STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS HEALTH AND REHABILITATION	430 BROOKWOOD AVENUE NE CONCORD, NC 28025

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 4/9/25 through 4/10/25. Additional information was obtained on 4/11/25. Therefore, the exit date was changed to 4/11/25. The following intake was investigated: NC00229010. 1 of 1 complaint allegations did not result in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		5/2/25

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

Electronically Signed | 05/05/2025

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) 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). 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 Physician and the Responsible Party immediately of Resident #1's change in condition after an unwitnessed fall for 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/29/17 with diagnoses which included dementia and osteoarthritis. Review of incident report dated 3/27/25, written	F 580	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. F580 1. Address how corrective action will be accomplished for those residents found to	

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F 580	Continued From page 2 by Nurse #1 on 3/28/25, revealed Resident #1 had an unwitnessed fall in her room . A physical assessment was completed , no injury or reports of pain and Nurse #1 and Nursing Assistant (NA #1) transferred resident to her bed. An interview was conducted with Nurse #3 on 4/9/25 3:43 PM and revealed she was the assigned nurse for Resident #1 on 3/27/25 from 7:00 PM - 7:00 AM. Nurse #3 indicated she was not made aware of Resident #1's fall earlier in the day and therefore did not know to document or monitor changes related to a fall. Nurse #3 indicated that NA #2 alerted her around 12:00 AM that Resident#1 was awake and was complaining of pain and provided routine pain medication which was effective. At approximately 6:00 AM NA #2 reported to Nurse #3 that Resident #1 was awake and complaining of pain again. Nurse #3 indicated that this was not normal behavior for Resident #1 to be awake at night with repeated complaints of pain, so she and NA #2 went down to talk to Resident #1. NA #2 told her that Resident #1 had reported a fall to her, but NA #2 was new to this resident and just thought she was referencing an old fall as she had not been made aware of a recent fall. Nurse #3 indicated that she then assessed Resident #1 and observed swelling to her right leg and the color looked off. Nurse #3 indicated she medicated Resident #1 with her routine pain medication and it was effective. Nurse #3 indicated she did not contact the Physician or the Responsible Party at that time as it was during shift change and reported the change in condition to the oncoming Nurse (Nurse #4). An interview was conducted with Nurse #4 on 4/10/25 at 10:45 AM who was assigned to	F 580	have been affected by the deficient practice. An incident report was completed on 3/27/25 revealed that resident #1 had an unwitnessed fall in her room. Resident #1 was assessed; no injury or reports of pain were noted. The resident was transferred to her bed by the charge nurse and nursing assistant. The facility failed to notify the medical provider and responsible party of the fall on 3/27/25. On 3/28/25 7:00 AM-7:00 PM the resident began to complain of pain. There was noted pain and right leg swelling. The Nurse Practitioner was notified on 3/28/25 at approximately 9:30 AM and a stat x-ray was ordered. On 3/28/25 the assigned nurse also notified the responsible party to inform her of the fall and ordered x-ray. On 3/29/25 at 2:10PM the resident was sent to the emergency department for evaluation. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who have an experience of falling within the facility have the potential to be affected by this deficient practice. On 4/28/25 the Regional Director of Clinical Services will identify these residents that are at risk through review of the incident reports for the last 30 days to ensure that all notifications have been made as required per policy and procedure to the medical provider and responsible party. Any instances of failure to notify the medical provider and responsible party	

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F 580	Continued From page 3	F 580		

Resident #1 on 3/28/25 7:00 AM-7:00 PM . Nurse #4 indicated the nurse supervisor made her aware that Resident #1 had a fall on 3/27/25 and had reported pain and had right leg swelling noted. Nurse #4 stated that at approximately 9:30 AM she notified the Nurse Practitioner (NP #1) to let her know of Resident #1's fall that occurred on 3/27/25 and that Resident #1 had been complaining of right leg pain and NP #1 ordered a stat x-ray. Nurse #4 indicated that she then contacted the Responsible Party to let her know about the fall and that the x- ray had been ordered.

A review of Resident #1's physician orders revealed an order on 3/28/25 for a stat x-ray for right hip, femur and knee.

A review of Resident #1's x-ray results of her right hip, femur and knee dated 3/28/25 were reported on 3/28/25 at 1:40 PM. The report documented an intertrochanteric fracture of the right femur of an unknown age.

A review of Resident #1's 2nd x-ray result of her right hip, femur and knee dated 3/29/25 were reported on 3/28/25 at 1:40 PM. The report documented a deformity of the neck of the right femur which is suspicious for a fracture of unknown age. Follow- up with Computed Tomography Scan (a medical imaging technique that uses x-rays to create detailed images of the inside of the body) was recommended.

A review of change of condition note dated 3/29/25 at 2:10 PM indicated the results of the 2nd x-ray were received and Unit Manager #1 contacted the on-call provider who ordered Resident #1 to be sent to the emergency room for

will be corrected by making the proper notifications as required.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
On 4/28/25 the Staff Development Coordinator, Assistant Director of Nursing and Unit Managers began in-person education for all nursing staff, including agency nurses. This education included:
" the facility policy and procedures for notification of changes related to fall incidents within the facility which states that the provider, responsible party and/or EMS (if indicated, should be notified as appropriate.
" Types of incidents and changes in condition that required notification to the medical provider and responsible party.
" Shift to shift reporting process for all licenses nurse, including agency staff.
" Process for shift huddles by charge nurses and nurse management with nursing assistants to communicate significant incidents and changes in condition of residents.
All nurse aides were also educated on the process of notification to licensed nurse of any identified resident issues such as pain or other resident concerns and use the electronic medical record, which is to document the pain and/or concerns of the resident in their electronic medical record.
All incident reports, progress notes and 24-hour reports will be reviewed daily to identify any fall incidents for proper notification to the medical provider and

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F 580	Continued From page 4 evaluation. An interview was conducted with the Responsible Party on 4/9/25 at 4:22 PM. She indicated that Resident #1 had a diagnosis of osteoarthritis had a previous fall in 2024 that resulted in a left hip fracture and has been receiving routine and as needed pain medication ever since. She indicated that she was not notified that Resident #1 had a fall on 3/27/25 or that she had started to report pain later that evening until mid-morning on 3/28/25. She further indicated that if she had been notified at the time the pain started, and the nurse observed swelling of her right leg then she would have wanted Resident #1 sent out to the hospital for an evaluation at that time. A telephone interview was conducted on 4/10/25 at 11:09 AM with NP #1. NP #1 indicated she was made aware by nursing staff on the morning of 3/28/25 of Resident #1's fall that occurred on 3/27/25 and that Resident #1 had been experiencing pain. NP #1 indicated once she was notified, she ordered a stat x-ray of the right hip, leg and knee and came in to evaluate Resident #1 later that morning. She 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 spoken to the responsible party who expressed concern that Resident #1 never had a fracture in her right leg, so she ordered a 2nd x-ray for clarification. NP #1 indicated that she did not order the 2nd x-ray stat based on the	F 580	responsible party. This education will be completed by 4/31/25. This education will become a part of the new hire orientation process for newly hired nursing staff, including agency staff. The Staff Development Coordinator will track the education for all staff who did not receive the education to ensure they receive the education prior to their first assigned shift. The Staff Development Coordinator was notified of her responsibilities on 4/31/25. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will be responsible for completing a daily audit of all incident reports, progress notes and 24-hour reports daily x 4 weeks, biweekly x4 weeks and then weekly until substantial compliance is achieved. This audit will ensure that all proper notifications were made to the medical provider and responsible party as appropriate. The Administrator is responsible for the entire plan of corrections. 5. All corrective actions will be completed on 5/2/25.	

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F 580	Continued From page 5 first x-ray results likely being an old fracture. 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 fall and reports of pain and right leg swelling on 3/28/25 at 9:29 AM. In an interview with the Acting Director of Nursing (DON) on 4/10/25 at 12:43 PM, she indicated she did not become aware of Resident #1's fall that occurred on 3/27/25 until the morning of 3/28/25. She indicated that she was made aware that Resident #1 did not initially report pain at the time of the incident but did verbalize pain in right leg during the night shift. The DON indicated that once she was made aware NP #1 was notified around 10:00 AM on 3/28/25 and an x-ray was ordered. The DON indicated she felt there was no delay in notification to the provider or the Responsible Party since they were both notified at approximately 10:00 AM on 3/28/25. An interview was conducted with the Medical Director on 4/10/25 at 1:20 PM. He indicated that he would not have needed to have been notified of Resident #1's fall on 3/27/25 as the resident had no visible injury and was not reporting pain at that time. He further indicated that he would have wanted a provider to have been notified when Resident #1 first verbalized pain and when swelling of the right leg was observed by nursing staff.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		5/2/25

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F 684	Continued From page 6 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Responsible Party, and Nurse Practitioner interviews, the facility failed to provide complete, thorough and ongoing assessments after a fall which caused a delay in receiving treatment for 1 of 3 sampled residents reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/29/17 with diagnoses which included dementia, osteoarthritis and left hip fracture. Review of the quarterly Minimum Data Set (MDS) dated 3/11/25 revealed Resident #1 was moderately cognitively impaired and was dependent on staff for transfers. Review of Resident #1's care plan created on 8/27/24 with a revision date of 3/12/25 revealed a focus area for at risk for falls related to combativeness during care and dependency. Interventions included reminding resident to use call light for assistance. A telephone interview was conducted with Nurse Aide (NA) #1 on 04/9/25 at 6:25 PM . She revealed on 3/27/25 between 1:00 PM- 2:00 PM she observed Resident #1 in her room, on the floor in front of her bed sitting up with the	F 684	F684 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. An incident report was completed on 3/27/25 revealed that resident #1 had an unwitnessed fall in her room. Resident #1 was assessed; no injury or reports of pain were noted. The resident was transferred to her bed by the charge nurse and nursing assistant. The facility failed to provide complete, thorough and ongoing assessments after a fall which caused a delay in receiving treatment. On 3/28/25 7:00 AM-7:00 PM the resident began to complain of pain. There was noted pain and right leg swelling. The Nurse Practitioner was notified on 3/28/25 at approximately 9:30 AM and a stat x-ray was ordered. On 3/28/25 the assigned nurse also notified the responsible party to inform her of the fall and ordered x-ray. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who experience falls are at risk of being affected by this deficient practice.	

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F 684	Continued From page 7 wheelchair approximately 3 feet away with the lift pad in the chair. NA #1 indicated she immediately went to find a nurse for assistance, but she did not see Resident #1's assigned nurse, but she was able to locate Nurse #1 and requested her assistance. NA #1 indicated that she and Nurse #1 entered the room and asked Resident #1 what had happened, and she stated that she had fallen. Nurse #1 asked NA #1 if she had observed the fall and she explained that she did not observe the fall but assumed the resident had just slid out on the floor from her wheelchair. Nurse #1 assessed the resident; there was no reported pain and no injuries at that time. NA #1 indicated that when the nurse felt it was safe to transfer Resident #1 from floor to her bed, she then left the room to get the mechanical lift and then she and Nurse #1 assisted Resident #1 to bed. NA #1 also indicated that Resident #1 did not voice any complaints of pain or discomfort to her for the remainder of the shift. NA #1 further revealed that she did not report this incident to the assigned nurse and that she thought Nurse #1 would have reported it to Resident #1's assigned nurse. An interview was conducted with Nurse #1 on 4/9/25 at 3:00 PM. She indicated on 3/27/25 around 1:00 PM NA #1 requested her assistance with Resident #1. She and NA #1 entered Resident #1's room and observed Resident #1 sitting on the floor with her back against her bed. The wheelchair was locked and was about 3-5 feet away from Resident #1 and had the lift pad in the wheelchair. Nurse #1 asked Resident #1 what had happened, and she responded that she had fallen , denied pain but was unable to offer any additional information regarding the details of the fall. Nurse #1	F 684	The Regional Director of Clinical Services completed a review of all fall incidents for the previous 30 days to ensure that resident assessments and post fall documentation were completed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/29/25 the Regional Director of Clinical Services completed education for all licensed nurses, including agency nurses that included: " Definition of a fall, " Steps to take when a fall occurs. o These steps included the nurse completing a physical and cognitive assessment, assessing, intervening and providing necessary interventions for any resident experiencing a fall, o Notification to the provider and responsible party o Initiation of appropriate intervention to aid in prevention of another fall. o Evaluating, monitoring and documenting the resident□s response every shift for 72 hours post fall. " Completion of the Post Fall Investigation to determine, to the extent possible the case of the residents fall. o Completion of appropriate additional documentation such as the Post Fall investigation, post fall assessment and neurological assessment. Any licensed nurse that did not receive education before 5/2/25, will receive the education before the start of their next scheduled shift. This education will become a part of the new hire orientation.	

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F 684	Continued From page 8 indicated that she asked NA #1 if the resident fell, and NA #1 indicated that she did not fall but slid from her wheelchair. Nurse #1 indicated that she assessed the resident, performed range of motion on both upper and lower extremities and observed no signs of injury. Resident #1 denied hitting her head and denied having any pain. Nurse #1 and NA #1 assisted Resident #1 back to bed using the mechanical lift. Nurse #1 indicated that she instructed NA #1 to report the incident to Resident #1's assigned nurse and did not complete a fall incident report or notify the Responsible Party or the Physician of the fall on 3/27/25. Nurse #1 revealed she was approached by Nursing Supervisor #1 on 3/28/25 who requested that she complete the incident report regarding the fall that occurred on 3/27/25. An interview was conducted with Nurse #2 on 4/9/25 at 3:30 PM. She indicated she was the assigned nurse for Resident #1 on 3/27/25 from 7:00 AM- 7:00 PM and that NA #1 and Nurse #1 did not make her aware of Resident #1's fall that had occurred on 3/27/25 so she did not monitor or document Resident #1's response on her shift. An interview was conducted with Nurse #3 on 4/9/25 3:43 PM and revealed she was the assigned nurse for Resident #1 on 3/27/25 from 7:00 PM - 7:00 AM. Nurse #3 indicated she was not made aware of Resident #1's fall earlier in the day and therefore did not know to document or monitor changes related to a fall. Nurse #3 indicated Resident #1 had a history of pain related to a previous left hip fracture and arthritis and had orders for routine and as needed pain. She further revealed that Resident #1 normally slept well through the night and current pain management treatment was effective. Nurse #3	F 684	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will be responsible for completing a daily audit of all incident reports, progress notes and 24-hour reports daily to identify fall incidents. The audits will be completed weekly x 4 weeks, biweekly x4 weeks and then weekly until substantial compliance is achieved. This audit review of all falls incidents will include the completion of a physical assessment, neurological assessment (if indicated), post fall documentation, post fall notification to medical provider and responsible party and completion of the 72-hour post fall documentation. The Director of Nursing will report the findings from the audits to the Quality Assurance Performance Improvement Committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for the entire plan of correction. 5. All corrective actions will be completed on 5/2/25.	

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F 684	Continued From page 9	F 684		

indicated that NA #2 alerted her around 12:00 AM that Resident#1 was awake and complaining of pain. Nurse #3 went to see Resident #1 and she did not indicate that she had a fall earlier that day or specify to her where the pain was located so she assumed the reported pain was due to an old injury and not a new concern. Nurse #2 medicated Resident #1 with her routine pain medication and it was effective. At approximately 6:00 AM NA #2 reported to her that Resident #1 was awake and complaining of pain again. Nurse #3 indicated that this was not normal behavior for Resident #1, so she and NA #2 went down to talk to Resident #1. NA #2 told her that Resident #1 had reported a fall to her, but NA #2 was new to this resident and just thought she was referencing an old injury as she had not been made aware of a recent fall. Nurse #3 indicated that she then assessed Resident #1 and observed swelling to her right left and the color looked off. Nurse #3 indicated she medicated Resident #1 with her routine pain medication and it was effective. Nurse #3 indicated she did not contact the physician or the party responsible at that time as it was during shift change and she wanted to talk with Nurse #2 who had been assigned to Resident #1 on the previous day. Nurse #3 indicated that she made Nurse #2 aware of Resident #1 reporting a fall that occurred on her shift on 3/27/25 and that Resident #1 had started to complain of pain in right leg and swelling was also observed. Nurse #2 indicated that she was not aware of a fall but would follow up with the Nursing Supervisor for direction.

A review of the incident report completed on 3/28/25 , written by Nurse #1, revealed Resident #1 had an unwitnessed fall in her room on 3/27/25 with time not specified. The report

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(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
F 684	Continued From page 10	F 684		

indicated NA #1 verbalized that Resident #1 slid to the floor. An initial physical assessment was completed , no injury was observed, and Resident #1 indicated no pain at the time of the incident. Resident #1 was transferred back to bed via mechanical lift by Nurse #1 and NA #1.

Review of the Post Fall Investigation form completed on 3/29/25 by Nursing Supervisor #1. The form indicated Resident #1 had an unwitnessed fall that occurred on 3/27/25. The fall occurred in Resident #1's room while she was transferring herself unattended and she was observed not to have nonskid socks in use.

An interview was conducted with the Responsible Party on 4/9/25 at 4:22 PM. She indicated Resident #1 had a previous fall in 2024 that resulted in a left hip fracture and has been receiving routine and as needed pain medication ever since. She indicated that she was not notified that Resident #1 had a fall on 3/27/25 or that she had started to report pain later that evening until mid-morning on 3/28/25. She further indicated that if she had been notified at the time the pain started, and when the nurse observed swelling of her right leg then she would have wanted Resident #1 to have been sent out to the hospital for an evaluation at that time.

During a telephone interview on 4/10/25 at 11:09 AM with the Nurse Practitioner (NP #1) and she indicated she was made aware by nursing staff on the morning of 3/28/25 of Resident #1's fall that occurred on 3/27/25 and that Resident #1 had been experiencing pain. NP #1 indicated once she was notified, she ordered a stat x-ray of the right hip, leg and knee and came in to evaluate Resident #1 later that morning. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING _____ B. WING _____	C 04/11/2025

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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 spoken to the responsible party who expressed concern that Resident #1 never had a fracture in her right leg, so she ordered a 2nd x-ray for clarification. NP #1 indicated that she did not order the 2nd x-ray stat based on the first x-ray results likely being an old fracture.

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 fall and reports of pain and right leg swelling on 3/28/25 at 9:29 AM.

A review of hospital discharge summary dated 4/2/25 indicated Resident #1 was discharged back to the facility on 4/2/25 with a diagnosis that include a closed right hip fracture, closed fracture of femur, intertrochanteric, right and closed fracture of distal end of right femur.

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, and she expected nursing staff to follow the facility policy and procedures for fall management for all resident falls.