| DEPART                   | MENT OF HEALTH AN   | ID HUMAN SERVICES   |                     |   | FORM A                  | PPROVED                    |
|--------------------------|---|---|---------------------|---|-------------------------|----------------------------|
| CENTER                   | S FOR MEDICARE &  | MEDICAID SERVICES   |                     |   | OMB NO. 0               | 938-0391                   |
|                          | DF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  | (X3) DATE SU<br>COMPLET |                            |
|                          |   | 345183  | B. WING             |   | C<br>04/11/             | /2025                      |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                         |                            |
| CABARRI                  | JS HEALTH AND REHAB   | ILITATION   |                     | 430 BROOKWOOD AVENUE NE   |                         |                            |
|                          |   |   |                     | CONCORD, NC 28025   | I                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | IOULD BE                | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENTS  |   | F 00                | 00  |                         |                            |
|                          | was conducted on 4/s<br>Additional information  | n was obtained on 4/11/25.<br>te was changed to 4/11/25.  |                     |   |                         |                            |
| F 580<br>SS=D            | deficiency.<br>Notify of Changes (In  | ations did not result in a<br>jury/Decline/Room, etc.)<br>·)(i)-(iv)(15)  | F 58                | 30  | 5/                      | 2/25                       |
|                          | consult with the resid<br>consistent with his or<br>representative(s) whe<br>(A) An accident involve<br>results in injury and h<br>physician intervention<br>(B) A significant chan<br>mental, or psychosoco<br>deterioration in health<br>status in either life-the<br>clinical complications<br>(C) A need to alter tree<br>a need to discontinue<br>treatment due to advec<br>commence a new form<br>(D) A decision to tran<br>resident from the faci<br>§483.15(c)(1)(ii).<br>(ii) When making noti<br>(14)(i) of this section,<br>all pertinent information<br>is available and provi-<br>physician. | ediately inform the resident;<br>ent's physician; and notify,<br>her authority, the resident<br>en there is-<br>ving the resident which<br>as the potential for requiring<br>n;<br>ge in the resident's physical,<br>ial status (that is, a<br>n, mental, or psychosocial<br>reatening conditions or<br>);<br>eatment significantly (that is,<br>e an existing form of<br>erse consequences, or to<br>m of treatment); or<br>sfer or discharge the<br>lity as specified in<br>fication under paragraph (g)<br>the facility must ensure that<br>on specified in §483.15(c)(2)<br>ded upon request to the |                     |   |                         |                            |
| LABORATORY               | DIRECTOR'S OR PROVIDER/S  | SUPPLIER REPRESENTATIVE'S SIGNATUR  | RE                  | TITLE   | (X6                     | ) DATE                     |

**Electronically Signed** 

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.

05/05/2025

|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |   | PRINTED: 05/20/202<br>FORM APPROVEI<br>OMB NO. 0938-039  |  |  |
|--------------------------|--|---|---------------------|---|--|--|--|
|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | · ,                 | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |  |  |
|                          |  | 345183  | B. WING _           |   | C<br>04/11/2025  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | •   |                     | STREET ADDRESS, CITY, STATI   | E, ZIP CODE  |  |  |
| CABARRI                  | IS HEALTH AND REHAB  |   |                     | 430 BROOKWOOD AVENUE NE   |  |  |  |
| 0,12,11110               |  |   |                     | CONCORD, NC 28025   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | ( (EACH CORRECTI<br>CROSS-REFERENCE   | LAN OF CORRECTION (X5)<br>VE ACTION SHOULD BE COMPLETION<br>ED TO THE APPROPRIATE DATE<br>FICIENCY)                        |  |  |
| F 580                    | <ul> <li>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</li> <li>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</li> <li>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</li> <li>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</li> <li>§483.10(g)(15)</li> <li>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</li> <li>This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Medical Director, and Responsible Party interviews, the facility failed to notify the</li> </ul> |   | F                   | -   | a the following plan of<br>n compliance with all   |  |  |
|                          | Physician and the Re<br>of Resident #1's char<br>unwitnessed fall for 1<br>accidents (Resident #<br>The findings included<br>Resident #1 was adm   | sponsible Party immediately<br>of 3 residents reviewed for<br>#1).<br>:<br>:          |                     | has taken or will take<br>in the plan of correcti<br>plan of correction cor<br>allegation of compliar | the actions set forth<br>on. The following<br>nstitutes the facility's<br>nce. All deficiencies<br>ill be corrected by the |  |  |
|                          | and osteoarthritis.  | es which included dementia  |                     | F580<br>1. Address how corre  | ective action will be  |  |  |
|                          | Review of incident re  | port dated 3/27/25, written   |                     | accomplished for thos   | se residents found to  |  |  |

Facility ID: 923114

If continuation sheet Page 2 of 12

|                          | OF DEFICIENCIES        | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   |                     | E CONSTRUCTION   |                | O. 0938-03<br>E SURVEY    |
|--------------------------|------------------------|---|---------------------|--|----------------|---------------------------|
|                          | CORRECTION             | IDENTIFICATION NUMBER:  |                     |  |                | IPLETED                   |
|                          |                        | 345183  | B. WING             |  | 04             | C<br>I/11/2025            |
| NAME OF PI               | ROVIDER OR SUPPLIER    |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD   | E              |                           |
|                          |                        |   |                     | 430 BROOKWOOD AVENUE NE  |                |                           |
| CABARRI                  | JS HEALTH AND REHAE    | SILITATION  |                     | CONCORD, NC 28025  |                |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC        | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE      | (X5)<br>COMPLETIO<br>DATE |
| F 580                    | Continued From page    | e 2   | F 580               |  |                |                           |
| 1 300                    | 15                     |   | F SOL               |  | ,              |                           |
|                          |                        | 25, revealed Resident #1  |                     | have been affected by the def  | Icient         |                           |
|                          |                        | fall in her room . A physical   |                     | practice.  | ted as         |                           |
|                          |                        | npleted , no injury or reports  |                     | An incident report was comple<br>3/27/25 revealed that resident                            |                |                           |
|                          | #1) transferred reside | and Nursing Assistant (NA   |                     | unwitnessed fall in her room.  |                |                           |
|                          |                        |   |                     | was assessed; no injury or rej   |                |                           |
|                          | An intonviow was con   | nducted with Nurse #3 on  |                     | was assessed, no injury of rej   |                |                           |
|                          | 4/9/25 3:43 PM and r   |   |                     | to her bed by the charge nurs  |                |                           |
|                          |                        | esident #1 on 3/27/25 from  |                     | nursing assistant. The facility  |                |                           |
|                          | -                      | Nurse #3 indicated she was  |                     | notify the medical provider an   |                |                           |
|                          |                        | esident #1's fall earlier in the  |                     | responsible party of the fall or   |                |                           |
|                          |                        | I not know to document or   |                     | On 3/28/25 7:00 AM-7:00 PM   |                |                           |
|                          | -                      | ited to a fall. Nurse #3  |                     | began to complain of pain. Th  |                |                           |
|                          |                        | alerted her around 12:00 AM   |                     | noted pain and right leg swelli  |                |                           |
|                          | that Resident#1 was    | awake and was complaining   |                     | Nurse Practitioner was notified  |                |                           |
|                          |                        | routine pain medication   |                     | at approximately 9:30 AM and   | a stat x-ray   |                           |
|                          |                        | At approximately 6:00 AM  |                     | was ordered. On 3/28/25 the  | -              |                           |
|                          |                        | irse #3 that Resident #1 was  |                     | nurse also notified the respon   | sible party to |                           |
|                          | awake and complaini    | ing of pain again. Nurse #3   |                     | inform her of the fall and orde  | red x-ray.     |                           |
|                          | indicated that this wa | is not normal behavior for  |                     | On 3/29/25 at 2:10PM the res   | ident was      |                           |
|                          | Resident #1 to be aw   | ake at night with repeated  |                     | sent to the emergency depart   | ment for       |                           |
|                          |                        | o she and NA #2 went down   |                     | evaluation.  |                |                           |
|                          |                        | . NA #2 told her that   |                     | 2 Address how the facility will  | identify       |                           |
|                          |                        | orted a fall to her, but NA #2<br>ent and just thought she was                        |                     | 2. Address how the facility wil other residents having the pot                             |                |                           |
|                          |                        | Il as she had not been made   |                     | affected by the same deficient   |                |                           |
|                          | -                      | . Nurse #3 indicated that she   |                     | All residents who have an exp  | •              |                           |
|                          |                        | dent #1 and observed  |                     | falling within the facility have t   |                |                           |
|                          |                        | eg and the color looked off.  |                     | to be affected by this deficient   |                |                           |
|                          |                        | he medicated Resident #1  |                     | On 4/28/25 the Regional Direct   |                |                           |
|                          |                        | medication and it was   |                     | Clinical Services will identify the  |                |                           |
|                          |                        | idicated she did not contact  |                     | residents that are at risk through   |                |                           |
|                          |                        | Responsible Party at that   |                     | the incident reports for the las   |                |                           |
|                          |                        | shift change and reported   |                     | ensure that all notifications ha   |                |                           |
|                          |                        | on to the oncoming Nurse  |                     | made as required per policy a  |                |                           |
|                          | (Nurse #4).            | č   |                     | procedure to the medical prov  |                |                           |
|                          |                        |   |                     | responsible party.   |                |                           |
|                          | An interview was con   | nducted with Nurse #4 on  |                     | Any instances of failure to not  | ify the        |                           |
|                          | 1                      |   | 1                   | medical provider and respons   | -              | 1                         |

Facility ID: 923114

If continuation sheet Page 3 of 12

| TATEMENT C               | OF DEFICIENCIES<br>CORRECTION  | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | ` <i>`</i>         |       | CONSTRUCTION   | (X3) DATE  | <u>D. 0938-039</u><br>E SURVEY<br>PLETED |  |
|--------------------------|--|--|--------------------|-------|--|------------|--|--|
|                          | CONNECTION   | IDENTIFICATION NOMBER.   | A. BUILD           | ING _ |  | C          |  |  |
|                          |  | 345183   | B. WING            |       |  | 04/11/2025 |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | •  | •                  | S     | TREET ADDRESS, CITY, STATE, ZIP CODE   |            |  |  |
| CABARRI                  | IS HEALTH AND REHAB  |  |                    | 43    | 30 BROOKWOOD AVENUE NE   |            |  |  |
| <i>o, 12,</i> 11110      |  |  |                    | С     | CONCORD, NC 28025  |            |  |  |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFI<br>TAG |       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE         | (X5)<br>COMPLETIO<br>DATE                |  |
| F 580                    | Continued From page  | a 3  |                    | 580   |  |            |  |  |
| 1 000                    |  |  | F                  | 500   | will be corrected by making the property   | r          |  |  |
|                          |  | 25 7:00 AM-7:00 PM . Nurse<br>e supervisor made her                        |                    |       | will be corrected by making the prope<br>notifications as required.  | 71         |  |  |
|                          |  | #1 had a fall on 3/27/25 and   |                    |       |  |            |  |  |
|                          |  | d had right leg swelling   |                    |       | 3. Address what measures will be pu  | t into     |  |  |
|                          | noted. Nurse #4 stat   | ed that at approximately   |                    |       | place or systemic changes made to  |            |  |  |
|                          |  | the Nurse Practitioner (NP   |                    |       | ensure that the deficient practice will  | not        |  |  |
|                          | ,  | Resident #1's fall that  |                    |       | recur:   |            |  |  |
|                          |  | and that Resident #1 had   |                    |       | On 4/28/25 the Staff Development   |            |  |  |
|                          |  | right leg pain and NP #1<br>Nurse #4 indicated that she                    |                    |       | Coordinator, Assistant Director of Nu<br>and Unit Managers began in-person                                       | rsing      |  |  |
|                          | -  | esponsible Party to let her  |                    |       | education for all nursing staff, includi   | na         |  |  |
|                          |  | nd that the x- ray had been  |                    |       | agency nurses. This education include  |            |  |  |
|                          | ordered.   | ,  |                    |       | " the facility policy and procedures   |            |  |  |
|                          |  |  |                    |       | notification of changes related to fall  |            |  |  |
|                          |  | #1's physician orders  |                    |       | incidents within the facility which state  |            |  |  |
|                          |  | 3/28/25 for a stat x-ray for   |                    |       | that the provider, responsible party a   |            |  |  |
|                          | right hip, femur and k   | nee.   |                    |       | EMS (if indicated, should be notified  | as         |  |  |
|                          | A review of Regident   | #1's x row rooults of hor right  |                    |       | appropriate.<br>" Types of incidents and changes   | in         |  |  |
|                          |  | #1's x-ray results of her right dated 3/28/25 were reported                |                    |       | condition that required notification to  |            |  |  |
|                          | -  | A. The report documented   |                    |       | medical provider and responsible par   |            |  |  |
|                          |  | acture of the right femur of   |                    |       | " Shift to shift reporting process fo  |            |  |  |
|                          | an unknown age.  | 3  |                    |       | licenses nurse, including agency staf  |            |  |  |
|                          |  |  |                    |       | " Process for shift huddles by chail   | rge        |  |  |
|                          |  | #1's 2nd x-ray result of her   |                    |       | nurses and nurse management with   |            |  |  |
|                          |  | nee dated 3/29/25 were   |                    |       | nursing assistants to communicate  |            |  |  |
|                          |  | at 1:40 PM. The report   |                    |       | significant incidents and changes in   |            |  |  |
|                          | femur which is suspic  | nity of the neck of the right  |                    |       | condition of residents.<br>All nurse aides were also educated o  | n the      |  |  |
|                          | unknown age. Follow  |  |                    |       | process of notification to licensed nur  |            |  |  |
|                          |  | medical imaging technique  |                    |       | any identified resident issues such as   |            |  |  |
|                          |  | eate detailed images of the  |                    |       | or other resident concerns and use th  | -          |  |  |
|                          | inside of the body) wa   | 0  |                    |       | electronic medical record, which is to   |            |  |  |
|                          |  |  |                    |       | document the pain and/or concerns of   |            |  |  |
|                          | -  | f condition note dated   |                    |       | resident in their electronic medical re  |            |  |  |
|                          |  | idicated the results of the  |                    |       | All incident reports, progress notes a   |            |  |  |
|                          | -  | /ed and Unit Manager #1  |                    |       | 24-hour reports will be reviewed daily   | to         |  |  |
|                          | contacted the on-call  | provider who ordered   |                    |       | identify any fall incidents for proper<br>notification to the medical provider ar                                |            |  |  |

Facility ID: 923114

If continuation sheet Page 4 of 12

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |         |              |   | FOR  | D: 05/20/2025<br>MAPPROVED<br>O. 0938-0391 |
|--------------------------|---|--|---------|--------------|---|--|--|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · ,     | CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |  |  |
|                          |   | 345183   | B. WING |              |   | 04   | C<br>//11/2025                             |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |         | S            | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |  |
| CARADDI                  | JS HEALTH AND REHAB   |  |         | 43           | 30 BROOKWOOD AVENUE NE  |  |  |
| CADARIC                  |   |  |         | С            | ONCORD, NC 28025  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |         |              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE                 |
| F 580                    | Continued From page   | 24   | F       | 580          |   |  |  |
|                          | evaluation.   |  |         |              | responsible party. This education will completed by 4/31/25.  |  |  |
|                          | Party on 4/9/25 at 4:2<br>Resident #1 had a dia<br>a previous fall in 202<br>fracture and has been<br>needed pain medicati<br>that she was not notif<br>fall on 3/27/25 or that<br>pain later that evening<br>3/28/25. She further i<br>been notified at the tii<br>nurse observed swell<br>would have wanted R<br>hospital for an evalual<br>A telephone interview<br>at 11:09 AM with NP<br>was made aware by<br>morning of 3/28/25 of<br>occurred on 3/27/25 at<br>been experiencing pa<br>she was notified, she<br>right hip, leg and knew<br>Resident #1 later that<br>she did not write any<br>as the x-ray results w<br>Resident #1 already fa<br>available. NP #1 indic<br>results of the first x-ray | was conducted on 4/10/25<br>#1. NP #1 indicated she<br>nursing staff on the<br>Resident #1's fall that<br>and that Resident #1 had<br>in. NP #1 indicated once<br>ordered a stat x-ray of the<br>e and came in to evaluate<br>morning. She indicated that<br>additional orders at that time<br>ere still pending and |         |              | <ul> <li>This education will become a part of t<br/>new hire orientation process for newly<br/>hired nursing staff, including agency s<br/>The Staff Development Coordinator w<br/>track the education for all staff who di<br/>receive the education prior to their firs<br/>assigned shift. The Staff Development<br/>Coordinator was notified of her<br/>responsibilities on 4/31/25.</li> <li>4. Indicate how the facility plans to<br/>monitor its performance to make sure<br/>solutions are sustained.<br/>The Director of Nursing will be<br/>responsible for completing a daily aud<br/>all incident reports, progress notes an<br/>24-hour reports daily x 4 weeks, biwe<br/>x4 weeks and then weekly until<br/>substantial compliance is achieved. Ta<br/>audit will ensure that all proper<br/>notifications were made to the medica<br/>provider and responsible party as<br/>appropriate.<br/>The Administrator is responsible for the<br/>entire plan of corrections.</li> <li>5. All corrective actions will be complet<br/>on 5/2/25.</li> </ul> | y<br>staff.<br>rill<br>d not<br>st<br>that<br>that<br>lit of<br>id<br>ekly<br>This<br>al |  |
|                          | contacted again by th<br>the nurse had spoker<br>who expressed conce<br>had a fracture in her<br>2nd x-ray for clarificat   | ospital at that time. She was<br>the nurse later that day after<br>to the responsible party<br>ern that Resident #1 never<br>right leg, so she ordered a<br>tion. NP #1 indicated that<br>2nd x-ray stat based on the  |         |              |   |  |  |

Facility ID: 923114

If continuation sheet Page 5 of 12

|                          |  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |           | FORM AP<br>OMB NO. 09  |                                       |                   |                            |  |  |
|--------------------------|--|--|-----------|--|---------------------------------------|-------------------|----------------------------|--|--|
| STATEMENT O              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |           |  | E CONSTRUCTION                        | (X3) DATE<br>COMF | SURVEY<br>PLETED           |  |  |
|                          |  | 345183   | B. WING _ |  |                                       |                   | C<br>11/2025               |  |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |           | S  | STREET ADDRESS, CITY, STATE, ZIP CODE |                   |                            |  |  |
| CABARRI                  | IS HEALTH AND REHAB  | ILITATION  |           | 430 BROOKWOOD AVENUE NE<br>CONCORD, NC 28025   |                                       |                   |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |           | ID PROVIDER'S PLAN OF CORRECTION<br>PREFIX (EACH CORRECTIVE ACTION SHOULD BE<br>TAG CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                       |                   | (X5)<br>COMPLETION<br>DATE |  |  |
| F 580                    | A follow- up interview<br>on 4/11/25 at 10:28 A<br>was first notified of Re<br>of pain and right leg s<br>AM.<br>In an interview with th<br>(DON) on 4/10/25 at<br>did not become aware<br>occurred on 3/27/25 d<br>She indicated that she<br>Resident #1 did not in<br>of the incident but did<br>during the night shift.<br>once she was made a<br>around 10:00 AM on<br>ordered. The DON ind<br>delay in notification to<br>Responsible Party sin<br>at approximately 10:00<br>An interview was con | y being an old fracture.<br>was conducted with NP #1<br>M and she confirmed she<br>esident #1's fall and reports<br>welling on 3/28/25 at 9:29<br>he Acting Director of Nursing<br>12:43 PM, she indicated she<br>e of Resident #1's fall that<br>until the morning of 3/28/25.<br>e was made aware that<br>nitially report pain at the time<br>verbalize pain in right leg<br>The DON indicated that<br>aware NP #1 was notified<br>3/28/25 and an x-ray was<br>dicated she felt there was no<br>o the provider or the<br>nee they were both notified | F         | 580  |                                       |                   |                            |  |  |
| F 684                    | that he would not hav<br>notified of Resident #<br>resident had no visibl<br>reporting pain at that<br>that he would have w<br>been notified when R<br>pain and when swellin<br>observed by nursing s  | ve needed to have been<br>1's fall on 3/27/25 as the<br>e injury and was not<br>time. He further indicated<br>anted a provider to have<br>esident #1 first verbalized<br>ng of the right leg was   | F         | 684  |                                       |                   | 5/2/25                     |  |  |
| SS=D                     | CFR(s): 483.25<br>§ 483.25 Quality of ca<br>Quality of care is a fu  | are<br>ndamental principle that  |           |  |                                       |                   |                            |  |  |

Facility ID: 923114

If continuation sheet Page 6 of 12

|                          |  | ND HUMAN SERVICES   |                            |   | PRINTED: 05/20<br>FORM APPR<br>OMB NO. 0938 | OVE  |
|--------------------------|--|---|----------------------------|---|---|------|
|                          | DF DEFICIENCIES<br>CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                 | (X2) MULTIP<br>A. BUILDING | (X3) DATE SURVEY<br>COMPLETED   | ,   |      |
|                          |  | 345183  | B. WING                    |   | C<br>04/11/202                              | 5    |
| NAME OF PI               | ROVIDER OR SUPPLIER                            |   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |      |
|                          | JS HEALTH AND REHAE                            |   |                            | 430 BROOKWOOD AVENUE NE   |   |      |
|                          |  | SERATOR   |                            | CONCORD, NC 28025   |   |      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE COMPL                              | ETIO |
| F 684                    | Continued From page                            | e 6   | F 68                       | 4   |   |      |
|                          | applies to all treatme                         | nt and care provided to   |                            |   |   |      |
|                          |  | sed on the comprehensive  |                            |   |   |      |
|                          |  | dent, the facility must ensure  |                            |   |   |      |
|                          |  | e treatment and care in<br>ressional standards of                                     |                            |   |   |      |
|                          | -  | hensive person-centered   |                            |   |   |      |
|                          | care plan, and the re-                         |   |                            |   |   |      |
|                          | •  | Γ is not met as evidenced   |                            |   |   |      |
|                          | by:  |   |                            |   |   |      |
|                          |  | view, and staff, Responsible  |                            | F684  |   |      |
|                          |  | ctitioner interviews, the   |                            | 1. Address how corrective ac  |   |      |
|                          |  | de complete, thorough and<br>s after a fall which caused a                            |                            | accomplished for those residen<br>have been affected by the defic                                 |   |      |
|                          |  | atment for 1 of 3 sampled   |                            | practice.   |   |      |
|                          |  | or accidents (Resident #1).   |                            | An incident report was complete<br>3/27/25 revealed that resident #                               |   |      |
|                          | The findings included                          | 1:  |                            | unwitnessed fall in her room. R<br>was assessed; no injury or repo                                |   |      |
|                          |  | nitted to the facility on   |                            | were noted. The resident was  |   |      |
|                          |  | es which included dementia,   |                            | to her bed by the charge nurse  | and   |      |
|                          | osteoarthritis and left                        | hip fracture.   |                            | nursing assistant.  | nalata                                      |      |
|                          | Review of the quarte                           | rly Minimum Data Set (MDS)  |                            | The facility failed to provide cor thorough and ongoing assessm                                   |   |      |
|                          | dated 3/11/25 revealed                         |   |                            | a fall which caused a delay in re   |   |      |
|                          | moderately cognitive                           |   |                            | treatment.  | 5   |      |
|                          | dependent on staff fo                          |   |                            | On 3/28/25 7:00 AM-7:00 PM th   |   |      |
|                          |  |   |                            | began to complain of pain. The  |   |      |
|                          |  | 1's care plan created on  |                            | noted pain and right leg swelling   | -   |      |
|                          | 6/27/24 with a revision focus area for at risk | on date of 3/12/25 revealed a for falls related to                                    |                            | Nurse Practitioner was notified<br>at approximately 9:30 AM and a                                 |   |      |
|                          |  | g care and dependency.  |                            | was ordered. On 3/28/25 the a   | -   |      |
|                          |  | d reminding resident to use   |                            | nurse also notified the responsi  | •   |      |
|                          | call light for assistant                       | -   |                            | inform her of the fall and ordere   |   |      |
|                          |  |   |                            | 2. Address how the facility wi  | -   |      |
|                          | -  | was conducted with Nurse  |                            | other residents having the pote   |   |      |
|                          | Aide (NA) #1 on 04/9                           |   |                            | affected by the same deficient p  |   |      |
|                          |  | between 1:00 PM- 2:00 PM  |                            | All residents who experience fa   |   |      |
|                          | floor in front of her be                       | ent #1 in her room, on the  |                            | risk of being affected by this de   | licient                                     |      |
|                          |  | su shung up whith the   |                            | practice.   |   |      |

Facility ID: 923114

|                          | S FOR MEDICARE &         | MEDICAID SERVICES   |                     | LE CONSTRUCTION  | OMB N        | M APPROVI<br>O. 0938-03<br>E SURVEY |
|--------------------------|--------------------------|---|---------------------|--|--------------|-------------------------------------|
|                          | CORRECTION               | IDENTIFICATION NUMBER:  |                     |  |              | PLETED                              |
|                          |                          | 345183  | B. WING             |  | 04           | U<br>11/2025                        |
| NAME OF PI               | ROVIDER OR SUPPLIER      |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD   | E            |                                     |
|                          |                          |   |                     | 430 BROOKWOOD AVENUE NE  |              |                                     |
| CABARRI                  | JS HEALTH AND REHAE      | SILITATION  |                     | CONCORD, NC 28025  |              |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC          | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE    | (X5)<br>COMPLETIO<br>DATE           |
| F 684                    | Continued From page      | a 7   | F 68                |  |              |                                     |
| 1 004                    |                          |   |                     |  |              |                                     |
|                          |                          | ately 3 feet away with the lift   |                     | The Regional Director of Clini   |              |                                     |
|                          |                          | #1 indicated she immediately<br>or assistance, but she did                            |                     | completed a review of all fall i   |              |                                     |
|                          |                          | or assistance, but she did<br>s assigned nurse, but she                               |                     | the previous 30 days to ensur<br>resident assessments and po                               |              |                                     |
|                          |                          | urse #1 and requested her   |                     | documentation were complete  |              |                                     |
|                          |                          | dicated that she and Nurse  |                     | 3. Address what measures   |              |                                     |
|                          |                          | and asked Resident #1 what  |                     | into place or systemic change  | •            |                                     |
|                          |                          | the stated that she had   |                     | ensure that the deficient pract  |              |                                     |
|                          |                          | d NA #1 if she had observed   |                     | recur.   |              |                                     |
|                          | the fall and she expla   |   |                     | On 4/29/25 the Regional Direct   | ctor of      |                                     |
|                          |                          | ssumed the resident had   |                     | Clinical Services completed e  |              |                                     |
|                          | just slid out on the flo | or from her wheelchair.   |                     | all licensed nurses, including   |              |                                     |
|                          | -                        | ne resident; there was no   |                     | nurses that included:  | 0 1          |                                     |
|                          | reported pain and no     | injuries at that time. NA #1  |                     | " Definition of a fall,  |              |                                     |
|                          | indicated that when th   | he nurse felt it was safe to  |                     | " Steps to take when a fall  | occurs.      |                                     |
|                          | transfer Resident #1     | from floor to her bed, she  |                     | o These steps included the   | nurse        |                                     |
|                          | then left the room to    | get the mechanical lift and   |                     | completing a physical and cog  | gnitive      |                                     |
|                          | then she and Nurse #     | #1 assisted Resident #1 to  |                     | assessment, assessing, interv  | ening and    |                                     |
|                          | bed. NA #1 also indic    | ated that Resident #1 did   |                     | providing necessary intervent  | ions for any |                                     |
|                          |                          | ints of pain or discomfort to   |                     | resident experiencing a fall,  |              |                                     |
|                          |                          | of the shift. NA #1 further   |                     | o Notification to the provide  | er and       |                                     |
|                          |                          | not report this incident to   |                     | responsible party  |              |                                     |
|                          | -                        | nd that she thought Nurse   |                     | o Initiation of appropriate in   |              |                                     |
|                          | #1 would have report     | ed it to Resident #1's  |                     | aid in prevention of another fa  |              |                                     |
|                          | assigned nurse.          |   |                     | o Evaluating, monitoring an  |              |                                     |
|                          | An intonious             | ductod with Nurses #4 ==  |                     | documenting the resident⊡s r   |              |                                     |
|                          |                          | ducted with Nurse #1 on<br>he indicated on 3/27/25                                    |                     | every shift for 72 hours post fa<br>" Completion of the Post Fa                            |              |                                     |
|                          | around 1:00 PM NA        |   |                     | Investigation to determine, to   |              |                                     |
|                          |                          | dent #1. She and NA #1  |                     | possible the case of the reside  |              |                                     |
|                          | entered Resident #1's    |   |                     | o Completion of appropriate  |              |                                     |
|                          |                          | h the floor with her back   |                     | documentation such as the Po   |              |                                     |
|                          |                          | wheelchair was locked and   |                     | investigation, post fall assessi   |              |                                     |
|                          |                          | way from Resident #1 and  |                     | neurological assessment.   |              |                                     |
|                          |                          | wheelchair. Nurse #1 asked  |                     | Any licensed nurse that did no   | ot receive   |                                     |
|                          | Resident #1 what had     |   |                     | education before 5/2/25, will r  |              |                                     |
|                          |                          | ad fallen , denied pain but   |                     | education before the start of the  |              |                                     |
|                          | -                        | ny additional information   |                     | scheduled shift. This education  |              |                                     |
|                          |                          |   | 1                   |  |              | 1                                   |

Facility ID: 923114

If continuation sheet Page 8 of 12

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                    |  |  | FO   | ED: 05/20/2025<br>RM APPROVED<br>NO. 0938-0391 |
|--------------------------|---|---|--------------------|--|--|--|--|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ,                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | TE SURVEY<br>MPLETED                           |
|                          |   | 345183  | B. WING            |  |  | 0  | C<br>4/11/2025                                 |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                    | S                                      | TREET ADDRESS, CITY, STATE, ZIP CODE   |  |  |
| CARADDI                  | JS HEALTH AND REHAB   |   |                    | 43                                     | 30 BROOKWOOD AVENUE NE   |  |  |
| CADANIN                  |   |   |                    | С                                      | ONCORD, NC 28025   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE                     |
| F 684                    | indicated that she ask<br>and NA #1 indicated to<br>from her wheelchair.<br>assessed the residen<br>motion on both upper<br>observed no signs of<br>hitting her head and of<br>Nurse #1 and NA #1<br>bed using the mechan<br>that she instructed N/<br>Resident #1's assigned<br>complete a fall incide<br>Responsible Party or<br>3/27/25. Nurse #1 re<br>approached by Nursi<br>who requested that she<br>report regarding the f<br>An interview was con<br>4/9/25 at 3:30 PM. S<br>assigned nurse for Re<br>7:00 AM- 7:00 PM and<br>did not make her awa<br>had occurred on 3/27<br>or document Residen<br>An interview was con<br>4/9/25 3:43 PM and<br>assigned nurse for Re<br>7:00 PM - 7:00 AM. I<br>not made aware of Re<br>day and therefore did<br>monitor changes relai<br>indicated Resident #<br>related to a previous<br>and had orders for ro<br>She further revealed<br>slept well through the | ked NA #1 if the resident fell,<br>that she did not fall but slid<br>Nurse #1 indicated that she<br>t, performed range of<br>and lower extremities and<br>injury. Resident #1 denied<br>denied having any pain.<br>assisted Resident #1 back to<br>nical lift. Nurse #1 indicated<br>A #1 to report the incident to<br>ed nurse and did not<br>nt report or notify the<br>the Physician of the fall on<br>vealed she was<br>ing Supervisor #1 on 3/28/25<br>he complete the incident<br>all that occurred on 3/27/25.<br>ducted with Nurse #2 on<br>he indicated she was the<br>esident #1 on 3/27/25 from<br>id that NA #1 and Nurse #1<br>are of Resident #1's fall that<br>i/25 so she did not monitor<br>at #1's response on her shift. | F                  | 684                                    | <ul> <li>4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained.</li> <li>The Director of Nursing will be responsible for completing a daily audall incident reports, progress notes ar 24-hour reports daily to identify fall incidents.</li> <li>The audits will be completed weekly of weeks, biweekly x4 weeks and then weekly until substantial compliance is achieved. This audit review of all falls incidents will include the completion of physical assessment, neurological assessment (if indicated), post fall documentation, post fall notification to medical provider and responsible par and completion of the 72-hour post fadocumentation.</li> <li>The Director of Nursing will report the findings from the audits to the Quality Assurance Performance Improvement Committee for recommendations and modifications until a pattern of complisis achieved.</li> <li>The Administrator is responsible for the entire plan of correction.</li> <li>All corrective actions will be completed on 5/2/25.</li> </ul> | dit of<br>nd<br>( 4<br>of a<br>by<br>III<br>t<br>/or<br>ance |  |

Facility ID: 923114

If continuation sheet Page 9 of 12

|                          |   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |  |   | FOF     | ED: 05/20/2025<br>RM APPROVED<br>IO. 0938-0391 |  |
|--------------------------|---|--|---------------------|--|---|---------|--|--|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | `, ´                | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |         | TE SURVEY<br>MPLETED                           |  |
|                          |   | 345183   | B. WING _           |  |   | 0       | C<br>04/11/2025                                |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                     | STREE                                  | TADDRESS, CITY, STATE, ZIP CODE   |         |  |  |
|                          |   |  |                     | 430 BF                                 | ROOKWOOD AVENUE NE  |         |  |  |
| CADARRI                  | JS HEALTH AND REHAB   | SIEITATION   |                     | CONC                                   | ORD, NC 28025   |         |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ×                                      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE                     |  |
| F 684                    | that Resident#1 was<br>pain. Nurse #3 went to<br>did not indicate that s<br>or specify to her when<br>she assumed the rep<br>injury and not a new of<br>medicated Resident #<br>medication and it was<br>6:00 AM NA #2 report<br>was awake and comp<br>#3 indicated that this<br>Resident #1, so she a<br>to Resident #1. NA #2<br>had reported a fall to<br>this resident and just<br>an old injury as she h<br>a recent fall. Nurse #3<br>assessed Resident #<br>her right left and the of<br>indicated she medicated<br>Nurse #3 indicated sh<br>physician or the party<br>it was during shift chat<br>with Nurse #2 who has<br>Resident #1 on the pr<br>indicated that she mas<br>Resident #1 reporting<br>shift on 3/27/25 and t<br>to complain of pain in<br>also observed. Nurse<br>not aware of a fall but<br>Nursing Supervisor for<br>A review of the incide<br>3/28/25, written by N<br>#1 had an unwitnesse | alerted her around 12:00 AM<br>awake and complaining of<br>to see Resident #1 and she<br>the had a fall earlier that day<br>re the pain was located so<br>orted pain was due to an old<br>concern. Nurse #2<br>#1 with her routine pain<br>s effective. At approximately<br>ted to her that Resident #1<br>blaining of pain again. Nurse<br>was not normal behavior for<br>and NA #2 went down to talk<br>2 told her that Resident #1<br>her, but NA #2 was new to<br>thought she was referencing<br>ad not been made aware of<br>3 indicated that she then<br>#1 and observed swelling to<br>color looked off. Nurse #3<br>ted Resident #1 with her<br>on and it was effective.<br>he did not contact the<br>responsible at that time as<br>ange and she wanted to talk<br>ad been assigned to<br>revious day. Nurse #3<br>ade Nurse #2 aware of<br>g a fall that occurred on her<br>hat Resident #1 had started<br>right leg and swelling was<br>t would follow up with the<br>or direction. | F                   | 584                                    |   |         |  |  |

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  |   | FC        | TED: 05/20/2025<br>RM APPROVED<br>NO. 0938-0391 |
|--------------------------|---|---|---------------------|--|---|-----------|---|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |           | ATE SURVEY<br>DMPLETED                          |
|                          |   | 345183  | B. WING _           |  |   |           | 04/11/2025                                      |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                     | STF                                    | REET ADDRESS, CITY, STATE, ZIP CODE   |           |   |
| CABARRI                  | JS HEALTH AND REHAB   | BILITATION  |                     |  | BROOKWOOD AVENUE NE   |           |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIZ<br>TAG |  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE                      |
| F 684                    | to the floor. An initial<br>completed , no injury<br>Resident #1 indicated<br>incident. Resident #1<br>bed via mechanical li<br>Review of the Post Fa<br>completed on 3/29/25<br>The form indicated R<br>unwitnessed fall that<br>occurred in Resident<br>transferring herself un<br>observed not to have<br>An interview was con<br>Party on 4/9/25 at 4:2<br>Resident #1 had a pr<br>resulted in a left hip fi<br>receiving routine and<br>ever since. She indica<br>notified that Resident<br>that she had started t<br>evening until mid-mod<br>indicated that if she h<br>the pain started, and<br>swelling of her right le<br>wanted Resident #1 thospital for an evalua<br>During a telephone in<br>AM with the Nurse Pr<br>indicated she was m<br>on the morning of 3/2<br>that occurred on 3/27<br>had been experiencir<br>once she was notified<br>the right hip, leg and | alized that Resident #1 slid<br>physical assessment was<br>was observed, and<br>d no pain at the time of the<br>1 was transferred back to<br>ft by Nurse #1 and NA #1.<br>all Investigation form<br>5 by Nursing Supervisor #1.<br>esident #1 had an<br>occurred on 3/27/25. The fall<br>#1's room while she was<br>nattended and she was<br>nonskid socks in use.<br>ducted with the Responsible<br>22 PM. She indicated<br>evious fall in 2024 that<br>racture and has been<br>as needed pain medication<br>ated that she was not<br>: #1 had a fall on 3/27/25 or<br>to report pain later that<br>rning on 3/28/25. She further<br>iad been notified at the time<br>when the nurse observed<br>eg then she would have<br>to have been sent out to the<br>attor at that time.<br>terview on 4/10/25 at 11:09<br>ractitioner (NP #1) and she<br>hade aware by nursing staff<br>t8/25 of Resident #1's fall<br>/25 and that Resident #1<br>ng pain. NP #1 indicated<br>d, she ordered a stat x-ray of | F                   | 584                                    |   |           |   |

Facility ID: 923114

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING       (X3) DATE SURVEY<br>COMPLETED         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING       (X3) DATE SURVEY<br>COMPLETED         NAME OF PROVIDER OR SUPPLIER       B. WING       04/11/2025         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE<br>430 BROOKWOOD AVENUE NE<br>CONCORD, NC 28025       430 BROOKWOOD AVENUE NE<br>CONCORD, NC 28025         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)   |             | -   | ID HUMAN SERVICES  |         |     |  | FORM      | APPROVED<br>0. 0938-0391 |
|---|-------------|---|--|---------|-----|--|-----------|--------------------------|
| 345183         B_WING         04/11/2025           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE         309 REGXMOOD AVENUE NE<br>CONCORD, NC 28025           (%1,0)<br>PHECK<br>No         SUMAMY STREAMENT OF DEFICIENCIES<br>PROVIDERS PLAN OF CORRECTION<br>REGULTORY OR LSC DENTRYING INFORMATION)         D<br>PLAN ADDRESS, CITY, STATE, ZP CODE         309 REGXMOOD AVENUE NE<br>CONCORD, NC 28025           (%1,0)<br>PHECK<br>No         SUMAMY STREAMENT OF DEFICIENCIES<br>PROVIDERS PLAN OF CORRECTION<br>REGULTORY OR LSC DENTRYING INFORMATION)         D<br>PLAN ADDRESS, CITY, STATE, ZP CODE         309 REGXMOOD AVENUE NE<br>CONCORD, NC 28025           F 684         Continued From page 11<br>Indicated that she did not write any additional<br>orders at that time. She x-ray results were still<br>pending and Resident #1 already had pain<br>medication available. NP #1 indicated she<br>received the results of the first x-ray which<br>indicated that tay after the nurse had<br>spoken to the responsible party who expressed<br>concern that Resident #1 arever had a fracture in<br>her right leg, so she ordered a 2nd x-ray for<br>clarification. NP #1 indicated that she did not<br>order the 2nd x-ray stat based on the first x-ray<br>results likely being an old fracture.         A follow- up interview was conducted with NP #1<br>on 41/125 at 10/28 AM and she confirmed she<br>was first notified of Resident #1's fail and reports<br>of pain and right leg swelling on 3/28/25 at 9:29<br>AM.         A neview of hospital discharge summary dated<br>42/25 indicated Resident #1's wad singht and dosed<br>fracture of distal end or fight ferrur.         A niterview was conducted with the Acting<br>Director of Nursing on 04/10/25 at 12:43 PM. She<br>revavaide she was not made awar of the fail on<br>33/3725 unt   | STATEMENT C | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  |         |     | CONSTRUCTION   | (X3) DATE | SURVEY                   |
| CABARRUS HEALTH AND REHABILITATION         30 BROOKWOOD AVENUE NE<br>CONCORD, NC 28225           YM, ID<br>PRETX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH OBRICENCY MUST BE PRECIDED BY FULL<br>RECULTORY OR LSC IDENTIFYING INFORMATION)         IPRETX<br>TAG         PROVIDERS FLAV OF CORRECTION<br>(EACH OBRICENT ACTION SHOULD BE<br>CROSS REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         05<br>0000000           F 684         Continued From page 11<br>indicated that she did not write any additional<br>orders at that time as the x-ray results were still<br>pending and Resident #1 already had pain<br>medication available. NP #1 indicated she<br>received the results of the first x-ray which<br>indicated that it was an old break and not an<br>acute issue, so she did not send her to the<br>hospital at that time. She was contacted again by<br>the nurse later that day after the nurse had<br>spoken to the responsible party who expressed<br>concern that Resident #1 never had a fracture in<br>her right leg, so she ordered a 2 nd x-ray for<br>clarification. NP #1 indicated that she did not<br>order the 2nd x-ray stat based on the first x-ray<br>results likely bein gon old fracture.         A follow- up interview was conducted with NP #1<br>on 411122 at 10:28 AM and she confirmed she<br>was first notified of Resident #1 was discharged<br>back to the facility on 3/28/25 at 9:29<br>AM.         A review of hospital discharge summary dated<br>fracture of distal end of right femur.           A review of hospital discharge summary dated<br>fracture of distal end of right femur.         An interview was conducted with the Acting<br>Director of Nursing on 04/10/25 at 12:43 PM. She<br>revealed she was not made aware of the fall on<br>33/725 until 3/28/25, and she expected nursing<br>staff to follow the facility poils and procedures for   |             |   | 345183   | B. WING |     |  |           | -                        |
| CABARUS HEALTH AND REHABILITATION         CONCORD, NC 28925           (M) ID<br>PREPK<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH EDERS PLAN OF CORRECTION BE<br>(EACH EDERS)<br>(EACH EDERS PLAN OF CORRECTION BE<br>(EACH EDERS)<br>(EACH EDERS | NAME OF PF  | ROVIDER OR SUPPLIER   |  |         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE                                 |           |                          |
| CONCORD, NC 2023           YM ID<br>PREEX<br>TAG         SUMMARY STATEMENT OF DEFICIENCIES<br>(REACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         D<br>PRETX<br>TAG         PROVIDERS PLAN OF CORRECTION<br>(REACH ORDERCTWE ACTION SHOLD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)         00           F 684         Continued From page 11<br>indicated that she did not write any additional<br>orders at that time as the X-ray results were still<br>pending and Resident #1 already had pain<br>medication available. NP #1 indicated she<br>received the results of the first X-ray<br>which<br>indicated that it was an old break and not an<br>acute issue, so she did not so the dar to the<br>hospital at that time. She was contacted again by<br>the nurse later that day after the nurse had<br>spoken to the responsible party who expressed<br>concern that Resident #1 never had a fracture in<br>her right leg, so she ordered a 27 dx X-ray<br>results likely being an olf fracture.         A follow- up interview was conducted with NP #1<br>on 4/11/25 at 10.28 AM and she confirmed she<br>was first notified of Resident #1 soll and reports<br>of pain and right leg swelling on 3/28/25 at 9:29<br>AM.         A review of hospital discharge summary dated<br>4/2/25 indicated Resident #1 was discharged<br>back to the facility on 4/21/25 with a diagnosis that<br>include a closed right hip fracture, closed fracture<br>of femu, interview was conducted with the Acting<br>Director of Nursing on 0/10/26 at 12:43 PM. She<br>revealed she was not made aware of the fail on<br>3/37/25 unit 3/28/25, and she expected nursing<br>staff to follow the facility poil yad procedures for  |             |   |  |         | 4   | 30 BROOKWOOD AVENUE NE   |           |                          |
| Predictive<br>Txg         (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         PREIN<br>Txg         (EACH CORRECTIVE ACTION BHOLD BE<br>CROSS-REFERENCED To THE APPROPRIATE<br>DEFICENCY)         COMMENTION<br>DEFICENCY           F 684         Continued From page 11<br>indicated that she did not write any additional<br>orders at that time as the x-ray results were still<br>pending and Resident #1 already had pain<br>medication available. NP #1 indicated she<br>received the results of the first x-ray which<br>indicated that it was an old break and not an<br>acute issue, so she did not send her to the<br>hospital at that time. She was contacted again by<br>the nurse later that day after the nurse had<br>spoken to the responsible party who expressed<br>concern that Resident #1 never had a fracture in<br>her right leg, so she ordered a 2nd x-ray for<br>olarification. NP #1 indicated that she did not<br>order the 2nd x-ray stat based on the first x-ray<br>results likely being an old fracture.           A follow- up interview was conducted with NP #1<br>on 4/11/25 at 10:28 AM and she confirmed she<br>was first notified of Resident #1 ts fail and reports<br>of pain and right leg swelling on 3/28/25 at 9:29<br>AM.         A<br>A review of hospital discharge summary dated<br>4/2/25 indicated Resident #1 was discharged<br>back to the facility on 4/225 with a diagnosis that<br>include a closed right hip fracture, closed fracture<br>of femur, intertrochanteric, right and closed<br>fracture of distal end of right femur.           An interview was conducted with the Acting<br>Direct or Nurrisg on 04/10/25 at 12:43 PM. She<br>revealed she was not made aware of the fail on<br>3/37/25 until 3/28/25, and she expected nursing<br>staff to follow the facility policy and procedures for   | CADARRU     | IS REALTH AND REHAD   | ILITATION  |         | c   | CONCORD, NC 28025  |           |                          |
| <ul> <li>indicated that she did not write any additional orders at that time as the x-ray results were still pending and Resident #1 already had pain medication available. NP #1 indicated she received the results of the first x-ray which indicated that it was an old break and not an acute issue, so she did not send her to the hospital at that time. She was contacted again by the nurse later that day after the nurse had a fracture in her right leg, so she ordered a 2nd x-ray for clarification. NP #1 indicated that she did not or order the 2nd x-ray stat based on the first x-ray results likely being an old fracture.</li> <li>A follow- up interview was conducted with NP #1 on 4/11/25 at 10:28 AM and she confirmed she was first notified of Resident #1's fail and reports of pain and right leg swelling on 3/28/25 at 9:29 AM.</li> <li>A review of hospital discharge summary dated 4/2/25 indicated Resident #1' was discharged back to the facility on 4/12/25 with a diagnosis that include a closed right hip fracture, closed fracture of femur, interfrochanteric, right and closed fracture of femur.</li> <li>An interview was conducted with the Acting Director of Nursing on 04/10/25 at 12:43 PM. She revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not adoe aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not adoe aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed she was not made aware of the fall on 3/37/25 until 3/28/25, at 3e, be revealed unk fall bolicy on diverged unk she fall bolicy on the facility policy and procedures for</li> </ul>  | PREFIX      | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |         |     | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI |           | COMPLETION               |
|   | F 684       | indicated that she did<br>orders at that time as<br>pending and Residen<br>medication available.<br>received the results of<br>indicated that it was a<br>acute issue, so she di<br>hospital at that time. S<br>the nurse later that da<br>spoken to the respons<br>concern that Residen<br>her right leg, so she of<br>clarification. NP #1 in<br>order the 2nd x-ray st<br>results likely being an<br>A follow- up interview<br>on 4/11/25 at 10:28 A<br>was first notified of Re<br>of pain and right leg s<br>AM.<br>A review of hospital<br>4/2/25 indicated Resid<br>back to the facility on<br>include a closed right<br>of femur, intertrochan<br>fracture of distal end of<br>An interview was con<br>Director of Nursing or<br>revealed she was not<br>3/37/25 until 3/28/25,<br>staff to follow the facili | not write any additional<br>the x-ray results were still<br>t #1 already had pain<br>NP #1 indicated she<br>f the first x-ray which<br>an old break and not an<br>id not send her to the<br>She was contacted again by<br>ay after the nurse had<br>sible party who expressed<br>t #1 never had a fracture in<br>ordered a 2nd x-ray for<br>dicated that she did not<br>at based on the first x-ray<br>old fracture.<br>was conducted with NP #1<br>M and she confirmed she<br>esident #1's fall and reports<br>welling on 3/28/25 at 9:29<br>discharge summary dated<br>dent #1 was discharged<br>4/2/25 with a diagnosis that<br>hip fracture, closed fracture<br>teric, right and closed<br>of right femur.<br>ducted with the Acting<br>n 04/10/25 at 12:43 PM. She<br>made aware of the fall on<br>and she expected nursing<br>lity policy and procedures for | F       | 684 |  |           |                          |

Facility ID: 923114

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