

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Lexington Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 17 Cornelia Drive , Lexington, North Carolina, 27292	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The survey team entered the facility on 8/27/2025 to conduct a complaint investigation survey. The survey team was onsite 8/27/1025 through 8/28/2025. Additional information was obtained off site on 8/29/2025 and on 9/2/2025. Therefore, the exit date was 9/2/2025. The following intakes were investigated: NC002560396, NC002570368, NC2598685 and 836489. 1 of the 6 complaint allegations resulted in a deficiency.	F0000		09/15/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: 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 July 2025, 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	F0602	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F602 Corrective actions accomplished for those residents found to be affected by the deficient practice: NA #1 was suspended on 7/10/2025. NA #1 failed to move into Resident #1 house as family interceded. NA #1 was terminated from the facility. Resident # 1 was admitted on 06-25-25 and was discharged to the hospital with a planned procedure on 9-11-25 with return anticipated. Identification of other residents having the potential to be affected by the same deficient practice:, 100% interview of current alert and oriented residents with BIMS score of >13 was completed between 9-16-25 and 9-17-25 by the facility Social Worker. There were no other issues identified during these interviews. For residents with a BIMS of below 13, their Responsible Parties were contacted and interviewed this will be completed by 10/3/2025. No issues were identified.	10/03/2025

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 reverse for further 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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F0602 SS = D	<p>Continued from page 1 belongings. The deficient practice occurred for 1 of 3 residents reviewed for abuse, neglect and/or misappropriation of property/exploitation (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 6/25/2025 with diagnoses that included depression and cognitive communication deficit.</p> <p>The admission Minimum Data Set (MDS) assessment dated 7/2/2025 indicated Resident #1 was moderately cognitively impaired and was receiving antidepressant medication and opioid medication (pain medication).</p> <p>Psychological Provider #1 notes dated 7/9/2025 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.</p> <p>In an interview with Nurse Manager #1 on 8/27/2025 at 2:58 pm, she recalled Resident #1's Family Member and a friend (Resident #1's neighbor) came to the facility in July 2025 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.</p> <p>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</p>	F0602	<p>Continued from page 1 Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:</p> <p>Between 9-5-25 and 9-12-25, 100% of staff were educated by the Staff Development Coordinator (SDC) regarding Misappropriation and Exploitation. Staff will be trained prior to their shift.</p> <p>Effective 9-5-12, all new hires will be educated on prevention of Misappropriation and Exploitation of Resident property and belongings during the orientation process. This education will be completed by the SDC or designee.</p> <p>Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:</p> <p>This systemic process will take place starting 9-19-25. Department heads will be interviewed by administrator to identify Misappropriation/Exploitation concerns found during their daily Monday-Friday Rounds. Any concerns noted will be promptly addressed by the administrator. Concerns will be discussed Monday through Friday in both morning and clinical meetings.</p> <p>Effective 9-19-25 Daily rounds will be completed by department heads Monday – Friday. These will take place 5 x weekly x 12 weeks. For residents below 13 BIMS, responsible parties will be contacted to ensure no issues. This will take place x 12 weeks.</p> <p>Any negative findings during these meetings will be addressed promptly by the administrator and recorded on a Facility Reportable Incident Tracking log kept in the administrator's office.</p> <p>Effective 9-18-25, the administrator will report findings of the monitoring process to the facility's Quality Assurance and Performance Improvement (QAPI) Committee for three months.</p> <p>Compliance date 10-3-2025</p>	

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F0602 SS = D	<p>Continued from page 2 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 notified the local law enforcement on 7/10/2025 at 12:41 pm of the allegation.</p> <p>The facility's investigation report signed by the former Administrator on 7/16/2025 was faxed to the State Agency on 7/17/2025. 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 7/14/2025. The termination was noted to not be related to the allegation. The allegation was not substantiated.</p> <p>In an interview with Resident #1 on 8/27/2025 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 July 2025 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 "rough boyfriend" who he did not want in his personal house. He explained NA #1 went to his house but was unable to find the key to his personal home and she (NA #1) then went to Resident #1's neighbor's home to get the key to enter Resident #1's personal home. The neighbor would not give NA #1 the key to his (the resident's) house and the neighbor called one of his (the resident's) family members who told him (the neighbor) not to give NA #1 a key. Resident #1 stated he did not feel pressured when talking with NA #1 and admitted he had not gotten a chance to inform NA #1 before she went to enter his personal home that he wasn't considering</p>	F0602		

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F0602 SS = D	<p>Continued from page 3 having anyone house-sit his personal home anymore. During the interview, Resident #1 asked if he was in trouble and was explained he was not in trouble, and the interview was to gather information.</p> <p>In a phone interview with NA #1 on 8/28/2025 at 11:16 pm, NA #1 stated in July 2025 while talking with Resident #1, he (the resident) asked her (NA #1) if she would provide private care to help him when he was discharged to his personal house. NA #1 was unable to recall the exact date. NA #1 admitted going to Resident #1's personal house to check out the living quarters to see if his personal home was conducive to caring for Resident #1. NA #1 stated she went to the house on a professional level only and did not plan to live in Resident #1's house. She explained she never went there to live as a permanent home; only to live in the house to care for Resident #1 and stay when housework was needed to be performed. NA #1 stated Resident #1 asked her to go to his personal house and told her the key was in the garage. NA #1 explained when she went to Resident #1's personal house in July 2025 she informed Resident #1 by phone that there was no key in the garage and Resident #1 told her to go to the neighbor's house for the key to enter his (Resident #1's) personal house. NA #1 stated the neighbor called Resident #1's family member and she (NA #1) was not given a key to enter Resident #1's personal house. She stated she did not pursue this any further and left the situation alone. NA #1 stated she never entered or lived in Resident #1's personal house and stated she never asked to go live in Resident #1's personal house. She explained she was placed on suspension when she reported to work on 7/10/2025 for attendance issues and was fired three days later on 7/14/25 for attendance issues. NA #1 stated the Administration never discussed the situation with Resident #1 with her.</p> <p>In a phone interview with Resident #1's Neighbor on 8/28/2025 at 9:24 am, he stated NA #1 came to his house requesting a key to Resident #1's personal house and stated she was going to stay in Resident #1's personal house for a while. He was unable to recall the specific date this occurred but knew it was in July of 2025. Resident #1's Neighbor stated he did not give NA #1 the key to Resident #1's personal house. He stated he called Resident #1's family member, who headed to his (Resident #1's Neighbor) house, to speak with NA #1, but NA #1 left prior to the family member arriving. Resident #1's Neighbor stated when he talked to Resident #1 on the phone after NA #1 left the his (Resident #1's Neighbor) home, Resident #1 told him not to give NA #1 a key to his personal house. Resident #1's Neighbor stated NA #1 did not display a temper but</p>	F0602		

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F0602 SS = D	<p>Continued from page 4 NA #1 was not happy about not receiving the key to Resident #1's personal house. He stated Resident #1 was a friendly and helpful individual.</p> <p>In a phone interview with Resident #1's Family Member on 8/28/2025 at 8:51 am, he stated NA #1 tried to go live in Resident #1's personal house. The Family Member stated he could not recall the exact date of the incident. He explained he found out about the situation late in the evening hours of a day in July 2025 and went to the facility the next day to report the incident. The family member explained Resident #1's Neighbor called him explaining NA #1 was at his home requesting a key to Resident #1's personal house and no one had called him (the neighbor) about giving NA #1 a key to Resident #1's personal house. He stated NA #1 got upset when the neighbor would not give her a key to Resident #1's personal house and when he (the Family Member) arrived at the neighbor's home approximately 8-9 minutes later, NA #1 had already left. He stated when he called Resident #1 on that same evening in July 2025 to ask about the situation, he (Resident #1) stated not to give NA #1 a key to his personal house. He stated Resident #1 told him (the Family Member) NA #1 had told Resident #1 she wanted to stay in his personal house for a few weeks until she found somewhere else to live and Resident #1 felt sorry for NA #1. He stated Resident #1 explained to him (the Family Member) NA #1 and Resident #1 were having a general conversation (date unknown) when NA #1 was assigned to Resident #1. The Family Member stated Resident #1 told him NA #1 informed Resident #1 about her current living situation, rent increase and lease agreement expiration. Resident #1's family member stated Resident #1 was "easy prey" because he was a kind person and thought he was doing good. The family member reported Resident #1 had been receiving a lot of pain medications due to post surgical care and felt Resident #1 would have not made the decision to let NA #1 into his personal home to live if Resident #1 was thinking clearly.</p> <p>In a phone interview with NA #2 on 8/27/2025 at 4:57pm, she stated when Resident #1 told her in July 2025 NA #1 was going to live in his personal house, she advised Resident #1 against allowing NA #1 to live in his personal house because she (NA #2) would not allow NA #1 to stay/live at her house. NA #2 stated she was unable to recall the date of the day she told the resident not to let NA #1 live in his personal house. NA #2 stated she was aware that Resident #1 and NA #1 had exchanged phone numbers in July 2025 but was unable to recall a specific date. NA #2 couldn't recall observing or overhearing Resident #1 and NA #1 talk</p>	F0602		

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F0602 SS = D	<p>Continued from page 5 about her staying/living in Resident #1's personal house. NA #2 stated she informed a couple nurses about the situation (NA #1 staying/living in Resident #1 personal house) and was unable to recall when in July 2025 she informed the other nurses of this, and which nurses she informed. NA #2 stated she felt Resident #1 was taken advantage of in the situation by NA #1 telling Resident #1 of her (NA #1's) problems and NA #1 needing someone to help her with her living situation.</p> <p>In an interview with the Director of Nursing on 8/28/2025 at 3:46 pm, she stated when Resident #1's Family Member learned NA #1 was trying to go stay/live in Resident #1's personal house, the family member brought it to Administration's attention. She stated although Resident #1 said it was okay for NA #1 to stay/live in his personal house, it was inappropriate for NA #1 to think she could go stay/live in Resident #1's personal house because employees cannot access goods or property from residents. The DON stated NA #1 was suspended during the investigation and then terminated for attendance issues. She stated NA #1 did not work after the facility was aware of the allegation.</p> <p>A phone interview on 9/2/2025 at 9:38am with the local law enforcement officer whose name was listed on the initial allegation report dated 7/10/2025. He stated he was unable to recall responding to the call or any circumstances regarding the allegation. He stated he did not complete a report, and he was unable to review notes that may have been written on the call sheet (the call sheet is documentation recorded by the local 911 call center that is provided to local law enforcement to respond to a 911 call).</p> <p>A request was made during the survey for a copy of the law enforcement call sheet related to the 7/10/2025 allegation involving Resident #1 and NA #1. This was not received.</p> <p>In a phone interview with the former Administrator on 8/27/2025 at 4:44pm, she explained she was not aware of conversations between Resident #1 and NA #1 until Resident #1's family member and neighbor came to the facility on 7/10/2025 and reported NA #1 had attempted to obtain a key to enter Resident #1's personal house. She explained Resident #1's wife had recently died, and she learned from Resident #1 that he felt sorry for NA #1 when he (the resident) learned from NA #1 that she would have nowhere to live at the first of the month. She stated the resident admitted giving NA #1 permission to stay at his personal house and when he learned about NA #1's boyfriend, Resident #1 was</p>	F0602		

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F0602 SS = D	Continued from page 6 concerned and changed his mind. She stated the facility identified NA #1 through matching the phone number on the text messages observed on Resident #1's cellular phone after learning NA #1 had attempted to obtain a key to Resident's #1 personal house from Resident #1's neighbor. She stated the allegation for misappropriation of property and resident abuse was not substantiated because Resident #1 was not harmed and NA #1 did not access Resident #1's personal house or obtain any of Resident #1's property. The former Administrator stated she had not thought about exploitation for Resident #1 because NA #1 had not benefited from the situation. She indicated looking back, she should have substantiated the allegation for exploitation because after NA #1 discussed staying/ living at Resident #1's personal house with Resident #1, she attempted to enter Resident #1's personal house without the resident being present. In an interview with the Administrator, Regional Clinical Consultant and Director of Nursing present on 8/28/2025 at 5:30 pm, they stated the facility had not completed a plan of correction for misappropriation of property/exploitation.	F0602		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance	F0609	F0609 Corrective actions accomplished for those residents found to be affected by the deficient practice: Adult Protective services was contacted on 10/2/2025 for resident #1 and a report was filed. Identification of other residents having the potential to be affected by the same deficient practice: On 9-16-25, the administrator conducted an audit of all Facility Reportable Incidents (FRI) submitted within the last 30 days to ensure Adult Protective Services (APS) was notified in each case. No other deficient practices were identified by the Administrator during this 9-16-25 Audit. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Education was provided to the facility administrator, Medical Director, and Social Worker on 8/29/2025 regarding the necessity of calling APS for any allegation of abuse, neglect and misappropriation. Education was provided by the Regional Director of Clinical Services (RDCS)	10/03/2025

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F0609 SS = D	<p>Continued from page 7 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>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).</p> <p>Findings included:</p> <p>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.</p> <p>Resident #1 was admitted to the facility on 6/25/2025.</p> <p>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.</p> <p>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</p>	F0609	<p>Continued from page 7</p> <p>Effective 9-16-25, the Administrator will ensure that all necessary items, including calling APS, are all notified and completed throughout the investigation of an FRI.</p> <p>Any changes in the administrator, social worker, or medical director, will receive the education during orientation.</p> <p>Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:</p> <p>Effective 9-16-25 All Facility Reportable Incident will be reviewed by the Administrator prior to submission to ensure every necessary aspect per FRI reporting policy is completed. This will occur weekly x 12 weeks.</p> <p>Effective 9-18-25, the Administrator will report the findings of this monitoring process to the facility Quality and Performance Improvement (QAPI) committee for any additional monitoring or modification of this process for three months.</p> <p>Date of Compliance: 10-3-2025</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345419	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Lexington Health Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE 17 Cornelia Drive , Lexington, North Carolina, 27292	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	<p>Continued from page 8 that APS was notified of the allegation of misappropriation of property and/or exploitation.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	F0609		