STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cabarrus Health and Rehabilitation	**430 Brookwood Avenue NE , Concord, North Carolina, 28025**

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F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/6/2025 through 8/7/2025. Event ID#1D3184-H1. The following intakes were investigated: 2574133, 868469, 2569188, 2571599, 2572595, and 2576187. 16 of the 16 complaint allegations did not result in deficiency.	F0000		08/26/2025
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide foot care treatment ordered by the Podiatrist for 1 of 3 residents reviewed for foot care (Resident #1). The findings included: Resident #1 was admitted to the facility 2/24/25 with diagnoses including stroke and feeding tube. The significant change Minimum Data Set (MDS) assessment dated 6/23/25 documented Resident #1 was severely cognitively impaired. A podiatry note dated 7/1/25 documented foot care provided to Resident #1. The note included that	F0687	F0687 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 was admitted to the facility 2/24/25 with diagnoses including stroke and feeding tube. The order was clarified and verified by the Assistant Director of Nursing (ADON) on 8-27-25 for the podiatry note dated 7/1/25 that included the order Apply Eucerin Cream to both feet QD but not between toes x 3 months. The order was transcribed in the electronic medical record on 8-27-25 by Unit Coordinator (UC)#1. Identification of other residents having the potential to be affected by the same deficient practice: Effective 8-25-25, a 100% audit on 8-27-25 by UC #1 & ADON of all current residents that had been seen by the Podiatrist the last 30 days to ensure that no other orders or recommendations have been missed to include in the electronic medical record and/or care plan. This audit was completed by the ADON and Unit Coordinator #1 & #2 on 8-27-25 The ADON and UC #1 & #2 verified that all podiatry recommendations and orders have been transcribed on the electronic medical record and / or Care plan on 8-27-25. Effective 8-25-25, the Unit Coordinator #1 & #2 and ADON were to identify any other resident that requires foot care orders and treatments transcribed on the electronic medical record related to Podiatry visits and recommendations. Care planning will also be updated	08/29/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0687 SS = D	Continued from page 1 Resident #1 had a chronic problem with dry skin (xerosis) and treatment included exfoliation and moisturization to prevent skin breakdown, which could increase the potential for infection. The note included the order to use a moisturizing cream daily to both feet, avoiding the area between the toes. This treatment was to continue for 3 months. Review of physician orders for Resident #1 revealed no order had been written to apply moisturizing cream to Resident #1's feet daily. Review of the treatment record for Resident #1 revealed no order had been written to apply moisturizing cream daily to Resident #1's feet. Resident #1 was observed on 8/6/25 at 11:51 AM in bed. His feet were noted to be very dry, with thick and flakey dead skin noted. Nurse #1 was interviewed on 8/6/25 at 1:13 PM. Nurse #1 reported she was assigned to Resident #1 and did not know about the podiatrist order for moisturizing cream to be applied to his feet. Unit Manager (UM) #1 was interviewed on 8/7/25 at 1:58 PM. UM #1 reported that she had not seen the podiatrist note dated 7/1/25 ordering the moisturizing cream to his feet. UM #1 explained that consultant visit notes were typically put into her box for her to review, but the podiatry note dated 7/1/25 had gone directly to medical records to be scanned into the electronic document system. UM #1 reported the order for the moisturizing cream should have been entered as a treatment order. A phone interview was conducted with nursing assistant (NA) #1 on 8/6/25 at 9:06 PM. NA #1 reported she had been assigned to Resident #1 this afternoon (8/6/25) and had not applied lotion or moisturizing cream to his feet. NA #2 was interviewed by phone on 8/6/25 at 9:20 PM and she reported she had not applied lotion or moisturizing cream to Resident #1's feet. NA #2 reported she had provided care to Resident #1 before he was hospitalized in July 2025. An interview was conducted with NA #3 on 8/7/25 at 12:43 PM. NA #3 reported she had been assigned to Resident #1 for the past several days (8/5, 8/6, and 8/7/25). NA #3 reported she had not applied moisturizing cream to his feet after his bath.	F0687	Continued from page 1 as needed by the MDS (Minimum Data Set) Nurse or assigned Licensed Nurse. There were 3 out of 31 residents seen by Podiatrist that required an order for foot care treatment noted by the UC#1 " b DôâÂ æB —@ was corrected on 8-27-25 by the UC#1 " æB Dôâà There was a total of 3 transcribed with a new order per Podiatry recommendations. Findings of this audit are documented on the 100% “Foot Care” audit tool effective 8-25-25 located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Regional Director of Clinical Services (RDCS) educated the ADON on 8-25-25 & 8-26-25 related to Podiatry visits, notes, recommendations, and foot care/ treatments by reviewing list of Podiatry visits and reviewing notes and orders to ensure that orders are transcribed and / or care planned accordingly. Also to review new admissions, readmissions or change in condition for any foot care/ treatment recommendations and to ensure the orders are transcribed accordingly. ADON will educate the Medical Director and Podiatry provider on 8-28-25 to ensure that orders are entered onto the Electronic Medical Record during each visit. Education will include consultants i.e. Podiatrist to exit with UC#1 or #2, DON or ADON post visits. This will be completed on 8-28-25. Effective 8-25-25, all licensed nurses on duty and assigned to care for residents requiring podiatry visit will review the Podiatry orders and notes to ensure that the recommendations are transcribed on the Electronic Medical Records timely for any foot treatment or care or referrals. All new admission, readmission, and any with any significant or condition changes will also be reviewed for any footcare recommendations or orders. Effective 8-25-25, all licensed nurses on duty will be educated by the ADON and/ or Staff Development Coordinator (SDC) on order transcription, discontinuation and adding interventions on care plan related to Podiatry Visits, notes, and foot care orders/ recommendations. Effective 8-25-25, the Clinical team, which consists of the Director of Nursing, Assistant Director of Nursing ADON, Minimum Data set (MDS), and/or Unit Coordinators (1, 2) will incorporate the process of discussing residents seen by consultants (i.e. Podiatrist),	

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F0687 SS = D	Continued from page 2 The Director of Nursing (DON) was interviewed on 8/7/25 at 2:54 PM. The DON reported she was not aware the podiatrist had ordered moisturizing cream for Resident #1's feet to be applied daily. The DON reported that all consultant notes should be reviewed for orders. The Administrator reported that he expected all consultant notes to be reviewed for orders and entered into the electronic document system.	F0687	Continued from page 2 recently admitted/readmitted with foot care orders or recommendations to validate proper transcription of orders by licensed nurses. This systemic process will take place starting 8-27-25. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting that takes place Mondays to Fridays. The Staff Development Coordinator will complete 100% of education for all licensed nurses to include full-time, part-time, agency employees, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring each resident with foot care orders and recommendations are transcribed on the electronic medical record. Any licensed nurses who are not educated by 8-28-25 will not be allowed to work until they are educated. This education will also be provided annually and implemented in a new hire orientation for licensed nurses, effective 8-28-25. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 8-28-25, the Director of Nursing and/or Assistant Director of Nursing will monitor compliance with foot care by completing rounds on random residents with foot care orders to ensure compliance. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for two months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of Nursing promptly. This monitoring process will be documented on a "Foot Care Audit" monitoring tool located in the facility compliance binder. Effective 8-28-25, the Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement (QAPI) Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 08-29-25	
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F0693	F0693 Corrective actions accomplished for those residents found to be affected by the deficient practice:	08/29/2025

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F0693 SS = D	Continued from page 3 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to enter hospital discharge orders for tube feedings and free water administration for 1 of 3 residents reviewed for tube feedings (Resident #1). The findings included: Resident #1 was admitted to the facility 2/24/25 with diagnoses including stroke and feeding tube. The significant change Minimum Data Set (MDS) assessment dated 6/23/25 documented Resident #1 was severely cognitively impaired. The MDS documented Resident #1 received tube feedings. An order dated 7/11/25 indicated for tube feedings (Nutren 2.0) to be administered by pump at 60 milliliters (ml) per hour for 22 hours and turned off from 1:00 PM to 3:00 PM daily. The order directed a total of 1320 ml to be administered. An order dated 7/11/25 revealed free water flushes of 300 milliliters (ml) to be administered 5 times per day. Resident #1 was transferred to the hospital on 7/31/25 and was readmitted to the facility 8/5/25 after hospitalization.	F0693	Continued from page 3 Resident #1 was admitted on 8-5-25 and was discharged to the hospital on 8-8-25. The order was clarified and verified for the Free water Bolus via Tube Feeding on 8-6-25 by the Director of Nursing with the Registered Dietician. The order was transcribed in the electronic medical record on 8-6-25. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of all current residents requiring enteral nutrition in the facility completed on 8-8-25 by unit by the Unit Coordinator and was verified by the Director of Nursing to identify any other resident that requires enteral nutrition management orders on the electronic medical record related to Flush order, Placement, G-Tube (Gastric Tube) Ostomy, Residual check, Registered referral as needed, Care planning and Tube feeding care. There was only 1 out of 8 Tube Feeding residents that required an order for Residual checks, and it was corrected on 8-12-25. The other 2 out of the 8 Tube Feeding residents were transcribed with a new order per Registered Dietician's recommendation. Findings of this audit are documented on the 100% enteral feeding audit tool dated 8-8-25 located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur: Effective 8-12-25, all licensed nurses on duty and assigned to care for residents requiring enteral feedings will be educated on enteral feeding management upon admission, readmission and with any significant or condition changes. Effective 8-12-25, all licensed nurses on duty will be educated on order transcription, discontinuation and adding interventions on care plan related to Tube Feeding Management and Care. Effective 8-12-25, the Clinical team, which consists of the Director of Nursing, Assistant Director of Nursing ADON, Minimum Data set (MDS), and/or Unit Coordinators (1, 2) will incorporate the process of discussing residents admitted/readmitted with enteral tube devices to validate proper handling of eternal feeding orders by licensed nurses. Effective 8-12-25, the Unit Coordinator #1" v–ÆÂ complete the admission audit checklist to include Tube Feeding checklist. This Admission Audit Checklist will	

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F0693 SS = D	Continued from page 4 Hospital discharge orders dated 8/5/25 specified that Resident #1 should return to his previous diet. Review of the medication administration record (MAR) revealed there were no orders for tube feeding or free water flushes. Resident #1 was observed on 8/6/25 at 11:51 AM in bed. Tube feeding Nutren was infusing by pump at 60 ml per hour. An interview was conducted with Nurse #2 on 8/6/25 at 1:18 PM. Nurse #2 explained she received report from the hospital for Resident #1 before he arrived to the facility. Nurse #2 reported the hospital instructed her to continue previous tube feeding orders, and she reported this to Nurse #1. When Resident #1 returned to the facility, Nurse #2 hung the Nutren tube feeding. Nurse #2 reported she was not assigned to Resident #1 and did not notice the orders for the tube feeding or free water flushes were not added to the medication administration record. Nurse #1 was interviewed on 8/6/25 at 1:13 PM. Nurse #1 reported she was assigned to Resident #1 on 8/5/25 when he returned from the hospital and she was told by Nurse #2, who received report from the hospital, to continue the same tube feeding as before. Nurse #1 explained she hung the Nutren at 60 ml per hour as before and gave him free water flushes as before, but she did not notice that the orders for the tube feeding had not been added to the medication administration record. Nurse #1 explained she had hung a replacement container of the tube feeding at 9:30 AM because the previous container was empty and had given him flushes of water after the medication administration but had not administered free water flushes this date. Nurse #1 reported the Unit Manager was responsible for entering hospital discharge orders into the electronic documentation system. The Unit Manager (UM) #1 was interviewed on 8/6/25 at 1:25 PM and she reported she had received the hospital discharge orders for Resident #1 and had entered the orders on 8/5/25. UM #1 reviewed the medication administration record and reported that she must have forgotten to add the tube feeding formula, the rate of administration, and the free water flushes to the orders. UM #1 explained she was going to review the orders that morning on 8/6/25 but did not have the opportunity. A phone interview was conducted with the Registered	F0693	Continued from page 4 be reviewed and verified completed by the Director of Nursing or Assistant Director of Nursing or designee within 24 hours of admission/ re-admission or any significant or changes in condition related to Tube Feeding orders and management. This systemic process will take place starting 8-13-25. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting that takes place Mondays to Fridays. The Staff Development Coordinator will complete 100% of education for all licensed nurses to include full-time, part-time, agency employees, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring each resident with an enteral feeding has Tube Feeding orders transcribed on the electronic medical record to include Free Bolus Water flushes aside from keeping a clean and dry enteral feeding syringe for medication and feeding administration. Any licensed nurses who are not educated by 8-13-25 will not be allowed to work until they are educated. This education will also be provided annually and implemented in a new hire orientation for licensed nurses, effective 8-13-25 Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 8-13-25, the Director of Nursing and/or Assistant Director of Nursing will monitor compliance with enteral feeding maintenance by completing rounds on random residents with enteral feeding devices to ensure compliance. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for two months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of Nursing promptly. This monitoring process will be documented on a “Tube QA Audit” monitoring tool located in the facility compliance binder. Effective 8-20-25, the Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement (QAPI) Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date 08-29-25	

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F0693 SS = D	Continued from page 5 Dietician (RD) on 8/6/25 at 12:36 PM. The RD explained that Resident #1 was receiving continuous feeding by feeding tube and receiving 2640 calories per day, plus 1500 ml of free water flushes. The RD reported she did not receive a phone call from the facility requesting clarification of dietary orders after Resident #1 returned to the facility after hospitalization. A phone interview was conducted with Nurse #3 on 8/6/25 at 10:21 PM. Nurse #3 reported he was assigned to Resident #1 for the night shift 7:00 PM on 8/5/25 to 7:00 AM on 8/6/25. Nurse #3 explained the tube feeding was running at 60 ml per hour and he had allowed that to run all night. Nurse #3 reported he had not noticed there were no orders for the tube feeding nutrition or for the free water flushes, but he had given water after administering medications (amount unknown) and had given him 240 ml of water at bedtime and in the morning. Nurse #3 reported he did not document the administration of these water flushes, and he used his nursing judgment for the administration of the water flushes. The physician was interviewed on 8/7/25 at 11:05 AM and he reported that nursing staff should not use their nursing judgement for tube feeding water flushes, and the facility should have called him on 8/5/25 to receive tube feeding and free water flushes orders and to clarify the hospital orders. The Director of Nursing (DON) was interviewed on 8/7/25 at 2:54 PM. The DON reported the facility reviewed orders received the day before during the morning meeting and she did not know why UM #1 did not call to clarify the tube feeding and free water flushes orders with the physician. The DON reported the hospital discharge orders for Resident #1 dated 8/5/25 were not reviewed during the morning meeting on 8/6/25. The Administrator reported that he expected all hospital discharge orders to be clarified as needed and entered into the electronic document system.	F0693		