clothes to wear.</p> <p>During an observation and interview on 02/10/26 at 3:25 PM with Resident #106, she was observed wearing a house coat. She revealed the staff brought back her 4 house coats late in the afternoon on 02/09/26.</p> <p>An interview was conducted with Housekeeper #1 on 02/12/26 at 10:00 AM. Housekeeper #1 stated that she and Housekeeper #2 were assigned to collect the laundry for the 500 hall each Friday. Housekeeper #1 stated once she brought the laundry and linens to the laundry department on Fridays; the laundry staff would launder the 500 hall's items and were supposed to return the clothing the same day. Housekeeper #1 stated the laundry was returned the same day on the 500 - hall because these residents were at the facility for rehabilitation services and they were discharged quicker than residents on other halls. Housekeeper #1 stated she did not work on Friday 02/05/26 so she did not pick up Resident #106's laundry.</p> <p>An interview with the Housekeeping Director on 02/12/26 at 10:30 AM revealed she had picked up the laundry from Resident #106's room on Friday 02/05/26 and returned the clean laundry the same day. The Housekeeping Director stated she returned the folded clothing items and left them in Resident #106's room to be put away on 02/05/26.</p> <p>A follow-up interview was conducted with the Housekeeping Director on 02/12/26 at 12:32 PM. The Housekeeping Director stated she did not bring Resident #106's clothes back to her room on Friday (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code a resident's Minimum Data Set (MDS) assessment for 2 of 30 MDS assessments reviewed (Resident #3, Resident #59). Findings included:</p> <p>1. Resident #3 was admitted to the facility on [DATE]. Her active diagnoses included anemia, heart failure and diabetes mellitus.</p> <p>Review of Resident #3's Election of Benefits for Hospice dated 1/19/26 revealed she elected hospice and services were started for her on this date.</p> <p>Review of Resident #3's admission Minimum Data Set assessment dated [DATE] did not indicate she received hospice care.</p> <p>During an interview on 2/11/25 at 8:19 AM the MDS Coordinator stated he used the census report while completing the MDS assessment which had not been updated to reflect the hospice admission for Resident #3. The MDS Coordinator explained Resident #3's MDS assessment dated [DATE] did not capture her hospice status and it should have.</p> <p>During an interview on 2/11/25 at 9:34 AM the Administrator stated MDS assessments should accurately reflect resident's hospice status.</p> <p>2. Resident #59 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2 (DM 2).</p> <p>A physician's order for Resident #59 dated 10/31/25 revealed Ozempic (0.25 or 0.5 milligram (MG/DOSE) subcutaneous (beneath the skin) Solution Pen-injector 2 MG/1.5 milliliter (ML) (Semaglutide) Inject 0.5 mg subcutaneously one time a day every 7day(s) for DM2 0.5 mg once every week.</p> <p>Resident #59's medical record did not reveal any physician's orders for Resident #59 to receive insulin in October 2025 or November 2025.</p> <p>Resident #59's October 2025 and November 2025 Medication Administration Record (MAR) did not reveal any documentation indicating insulin was administered to Resident #59. Resident #59's November 2025 MAR revealed documentation indicating Ozempic (0.25 or 0.5 MG/DOSE) Subcutaneous Solution Pen-injector 2 MG/1.5ML (Semaglutide) Inject 0.5 mg subcutaneously was administered to her on 11/1/25 at 9:00 AM.</p> <p>Resident #59's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #59 received one insulin injection in the last 7 days.</p> <p>On 2/11/26 at 12:59 PM an interview with MDS Nurse #1 indicated she coded the Medications section of Resident #59's 11/5/25 MDS assessment to indicate Resident #59 received one (1) insulin injection in the 7-day look-back period which included 10/30/25 through 11/5/25 because of the documentation on Resident #59's November 2025 MAR indicating Resident #59 received an Ozempic injection subcutaneously on 11/1/25. She reported that she thought because the medication was (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ordered for Resident #59's DM 2, it was to be coded as an insulin injection.</p> <p>On 2/11/26 at 1:08 PM an interview with the MDS Director revealed that although Ozempic was ordered for Resident #59's DM 2, it was not an insulin and should not be coded as insulin on MDS assessments.</p> <p>The facility's Director of Nursing was not present in the facility during the investigation and was unavailable for telephone interview.</p> <p>On 2/12/26 at 3:51 PM an interview with the Administrator indicated MDS assessments should be coded to accurately reflect the medication residents received.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations and staff interviews, the facility failed to secure a medication cart when the cart was left unattended for 1 of 4 medication carts observed for medication storage (500 Hall medication cart). Findings included: A continuous observation was conducted on 02/11/26 at 8:35 AM through 8:38 AM and revealed a medication cart on the 500 hall was left unattended and unsecured. The medication cart was noted to have 3 drawers containing prescription medications that were pulled open and medications were exposed. Additionally, the medication cart was noted to be unlocked with the keys hanging from the lock. The medication cart was facing the hallway and there were no staff or residents visible on the 500 - hall near or around the medication cart during the observation. Nurse #3 exited a resident's room and approached the unsecured cart. An interview was conducted with Nurse #3 on 02/11/26 at 8:38 AM when she returned to the medication cart. Nurse #3 stated she had her eyes on the cart the whole time. Nurse #3 then reported that she was assisting a resident to his room and did not have her eyes on the medication cart. Nurse #3 stated she knew the cart should not have been left unattended and unsecured with drawers' open and the keys left in the lock. Nurse #3 stated she was rushing and did not realize she left the drawers open or that she kept the key in the lock. An interview was conducted with the Administrator on 02/13/26 at 3:40 PM. The Administrator stated he expected his nursing staff to ensure the medications carts were secured at all times whenever the nursing staff stepped away from their cart. He stated it was important to keep the medications carts secured while unattended to prevent any residents or staff from taking medications from the cart who were not issued access to the medication cart.</p>