| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345183 | A. Building<br>B. Wing | 04/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cabarrus Health and Rehabilitation | 430 Brookwood Avenue NE<br>Concord, NC 28025 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725<br><br>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).<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on [DATE] with diagnoses which included dementia and osteoarthritis.<br><br>Review of incident report dated 3/27/25, written 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.<br><br>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).<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with Nurse #4 on 4/10/25 at 10:45 AM who was assigned to 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 evaluation.<br><br>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.<br><br>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 first x-ray results likely being an old fracture.<br><br>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.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725<br><br>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).<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on [DATE] with diagnoses which included dementia, osteoarthritis and left hip fracture.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was moderately cognitively impaired and was dependent on staff for transfers.<br><br>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.<br><br>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 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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 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.<br><br>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.<br><br>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 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.<br><br>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 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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>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.<br><br>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 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.<br><br>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.<br><br>A review of hospital discharge summary dated 4/2/25 indicated Resident #1 was discharged back to the facility on [DATE] 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.<br><br>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. |