

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Cabarrus Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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. 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.</p>

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
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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. 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 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</p>		