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	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cabarrus Health and Rehabilitation Center	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (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

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Consultant Pharmacist and Medical Director interviews, the Consultant Pharmacist failed to identify and report medication transcription errors for 1 of 3 residents reviewed for medication review (Resident #6).The findings included: Resident #6 was admitted on [DATE] with diagnoses including dementia and benign prostatic hyperplasia (BPH, an enlarged prostate). Hospital discharge summary medication list dated 10/8/25 for Resident #6 included in part:- -Finasteride 5 milligrams (mg) tablet by mouth daily for BPH.- -Melatonin (sleep aid) 10 mg capsules, take 30 mg by mouth at bedtime. The facility's physician orders dated 10/8/25 included in part:- -Finasteride 5 mg by mouth two times a day for BPH.- -Melatonin 10 mg, 1 tablet by mouth at bedtime for supplement/prophylaxis.Further review of physician's orders dated 10/8/25 revealed there was no documentation for a verbal order changing the Finasteride or Melatonin doses from the hospital discharge summary medication list dated 10/8/25. Review of Resident #6's Medication Administration Record (MAR) for October indicated Resident #6 received:- -Finasteride 5 mg twice a day from 10/9/25 through 10/27/25. - - Melatonin 10 mg, 1 tablet at bedtime from 10/08/25 through 10/28/25. The Consultant Pharmacist Medication Regimen Review dated 10/19/2025, revealed that Resident #6's medication regimen contained no new irregularities or recommendations.During an interview with the Consultant Pharmacist on 10/29/25 at 1:05 PM she revealed that the process of reviewing a newly admitted resident's medications was to look at both the hospital discharge summary and the facility orders, and she would also look at the medical record history and physical if needed but doesn't think she noted that for Resident #6. She did not say that she had noted any discrepancies. The Consultant Pharmacist explained that she would have sent the DON an email for clarification if there had been a discrepancy. The Consultant Pharmacist further explained that she had done Resident #6's monthly Medication Regimen Review on 10/19/25 and she had not noticed any dose errors with Resident #6's Finasteride and Melatonin orders to have made any recommendations. The Consultant Pharmacist reviewed Resident #6's hospital discharge summary and facility physician orders during the interview and said that the facility had transcribed the Finasteride incorrectly. She said she thought the hospital had transcribed the melatonin dose incorrectly. The Consultant Pharmacist revealed that when discrepancies or recommendations were found with Medication Regimen Reviews that a Consultant Pharmacist Medication Regimen Review Report is sent electronically to the facility. An interview was conducted with the Director of Nursing (DON) on 10/29/25 at 9:30 AM. She explained that pharmacy usually sent a notification if there was a discrepancy about a medication order. The DON confirmed the facility had not received a notification related to a discrepancy for Resident #6. During an interview with the Medical Director on 10/29/25 at 10:15 AM, he reviewed the hospital discharge summary and facility medication orders with the surveyor. He revealed that 30 mg of Melatonin was a large dose and that he remembered having spoken with someone about this but could not remember who. The Medical Director stated he would expect the nursing staff and Consultant Pharmacist to cross-check admission medication orders for accuracy. The Administrator was interviewed on 10/29/25 at 1:20 PM. The Administrator explained that the Consultant Pharmacist would email or fax with any medication order discrepancies.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff, Consultant Pharmacist and Medical Director interviews, the facility failed to have effective systems in place for ensuring medication orders for a new admission were transcribed accurately. Resident #6 was prescribed Finasteride (medication for enlarged prostate) 5 milligrams daily and instead was administered the Finasteride twice a day from 10/10/25 through 10/27/25. This occurred for 1 of 3 residents reviewed for unnecessary medications (Resident #6).The findings included: Resident #6 was admitted on [DATE] with diagnosis including benign prostatic hyperplasia (BPH, which is an enlarged prostate). There was no Minimum Data Set (MDS) assessment available.The hospital discharge summary medication list dated 10/8/25 for Resident #6 included Finasteride 5 milligrams (mg) one time a day by mouth.The facility's physician order dated 10/8/25 for Finasteride was to give 5 mg by mouth two times a day for BPH. Further review of the physician's orders dated 10/8/25 revealed there was no documentation of a verbal order changing the Finasteride dose from the hospital discharge summary medication list.Review of Resident #6's Medication Administration Record for October 2025 indicated Resident #6 received Finasteride 5 mg twice a day from 10/10/25-10/27/25. An interview with Unit Manager #1 occurred on 10/29/25 at 9:30 AM. Unit Manager #1 reviewed the hospital discharge medication list and facility's medication orders for Resident #6. She confirmed the dose of Finasteride was transcribed incorrectly. Unit Manager #1 further explained the cross-check process which included the other Unit Manager or the hall nurse reviewing admission medication transcription for accuracy. Unit Manager #1 also confirmed there was no documentation that the physician was notified to change the Finasteride order. During an interview with Nurse #1 on 10/29/25 at 10:00 AM, Nurse #1 stated she transcribed the medication orders for Resident #6 from the hospital Discharge summary dated [DATE]. During the interview an observation of the computer screen labeled medication audit for Resident #6 on 10/8/25 confirmed Nurse #1's name as the nurse that entered the order for Finasteride. Nurse #1 stated she didn't remember Resident #6's admission and after reviewing the hospital discharge medication list and the facility's physician orders, Nurse #1 stated that she made an error during the transcription. She also stated she would notify the nurse practitioner or physician if there was a discrepancy but doesn't remember doing this for Resident #6. In an interview with Unit Manager #2 on 10/29/25 at 11:15 AM, she stated there was a cross-check process for admission orders. Unit Manager #2 explained the admission nurse or the Unit Manager would transcribe the orders; the second check was the other Unit Manager and/or the nurse on the hall who also checked the accuracy of medication orders upon admission. She did not recall Resident #6's admission. The Consultant Pharmacist was interviewed on 10/29/25 at 1:32 PM. She stated the pharmacy had both the facility medication order and the hospital discharge summary order for Resident #6's Finasteride. The Consultant Pharmacist discussed the Finasteride order on 10/8/25 as 5mg once a day and that was what the medication card said. She further explained that the pharmacy sent 30 tablets and there were no refills. When discussing if an order didn't match a medication card, she stated that when a physician's medication order didn't match the card that staff should follow the order on the card. An interview with Nurse #2 was done on 10/29/25 at 1:40 PM, who was assigned to Resident #6 this day. Nurse #2 stated she didn't have Resident #6's Finasteride medication card, that she might have put it in the shred box. During the interview an observation of Resident #6's Medication Record on the computer screen showed the Finasteride scheduled for two times a day at 9:00 AM and 9:00 PM and that Finasteride had been re-ordered on 10/28/25. An observation of the medication card was unavailable. An interview was conducted with the Director of Nursing (DON) on 10/29/25 at 9:30 AM. The DON discussed that there was a checks and balance system in place to ensure accuracy for admission medication orders. She explained that there was a three-level system that included the hall nurse, the Unit Manager on the resident's hall, and the other Unit Manager checking admission orders for accuracy. The DON stated Resident #6's admission orders were transcribed incorrectly due to human error, and the cross-checks probably were not completed. She further explained that pharmacy usually sent an alert if there was a discrepancy and no alert was received. The DON also discussed the admission Audit Checklist process. This document included a review that admission orders entered into the medical record matched the hospital discharge summary. It also included that if the in-house physician changed the orders, a clarifying progress note would be present. The DON stated the Unit Manager then the Assistant Director of Nursing would review the audit check list for completion, and she would have received the completed audits