STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	4748 Old Salisbury Road Lexington, NC 27295

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and Nurse Practitioner interview, the facility failed to immediately notify the Responsible Party (RP) and the physician of Resident #1 experiencing a fall with reported pain immediately after the fall and throughout the day. This failure to immediately notify the physician resulted in a delay in diagnostics and necessary medical treatment for a fractured hip. The result of the x-ray that followed was the diagnosis of a fractured hip that resulted in the resident being sent out for medical treatment. This deficient practice affected 1 of 3 residents reviewed for notification of change (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding near the brain) without loss of consciousness, fractured ribs, type II diabetes, muscle weakness, and unsteadiness on her feet.A review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. She was assessed as requiring supervision with toilet transfers and toileting hygiene. Resident #1 was coded as having a fall with a fracture prior to admission.A phone interview was conducted with Resident #1 on 2/26/26 at 1:45 PM who stated on 1/28/26 she had turned her call light on sometime during the night, she was unsure of the time, to request help to go to the bathroom. She stated nobody answered her call light, so she tried to get up by herself. Resident #1 explained she lost her balance and fell to the floor. According to the resident, a while later, time unknown, two ladies picked her up off the floor and put her in a wheelchair then assisted her into bed. She stated neither lady completed an exam on her because she would have remembered that. Resident #1 stated her right leg hurt after the fall, and she rated the pain level a 10/10 (0 meaning no pain and 10 meaning the worst pain the resident experienced). A phone interview was conducted with Nurse #1 on 2/25/26 at 9:24 AM who was assigned the 7:00 PM shift to the 7:00 AM shift on 1/27/26 through the morning of 1/28/26. Nurse #1 stated she was notified by Nurse Aide (NA) #1 that Resident #1 had fallen in her room on the morning of 1/28/26. She stated she was completing her medication pass around 5:30 AM when the NA informed her. Nurse #1 stated she and NA #1 got the resident off the floor and up into her wheelchair. She stated she asked the resident what happened but said she did not complete an assessment on the resident. Nurse #1 stated Resident #1 winced and said Oh my leg when she and NA #1 got her up, but she didn't think the resident was hurt because she looked like she had full range of motion of her leg. Nurse #1 stated she had NA #1 take the resident to the bathroom then put her back to bed. She indicated she looked in at Resident #1 a while later, time unknown, and the resident looked fine, so she went down the hall. Nurse #1 further indicated she did not report the fall to the Doctor or the Nurse Practitioner and stated, I used bad judgement.An interview was conducted with NA #2 on 2/23/26 at 1:57 PM who stated she checked on Resident #1 before breakfast on 1/28/26, she estimated the time to be around 8:00 AM, to get the resident ready for the day. NA #2 indicated she was changing the resident's brief, and Resident #1 kept saying ouch as she (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	moved her in the process. NA #2 stated the resident informed her she had fallen during the night. The NA stated she had not been informed the resident had fallen so she reported what the resident said to the Medication Aide. NA #2 indicated the Medication Aide informed her she was not aware Resident #1 had fallen. The NA stated she reported the resident's statement to the Unit Manager after she discussed the reported fall with the Medication Aide, and the UM replied she would get right on it.A phone interview was conducted with Medication Aide (MA) #1 on 2/24/26 at 12:12 PM who stated on 1/28/26 she was standing beside Resident #1's room at the medication cart passing medications between 8:00 AM and 9:00 AM when NA #2 came out of the room and told her the resident reported she fell during the night. According to MA #1 she did not receive notice of Resident #1 having a fall during shift change report. MA #1 indicated she immediately went to the resident and could tell Resident #1 did not look the same as she had when she worked with her on 1/27/26. She stated the resident had a look of agony on her face and reported her pain level was 10/10. MA #1stated she looked up and noted the Unit Manager was headed down the hall towards her to Resident #1's room to assess her. A phone interview was conducted with Nurse #2 who was assigned to Resident #1 on the morning of 1/28/26 for the shift of 7:00 AM to 7:00 PM. Nurse #2 stated she received a report from the previous shift nurse (Nurse #1) that Resident #1 had an unwitnessed fall during her shift. According to Nurse #2, she did not know if Nurse #1 reported the fall to the provider or the Unit Manager, and she did not know where to look in Resident #1's medical record to determine if the fall was reported.A review of the vital signs documented in the electronic medical record for Resident #1 revealed on 1/28/26 at 8:58 AM the resident reported a pain level of 8/10. The acceptable pain range for Resident #1 was documented to be between 0-4/10. Acetaminophen was administered at 8:59 AM. At 12:20 PM another vital signs documented in Resident #1's chart indicated the resident reported a pain level of 5/10, no interventions were listed.At 1:02 PM another vital signs indicated Resident #1 reported a pain level of 5/10, no interventions were listed.At 2:12 PM a vital sign documented in Resident #1's chart indicated the resident reported a 10/10 pain level and had acetaminophen administered at 2:13 PM.A final vital sign documented at 3:00 PM indicated Resident #1 reported a pain level of 10/10, and there were no interventions listed.A nursing progress note dated 1/28/26 written by the Unit Manager at 2:28 PM indicated Resident #1 informed the staff she attempted to walk to the bathroom without assistance that morning and slipped and fell to the floor. According to the progress note, Resident #1 stated two females assisted her off the floor and back to bed. Upon assessment, the resident complained of hip pain and was unable to bear weight on the right lower extremity. The right leg was noted to have limited range of motion and increased pain with movement. The resident was kept in bed for safety and Tylenol was given. The physician and family were notified of the fall and change in condition. Orders were received and a right hip fracture was noted. The provider was updated. A new order was received to send Resident #1 to the emergency department for further evaluation. The family was notified.An interview was conducted with the Unit Manager (UM) on 2/23/26 at 1:39 PM. The UM stated when she arrived at work on 1/28/26, sometime between 8:00 and 8:30 AM, the Medication Aide reported that Resident #1 had fallen earlier that morning and was complaining of pain. According to the UM, she assessed Resident #1 immediately. She stated the resident was alert and oriented, and very emotional during her assessment as she complained of right leg pain. The resident informed her during the night two females got her off the floor and helped her get into bed. The UM stated she instructed the Medication Aide to give the resident Tylenol for pain as she assessed Resident #1's leg. She stated she then called the Nurse Practitioner and got an order to obtain an x-ray of the resident's right hip. The Unit Manager stated she questioned both the Medication Aide and Nurse #2 if the night shift nurse had (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	reported Resident #1 had a fall, and both denied they had received a report. The UM stated she called Nurse #1, the previous night shift nurse, to ask if the resident had a fall during the previous shift, and Nurse #1 denied it. She indicated she investigated and reviewed the camera footage for the previous shift and noted Nurse #1 and Nurse Aide #1 had entered the resident's room together at 5:45 AM on 1/28/26. The UM stated she called Nurse #1 back and informed her she was observed entering Resident #1's room at 5:45 AM with Nurse Aide #1 (NA), and Nurse #1 admitted the resident had a fall and she had messed up by not reporting it.A review of the electronic medical record revealed orders for post-fall monitoring and a stat (immediate) x-ray of the right hip were ordered by the physician on 1/28/26 at 11:50 AM.On 2/26/26 at 1:05 PM a phone interview was conducted with Customer Service Representative #1 with the facility's mobile imaging provider. She stated Resident #1's mobile imaging record revealed they received an order to perform a hip x-ray for the resident on 1/28/26 at 11:57 AM. The record further indicated that the service was dispatched to the facility at 12:54 PM.A phone interview was conducted with the Responsible Party (RP) on 2/25/26 at 12:50 PM who stated on the afternoon of 1/28/26 he was notified Resident #1 had fallen and was injured. He stated he arrived at the facility sometime between 2:45 and 2:50 PM and saw that his mother's right leg appeared injured. He stated the Unit Manager told him the facility was unsure when the fall had happened, but they were reviewing tapes to see if they could determine a time. According to the RP, he had believed the injury happened just before he arrived at the facility, but he found out instead he had not been notified that Resident #1 had fallen hours earlier in the day. The RP indicated the ambulance arrived to take the resident to the local hospital while he was at the facility.A further review of Resident #1's facility electronic medical record revealed an order from the physician dated 1/28/26 at 2:34 PM to send Resident #1 to the local hospital for evaluation and treatment, stat (immediately).A review of the local hospital treatment record dated 1/28/26 at 3:54 PM indicated Resident #1 presented to the emergency room (ER) with deformity and tenderness to the right hip. An x-ray of the right hip completed 1/28/26 revealed a comminuted, displaced, and impacted right hip fracture (a severe injury where the bone shatters into three or more pieces, the fragments are out of alignment, and the broken ends are driven into each other). The hospital record indicated the resident denied hitting her head when she fell, but due to the history of an existing subdural hematoma (bleeding near the brain) with CT (computed tomography) evidence of recent bleeding, the resident was admitted to the trauma intensive care unit for monitoring and neurological checks. Resident #1 was then transferred to a secondary hospital for surgical repair of the right hip fracture.The Director of Nursing (DON) was interviewed on 2/24/26 at 2:30 PM who stated Nurse #1 failed to report Resident #1 had fallen during her shift on 1/28/26. The DON stated she reviewed the 24-hour shift report and noted the time 5:45 was written and underlined next to Resident #1's name on the report, but there was no documentation in the medical record to indicate what had happened. She further stated that Nurse #1 did not report the fall to the oncoming shift. According to the DON, the staff should have done what was right for the resident and completed an assessment of the resident and notified the provider the resident had a fall. The Nurse Practitioner (NP) was interviewed on 2/23/26 at 4:41 PM and stated she was notified by the Unit Manager during the morning of 1/28/26 that Resident #1 had fallen but was unsure of the time she received the call. She stated she gave orders to obtain an x-ray of the resident's right hip due to reports of pain. The NP indicated if she had known the severity of the resident's pain level, she would have possibly given different treatment orders.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the resident, staff, mobile imaging provider Representative, and the Nurse Practitioner, the facility failed to identify the seriousness of a resident's unwitnessed fall and immediate reports of pain and complete and document comprehensive assessments following the fall to determine the need for transfer to a higher level of care. The Nurse did not complete a thorough assessment of Resident #1 before the resident was transferred from the floor to the bed. In addition, there were no comprehensive nursing assessments of the resident's condition documented in the medical record. The Unit Manager called the order for the stat (immediately) x-ray of the right hip to the mobile imaging provider instead of the computerized ordering system which further delayed transfer to the hospital for evaluation and treatment. An x-ray of the right hip completed at the hospital on 1/28/26 confirmed a comminuted, displaced, and impacted right hip fracture (a severe injury where the bone shatters into three or more pieces, the fragments are out of alignment, and the broken ends are driven into each other). Resident #1 was transferred to a secondary hospital for surgical repair of the right hip fracture on 1/28/26. This deficient practice was identified for 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding near the brain) without loss of consciousness, fractured ribs, type II diabetes, muscle weakness, and unsteadiness on her feet.A review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. She was assessed as requiring supervision with toilet transfers and toileting hygiene. Resident #1 was coded as having a fall with a fracture prior to admission.A phone interview was conducted with Resident #1 on 2/26/26 at 1:45 PM who stated on 1/28/26 she had turned her call light on sometime during the night, she was unsure of the time, to request help to go to the bathroom. She stated nobody answered her call light, so she tried to get up by herself. Resident #1 explained she lost her balance and fell to the floor. According to the resident, a while later, time unknown, two ladies picked her up off the floor and put her in a wheelchair then assisted her into bed. Resident #1 stated she was not assessed by a nurse after she fell, and she would have remembered if the nurse did assess her because her right hip was in pain at a level 10 out of 10 (0 meaning no pain and 10 meaning the worst pain the resident experienced).A phone interview with NA #1 was conducted on 2/26/26 at 9:46 AM who confirmed she was assigned to Resident #1 from 7:00 PM on 1/27/26 through 7:00 AM on 1/28/26. NA #1 reported that on 1/28/26 at approximately 5:30 AM, while completing final rounds on her assigned hall, she heard Resident #1 make a noise. She looked into the resident's room and observed the resident lying on the floor. NA #1 stated that when she asked what happened, the resident reported she had attempted to go to the bathroom and fell. NA #1 stated she asked the resident if she was injured, and Resident #1 replied she was not certain. NA #1 then notified Nurse #1. Upon returning with Nurse #1, NA #1 stated they assisted the resident from the floor into a wheelchair so they could transfer the resident more easily into bed. NA #1 did not indicate she checked on Resident #1 any further that shift.A phone interview with Nurse #1 was conducted on 2/25/26 at 9:24 AM. Nurse #1 confirmed she was assigned to Resident #1 from 7:00 PM on 1/27/26 through 7:00 AM on 1/28/26. Nurse #1 reported that around 5:30 AM on 1/28/26, NA #1 informed her that Resident #1 had fallen in her room. Nurse #1 stated she and NA #1 assisted the resident from the floor to her wheelchair. She asked the resident what occurred, and Resident #1 reported she attempted to get out of bed to use the bathroom and fell. Nurse #1 stated the resident winced and said, Oh my leg, during the transfer; however, she did not complete a full assessment, because Resident #1 appeared to have (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	intact range of motion. She reported she instructed NA #1 to assist the resident to the bathroom and back to bed. Nurse #1 stated she looked in on the Resident #1 later (time unknown), observed her to appear fine, although she did not complete an assessment on Resident #1 at the time and continued down the hall. Review of Resident #1's nursing progress notes for 1/27/26 through 1/28/26 revealed no documentation by Nurse #1 about Resident #1's fall or any assessments.A phone interview was conducted with Nurse #2, who was assigned to Resident #1 on 1/28/26 for the 7:00 AM to 7:00 PM shift. Nurse #2 stated she received report from Nurse #1 that Resident #1 had an unwitnessed fall during the previous shift. Nurse #2 reported she did not complete an assessment of Resident #1 on 1/28/26 because her day was so busy. She stated that at an unspecified time during her rounds, she visually checked on Resident #1 and observed the resident to appear OK and not in discomfort. Nurse #2 stated that the Physical Therapist later informed her that during his visit Resident #1 reported pain rated 10/10. Nurse #2 acknowledged she did not immediately assess the resident after receiving this information. She stated she was preparing to text the Unit Manager for guidance when she observed the Unit Manager and another staff member already proceeding to Resident #1's room.A review of the vital signs documented in the electronic medical record for Resident #1 revealed on 1/28/26 at 8:58 AM Resident #1 reported a pain level of 8/10. The acceptable pain range for Resident #1 was documented to be between 0-4/10. According to the Medication Administration Record (MAR) acetaminophen was administered at 8:59 AM by Nurse #2. An interview was conducted with NA #2 on 2/23/26 at 1:57 PM who stated she checked on Resident #1 before breakfast on 1/28/26, she estimated the time to be around 8:00 AM, to get the resident ready for the day. NA #2 indicated she was changing the resident's brief, and Resident #1 kept saying ouch as she moved her in the process. NA #2 stated the resident informed her she had fallen during the night. The NA stated she had not been informed the resident had fallen so she reported what the resident said to the Medication Aide. NA #2 indicated the Medication Aide informed her she was not aware Resident #1 had fallen. The NA stated she reported the resident's statement to the Unit Manager after she discussed the reported fall with the Medication Aide, and the UM replied she would get right on it.A phone interview was conducted with Medication Aide (MA) #1 on 2/24/26 at 12:12 PM who stated on 1/28/26 she was standing beside Resident #1's room at the medication cart passing medications between 8:00 AM and 9:00 AM when NA #2 came out of the room and told her the resident reported she fell during the night. According to MA #1 she did not receive notice of Resident #1 having a fall during shift change report. MA #1 indicated she immediately went to the resident and could tell Resident #1 did not look the same as she had when she worked with her on 1/27/26. She stated the resident had a look of agony on her face and reported her pain level was 10/10. MA #1 stated she looked up and noted the Unit Manager was headed down the hall towards her to Resident #1's room to assess her after NA #2 reported the fall to her.A nursing progress note dated 1/28/26 written by the Unit Manager at 2:28 PM indicated Resident #1 informed the staff she attempted to walk to the bathroom without assistance that morning and slipped and fell to the floor. According to the progress note, Resident #1 stated two females assisted her off the floor and back to bed. Upon assessment, the resident complained of hip pain and was unable to bear weight on the right lower extremity. The right leg was noted to have limited range of motion and increased pain with movement. The resident was kept in bed for safety and acetaminophen was given. The physician and family were notified of the fall and change in condition. Orders were received and a right hip fracture was noted and the provider was updated. A new order was received to send Resident #1 to the emergency department (ED) for further evaluation and the family was notified. The progress note did not include pain scale, vital signs or details about the presence of redness, swelling, bruising or external rotation of the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	right leg. An interview was conducted with the Unit Manager (UM) on 2/23/26 at 1:39 PM. The UM stated when she arrived at work on 1/28/26, sometime between 8:00 and 8:30 AM, the Medication Aide reported that Resident #1 had fallen earlier that morning and was complaining of pain. According to the UM, she assessed Resident #1 immediately after she was notified. She stated the resident was alert and oriented, and very emotional during her assessment as she complained of a pain scale of 8/10 of her right leg. The resident informed her during the night two females got her off the floor and helped her get into bed. The UM stated she instructed the Medication Aide to give the resident acetaminophen for pain as she assessed Resident #1's leg. According to the UM, she did not observe any obvious signs of injury to the resident's leg. However, she did not explain how she determined the resident did not have an injury. The UM stated she then called the Nurse Practitioner and got an order to obtain an x-ray of the resident's right hip. The UM stated she called the mobile x-ray provider sometime around 9:00 AM to inform them of the stat (immediately) order for a hip x-ray and was told later that morning (time unknown) by a caller from the mobile imaging provider that they did not accept verbal orders and the order would need to be entered into the electronic chart. The Unit Manager indicated she was unaware the mobile x-ray provider did not accept a verbal order for imaging. According to the UM, the mobile x-ray unit arrived at the facility around 2:00 PM and she said the Director of Therapy saw the preliminary image when the x-ray tech obtained the x-ray, and the Director of Therapy, who is a Certified Occupational Therapy Assistant (COTA), told her it looked like a fracture. The UM explained she reported this to the NP and got the order to send the resident out.A review of the therapy progress note written by the Director of Therapy on 1/28/26 indicated he assessed Resident #1 between 8:50 AM and 9:10 AM. The note indicated upon arrival Resident #1 stated she was in extreme pain in her right hip and rated her pain to be 10/10. The note indicated that the therapist notified the nurse and management and that x-rays had been ordered.An interview was conducted with the Director of Therapy on 2/23/26 at 3:30 PM who stated he assessed Resident #1 for a routine visit on 1/28/26 between 8:50 AM and 9:10 AM, and the resident reported extreme pain in her right hip. The Director of Therapy, who is a Certified Occupational Therapy Assistant (COTA), stated this was reported to the Unit Manager, and he was told the UM had ordered a hip x-ray. According to the Director of Therapy, he did not see any bruising, rotation, or deformity of Resident #1's right leg during his assessment. He did say he thought Resident #1 had a fracture when he saw the imaging taken when the mobile imaging company was at the facility, but he was not trained to read x-rays.A review of a Physical Therapist (PT) note written by PT #1 on 1/28/26 indicated he assessed Resident #1 between 11:01 AM and 12:10 PM. The note indicated the resident complained of pain in her right hip rated 7/10, and the resident reported she had a fall earlier that morning. The PT documented the resident was tender to palpation (touch) and had significant pain with passive range of motion. The note indicated the PT reported the concerns to the nurse.An interview was conducted with PT #1 on 2/24/26 at 11:41 AM who stated he saw Resident #1 for an initial evaluation on 1/28/26 around 11:00 AM. He stated the resident informed him she had fallen the night before when she was trying to go to the bathroom. He stated Resident #1 did not initially report pain in her hip, but after attempting passive range of motion with Resident #1 she winced and complained of hip pain 10/10. According to PT #1, he did not see a deformity of Resident #1's leg, but he stopped the range of motion and reported the pain level to Nurse #2.A review of the electronic medical record revealed orders for post-fall monitoring and a stat (immediate) x-ray of the right hip were written by the Unit Manager as a verbal order from the Medical Director on 1/28/26 at 11:50 AM.At 12:20 PM vital signs completed by Nurse #2 indicated Resident #1 reported a pain level of 5/10, no interventions were documented.At 1:02 PM vital signs (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	completed by Nurse #2 indicated Resident #1 reported a pain level of 5/10, no interventions were documented.At 2:12 PM vital signs completed by Nurse #2 indicated Resident #1 reported a 10/10 pain level. A review of the MAR indicated Nurse #2 administered acetaminophen at 2:13 PM.Vital signs completed by Nurse #2 at 3:00 PM indicated Resident #1 reported a pain level of 10/10, and there were no interventions documented. A review of Resident #1's nursing progress notes did not reveal any documentation of a post-fall assessment completed by Nurse #2.On 2/26/26 at 1:05 PM a phone interview was conducted with Customer Service Representative #1 with the facility's mobile imaging provider. She stated Resident #1's mobile imaging record revealed they received an order to perform a hip x-ray for the resident on 1/28/26 at 11:57 AM. The mobile x-ray provider stated the record further indicated that the service was dispatched to the facility at 12:54 PM. A review of the x-ray findings revealed the results were not signed by the radiologist until 1/28/26 at 9:42 PM. A further review of Resident #1's facility electronic medical record revealed an order from the Physician dated 1/28/26 at 2:34 PM to send Resident #1 to the local hospital for evaluation and treatment, stat. A review of the emergency medical services (EMS) transport record indicated EMS arrived at the facility on 1/28/26 at 2:48 PM. According to the report, when EMS personnel assessed Resident #1, she complained of right hip pain rated 5/10. The personnel did not find obvious injuries, contusions (bruises), or deformities to the hip area but pain when the area was palpated (touched). No treatment options were noted in the EMS report, and Resident #1's care was transferred to the local emergency department at 3:09 PM.A review of the local hospital treatment record dated 1/28/26 at 3:54 PM indicated Resident #1 presented to the ED with deformity and tenderness to the right hip. Resident #1's pain was not quantified using a pain scale assessment, and the medical record indicated Resident #1 refused analgesics (pain relievers) upon arrival at the ED. An x-ray of the right hip completed 1/28/26 revealed a comminuted, displaced, and impacted right hip fracture. The hospital record indicated the resident denied hitting her head when she fell, but due to the history of an existing subdural hematoma (bleeding near the brain) with CT (computed tomography) evidence of recent bleeding, the resident was admitted to the trauma intensive care unit for monitoring and neurological checks. Resident #1 was then transferred to a secondary hospital for surgical repair of the right hip fracture on 1/28/26.The resident did not return to the facility after the surgical repair of the right hip fracture.The Director of Nursing (DON) was interviewed on 2/24/26 at 2:30 PM who stated she was not working the morning of 1/28/26 but received a call from the Unit Manager that Nurse #1 failed to report to the physician that Resident #1 had fallen during her shift on 1/28/26. She further stated that Nurse #1 did not report the fall to the oncoming shift. The DON indicated she and the Unit Manager interviewed the nurses and nurse aides on the hall where Resident #1 resided to piece together the events that led to her injury. The DON stated later in the day of 1/28/26 it was discovered Nurse #1 and Nurse Aide #1 had entered Resident #1's room earlier that morning for a brief time. According to the DON, Nurse #1 was not in Resident #1's room long enough to have completed a post fall assessment. The DON stated Nurse #2 who was assigned to Resident #1 for the 7:00 AM to 7:00 PM on 1/28/26 was a new nurse, and she failed to document Resident #1's condition that day. The DON indicated she assumed Nurse #2 assessed the resident, but she did not find any documentation in the chart of a completed assessment. The DON stated the nurses should have completed a full post fall assessment on Resident #1 and notified the provider of the resident's level of pain to avoid delaying the level of care she required. According to the DON, the order for the mobile x-ray should have been entered into the computerized ordering system to avoid delay in diagnosing Resident #1's hip fracture.The Nurse Practitioner (NP) was interviewed on 2/23/26 at 4:41 PM and stated she was notified by the Unit Manager during the morning of (continued on next page)

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	345066	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davidson Health & Rehab Center	4748 Old Salisbury Road Lexington, NC 27295

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1/28/26 that Resident #1 had fallen but was unsure of the time she received the call. She stated she gave orders to obtain an x-ray of the resident's right hip due to reports of pain. The NP indicated if she had known the severity of the resident's pain level, she would have possibly given different treatment orders for the resident to receive the correct level of care to treat her injury.The facility provided a plan of correction for past non-compliance, however upon review, the plan of correction was found to have been lacking the necessary information and was found to be incomplete.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff, Responsible Party, and Nurse Practitioner interviews, the facility failed to provide effective pain management for a resident who reported acute severe pain rated a 10 out of 10 (0 meaning no pain and 10 meaning the worst pain the resident experienced) of the right hip after experiencing an unwitnessed fall. Despite receiving 2 doses of 1,000 milligrams (mg) of acetaminophen, the pain and discomfort the resident experienced caused the resident to cry out and wince in pain with movement. Resident #1 stated she told everyone she was in a lot of pain that day and she was not offered anything additional for pain relief. Resident #1 was transferred via Emergency Medical Services (EMS) to the hospital where an x-ray indicated the resident had a right hip fracture. This deficient practice affected 1 of 3 residents reviewed for effective pain management (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding near the brain) without loss of consciousness secondary to a prior fall at home, fractured ribs, diabetes, muscle weakness, and unsteadiness on her feet.A review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact. She was assessed as requiring supervision with toilet transfers and toileting hygiene. She was coded as having received pain medication within the past 5 days of the assessment period.Resident #1 had an active medication order with a start date of 1/23/26 for acetaminophen 500 milligrams (mg) 2 tablets by mouth for pain every six hours as needed.A phone interview was conducted with Resident #1 on 2/26/26 at 1:45 PM who stated on 1/28/26 she had turned her call light on sometime during the night (early morning), she was unsure of the time, to request help to go to the bathroom. She stated nobody answered her call light, so she tried to get up by herself. Resident #1 explained she lost her balance and fell to the floor. According to the resident, a while later, time unknown, two ladies (Nurse #1 and Nursing Assistant (NA) #1) picked her up off of the floor and put her in a wheelchair then assisted her into bed. She stated neither lady completed an exam on her because she would have remembered that. Resident #1 stated her right leg hurt after the fall, and she rated the pain level a 10 out of 10. Resident #1 indicated she told the ladies she was in pain, but she was not given anything for pain control at that time. Resident #1 stated she was given a dose of acetaminophen by someone later in the morning, but she was not offered any additional pain relief measures (ice, positioning) even though she told everyone she talked to that day (1/28/26) she was having a lot of pain.Review of Resident #1's nurses' notes for 1/27/26 through 1/28/26 revealed no documentation of a fall during the shift from 7:00 PM to 7:00 AM.A phone interview with NA #1, who worked the evening of 1/27/26 until the morning of 1/28/26, was conducted on 2/26/26 at 9:46 AM. NA #1 reported that on 1/28/26 at approximately 5:30 AM, while completing final rounds on her assigned hall, she heard Resident #1 make a noise. She looked into the resident's room and observed the resident lying on the floor. NA #1 stated that when she asked what happened, the resident reported she had attempted to go to the bathroom and fell. NA #1 stated she asked the resident if she was injured, and Resident #1 replied she was not certain. NA #1 then notified Nurse #1. Upon returning with Nurse #1, NA #1 stated they assisted the resident from the floor into a wheelchair so they could transfer the resident more easily into bed. NA #1 did not indicate she checked on Resident #1 any further that shift. A phone interview was conducted with Nurse #1 on 2/25/26 at 9:24 AM. Nurse #1 explained she was assigned to Resident #1 from 7:00 PM on 1/27/26 to 7:00 AM on 1/28/26. Nurse #1 stated she was notified by NA #1 that Resident #1 had fallen in her room on the morning of 1/28/26. She stated she was completing her medication pass around 5:30 AM when the NA informed her. Nurse #1 stated she and NA #1 got the resident off of the floor (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	and up into her wheelchair. Nurse #1 stated Resident #1 winced and said, Oh my leg, when she and NA #1 got her up, but she didn't think the resident was hurt because she looked like she had full range of motion of her leg. Nurse #1 stated she had NA #1 take the resident to the bathroom then put her back to bed. She indicated she looked in at Resident #1 a while later, time unknown, and the resident looked fine, so Nurse #1 said she went down the hall. Nurse #1 stated she did not complete a pain assessment on Resident #1.A review of the Medication Administration Record (MAR) revealed Nurse #1 did not administer any pain medication after Resident #1's unwitnessed fall.An interview was conducted with NA #2 on 2/23/26 at 1:57 PM who stated she was assigned to Resident #1 on 1/28/26 during the 7:00 AM to 7:00 PM shift. The NA explained she checked on Resident #1 before breakfast on 1/28/26, she estimated the time to be around 8:00 AM, to get the resident ready for the day. NA #2 indicated as she was changing the resident's brief before breakfast, Resident #1 kept saying ouch as she repositioned her in the process. NA #2 stated the resident informed her she had fallen during the night and her right leg hurt. NA #2 stated she reported the resident reporting she had fallen to the Unit Manager (UM) after her discussion with the MA, and the UM replied she would, Get right on it, (check on Resident #1).A phone interview with Medication Aide (MA) #1 was conducted on 2/24/26 at 12:12 PM. MA #1 reported she was assigned to Resident #1 on 1/28/26. She stated between 8:00 AM and 9:00 AM on 1/28/26, while administering medications near Resident #1's room, Nursing Assistant (NA) #2 informed her Resident #1 reported experiencing a fall during the night. MA #1 indicated that no fall had been communicated to her during shift?change report. According to MA #1, upon entering the resident's room, she observed that Resident #1's appearance had significantly changed from the prior day. The resident displayed an expression consistent with severe discomfort and reported a pain level of 10 out of 10.A nursing progress note dated 1/28/26 written by the Unit Manager at 2:28 PM indicated Resident #1 informed the staff she attempted to walk to the bathroom without assistance that morning and slipped and fell to the floor. According to the progress note, Resident #1 stated two females assisted her off the floor and back to bed. Upon assessment, the resident complained of hip pain and was unable to bear weight on the right lower extremity. However, the progress note did not include notation of a pain scale assessment. The right leg was noted to have limited range of motion and increased pain with movement. The resident was kept in bed for safety and acetaminophen was administered for pain. The physician and family were notified of the fall and change in condition. Orders were received and a right hip fracture was noted. The provider was updated. A new order was received to send Resident #1 to the emergency department for further evaluation. The family was notified.An interview was conducted with the Unit Manager (UM) on 2/23/26 at 1:39 PM. The UM stated when she arrived at work on 1/28/26, sometime between 8:00 and 8:30 AM, the Medication Aide reported Resident #1 had fallen earlier that morning and was complaining of pain. According to the UM, she went to Resident #1's room and assessed the resident immediately. The UM stated the resident was alert and oriented, and very emotional during the assessment as she complained of right leg pain. The UM stated she instructed the Medication Aide to give the resident acetaminophen for pain as she assessed Resident #1's leg. The Unit Manager stated she then called the Nurse Practitioner and got an order to obtain an x-ray of Resident #1's right hip. The UM did not disclose if she had followed up with Resident #1 to see if the acetaminophen was effective for the resident's complaints of pain.A review of the therapy progress note written by the Director of Therapy on 1/28/26 indicated he assessed Resident #1 between 8:50 AM and 9:10 AM. The note indicated upon arrival Resident #1 stated she was in extreme pain in her right hip and rated her pain to be 10 out of 10. The note indicated the therapist notified the nurse and management and x-rays had been ordered.An interview was conducted with the Director of (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Therapy on 2/23/26 at 3:30 PM. He stated he assessed Resident #1 for a routine visit on 1/28/26 between 8:50 AM and 9:10 AM, and the resident reported she had extreme pain in her right hip. He stated he reported this to the Unit Manager and was told she had ordered a hip x-ray.A review of the vital signs documented in the electronic medical record for Resident #1 revealed on 1/28/26 at 8:58 AM the resident reported a pain level of 8 out of 10 as documented by Nurse #2. The acceptable pain range for Resident #1 was documented to be between 0-4 out of 10.A review of the medication administration record (MAR) indicated Nurse #2 administered acetaminophen at 8:59 AM on 1/28/26. The MAR revealed Nurse #1 did not follow up after administering the medication until 12:20 PM when Resident #1 rated her pain 5/10 which was outside of the resident's documented acceptable range of pain. There was no follow-up intervention documented.A review of a physical therapist (PT) note written by PT #1 on 1/28/26 indicated he assessed Resident #1 between 11:01 AM and 12:10 PM. The note indicated the resident complained of pain in her right hip rated 7 out of 10, and the resident reported she had a fall earlier that morning. The PT documented the resident was tender to palpation (touch) and had significant pain with passive range of motion. The note indicated the PT reported the concerns to the nurse.An interview was conducted with PT #1 on 2/24/26 at 11:41 AM who stated he saw Resident #1 for an initial evaluation on 1/28/26 around 11:00 AM. He stated the resident informed him she had fallen the night before when she was trying to go to the bathroom. He stated Resident #1 did not initially report pain in her hip, but after attempting passive range of motion with Resident #1 she winced and complained of hip pain 10 out of 10. According to PT #1, he did not see a deformity of Resident #1's leg, but he stopped the range of motion and reported the pain level to the nurse. A review of the electronic medical record revealed orders for post-fall monitoring and a stat (immediate) x-ray of the right hip were ordered by verbal order from the Medical Director to the Unit Manager on 1/28/26 at 11:50 AM. After 1/28/26 at 8:58 AM the next pain assessment documented in vital signs was completed at 12:20 PM by Nurse #2 who noted Resident #1 reported a pain level of 5 out of 10, no interventions were listed.On 1/28/26 at 1:02 PM vital signs completed by Nurse #2 indicated Resident #1 reported a pain level of 5 out of 10, no interventions were listed. On 1/28/26 at 2:12 PM vital signs completed by Nurse #2 indicated the resident reported a 10 out of 10 pain level. Further review of the MAR revealed Nurse #2 had administered acetaminophen at 2:13 PM on 1/28/26.A phone interview was conducted with Nurse #2 who was assigned to Resident #1 on the morning of 1/28/26 for the shift of 7:00 AM to 7:00 PM. Nurse #2 reported she had a busy day on 1/28/26 but sometime during her rounds, time unknown, she checked on Resident #1 who looked OK and not in discomfort. Nurse #2 stated the resident informed her she had pain in her leg and rated the pain an 8 out of 10, but she did not assess the resident for the cause of pain. According to Nurse #2, she offered Resident #1 acetaminophen, and according to the medication administration record Nurse #2 administered acetaminophen at 8:59 AM. Nurse #2 stated she knew she should have rechecked Resident #1 an hour after her pain medication administration, but she was very busy that day and the time of her following up with the resident regarding her pain was probably longer than an hour. Nurse #2 stated the resident still looked fine, but she asked the resident about her pain. Nurse #2 stated the resident told her she had pain at 5 out of 10 and told her it was tolerable. However, when the physical therapist saw the resident at 11:00 AM, the resident told him her pain was 10 out of 10. Nurse #2 stated she did not go check on Resident #1 right away because she was busy that day. Nurse #2 Indicated she was about to text the Unit Manager to ask what she was supposed to do, but when she looked up, she saw the Unit Manager and another person were already headed to Resident #1's room.A phone interview was conducted with the Responsible Party (RP) on 2/25/26 at 12:50 PM who stated on the afternoon of 1/28/26 he was notified Resident #1 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	had fallen and was injured. He stated he arrived at the facility sometime between 2:45 and 2:50 PM and saw that Resident #1's right leg appeared injured because she could not straighten her leg, and the right knee was rotated outward as if it aligned with her underarm area. According to the RP, Resident #1 informed him she had asked several people for pain medication throughout the day, and someone had eventually given the resident acetaminophen. The RP stated Resident #1 informed him she told the physical therapist she was in significant pain, but the resident did not receive help, or pain medication.A further review of Resident #1's facility electronic medical record revealed a verbal order from the Medical Director given to the Unit Manager dated 1/28/26 at 2:34 PM to send Resident #1 to the local hospital for evaluation and treatment, stat (immediately).A final pain assessment at 3:00 PM on 1/28/26 completed by Nurse #2 indicated Resident #1 reported a pain level of 10 out of 10, and there were no interventions listed.The mobile x-ray report signed by the radiologist on 1/28/26 at 9:45 PM was reviewed and revealed Resident #1 had a right hip fracture with slight displacement. A review of the emergency medical services (EMS) report indicated EMS arrived at the facility at 2:48 PM. The report indicated Resident #1 complained of right hip pain with tenderness to touch. The EMS report did not note a numerical value for the reported pain. Per the EMS report, Resident #1 did not have an obvious injury, contusions (bruises), or deformities to the hip area, but the resident did have pain when the area was touched. The EMS report did not indicate any pain relief measures were administered for Resident #1. The resident was received at the local hospital at 3:09 PM. A review of the local hospital treatment record dated 1/28/26 at 3:54 PM indicated Resident #1 presented to the emergency department (ED) with deformity and tenderness to the right hip. According to the ED note, Resident #1 was alert and oriented, and she declined analgesics (pain relieving medications) upon arrival. An x-ray of the right hip completed at the hospital 1/28/26 revealed a comminuted, displaced, and impacted right hip fracture (a severe injury where the bone shatters into three or more pieces, the fragments are out of alignment, and the broken ends are driven into each other). Resident #1 was then transferred to a secondary hospital for surgical repair of the right hip fracture. The Director of Nursing (DON) was interviewed on 2/24/26 at 2:30 PM who stated Nurse #1 failed to report Resident #1 had fallen during her shift on 1/28/26. The DON stated there was no documentation in the medical record to indicate what had happened to Resident #1. The DON stated Nurse #2, who was assigned to Resident #1 from 7:00 AM to 7:00 PM on 1/28/26, was a new nurse, and she failed to document Resident #1's condition that day. The DON indicated she assumed Nurse #2 assessed the resident. The DON stated the physical therapist reported Resident #1 only reported pain when he touched the resident and if she was not being touched then Resident #1 did not complain of pain. According to the DON, the staff should have completed an assessment of the resident and notified the provider the resident had a fall and was in pain.The Nurse Practitioner (NP) was interviewed on 2/23/26 at 4:41 PM and stated she was not at the facility on the morning of 1/28/26 and she was notified by the Unit Manager that morning Resident #1 had fallen but was unsure of the time she received the call. She stated she gave orders to obtain an x-ray of the resident's right hip due to reports of pain. The NP indicated if she had known the severity of the resident's pain level, she would have possibly given different treatment orders.The facility provided a plan of correction for past non-compliance, however upon review, the plan of correction was found to have been lacking the necessary information and was found to be incomplete.