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	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cabarrus Health and Rehabilitation	430 Brookwood Avenue NE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff, resident representative, and physician interviews, the facility failed to effectively supervise a resident with moderate cognitive impairment, repeated falls, and impulsive behaviors. Around 12:00 PM on 7/13/25 Resident #1 left the facility without staff's knowledge and ambulated approximately 0.6 miles from the facility in 90-degree heat with 60% humidity. Resident #1 was discovered sitting in a ditch on the side of the road approximately 0.6 miles from the facility. Two passersby stopped to help him and called Emergency Medical Services (EMS). In addition, Housekeeper #1 was on her lunch break and in a car when she happened to see him on the ground on the side of the road. Housekeeper #1 stopped to give Resident #1 assistance and stayed with Resident #1 until EMS arrived. Resident #1 was sent to the hospital for evaluation and treatment for low blood pressure, weakness, urinary tract infection, and pneumonia. There was a high likelihood for serious injury or death considering the resident's cognition, impulsivity and resulting medical conditions. This deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents.Immediate jeopardy began on Sunday, 7/13/25, when Resident #1 left the facility without staff's knowledge and walked 0.6 miles away from the facility. Immediate jeopardy was removed on 7/17/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and ensure monitoring systems put into place are effective.The findings included: Resident #1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including chronic obstructive lung disease, Parkinson's disease, repeated falls, spinal stenosis (a narrowing of the spinal vertebra causing nerve pain and weakness), extrapyramidal symptoms (side effects from taking antipsychotics; involuntary muscle movements), schizophrenia, and anxiety disorder. Physician medication orders for Resident #1 were as follows:Gabapentin (an anti-seizure medication used for nerve pain) 400 milligrams (mg) three times per day ordered on 4/18/25. Haloperidol (an antipsychotic medication used for control of severe agitation and aggression) 10 mg three times per day ordered on 4/18/25.Clozapine (an atypical antipsychotic used to treat mental illness like schizophrenia) 100 mg 3 tablets twice per day and Clozapine 50 mg twice per day (for a total of 350 mg twice per day) ordered on 4/21/25. The most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #1 to be moderately cognitively impaired. The MDS documented Resident #1 did not wander and had no behaviors. The MDS assessed Resident #1 to require partial assistance to walk 10 feet, and he was dependent on walking 50 feet or more. The MDS documented Resident #1 did not use ambulation devices. The MDS documented Resident #1 was taking antipsychotic medications, antianxiety medications, and medications for seizure disorder. The active care plans in effect on 7/13/25 were as follows: Fall potential due to impulsivity. The interventions included resident education to call for staff assistance, place common items within reach, and remind Resident #1 to use call bell; Behaviors related to the use of psychotropic medications. The goal stated Resident #1's behaviors would not cause him distress, and interventions included to monitor for behaviors, including elopement, delusions, hallucinations, aggression, or refusing care;Cognitive impairment and included the goal that Resident #1 would not have any complications due to cognitive impairment. Interventions for this care plan included observing for changes in cognition and reorient Resident #1 as needed;Antipsychotics use, with interventions to monitor for behaviors, monitor for adverse medication reactions, and provide psychiatric services; andLevel II PASRR (Pre-admission Screening and Resident Review, a screening tool used for residents with a serious mental condition to ensure the resident receives appropriate services). The care plan interventions included psychological/psychiatric interventions or consultation as ordered. A Physician Assistant (PA) note dated 7/3/25 documented an examination after an unwitnessed fall on 7/2/25 where Resident #1 reported he had gotten up too quickly and his legs got weak. The note documented generalized weakness, fatigue, leg weakness, and anxiety. Resident #1 was confused, with impaired insight, and oriented to person. The note documented a recommendation for Resident #1 to use a wheelchair for mobility due to weakness, and to continue fall precautions and neurological checks. A phone interview was conducted with Resident #1's Representative on 7/17/25 at 10:42 AM. The Representative reported Resident #1 had paranoia and had delusions with auditory hallucinations episodes in the past and on Saturday 7/12/25 Resident #1 called the Representative and told them that a resident at the facility wanted to fight him. The Representative reported