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	06/27/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, responsible party, and staff interviews, the facility failed to afford the resident and/or responsible party the right to participate in the care plan process for 2 of 3 (Resident #28 and Resident #60) reviewed for quarterly care plan reviews. Finding included: a. Resident #28 was admitted to the facility on [DATE] with respiratory disease. During a review of Resident #28's medical record a care plan meeting invitation or documentation of a care plan with the resident and/or Responsible Party was not found. Resident #28's care plan was revised on 4/4/2025. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #28 was moderately cognitively impaired. On 6/17/2025 at 3:02 pm an interview was conducted with Resident #28 and the Responsible Party and the Responsible Party stated they had not had a care plan meeting for several months. b. Resident #60 was admitted to the facility on [DATE] with diagnoses of dementia and brain injury. A significant change Minimum Data Set assessment date 4/7/2025 indicated Resident #60 was severely cognitively impaired. Resident #60's care plan was revised on 12/5/2024 and 3/7/2025. During a phone interview with the Responsible Party on 6/16/2025 at 12:23 pm she stated she had not been invited to a care plan meeting for several months. (continued on next page)

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
	345183	A. Building B. Wing	06/27/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1was interviewed on 6/25/2025 at 1:11 pm and she stated she came to the facility in 4/2025, and the care plan meetings had not been completed quarterly when she arrived. Social Worker #1 stated she started the care plan meetings two weeks ago. Social Worker #1 stated the care plan meetings were scheduled according to the Minimum Data Set schedule quarterly and the facility's electronic dashboard lets her know when the assessments are due and she sends out an invitation to the resident and responsible party, and all of the department managers are also notified of the care plan meeting. During an interview with Social Worker #2, who no longer worked at the facility, on 6/25/2025 at 1:21 pm she stated she began working at the facility in 12/2024 and the care plan meetings were already behind when she came to the facility, and she was not able to get them caught up. Social Worker #2 stated she left the faciity on 3/2025. The Administrator was interviewed on 6/19/2025 at 3:16 pm and she stated a care plan meeting has not been completed for Resident #28 and Resident #60 since before the facility's last recertification survey on 4/18/2024. The Administrator stated the care plan meetings have not taken place and she was not aware of them not being done until this survey. The Administrator stated the Social Worker should have scheduled the meeting, and the Admissions Coordinator should have notified the family and/or residents of the meetings quarterly.

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	06/27/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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	06/27/2025

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 0585 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 and Resident Representative (RR) interviews, the facility failed to implement their grievance policy and procedure by failing to promptly address grievances, notify the resident and/or RR of the action that was taken to resolve their concerns or follow up with the Resident Representatives regarding resolution. This deficient practice occurred for 2 of 3 residents (Resident #220 and Resident #518) reviewed for grievances. The findings included:The facility's concerns/grievances policy and procedure dated 3/01/25 read in part: The management staff is charged with listening and responding to questions, needs, problems or concerns brought to their attention by patients and/or families within the facility. The Administrator serves as the grievance official and is responsible for overseeing the grievance process. 1. Nursing Staff, Social Work, Discharge Planners or any other team members receiving questions or issues of concern regarding care and/or services are to immediately respond at point of service in effort to satisfactorily resolve issues of concern.2. If an issue of concern cannot be immediately and satisfactorily resolved at point of service, the patient/family member will be notified that the concern is being submitted to the appropriate department manager and that follow-up for resolution will be provided as quickly as possible. The facility grievance form is to be promptly submitted by the staff member.3. The department manager receiving the concern actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern). The department manager will follow up with the patient/family to determine satisfaction, record and send their actions to the Administrator.a. Resident #220 was admitted to the facility on [DATE] and was discharged home on [DATE]. His admitting diagnoses included intracranial hemorrhage (brain bleed). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #220 was severely cognitively impaired. A review of the facility's grievance log from November 2024 to June 2025 indicated Resident #220's RR had filed a grievance on 12/11/24. A grievance/concern form dated 12/11/24 completed by the Former Social Worker revealed Resident #220's RR reported various items of clothing and personal hygiene products missing, and a detailed list of the items was attached to the form. The grievance was assigned to an individual/department to investigate on 12/16/24 but no name of the individual/department. The documented action taken indicated staff were made aware of the missing items, but no items were found. There was no follow-up or resolution documented on the grievance form.A phone interview was conducted with Resident #220's RR on 6/20/25 at 2:44 PM. The RR revealed she filed a grievance with the Former Social Worker on 12/11/24 because Resident #220 was missing clothing and some other personal items from his room. The RR stated she called several times and left messages for the Former Social Worker to check on the status of the grievance, but the calls were not returned. The RR indicated that Resident #220 was discharged home on [DATE], and no one at the facility provided any type of follow up or resolution regarding the items she reported missing. b. Resident #518 was admitted to the facility on [DATE] and discharged from the facility on 2/17/25. His admitting diagnoses included anoxic (complete lack of oxygen) brain injury.The annual Minimum Data Set (MDS) assessment indicated Resident #518 was severely cognitively impaired and was dependent on staff for all activities of daily living.A review of the facility's grievance log from November 2024 to June 2025 revealed a grievance was filed by Resident #518's RR on 11/22/24.A grievance/concern form dated 11/22/24 completed by the Former Social Worker indicated Resident #518's RR reported concerns related to nail care, Resident #518 not being dressed daily and staff keeping his room too dark. The grievance was referred to the nursing department. There was no other information documented on the form.A phone interview conducted with Resident #518's RR on 6/20/25 at 11:05 AM revealed she reported to the Former Social Worker she was concerned that Resident #518 was not receiving regular nail care and requested he was seen by the Podiatrist. The RR indicated the Former Social Worker did not provide any follow up regarding the grievance and it was not resolved.During a phone interview with the Former Social Worker on 6/19/25 at 11:08 AM she indicated she was employed at the facility November 2024 through March of 2025 and was responsible for completing grievance forms. She revealed after receiving a grievance and filling out the form she delegated the grievance to the appropriate department manager to investigate and resolve. She stated after the department manager addressed and resolved the grievance, she notified the resident and/or RR and provided verbal follow-up on the action taken to resolve their concern. The Former Social Worker stated she did not recall ever receiving a grievance from Resident #518's RR related to his care, a request to see the Podiatrist, or that she filled out a grievance form that was not addressed or completed. She indicated she

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	06/27/2025

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to transmit residents' Minimum Data Set assessments within 14 days of completing assessments for 4 of 5 residents reviewed for transmission of resident assessments (Resident #14, Resident #60, Resident #90, and Resident #61). Findings included: a. Resident #14 was admitted to the facility on [DATE]. Review of Resident #14's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the assessment was not transmitted until 4/9/2025. The MDS Submission Report indicated Resident #14's quarterly MDS assessment with an assessment reference date (ARD) was not transmitted until 4/9/2025. b. Resident #60 was admitted to the facility on [DATE]. A significant change MDS assessment with an Assessment Reference Date (ARD) of 4/7/2025 was transmitted on 4/22/2025. The MDS Submission Report indicated Resident #60's Significant Change MDS assessment was transmitted on 4/22/2025. c. Resident #90 was admitted to the facility on [DATE]. A review of her most recent quarterly MDS assessment with an ARD of 3/22/2025 was not transmitted until 4/14/2025. The MDS Submission Report indicated Resident #90's quarterly MDS assessment was transmitted on 4/14/2025. d. Resident #61 was admitted to the facility on [DATE]. Resident #61's most recent quarterly MDS assessment with an ARD of 3/10/2025 was transmitted on 3/26/2025. The MDS Submission Report indicated Resident #61's quarterly MDS assessment was transmitted on 3/26/2025. An interview was conducted with the Regional MDS Coordinator on 6/18/2025 at 10:16 am and she stated the MDS assessments were late because the previous MDS Coordinator was not very quick to get assessments transmitted. The Regional MDS Coordinator stated the facility had just hired a new MDS Coordinator. (continued on next page)

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	06/27/2025

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview with the Administrator on 6/19/2025 at 1:59 pm she stated the MDS assessments should have been transmitted within the time required. The Administrator stated at the time of the late transmissions the facility had a turnover of the MDS staff and a new full-time MDS Coordinator had recently been hired. The facility submitted a corrective action plan with a compliance date of 4/26/2025 and it was not validated due to insufficient evidence of compliance.

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	06/27/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of dental status for 1 of 34 residents reviewed for accuracy of assessments (Resident #21). Findings included: Resident #21 was admitted on [DATE]. A review of a dental clinical note dated 4/17/25 indicated Resident #21 had malpositioned, decayed, and missing teeth. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21 was cognitively intact and had no obvious or likely cavities or broken teeth. During an observation on 06/16/25 at 11:19 AM, Resident #21 was observed with black/brown discolored teeth and missing teeth. On 06/18/25 at 11:37 AM an interview was conducted with MDS Nurse #1. She indicated she completed the dental assessment for Resident #21's Annual MDS assessment and that she was not aware that Resident #21 had any decaying or missing teeth and it should have been coded on the MDS assessment. During an interview on 06/26/25 at 3:02 PM, the Administrator revealed MDS assessments should accurately reflect Resident #21 had decaying and missing teeth and she expected the assessment to be coded correctly for dental status.

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	06/27/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident representative and staff interviews, the facility failed to provide nail care and shave facial hair for 1 of 11 residents reviewed for activities of daily living (ADL) (Resident #56). The findings included: Resident #56 was admitted to the facility 2/24/25 and readmitted [DATE]. Diagnoses for Resident #56 included stroke and diabetes. A care plan developed on 2/26/25 and revised on 3/21/25 documented Resident # 56 required assistance with all ADL and included the goal that Resident #56 would maintain a clean, neat, odor-free appearance, and be free from discomfort. The significant change Minimum Data Set (MDS) assessment completed 5/7/25 documented Resident #56 as severely cognitively impaired, and he was dependent on others for all ADL care. Resident #56 was observed on 6/16/25 at 12:17 PM. Resident #56 had a full beard that appeared to be approximately 1/2 inch in length, and the hair was very dense and curly. Resident #56's fingernails extended past his fingertips by more than 1/4 inch. An observation of Resident #56 was conducted on 6/17/25 at 11:49 AM. Resident #56 had a full beard that appeared to be approximately 1/2 inch in length, and the hair was very dense and curly. Resident #56's fingernails extended past his fingertips by more than 1/4 inch. Nursing Assistant (NA) #1 was interviewed on 6/17/25 at 11:50 AM. When asked how frequently she provided nail care to residents, she reported she would check their nails every time she bathed them. NA #1 was asked to look at Resident #56's nails and she noted that the nails were long and extended past his fingertips. NA #1 reported she would clip his nails after he was bathed on 6/17/25. NA #1 reported she had been assigned to Resident #56 several times over the past week and had bathed him on 6/16/25 but had not noticed his fingernails. NA #1 was asked about Resident #56's facial hair and she reported that she could shave it. NA #1 reported she had not ever shaved Resident #56's facial hair and she had not asked his family if they wanted him shaved. NA #3 was observed assisting NA #1 with Resident #56's bath on 6/17/25 at 11:50 AM. During the bath, NA #3 was interviewed, and she reported she had provided bathing to Resident #56 several times but could not recall the dates. NA #3 reported she had never shaved Resident #56 or clipped his fingernails. NA #3 reported if a resident was unable to communicate their preferences, she asked a family member but had never asked Resident #56's family about shavingResident #56 was observed again on 6/18/25 at 9:24 AM. His fingernails were trimmed, but he had not had his face shaved and his facial hair remained more than 1/2 inch in length and remained very dense and curly.Resident #56's Representative was interviewed on 6/18/25 at 1:30 PM. The Representative reported that she offered to bring in a razor to shave Resident #56 but was told by the nursing staff that they had one and would provide that service to him. The Representative did not recall who she had talked to about shaving Resident #56. The Representative explained that she had asked several times for Resident #56 to be shaved and for his nails to be trimmed, but it had not been completed. The Representative explained that Resident #56 had been clean-shaven or had his beard closely clipped prior to his stroke and he would not like to have so much facial hair, and he would not like his nails to be so long. An interview was conducted with Nurse #11 at 6/18/25 at 9:40 AM. Nurse #11 reported that resident nails should be checked by the NA staff during each bath and clipped as needed. Nurse #11 reported she was not aware Resident #56's nails were so long and was not aware Resident #56's representative wanted his face to be shaved. The Director of Nursing (DON) was interviewed on 6/18/25 at 2:25 PM and she reported that she had told the NA staff to provide shaving to Resident #56 prior to the interview. The DON reported NAs should check fingernail length every time the resident received a bath and clip them as needed. The Administrator was interviewed by phone on 6/20/25 at 11:05 AM. The Administrator reported she did not know why Resident #56's nails had not been trimmed, and his beard had not been shaven. The Administrator reported that those should be completed as often as the residents needed. The Administrator reported she expected the staff to complete all ADL care for all residents.

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	06/27/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	06/27/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff, Physician Assistant (PA), and Medical Director interviews, the facility failed to identify a change in medical condition required medical evaluation and treatment. Resident #85 fell and complained of pain to his lower right extremity on 3/17/2025. Resident #85 was assessed by PA #1 on 3/18/25 and an x-ray of the right lower extremity was ordered. The x-ray was completed on 3/19/25 and the results of an intertrochanteric fracture of right femur (type of broken hip that occurs between the bumpy parts at the top of the thigh bone) were reported to the facility on 3/19/25 at 12:13 PM. A medical evaluation and treatment of the fracture was delayed due to the x-ray results not being reviewed by facility staff or communicated to PA #1 until 3/20/25. Resident #85 was sent to the hospital for an evaluation on 3/20/25 and on 3/21/25 Resident #85 received open reduction and internal fixation (a procedure to realign and secure broken bones with metal fasteners) to the right femur. Resident #85 was discharged back to the facility on 3/25/25. The deficient practice occurred for 1of 15 residents reviewed for accidents (Resident #85). The findings included:Resident #85 was admitted to the facility on [DATE] with diagnoses which included vascular dementia and hemiplegia (condition of complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following a stroke affecting the left non dominate side. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #85 was severely cognitively impaired and was dependent on staff for transfers. Review of Resident #85's care plan created on 7/15/24 with a revision date of 3/17/25 revealed a focus area for at risk for falls and injury related to weakness, altered mobility status and history of falls. Interventions included providing frequent reminders/cues to request assistance or wait for assistance with ambulation and transfers. A review of nursing progress note dated 3/17/25 at 10:00 PM, written by Nurse #8, revealed Resident #85 was found sitting on the floor with complaints of leg pain and had no new injury. A review of the eCare Triage (process used in healthcare settings to prioritize patients' treatment electronically to help prevent unnecessary emergency department visits) Note dated 3/17/24 at 10:11 PM indicated Nurse #8 contacted the on-call Provider #1 to report Resident #85 had an unwitnessed fall. The note further indicated Resident #85 had no injury and reported leg pain but was able to bear weight. On-call Provider #1 informed Nurse #8 that the pain may be coming from the fall but does not sound like a fracture or a dislocation concern. On-call Provider #1 gave an order for Acetaminophen 325 milligram (mg) 2 tablets by mouth every 8 hours as needed for pain up to 3 days. On-call Provider #1 also instructed Nurse #8 to monitor and report any changes to the provider and to follow up with Resident #85's primary care physician.A review of Resident #85's physician orders revealed an order on 3/17/25 for acetaminophen 325 milligrams (mg) orally two tablets every 8 hours as need for pain management status post fall for 3 days. A review of the initial incident report completed on 3/17/25 , written by Nurse #8, revealed Resident #85 had an unwitnessed fall in his room on 3/17/25 at 10:00 PM. The report indicated Nurse #7 called for Nurse #8 when Resident #85 was found sitting on the floor beside the bed. Nurse #8 completed a head-to-toe assessment with no injury noted. The report further revealed Resident #85 was wearing no skid socks but did not have any footwear in use. Resident #85 was able to move all extremities with right leg pain reported. The incident report did not state how Resident #85 was transferred post fall. Nurse #8 contacted the provider and the Responsible Party. The provider gave Nurse #8 an order for acetaminophen 325 mg 2 tablets every 8 hours as needed for pain which was administered and effective. An interview was conducted with Nurse #8 on 6/18/25 at 5:52 PM. She indicated she was the assigned nurse for Resident #85 on 3/17/25 from 7:00 PM to 7:00 AM and that Nurse #7 called for her when Nurse #7 observed Resident #85 in his room sitting on the floor beside the bed. Nurse #8 indicated she observed Resident #85's bed was in the lowest position, call light was in reach, and he was wearing nonskid socks. Nurse #8 indicated upon interviewing Resident #85 he indicated that he got up unassisted while trying to turn off the room light when he fell. Resident #85 denied hitting his head but reported right leg pain. Nurse #8 indicated there were no visible signs of injury noted at the time. Nurse #8 indicated that she completed a head-to-toe assessment which included moving Resident #85's upper and lower extremities was completed without difficulty. Nurse #8 further revealed that she pressed on the right leg to try and detect any injury, but no injury or source of pain was found. Nurse #8 indicated that although Resident #85 reported right leg pain, upon her assessment she did not discover any signs of injury, so she and Nurse #7 assisted him up to standing position and helped him back to bed. Nurse #8 further revealed that he was bearing weight at the

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	06/27/2025

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 - Actual harm 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)

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	06/27/2025

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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, and Nurse Practitioner (NP) interviews, the facility failed to provide safe transport for a resident (Resident #421) in a wheelchair when Nurse Aide (NA) #5 transported Resident #421 to the shower room in a wheelchair without footrests. Resident #421's feet got caught underneath the wheelchair and she fell forward out of the wheelchair and onto the floor. Resident #421 sustained an acute comminuted fracture (broken into pieces) of the right distal femur (thigh bone just above the knee) requiring hospitalization and surgery. This deficient practice occurred for 1 of 11 residents reviewed for accidents.The findings included:Resident #421 was admitted to the facility on [DATE] and discharged to the hospital on 3/24/25. Her admitting diagnoses included stage 4 chronic kidney disease, type 2 diabetes, diabetic neuropathy (nerve damage due to diabetes causing pain, numbness and/or weakness in the feet and hands), muscle weakness, abnormalities of gait and mobility, repeated falls, chronic pain syndrome, coronary artery disease (narrowing of arteries that supply blood to the heart), cerebrovascular accident (stroke), and epilepsy.The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #421 was cognitively intact, used a manual wheelchair and required supervision/touching assistance with wheeling 50 to 150 feet in the wheelchair.The care plan dated 2/12/25 indicated Resident #421 required assistance with activities of daily living due to chronic health conditions, weakness, poor balance and a history of falls. The interventions included 1-person assistance with transfers and the use of a manual wheelchair for mobility. An incident report dated 3/24/25 at 10:00 AM completed by Nurse #6 revealed NA #5 was transporting Resident #421 to the shower room in a wheelchair when her foot was caught under the wheelchair and she was thrown out of the wheelchair to the floor landing on her right side. Resident #421 was complaining of right leg pain and was assessed by Nurse #6 with no visible signs of injury. The NP was notified of the incident and ordered an x-ray. The report further noted that footrests were not being used when the incident occurred. An interview conducted on 6/17/25 at 1:38 PM with NA #5 revealed NA #9 was assigned to Resident #421 on 3/24/25. NA #5 was helping NA #9 with her assigned residents and transported Resident #421 in a wheelchair from her room to the shower room. NA #5 stated the wheelchair did not have footrests but Resident #421 was able to hold her feet up. She revealed while transporting Resident #421 in the wheelchair down the hall she suddenly dropped her feet to the floor, and they got caught underneath the wheelchair. She indicated Resident #421 fell forward out of the wheelchair to the floor landing on her right side. NA #5 stated several staff were in the hall and responded to help and stayed with Resident #421 while she went to notify Nurse #6. She stated Nurse #6 responded immediately and assessed Resident #421. NA #5 revealed Resident #421 was complaining of right leg pain but had no visible injuries or deformities in the leg. She stated Nurse #6 completed an assessment they used the mechanical lift to transfer Resident #421 into the wheelchair and then back into bed. NA #5 stated she did not see any footrests in Resident #421's room and since she was able to hold her feet up, she went ahead and transported her in the wheelchair without them. NA #5 further stated footrests should be used on a wheelchair when transporting a resident because it was a standard of safety.A phone interview conducted with Nurse #6 on 6/19/25 at 8:40 AM indicated she was Resident #421's assigned nurse on 3/24/25. Nurse #6 indicated at approximately 10:00 AM she was notified by NA #5 that Resident #421 fell out of her wheelchair in the hallway. She revealed NA #5 reported to her she was pushing Resident #421 to the shower room in a wheelchair without footrests and her feet got caught underneath the wheelchair and she fell forward out of the wheelchair onto the floor. Nurse #6 indicated when she responded Resident #421 was lying on her right side and reported right hip and leg pain. Nurse #6 revealed she assessed Resident #421 and there were no visible signs of injury. She indicated Resident #421 had no visible signs of injury and was transferred with a mechanical lift back into the wheelchair and brought back to her room. She stated Resident #421 was transferred with the lift back into bed and was resting comfortably. Nurse #6 revealed she notified NP #1 of the incident, and she gave an order for an x-ray of Resident #421's right hip and leg. Nurse #6 indicated she administered pain medication to Resident #421 that was ordered as needed and monitored her closely. She stated the x-ray was completed and the results indicated Resident #421 had a right femur fracture. She revealed NP #1 arrived at the facility, assessed Resident #421, reviewed the x-ray results, and gave the order to transfer Resident #421 to the ED for further evaluation. Nurse #6 stated she was unsure why NA #5 did not use footrests on the wheelchair, but they should have been used for safety. The radiology

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	06/27/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, physician, and staff interviews, the facility failed to change a suprapubic catheter per the Urologist's order for 1 of 2 residents reviewed for catheter care (Resident #56). The findings included: Resident #56 was admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses for Resident #56 included stroke and obstructive reflux uropathy (a blockage in the urinary tract that causes urine to flow backwards into the kidneys). A care plan dated 2/28/25 and revised on 3/25/25 addressed Resident #56's suprapubic catheter and indicated that the catheter would be changed according to physician orders. A Urologist note for Resident #56 dated 4/15/25 included an order to continue suprapubic tube changes at the facility once per month or as needed for clinical indications (blockage, leakage, signs of infection or malfunction). Review of the medical record revealed no record of the Urologists order to continue monthly suprapubic catheter changes. Hospital discharge orders dated 5/2/25 included an order to change the suprapubic catheter every 4 weeks. The discharge orders noted Resident #56's catheter had been changed on 4/23/25 upon admission to the hospital. A physician order for Resident #56 dated 5/7/25 directed for the catheter to be changed as needed (PRN) for clinical indications including signs of infection, obstruction, or when the closed system was compromised.The significant change of condition Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #56 to be severely cognitively impaired. The MDS documented Resident #56 had an indwelling urinary catheter for urine elimination. Review of the Medication and Treatment Administration Records for April and May 2025 for Resident #56 revealed he had a catheter change completed on 4//16/25 in the facility. There were no documented suprapubic catheter changes for May 2025. During an interview with Nurse #4 on 6/19/25 at 9:27 AM, she revealed that when a resident has an order to change their catheter, the order showed in the treatment administration record on the due date. Nurse #4 reported she was assigned to Resident #56 this date and was frequently assigned to Resident #56. Nurse #4 reported she did not recall having an order to change Resident #56's catheter. Nurse #4 reported Resident #56 went to the Urologist to have the catheter changed. The Physician was interviewed on 6/19/25 at 8:29 AM. The Physician reviewed the Urologist order to continue suprapubic tube changes at the facility once per month or as needed for clinical indications (blockage, leakage, signs of infection or malfunction) and reported the facility should have written the order to continue monthly catheter changes as well as change the catheter as needed. The Physician explained the facility should have called the Urologist to clarify the order. The Physician reported he was not aware Resident #56 did not have a suprapubic catheter change in May 2025. An interview was conducted with Nurse #12 on 6/19/25 at 12:00 PM and she reported that she did not recall seeing an order in the medication or treatment administration record to change Resident #56's catheter every month. Nurse #5 was interviewed on 6/19/25 at 12:33 PM by phone. Nurse #5 reported she frequently provided care to Resident #56 and had not seen an order to change his suprapubic catheter. Nurse #5 reported she thought Resident #56 went to the Urologist to have the catheter changed. The Director of Nursing (DON) was interviewed by phone on 6/20/25 at 11:05 AM. The DON reported a physician order would trigger the monthly catheter change, but the order had been entered as as needed catheter change, and staff had not clarified with the Urologist if the catheter was to be changed monthly or as needed. The DON reported staff should clarify any unclear physician orders. The Administrator was interviewed with the DON on 6/20/25 at 11:05 AM. The Administrator added that Resident #56 had an order to change the catheter every 30 days and that order was discontinued when he was hospitalized and readmitted to the facility. The Administrator reported expected unclear physician orders to be clarified by the nursing staff.

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	06/27/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff and Responsible Party interviews the facility failed to store an enteral feeding syringe with the plunger separated from the syringe for 1 of 4 resident (Resident #60) reviewed for enteral feeding management. This deficient practice has the potential for bacterial growth and contamination. Findings included:A physician's order dated 3/22/2025 indicated Resident #60's enteral feeding (intake of food through the gastrointestinal tract when you can't eat regularly by mouth) tube should be flushed with 30 milliliters of water before and after each medication administration.Resident #60 was admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses of dementia and gastrostomy (surgical procedure that involves creating an artificial opening in the abdomen to insert a tube directly into the stomach).A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 was severely cognitively impaired and received 51% or more of his calories from enteral feedings and 501 milliliters or more of his fluid intake from enteral feedings.On 6/16/2025 at 11:32 am Resident #60 was observed in his bed with the head of the bed elevated. Resident #60's enteral feeding was infusing at 60 milliliters an hour and the enteral feeding syringe was laying on the bedside table with the plunger engaged and clear liquid with white sediment in the syringe.Nurse #4, who was standing at the medication cart, was asked on 6/16/2025 at 11:35 am to observe Resident #60's enteral feeding syringe. She stated she had just started on the assignment and would change out the syringe for a new syringe.During an observation of Resident #60 on 6/17/2025 at 3:18 pm he was lying in bed with his head elevated with an enteral feeding syringe laying with the plunger engaged and a clear liquid with sediment noted in the tip of the syringe. Nurse #4 was interviewed on 6/17/2025 at 3:19 pm and she stated she gave Resident #60 his medications with the enteral feeding syringe at 8:30 am and gave him his medications at 12:00 pm. Nurse #4 stated she had not changed the enteral feeding syringe and had used the same syringe for administering Resident #60 medications and flushes. Nurse #4 stated she usually stored the enteral feeding syringe with the plunger engaged and did not know she should leave the plunger out of the syringe until it was dry to prevent bacteria growth. Nurse #4 stated she would place a new syringe for Resident #60's medication administration and flushes.On 6/18/2025 at 8:33 am Resident #60 was observed in bed and an enteral feeding flush syringe was on his bedside table in a plastic bag. The tip of the enteral feeding tube was filled with clear liquid and there were ants in the plastic bag on the enteral feeding tube. Nurse #5 was interviewed on 6/18/2025 at 12:58 pm and she stated she had used the syringe once and placed it on the bedside table, but she would discard in a get a clean syringe. Nurse #5 stated she usually washes the enteral feeding syringe after each use and leaves the plunger separate from the syringe to allow it to dry. During an observation on 6/18/2025 at 6:02 pm Resident #60 was observed in bed with his enteral feeding tube syringe lying on a brown paper towel, with the plunger engaged and several ants were crawling around on and in the plunger.Unit Manager #1 was interviewed by phone on 6/19/2025 at 9:10 am and she stated the staff should clean the enteral feeding tubes with soap and waster and place them on a clean towel to dry with the plunger out of syringe to prevent bacteria growth.On 6/19/2025 at 10:20 am the Director of Nursing was interviewed, and she stated the nurses should know the enteral feeding syringe should be washed after each use and allowed to air dry and then placed in the storage bag. The Administrator was interviewed on 6/19/2025 at 1:59 pm and stated Nurse #4 and Nurse #5 should have followed the facility's procedure for cleaning and storing enteral feeding syringes to prevent bacteria growth.

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	06/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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	06/27/2025

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 0697 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 observations, record review, and resident, hospice nurse, physician, physician assistant (PA), and staff interviews, the facility failed to effectively manage a hospice resident's pain and administer an ordered scheduled pain medication for 1 of 2 residents reviewed for pain control (Resident #100).The findings included: Resident #100 was admitted to the facility on [DATE] with diagnoses including breast cancer with metastasis, chronic pain syndrome, and neuralgia (nerve pain). A physician order dated 1/15/25 for gabapentin (a medication used to control nerve pain) 100 milligrams (mg) three times per day with administration times of 9:00 AM, 2:00 PM, and 9:00 PM. Review of the medication administration record for June 2025 revealed Resident #100 received gabapentin three times per day as ordered. The significant change Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #100 to be cognitively intact. The MDS documented Resident #100 received scheduled and as needed pain medications, she experienced pain almost constantly, and rated her pain 6 (1-10 scale, 10 most intense pain). A care plan dated 1/16/25 with a revision date of 6/12/25 addressed Resident #100's use of opioid pain medications for severe pain, and interventions included to administer the medications as ordered, observe for signs and symptoms of over-medication, and performing pain assessments as needed. Review of the physician orders for Resident #100 revealed an order written 5/19/25 for oxycodone (an opioid pain medication) 10 mg to be administered every 4 hours as needed (PRN) for pain or shortness of breath. A hospice medication order dated 6/13/25 ordered for oxycodone 10 mg to be administered every 8 hours. Review of the physician orders for Resident #100 revealed the hospice order was not entered into the electronic medical record or electronic physician orders. An interview was conducted with UM #1 on 6/18/25 at 12:46 PM. UM #1 explained that Hospice put handwritten physician orders into her inbox to be entered into the electronic system and once the orders were entered, she gave the order to medical records for filing. UM #1 reported that handwritten orders were checked against the electronic medical record during the morning meeting, but no morning meeting was conducted on 6/16/25. During the interview, UM #1 reviewed the physician orders for Resident #100 and discovered that the hospice order written on 6/13/25 had not been entered into the electronic medical record. UM #1 went to medical records and found the order and reported she had missed the order for oxycodone 10 mg every 8 hours and would enter the order. UM #1 explained that the handwritten hospice orders were checked against the electronic physician orders, but the order for Resident #100 was not reviewed. Pain assessment documentation for June 2025 was reviewed and the documented pain level for Resident #100 was 0 for dates 6/1/25 to 6/18/25. Resident #100 was observed on 6/16/25 at 2:02 PM in bed. Resident #100 reported she was experiencing pain all over with most intense pain in her feet. Resident #100 reported the pain medications did not control her pain and she had told the hospice nurse. Nurse #13 was interviewed on 6/16/25 at 2:10 PM and she reported she was on her way to medicate Resident #100 for pain. Nurse #13 reported Resident #100 requested pain medication when she needed it and she had an order for PRN oxycodone. The medication administration record was reviewed and Resident #100 received oxycodone 10 mg on 6/16/25 at 2:26 PM and rated her pain 6. Resident #100 was observed in bed on 6/17/25 at 11:37 AM. She reported she was experiencing pain in her legs and feet, and she was very uncomfortable. Review of the medication administration record reviewed that Resident #100 received oxycodone 10 mg at 8:12 PM on 6/17/25 and she rated her pain as 3. An observation of Resident #100 was conducted on 6/18/25 at 9:46 AM and she reported she was having pain in her neck and her legs. Resident #100 reported she had requested pain medication but had not received it yet. The Hospice Nurse was interviewed by phone on 6/18/25 at 10:01 AM. The Hospice Nurse reported she had completed a visit on Resident #100 on 6/13/25 and had written an order to administer her pain medication administration to every 8 hours for better pain control because Resident #100 was not requesting the PRN pain medication and was in continued severe pain. The Hospice Nurse explained the PRN order for oxycodone would continue, but the scheduled medications should help keep her comfortable. The Hospice Nurse revealed when she reviewed the electronic medication orders for the facility on 6/16/25 the orders were not in the system and Resident #100 was not receiving the scheduled pain medication. The Hospice Nurse reported she had talked to the Unit Manager (UM) #1 and UM #1 had told her that the medications had not been delivered by the pharmacy yet. The Hospice Nurse explained that she would handwrite a physician order and give it to the nurse at the facility. The Hospice Nurse explained that the nursing staff entered the orders into their

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	06/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observations, and staff interviews, the facility failed to date and label insulin (Medication Cart #3 and Medication Cart #5) and failed to discard an opened out of date insulin injection pen (Medication Cart #3). The deficient practice were found in 2 of 3 medications carts reviewed for medication storage (Medication Cart #3 and Medication Cart #5). Findings included: a. An observation of Medication Cart #3 on 6/19/2025 at 4:45 pm revealed one glargine insulin injection pen that was open and dated and had not been labeled with the resident's name. Medication Aide #2 was interviewed during the medication cart observation on 6/19/2025 at 4:45 pm and stated she did not know why the glargine insulin injection pen was not dated and she was not sure how long it had been open in the cart. b. During an observation of Medication Cart #5 on 6/19/2025 at 3:38 pm a degludec insulin pen was not dated when opened. Nurse #2 was interviewed during the observation of Medication Cart #5 on 6/19/2025 at 3:38 pm and she stated she did not know why the degludec insulin pen was not dated. Nurse #2 stated when she opens a new insulin pen, she dated the label but someone else must have opened that insulin pen and she had not noticed it was not dated and had not used that insulin pen on any residents. c. The manufacturer's directions for insulin lispro pen stated it should be discarded 28 days after opening. Medication cart #3 was observed o 6/19/2025 at 4:45 pm and an insulin lispro injection pen was opened and was dated 5/15/2025. Medication Aide #2 was interviewed during the observation of Medication Cart #3 and she stated she did not know how long lispro insulin could be used after it was opened. She stated she thought the insulin lispro should be discarded after 30 days and she did not realize it was dated 5/15/2025. The Director of Nursing (DON) was interviewed by phone on 6/20/2025 at 9:28 am and she stated the insulin injection pens on medication cart #3 and medication cart #5 should have been labeled with the resident's name along with the date it was opened when placed in the medication cart. The DON also stated the lispro insulin injection pen that was opened and dated 5/15/2025 should have been discarded within 30 days of the date it was opened by the manufacturer's instructions. The DON stated the lispro insulin should have been sent back to the pharmacy after 30 days. During an interview by phone with the Administrator on 6/20/2025 at 8:35 am she stated the nurses and medication aides should have properly labeled and dated the medications when they are placed in the medication cart.

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	06/27/2025

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 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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	06/27/2025

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 0777 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Medical Director, Physician Assistant (PA), and mobile x-ray provider interviews, the facility failed to notify a medical provider when the results of an x-ray revealing an intertrochanteric fracture of the right femur (type of broken hip that occurs between the bumpy parts at the top of the thigh bone) were reported to the facility on 3/19/25. This resulted in the fracture not being reported to PA #1 until 3/20/25 which delayed Resident #85's transfer to the hospital for evaluation and treatment. Resident #85 was sent to the hospital for an evaluation on 3/20/25 and on 3/21/25 Resident #85 received open reduction and internal fixation (a procedure to realign and secure broken bones with metal fasteners) to the right femur. This occurred for 1 of 15 residents (Resident #85) reviewed for accidents. The findings included:Resident #85 was admitted to the facility on [DATE] with diagnoses which included vascular dementia and hemiplegia (condition of complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following a stroke affecting the left non dominate side. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #85 was severely cognitively impaired and was dependent on staff for transfers. A review of the nursing progress note dated 3/17/25 at 10:00 PM, written by Nurse #8, revealed Resident #85 was found sitting on the floor with complaints of leg pain and had no new injury. A review of Physician Assistant (PA) #1's note dated 3/18/25 at 4:35 PM indicated PA #1 visited Resident #85 for acute visit due to a fall on 3/17/25. PA #1 indicated that Resident #85 reported pain in right hip and right femur during the evaluation and she ordered an x ray. On 3/18/25, the facility's Physician Assistant (PA #1) ordered x-ray of Resident #85's right lower extremity due to complaints of pain post fall . A review of the Radiology Report for Resident #85 indicated an examination occurred on 3/19/25 at 10:02 AM and the results were reported to the facility via the electronic medical record on 3/19/25 at 12:13 PM. The finding was an acute transverse non-displaced intertrochanteric fracture and mild osteopenia was noted.A review of progress note dated 3/20/25 at 7:13 AM which was authored by Unit Manager #1 indicated Nurse #9 received Resident #85's x-ray results and which indicated a right femur fracture. The nurse informed Resident #85 and the Responsible Party and noted PA #1 would assess Resident #85 that morning. A review of progress note dated 3/20/25 at 9:27 AM which was authored by Unit Manager #1 indicated she notified PA #1 that the result of the x-ray for Resident #85 was an acute transverse nondisplaced fracture of the femur and that PA #1 referred Resident #85 to orthopedic as soon as possible.A review of the progress note dated 3/20/25 at 11:45 AM authorized by the Assistant Director of Nursing indicated that PA #1 had given an order to send Resident #85 to the hospital and that the Responsible Party was notified by UM #1.Review of hospital progress notes revealed Resident #85 was admitted on [DATE] for evaluation of femur fracture. The note further revealed resident #85 sustained an intertrochanteric fracture of right femur. On 3/21/25 Resident #85 received open reduction and internal fixation (surgical procedure used to treat severe bone fractures) to the right femur. Resident #85 was discharged back to the facility on 3/25/25.An interview was conducted with Resident #85's Responsible Party on 6/17/25 at 1:58 PM. He indicated that he would have wanted Resident #85 to have been sent to the hospital on 3/19/25 when the positive X-ray results were sent to the facility. An interview was conducted on 6/18/25 at 3:20 PM with Unit Manager (UM) #1. She indicated that x-ray results were reported to the facility in real time via the Electronic Medical Record (EMR) and that all nurses have access to the report. However, she or a nursing supervisor are normally the nurses that review the results. She also indicated that the mobile x-ray provider may also send a fax and call the facility with any positive reports. UM #1 indicated that Resident #85's x-ray results from his fall on 3/17/25 were uploaded into the EMR on 3/19/25 at 12:14 PM and noted the finding of a right femur fracture. She indicated that she normally leaves her shift around 2:30 PM and that she did not see the x-ray result before she left on 3/19/25. UM #1 further revealed that there was not a nursing supervisor working that evening, so she reviewed the result on 3/20/25 around 7:15 AM. UM#1 indicated that she reported the x-ray results to PA #1 around 9:30 AM on 3/20/25. PA #1 initially ordered an orthopedic referral as soon as possible and was not sure why this was ordered instead of an order for hospitalization. UM#1 indicated that PA #1 later gave a telephone order to the ADON to send Resident #85 to the hospital and Resident #85 was sent out around 10:40 AM.An interview was conducted with Physician Assistant #1 on 6/19/25 at 10:38 AM. PA #1 indicated she became aware of Resident #85's fall when she came into the facility the morning of 3/18/25. PA #1 indicated she reviewed the provider's communication book and saw a note from Nurse #8 related to Resident #85's fall. The note

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	06/27/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and resident, Responsible Party, and staff interviews the facility failed to honor a resident's preference for sandwiches for 1 of 9 residents reviewed for nutritional status (Resident #26). Findings included: Resident #28 was admitted to the facility on [DATE] with heart disease and anemia. A Food Preference List dated 3/12/2025 indicated Resident #28 requested peanut butter and mayonnaise sandwiches at lunch. The Food Preference List also had a note that stated add peanut butter and mayonnaise sandwiches to lunch and dinner tray, and the resident stated she has not been getting the sandwich as requested. On 6/17/2025 at 3:02 pm an interview with Resident #28 was conducted with her Responsible Party was present. Resident #28 was sitting on the side of the bed eating food the Responsible Party brought from home. Resident #28 stated she cannot eat the food from the facility because it was too spicy, and the meat was too hard to chew. Resident #28 stated she had asked for a peanut butter and mayonnaise sandwich several times, but it was not brought to her. The Responsible Party stated she had also told the facility Resident #28 could not tolerate the food or chew the meat and had asked that a peanut butter and mayonnaise sandwich be put on her tray. An observation of Resident #28 during the lunch meal on 6/18/2024 at 12:43 pm revealed there was not a peanut butter and mayonnaise sandwich on her meal tray Resident #28's meal ticket did not include whether she should receive a peanut butter and mayonnaise sandwich. On 6/18/2024 at 1:08 pm Nurse Aide #4 was interviewed and stated Resident #28 liked peanut butter and mayonnaise sandwiches, and she had asked the kitchen to make them for her before, but they would not send the sandwiches to her. During an interview with Nurse #2 on 6/18/2025 at 1:01 pm Nurse #2 stated she was not aware that Resident #28 was not receiving peanut butter and mayonnaise sandwiches as she requested. The Dietary Manager was interviewed on 6/19/2024 at 1:46 pm and he stated he obtained residents' food preferences on admission and updated them quarterly. The Dietary Manager stated he does not remember what Resident #28 stated she likes or disliked but he would have updated the preference sheet. During a follow up phone interview with the Dietary Manager on 6/24/2025 at 4:25 pm he stated Resident #28's meal preferences were updated on 3/12/2025 and he placed a laminated sign on the refrigerator in the kitchen for staff that she should receive a peanut butter and mayonnaise sandwich at lunch every day. He stated the dietary staff should have sent the sandwich at lunch and dinner per Resident #28's request. A quarterly Minimum Data Set assessment dated [DATE] indicated resident #28 was moderately cognitively impaired, required set up assistance for meals, and did not have any significant weight loss or gain. (continued on next page)

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	06/27/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/2025 at 12:22 pm Registered Dietitian #2 was interviewed and stated she was not made aware that Resident #2 could not eat the food because it was too spicy; she could not chew the meat because it was too tough; and she would eat peanut butter and mayonnaise sandwiches if they were brought to her. The RD stated the Dietary Manager should have updated Resident #28's likes and dislikes every three months and document her requests. During an interview by phone with the Director of Nursing on 06/20/25 at 09:28 am she stated Nurse Aide #4 should have reported to the nurse she was not able to get what Resident #28 requested when she could not obtain the peanut butter and mayonnaise sandwich from dietary. The Administrator was interviewed on 6/19/2025 at 3:15 pm and stated the kitchen should have sent Resident #28 peanut butter and mayonnaise sandwiches as she requested.

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	06/27/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record reviews and staff interview the facility failed to maintain frozen foods at or below 0 degrees Fahrenheit and failed to sanitize a thermometer probe used to test internal temperatures of food. These practices had the potential to affect food served to residents. The findings included: 1. On 6/16/25 at 10:35 a.m., the walk-in freezer was observed with the Dietary Manager (DM). The observation of the walk-in freezer revealed the internal thermostat read 32 degrees Fahrenheit (F). The frozen food items stored in the walk-in freezer were soft to touch. Internal temperatures taken by the Dietary Manager revealed: - one sleeve of raw ground beef was 46 degrees F - one case of raw chicken thighs was 28 degrees F - one case of raw sausage patties was 31degrees F - one case of precooked diced turkey was 27degrees F - one case of meatballs was 29 degrees F - one case of fish squares was 27 degrees F - one case of hotdog franks was 37 degrees F The DM was interviewed and stated he first noticed the walk-in freezer was not working properly when he arrived at work this morning (6/16/25) and reported the problem to the facility's Maintenance Assistant at 7:15 a.m. The DM reported he would have to throw out all the food items. During an interview on 6/16/25 at 11:15 a.m., the Administrator revealed the DM made her aware of the walk-in freezer not functioning that morning (6/16/25) at approximately 10:45 a.m. During an interview on 6/16/25 at 11:30 a.m., the facility Maintenance Assistant revealed the DM first made him aware the walk-in freezer was not maintaining proper temperatures on the morning of 6/16/25 at 10:58 a.m. 2. On 6/18/25 at 12:25 p.m. an observation of the lunch meal tray line was made. During the tray line observation, [NAME] #1 used a soiled hand towel from a food preparation table to wipe the thermometer's probe and proceeded to insert the probe into food items to check the internal temperatures. [NAME] #1 was interviewed and stated he had not worked at the facility long and indicated he did not receive any training by the Dietary Manager. The Dietary Manager revealed Dietary [NAME] #1 was rehired and began working at the facility on 6/9/25 and he (the DM) had provided orientation training but did not document it.

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	06/27/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 2. A review of Resident #85's physician orders revealed an order on 3/17/25 for acetaminophen 325 milligrams (mg) orally two tablets every 8 hours as need for pain management status post fall for 3 days. A review of the nursing progress note dated 3/18/25 at 6:19 AM and authored by Nurse #8, indicated Resident #85 fell on 3/17/25 at 10:00 PM. The note further indicated Resident #85 had pain in his right leg and received an order for acetaminophen which was already given, (meaning the medication had been administered). A review of the administration progress note dated 3/18/25 at 10:05 PM indicated Nurse #8 administered acetaminophen 325 mg 2 tablets for pain. A review of progress notes dated 3/19/25 revealed a note authored by Nurse #8 that indicated she administered acetaminophen 325 mg 2 tablets for pain management at 7:27 PM and it was effective. A review of Resident #85's March 2025 Medication Administration Record (MAR) revealed acetaminophen 325 mg 2 tablets for pain was administered on 3/18/25 at 10:05 PM by Nurse #8. Resident #85 was documented to have pain at level 4 and the medication was effective. The MAR did not indicate if this medication was administered on 3/17/25 or 3/19/25. On 6/19/25 at 9:31 AM an interview was conducted with Nurse #8. She indicated that she did not recall what days she administered the acetaminophen or why the MAR was blank on 3/17/25 and 3/19/25 but if she administered the medication then she should have signed off that it was given. Based on record review and staff interviews, the facility failed to maintain accurate records related to documentation of medication administration for 2 of 2 residents reviewed for accurate medical records (Resident #421 and Resident #85). The findings included: 1. A review of Resident #421's physician orders revealed an order dated 2/05/25 for tramadol 50 milligrams (mg) to be administered every 12 hours as needed for pain. A nurse's note dated 3/24/25 completed by Nurse #6 indicated Resident #421 was being pushed in a wheelchair to the shower room and her foot was caught under the wheelchair and she was thrown out of wheelchair to the floor. Resident #421 was complaining of right leg and hip pain. A review of the controlled substance count sheet for tramadol revealed a pill was administered to Resident #421 on 3/24/25 at 11:00 AM. A review of Resident #421's March 2024 medication administration record (MAR) indicated tramadol was not documented as administered on 3/24/25. (continued on next page)

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	06/27/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with Nurse #6 on 6/19/25 at 8:40 AM revealed she was Resident #421's assigned nurse on 3/24/25. Nurse #6 indicated Resident #421 had a fall from her wheelchair and was complaining of right leg and hip pain. Nurse #6 stated she administered tramadol to Resident #421 due to her complaints of pain, but she did not recall the time. She revealed when a control substance was administered, she documented it was given on the MAR and the controlled substance count sheet. Nurse #6 indicated she was unsure why Resident #421's tramadol was not documented on the MAR as given on 3/24/25 and that she must have just forgotten. During an interview with the Administrator on 6/19/25 at 11:00 AM she stated medication administration should be accurately documented on the MAR.

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	06/27/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to maintain effective pest control in 2 of 13 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) reviewed for environmental concerns. Ants were observed in room [ROOM NUMBER] and room [ROOM NUMBER]. Findings included:The facility's extermination invoices were reviewed for the previous 6 months:On 12/11/2024 the facility received an extermination treatment for cockroaches and rodents.On 1/28/2025 the facility received extermination treatment for cockroaches and rodents and no pest were found in the facility during the visit.a. room [ROOM NUMBER] was observed on 6/17/2025 at 3:02 pm and ants were on the resident's bedside table and on the floor around her bedside table and bed. There were 5 ants on the floor and 3 ants on the top of the resident's bedside table that were reddish, brown in color. There was no open food or debris on the bedside table or the floor. During the observations the Responsible Party was present and stated they had killed several ants in the resident's room in the past few months and notified staff of the ants, but did not know what staff they told about the ants. On 6/18/2025 at 1:01 pm Nurse #2 stated she had not seen ants in room [ROOM NUMBER] until 6/17/2025 when the observation was made of room [ROOM NUMBER] and she was asked to observe the ants. Nurse #2 stated she made the Maintenance Director aware of the ants on 6/17/2025. Nurse Aide #4 was interviewed on 6/18/2025 at 1:08 pm and she stated she had seen several small, brown ants in room [ROOM NUMBER] several times, but she does not remember who she told. b. On 6/18/2025 at 8:33 am 3 ants were observed in room [ROOM NUMBER] crawling on the enteral feeding syringe that was in an open plastic bag which was on top of the bedside table and 2 ants on the towel that was on top of the bedside table. The tip of the enteral feeding tube was filled with clear liquid. Nurse #5, who was present in the room, stated they had been having problems with ants in the resident's rooms, and she had let the Maintenance Director know about the ants before today. During an interview with Nurse #5 on 6/18/20254 at 12:58 pm she stated she had seen ants in room [ROOM NUMBER] before today and they were on the beside table and the enteral feeding syringe that was in a plastic bag located on the top of the beside table. Nurse #5 stated she notified maintenance of the ants, disposed of the ants on the feeding syringe and the bedside table, and replaced the enteral feeding tube on the bedside table.An observation of room [ROOM NUMBER] was conducted 6/18/2025 at 6:02 pm and ants were observed crawling on the bedside table and on an enteral feeding syringe on the bedside table which was inside a plastic bag. During an interview with Nurse #5 on 6/18/2025 at 6:09 pm she stated she did not know what to do about the ants, but she would replace the enteral feeding syringe with a new syringe. Nurse #5 stated she had already notified the Maintenance Director about the ants before today and this morning when the observation was made of the ants on the bedside table and on the enteral feeding syringe that was in a plastic bag on top of the bedside table. During an interview with the Housekeeping Director on 6/19/2025 at 9:20 am she stated she had seen ants in the residents' rooms and the Maintenance Director was made aware and they had an exterminator treat the facility a week ago.The Maintenance Director was interviewed on 6/19/2025 at 9:23 am and he stated the facility was exterminated a week ago for pests and he does rounds to check for pests. An interview was conducted with the Director of Nursing on 6/19/2024 at 10:20 am and she stated she was not aware of ants being in room [ROOM NUMBER] or room [ROOM NUMBER] but the nursing staff should report any pests to the Nurse or Unit Manager so a work order can be sent to the Maintenance Director. During an interview with the Administrator on 6/19/2024 at 1:59 pm she stated the facility had been exterminated for other pests besides ants in the past two weeks but had not been exterminated for ants because no one had reported the ants to her. The Administrator stated the nursing, housekeeping, and maintenance staff should have notified her about the ants in room [ROOM NUMBER] and room [ROOM NUMBER] so that the extermination would remove the ants.