STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS A complaint investigation was conducted on 1/30/25. Event ID# GN2311. The following intake was investigated NC00226487. 2 of the 2 complaint allegations did not result in a deficiency.	F 000		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		2/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/10/2025

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F 657	Continued From page 1 by: Based on record review and staff interviews, the facility failed to revise a care plan for an indwelling urinary catheter for 1 of 3 residents whose care plans were reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on 6/20/24 with diagnoses that included a neuromuscular disorder of the bladder. A nursing progress note dated 9/18/24 read that Resident #1's indwelling urinary catheter was removed. A significant change in status Minimum Data Set (MDS) assessment dated 11/14/24 indicated Resident #1 had frequent urinary incontinence. He was not coded as having an indwelling urinary catheter. Review of Resident #1's active care plan, last reviewed on 12/3/24, revealed a care plan for an indwelling urinary catheter due to neurogenic bladder. On 1/30/25 at 1:40 PM, an interview occurred with the MDS nurse. She reviewed Resident #1's care plan and verified that he no longer had a urinary catheter, and the care plan should have been resolved. She felt it was an oversight. The Administrator was interviewed on 1/30/25 at 2:55 PM, and stated it was her expectation for the care plan to be an accurate representation of the resident.	F 657	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. F657 Care Plan Timing and Revision 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 1 comprehensive care plan was updated and revised by the Minimum Data Set Coordinator on 1/30/25 reflecting that resident does not have a urinary catheter. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Minimum Data Set Coordinator completed a 100% audit to verify current residents with or without urinary catheters is accurately reflected on the comprehensive care plan. No concerns were identified. Audit was completed by 2/7/25. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The Minimum Data Set Coordinator was educated by the Regional Director of	

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F 657	Continued From page 2	F 657	Clinical Reimbursement regarding updating and completion of the comprehensive care plan to reflect changes in foley use. Education was completed by 2/7/25. The Minimum Data Set Coordinator will review and update care plans daily during daily clinical meeting to reflect changes in urinary catheter changes that occur. Education will be included in the new hires orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Director of Clinical Reimbursement will audit 5 residents urinary catheter care plan for accuracy weekly x 12 weeks. The Administrator will report the results of the audit to the monthly Quality Assurance and Performance Improvement Committee for suggestions and/or recommendations x3 months or until substantial compliance is achieved and maintained. 5. Compliance date: February 20, 2025	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		2/20/25

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F 842	Continued From page 3	F 842		

to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 4 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records in the area of medication management for 1 of 3 residents reviewed for accurate medical records (Resident #1). The findings included: Resident #1 was admitted to the facility on 6/20/24. A review of the January 2025 physician orders included the following: - Atorvastatin 80 milligrams (mg) one tablet via G-tube in the evening for hyperlipidemia. - Insulin Lispro inject per sliding scale subcutaneously every six hours for diabetes type 2. - 150 milliliters (ml) water flush six times a day via G-tube for hydration.	F 842	F842 Resident Records -Identifiable Information 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 is receiving Atorvastatin, insulin lispro, and water flush as ordered, and administration is documented on the medication administration record. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Nurse management completed a 100% audit of resident□s medication administration records of current residents for the last 7 days to verify medications are being administered as ordered and documented. Audit was completed on 2/7	

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F 842	Continued From page 5 A review of the January 2025 Medication Administration Record (MAR) indicated that the Atorvastatin, Insulin Lispro and water flush were not signed off as provided or refused by Resident #1 on 1/18/25 at 6:00 PM. A phone interview occurred with Nurse #1 on 1/30/25 at 1:26 PM. She was assigned to care for Resident #1 on 1/18/25 from 7:00 AM to 7:00 PM. The January 2025 MAR was reviewed, and she stated that she provided Resident #1 with his medication and water flush as well as his insulin on 1/18/25 at 6:00 PM but forgot to sign off that it was completed. The Administrator was interviewed on 1/30/25 at 2:55 PM and stated that she expected the medical records to be complete and accurate.	F 842	/25. No concerns were identified. 3. Address what measures will be put in place or systemic changes made to ensure the deficient practice will not recur: The Director of Nursing educated the licensed nurses on administering medications as ordered and documenting on the medication administration record. If a resident refuses medications notify the physician and the responsible party and document in the resident□s medical record. Education was completed by 2/12/25. Education will be included in new hires orientation Nurse management will review medication administration and documentation daily during clinical meeting for completion and accuracy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of nursing will review medication administration and documentation during clinical meeting 5xper for 4 weeks; 3xper for 4 weeks; The Director of nursing will report the results of the audit monthly to the Quality Assurance performance improvement committee for suggestions and/or recommendations x3 months or until substantial compliance is achieved and maintained. 5. Compliance Date: February 20, 2025	

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