

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Cabarrus Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Brookwood Avenue NE Concord, NC 28025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on record review, observations, and staff interviews, the facility failed to serve 3 of 4 meals observed (the lunch meal on 7/19/26 and the breakfast and lunch meals on 7/21/26) at scheduled mealtimes. This failure had the potential to affect all residents who received food by mouth on 2 of 2 hallways (Halls 100 and 200). The facility had a census of 115. Findings included: a. Review of the meal serving times provided by the facility for the lunch meal on 7/19/26 revealed the lunch trays were scheduled as follows: 1st cart at 11:30 AM to the dining room 2nd cart at 12:00 PM to the 200 hallway 3rd cart at 12:15 PM to the 200 hallway 4th cart at 12:30 PM to the 100 hallway 5th cart at 12:45 PM to the 100 hallway During an observation on 7/19/26 at 11:30 AM, no resident was eating lunch in the dining room. At 12:00 PM, lunch trays had not arrived at the 200 hallway. Further observation revealed that the only trays delivered to any hallway were the trays for the 100 hallway, which was the first lunch cart. The first meal cart to arrive at the 200 hallway was delivered at 12:45 PM. During an interview on 7/19/26 at 1:30 PM, Nurse Aide (NA) #1 stated the kitchen alternated delivery of trays between hallways. NA #1 stated that sometimes the 100 hallway received trays first and sometimes the 200 hallway received trays first. NA #1 indicated that trays were delivered late on occasions. and nursing staff usually checked the hallways to see which hallway received trays first. During an interview on 7/20/26 at 10:00 AM, the Food Service Director stated dietary staff alternated which hallway received trays first for each meal. b. On 7/20/26 at 10:30 AM, the Food Service Director provided the breakfast meal service time schedule. Based on review, breakfast trays were scheduled as follows: 1st cart at 7:30 AM to the 100 hallway 2nd cart at 7:45 AM to the 100 hallway 3rd cart at 8:00 AM to the 100 hallway 4th cart at 8:30 AM to the 200 hallway 5th cart at 8:45 AM to the 200 hallway Tray line observation on 7/21/26 from 7:10 AM to 8:10 AM revealed only three dietary staff in the kitchen: the Food Service Director, Regional Dietary Manager, and Dietary Cook. The first breakfast cart to the 100 hallway did not leave the kitchen by 8:10 AM. During an interview on 7/21/26 at 7:15 AM, the Food Service Director stated two dietary aides who were scheduled had called out that morning. He stated he was working with the cook to ensure meals were prepared on time. He explained no other staff were available to come in because two dietary aides were on vacation, one had called in sick, and another was on bereavement leave. During an interview on 7/21/26 at 7:20 AM, the Regional Manager stated the Food Service Director notified him at 5:00 AM that two dietary aides had called out, so he came to assist. He stated he could call dietary staff from a sister facility if needed. Observation on 7/21/26 revealed that the first breakfast cart left the kitchen at approximately 8:20 AM and was delivered to the 100 hallway near the nursing station. Nursing staff began distributing meal trays from this cart at 8:23 AM. Additional observation on 7/21/26, conducted from 9:05 AM to 9:20 AM in the 200 hallway near the back area, revealed that (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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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nursing staff offered snacks and juice to residents waiting for their breakfast trays in their rooms and in the common area. Residents in the 200 hallway received their breakfast cart at 9:20 AM. During an interview on 7/21/26 at 9:40 AM, the Regional Dietary Manager was asked if additional staff were available to ensure lunch trays were delivered on time. Both the Regional Manager and Food Service Manager stated they did not need extra help and believed meals would be delivered on time. The lunch mealtime schedule for 7/21/26 was reviewed. Based on review of the meal serving times, lunch on 7/21/26 was scheduled as follows: 1st cart at 11:30 AM to the 100 hallway 2nd cart at 12:00 PM to the 100 hallway 3rd cart at 12:15 PM to the 100 hallway 4th cart at 12:30 PM to the 200 hallway 5th cart at 12:45 PM to the 200 hallway. Observation revealed the first lunch cart for the 100 hallway was delivered at 12:45 PM on 7/21/26. Lunch carts for the 200 hallway were delivered at approximately 1:30 PM. During an interview on 7/22/26 at 8:57 AM, the Food Service Director stated the kitchen had 11 dietary staff, including three cooks and eight dietary aides. He stated he was waiting for two additional aides to complete background checks. He stated he was not understaffed and usually ran the kitchen on schedule. He did not believe meal trays were delivered late. He stated the kitchen usually had two dietary aides, one cook, and himself during both AM and PM shifts. He stated he was on vacation on 7/19/26, and the cook was in charge in his absence. The Food Service Director stated he informed the Administrator of the two call outs and that the Regional Manager was coming to assist. During an interview on 7/22/26 at 9:05 AM, Nurse #8, who was assigned to the backside of the 200 hallway, stated residents' meal trays were usually delivered late. She stated staff were never notified when meal trays were running late. Nurse #8 stated she checked diabetic residents' blood sugars around mealtime to ensure they were not hypoglycemic. Residents were offered snacks until trays arrived, and insulin was administered only when trays were delivered. She stated dietary staffing concerns contributed to trays running late. During an interview on 7/22/26 at 9:10 AM, Unit Manager #1 stated dietary staff never notified her or nursing staff when meal trays were running late. Nursing staff notified her when trays were late, and NAs offered snacks to residents until trays arrived. She stated insulin was not administered until meal trays were delivered. During an interview on 7/22/26 at 10:00 AM, the Administrator stated the Food Service Director notified her of two dietary staff call outs and that the Regional Director was coming to assist. She stated the Food Service Director did not inform her that meals would be delivered late. The Administrator stated she was not aware that meal cart delivery between hallways alternated. She stated the dietary department was a contracted service, and the Food Service Director should notify management when meal trays were running late so that nursing staff could be informed and diabetic residents could be checked and medications administered appropriately.		

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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 observation and staff interviews, the facility failed to ensure food was stored, prepared, and maintained in a sanitary manner. The facility failed to label food stored for use and failed to discard expired food in the walk-in refrigerator. The facility failed to ensure employees' personal food was not stored in 1 of 1 reach-in refrigerator. Staff failed to keep the oven, stove, deep fryer, and ice machine clean and free of burnt food and food stains. In addition, the facility failed to keep trash containers in the kitchen covered, failed to store cleaning equipment away from clean dishes, and failed to discard chipped plates from the tray line. The facility also failed to maintain hot food on the tray line above 135 degrees Fahrenheit (F). These failures had the potential to affect the safety and quality of food served to residents. Findings included: 1a. Observation of the walk-in refrigerator with the Dietary [NAME] on 7/19/26 at 10:20 AM revealed: An eight-ounce cup with no lid or label containing yellow-orange food, A round clear plastic container of mixed cut fruit labeled Use by date - 7/18, A two-gallon clear plastic bag containing five boiled eggs labeled opened 7/14 and use by 7/17, A round clear container with creamy yellow pureed food dated 7/15, A white container labeled cucumbers and onions, dated 7/11/26. During an interview on 7/19/26 at 10:22 AM, the Dietary [NAME] stated the unlabeled food in the Styrofoam cups was fruit and she was unsure why it was in the refrigerator without a lid or label. She stated the mixed fruit was intended for lunch on 7/19/26, however after reviewing the date she discarded it. She indicated the boiled eggs should have been used previously. She stated the pureed food was pudding and should be discarded. She indicated the cucumbers and onions should also be discarded. She stated all leftover food should be discarded within three days and must be labeled with an opened or prep date and use-by date. During an interview on 7/21/26 at 2:00 PM, the Food Service Director stated all food placed in any refrigerator must be labeled and dated. He could not explain why the boiled eggs were not used earlier, stating boiled eggs were used almost daily for breakfast. He reported food could be stored between three to seven days depending on the food item and the label must include a use-by date. 1b. Observation of the reach-in refrigerator with the Dietary [NAME] on 7/19/26 at 10:25 AM revealed a blue insulated lunch box, an insulated water bottle, and an opened 16-ounce water bottle three-quarters full of purple liquid, all unlabeled. During an interview on 7/19/26 at 10:26 AM, the Dietary [NAME] stated the lunch box and water bottles belonged to dietary staff and should not have been stored in the reach-in refrigerator. She reiterated that staff personal food items were not permitted in this refrigerator. During an interview on 7/21/26 at 2:00 PM, the Food Service Director stated employees' personal food should not be stored in the reach-in refrigerator. 2. An observation on 7/19/26 at 10:40 AM with the Dietary [NAME] revealed: The double-door oven had dark brown burnt stains on the inside doors, shelves, and floor. A rack above the oven had dark burnt food stains. The oven had burnt food particles and white stains on the sides, The gas stove back splash guard and side splash guard had brown stains of oil and food on it, The deep fryer contained burnt food in the oil and on the fryer surface. [NAME] spots and burnt food and oil stains were present on the sides of the fryer. During an interview on 7/19/26 at 10:42 AM, the Dietary [NAME] stated kitchen equipment was cleaned per schedule and she was unsure of the source of the white spots. During an interview on 7/21/26 at 2:00 PM, the Food Service Director stated he personally cleaned the stove and dietary staff followed a cleaning schedule. He reported the oven was cleaned once weekly on Saturdays and the fryer was cleaned twice weekly. During a follow up walk-through of the kitchen with the Food Service Director on 7/21/26 at 2:02 PM, the stove still had brown stains, the oven still had burnt stains, and the sides (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the oven, stove, and fryer had white spots and food stains. The ice machine exterior had white stains. The Food Service Director could not state what the stains were or why these areas had not been cleaned according to the schedule.3a. Observation on 7/19/26 at 10:30 AM revealed a large black trash container without a lid placed near the dishwashing area and touching the ice machine. The trash container was half full and placed directly in front of the ice machine. The lid was found under the dishwashing machine. Staff were actively washing dishes. The ice machine was located on the other side of the wall of the dishwashing area.During an interview on 7/19/26 at 10:30 AM, the [NAME] stated the trash container should be in the dishwashing area and not near the ice machine.3b. Observation on 7/21/26 at 2:06 PM revealed meal tray carts containing dirty plates, cups, and utensils placed near and touching the ice machine.During an interview on 7/21/26 at 2:06 PM, the Food Service Director stated staff should not place dirty tray carts near the ice machine.4a. A continuous observation of the tray line on 7/21/26 from 7:15 AM to 8:10 AM revealed three of five divided plates were chipped and cracked and were set to be used for breakfast service.During an interview on 7/21/26 at 7:20 AM, the Food Service Director stated he would replace the cracked plates and that they may have been damaged during washing.4b. The temperatures of food on the tray line were taken by the Food Service Director using a calibrated thermometer on 7/21/25 at 7:36 AM. Observation revealed the following tray line temperatures: Pureed eggs: 121 F Turkey sausage patties: 122 F Pureed biscuit and gravy: 130 FAll items were below the required hot`holding temperature of 135 F.The Food Service Director removed the items, reheated them, and rechecked temperatures at 7:53 AM and at 7:55 AM.During an interview on 7/21/26 at 8:00 AM, the Food Service Director stated he cooked the food to the recommended temperature, but the temperature might have dropped while the food was holding on the steam table and the tray line was set up. 5.Observation of the dishwashing area on 7/21/26 at 2:06 PM revealed a broom and long`handled dustpan placed next to crates of clean cups and bowls, with the handles touching the clean dishware.During an interview on 7/21/26 at 2:06 PM, the Food Service Director stated a dietary aide had just swept the floor and must have placed the items there.During an interview on 7/22/26 at 10:05 AM, the Administrator stated leftover foods should be labeled and dated, including a use`by date, and discarded within three days unless the product had a longer manufacturer`approved shelf life. She stated staff should not store personal food in the reach`in refrigerator, chipped plates should be discarded immediately, and all staff should follow the cleaning schedule, with the Food Service Director verifying compliance.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident, and staff interviews, the facility failed to notify the physician of missed medication administration for 1 of 7 residents reviewed for medication administration (Resident #77).The findings included:Resident #77 was admitted to the facility on [DATE] with diagnoses including diabetes and sleep apnea.Lab results for Resident #77 included a hemoglobin A1C (labs used to measure average blood glucose results over the past 3 months) dated 9/11/25 of 6.8 (normal 4.0-6.0). Lab results for Resident #77 included a hemoglobin A1C dated 5/29/26 of 7.1 (normal 4.0-6.0). Resident #77 weighed 362 pounds on 9/5/25.Resident #77 weighed 384 pounds on 6/9/26. A physician order dated 11/19/25 ordered tirzepatide (a once weekly injectable medication used for the treatment of elevated blood glucose levels and used for the treatment of sleep apnea and weight management) 10 milligrams (mg) once weekly on Thursday for diabetes.The Medication Administration Record (MAR) documented on 1/19/26 the medication tirzepatide 10 mg was not administered.A progress note written by Nurse #1 dated 2/19/26 at 8:40 AM documented the tirzepatide was reordered. There was no documentation the Physician been notified of the missed dose of tirzepatide and no order to hold the medication.A phone interview was conducted with Nurse #1 on 7/21/26 at 1:34 PM. Nurse #1 reported she did recall that she had not called the Physician and explained she should have called the on-call provider to report the medication was not given and gotten an order to administer when the medication was delivered.A physician order dated 2/27/26 ordered tirzepatide increased to 12.5 mg to be injected every Thursday.Review of the MAR revealed on 3/5/26, Resident #77 did not receive tirzepatide 12.5 mg. There was no progress note written by Nurse #2 to explain why she did not receive the medication and no documentation the physician was notified.A phone interview with Nurse #2 was conducted on 7/21/26 at 3:08 PM. Nurse #2 reported she did not remember why Resident #77 did not receive the tirzepatide on 3/5/26. Nurse #2 reported if the medication was not given, the medication was not available, but she could not recall if she reordered the medication. Nurse #2 explained she should have called the on-call provider and written a note, as well as gotten a physician order to administer the medication when it was delivered.The MAR documented on 4/2/26 tirzepatide was not given and the progress note written by Nurse #3 documented waiting on pharmacy. There was no note indicating the physician had been notified.A phone interview was conducted with Nurse #3 on 7/21/26 at 10:24 AM. Nurse #3 reported she had not called the physician to notify him the medication had not been administered on 4/2/26 and Nurse #3 was unable to explain why she had not called.The MAR indicated Resident #77 did not receive tirzepatide 12.5 mg on 5/21/26 and there was a progress note written by Nurse #4 that the medication was not in stock and was not administered.There was no progress note indicating the physician had been notified written by Nurse #4.Attempts were made to contact Nurse #4 for interview, and those attempts were unsuccessful.On 6/11/26 tirzepatide 12.5 mg was not administered to Resident #77 and Nurse #5 documented medication reorder in a progress note. There was no documentation the physician had been notified.A phone interview was conducted with Nurse #5 on 7/21/26 at 12:45 PM. Nurse #5 reported she had not called the physician and had not received an order to hold the medication. A physician order dated 7/4/26 for tirzepatide 12.5 mg to be injected every Saturday.Resident #77 did not receive tirzepatide on 7/18/26. A progress note written by Nurse #7 documented waiting on pharmacy delivery and there no progress note indicated the physician had been notified the medication was not administered.Attempts were made to contact Nurse #7 for (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and those attempts were unsuccessful. Resident #77 was interviewed on 7/19/26 at 11:18 AM and she reported she had been missing doses of tirzepatide for months. Resident #77 explained she did not mention this to the Nurse Practitioner because she thought the nurses had reported the missing doses. The Unit Manager was interviewed on 7/21/26 at 2:09 PM. The Unit Manager reported she was not aware the Physician or the Nurse Practitioner had not been notified of the missing tirzepatide doses for Resident #77. The DON was interviewed on 7/21/26 at 2:26 PM. The DON explained she had been in her position for 3 weeks and had no idea that Resident #77 was not receiving her prescribed tirzepatide or that the Physician or Nurse Practitioner had not been notified. The facility Physician was interviewed by phone on 7/21/26 at 3:49 PM. The Physician reported he was not aware of the missing doses of tirzepatide for Resident #77, and he would have expected to be notified of each missing dose. A phone interview was conducted with the Nurse Practitioner on 7/22/26 at 11:09 AM. The Nurse Practitioner explained she was not aware Resident #77 had not been receiving doses of tirzepatide and Resident #77 had not mentioned this to her during her visits with the resident. The Nurse Practitioner reported she expected to be notified of all missed doses of medication so she could determine when the next dose should be administered. The Administrator was interviewed on 7/22/26 at 2:50 PM. The Administrator reported she was not aware the missing doses of Resident #77's tirzepatide had not been reported to the Physician or the Nurse Practitioner. The Administrator reported she expected the Physician or Nurse Practitioner was notified of all missed medications.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with resident, pharmacist, physician, Nurse Practitioner, and staff, the facility failed to protect a resident's right to be free from misappropriation of tirzepatide (a medication used for the treatment of elevated blood glucose levels, sleep apnea and weight management) for 1 of 3 residents reviewed for misappropriation of property (Resident #77). The findings included: Resident #77 was admitted to the facility on [DATE] with diagnoses including diabetes and sleep apnea. A physician order dated 11/19/25 ordered tirzepatide (a once weekly injectable medication) 10 milligrams (mg) once weekly on Thursdays for diabetes. Review of the pharmacy packing slip dated 2/24/26 documented 2 pens of tirzepatide 10 mg with 2 doses of medication per pen were delivered to the facility and signed by Nurse #10 as received on 2/24/26 at 12:42 AM. The Medication Administration Record (MAR) revealed Resident #77 received tirzepatide 10 mg on Thursday 2/26/26. A physician order dated 2/27/26 indicated Resident #77's tirzepatide dose increased from 10 mg to 12.5 mg to be injected every Thursday. The pharmacy packing slip dated 3/10/26 documented that 1 pen of tirzepatide 12.5 mg with 2 doses of medication was delivered on 3/10/26 at 1:24 AM. The signature on the receipt was illegible. The MAR indicated Resident #77 received tirzepatide 12.5 mg on Thursday 3/12/26 and Thursday 3/19/26. The pharmacy packing slip dated 3/20/26 documented that 2 tirzepatide 12.5 mg pens with 2 doses of medication per pen was delivered on 3/20/26 at 1:15 AM. The signature on the receipt was illegible. The MAR indicated Resident #77 received tirzepatide 12.5 mg on Thursday 3/26/26. On Thursday 4/2/26 tirzepatide was documented as not given and the progress note written by Nurse #3 indicated waiting on pharmacy. A phone interview was conducted with Nurse #3 on 7/21/26 at 10:24 AM. Nurse #3 reported she was aware that a lot of the time the tirzepatide was not available for administration, and she did not know why. Nurse #3 was unable to report the specific dates, but explained that at one time, the nurses were counting tirzepatide doses with the narcotic count, but that practice had not been done for a while. A pharmacy packing slip dated 4/2/26 documented that 2 tirzepatide 12.5 mg pens with 2 doses of medication per pen had been delivered to the facility on 4/2/26 at 8:29 PM. The signature on the receipt was illegible. The MAR revealed Resident #77 received tirzepatide 12.5 mg on the following Thursdays: 4/9/26, 4/16/26, 4/23/26, 4/30/26, 5/7/26 and 5/14/26. On 5/21/26 there was a notation by Nurse #4 that the medication was not in stock and was not administered. Attempts were made to contact Nurse #4 for interview, and those attempts were unsuccessful. A pharmacy packing slip dated 5/21/26 documented that 2 tirzepatide 12.5 mg pens with 2 doses of medication per pen were delivered on 5/21/26 at 12:43 PM. There was no signature on the receipt. A physician order dated 5/22/26 indicated tirzepatide 12.5 mg to be injected on Friday 5/22/26. The MAR indicated Resident #77 was administered tirzepatide 12.5 mg on Friday 5/22/26. The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #77 to be cognitively intact. The assessment coded her to have received one injection during the look-back period, and she was taking hypoglycemic medications (medications used to control blood glucose levels). Lab results for Resident #77 included a hemoglobin A1C (labs used to measure average blood glucose results over the past 3 months) dated 9/11/25 of 6.8 (normal 4.0-6.0). Lab results for Resident #77 included a hemoglobin A1C dated 5/29/26 of 7.1 (normal 4.0-6.0). The MAR revealed on Thursday 5/28/26 and Thursday 6/4/26 Resident #77 received 12.5 mg of tirzepatide. On Thursday 6/11/26 tirzepatide 12.5 mg was not administered and Nurse #5 documented medication reorder in a progress note. A phone interview was conducted with Nurse #5 on 7/21/26 at 12:45 PM. Nurse #5 reported she remembered the (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tirzepatide was not available for Resident #77 on 6/11/26 and she called the pharmacy to request a refill. Resident #77 weighed 362 pounds on 9/5/25. Resident #77 weighed 384 pounds on 6/9/26. A pharmacy packing slip dated 6/12/26 documented the delivery of 2 pens of tirzepatide 12.5 mg with 2 doses per pen. There was no signature indicating receipt of the medication on the packing slip and no date or time delivered. The MAR indicated Resident #77 received tirzepatide 12.5 mg on 6/18/26 and 6/25/26. Resident #77 did not receive tirzepatide on 7/2/26. A progress note written by Nurse #6 on 7/2/26 documented medication unavailable, awaiting order. Nurse #6 was interviewed on 7/21/26 at 11:49 AM. Nurse #6 reported she attempted to administer the medication to Resident #77 on 7/2/26 and the tirzepatide was not available. Nurse #6 explained she called the on-call provider and received an order to move the administration day to Saturday and then reordered the medication from the pharmacy. A physician order dated 7/4/26 discontinued the order to administer tirzepatide 12.5 mg on Thursday and indicated tirzepatide 12.5 mg to be injected every Saturday. A pharmacy packing slip dated 7/4/26 indicated 2 pens with 4 doses of tirzepatide per pen was delivered on 7/4/26 at 8:16 PM. The signature on the receipt was illegible. The MAR revealed Resident #77 received tirzepatide 12.5 mg on Saturday 7/4/26 and Saturday 7/11/26. Resident #77 did not receive tirzepatide on Saturday 7/18/26. A progress note written by Nurse #7 documented waiting on pharmacy delivery. Attempts were made to contact Nurse #7 for interview and those attempts were unsuccessful. A phone interview was conducted with the Pharmacist on 7/21/26 at 9:46 AM. The Pharmacist indicated that some tirzepatide pens had multiple doses and some had one dose per pen. The Pharmacist reviewed the packing slips for 2/24/26, 3/10/26, 3/20/26, 4/2/26, 5/21/26, 6/12/26, and 7/4/26 and explained the doses of tirzepatide and number of pens that had been delivered. The Pharmacist explained the medication could be refilled early with an override from the facility, but he did not know if an override had been completed for Resident #77's tirzepatide. The medication refrigerator was observed on 7/21/26 at 2:00 PM with Nurse #8. There were no doses of tirzepatide for Resident #77. The refrigerator was in the locked medication room. The refrigerator did not lock. Nurse #8 explained that all nurses on the B-side of the building had a key to the medication room. Resident #77 was interviewed on 7/19/26 at 11:18 AM and she reported she had been missing doses of tirzepatide for months. Resident #77 explained she was told by nursing staff that the medications had not been delivered from the pharmacy, but she felt like it happened at least once per month, and the doses had not been replaced. Resident #77 said she did not recall all the specific dates she did not receive the medication other than yesterday, 7/18/26. Resident #77 described feeling nauseated and fatigued when she missed a dose and then received the full dose a week later. It's almost like I'm starting all over with the medication. Resident #77 described the day after tirzepatide as a day where she didn't feel like she could do much because of fatigue and nausea and reported skipping a dose made the nausea and fatigue more intense. The Unit Manager was interviewed on 7/21/26 at 2:09 PM. The Unit Manager explained that on 7/2/26 Resident #77 had 4 doses of tirzepatide delivered to the facility. The Unit Manager reported on 7/6/26 she counted the doses and found that instead of having 3 remaining doses (after administration of the medication on 7/4/26), Resident #77 had only 2 doses of the medication. The Unit Manager explained that a tirzepatide pen was missing from the refrigerator. The Unit Manager reported she suspected someone had taken the tirzepatide. Unit Manager reported she started a count sheet on 7/6/26 for the medication and when nursing staff administered the tirzepatide, they were to count the remaining doses. The Unit Manager reported on 7/18/26 when Nurse #7 went to administer the medication, there were no doses left for administration. The Unit Manager explained she called the pharmacy and determined that one dose of medication would be sent weekly and kept in a locked refrigerator in her (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	office, and the administration date and time would be moved to day shift on Tuesday, so the medication would be handed to the nurse and she or the Director of Nursing (DON) could monitor the medication. The Unit Manager reported they attempted to determine which nurse was taking the medication, but they were unable to because there were too many nurses assigned to work with that medication cart. The Unit Manager reported Resident #77 was the only resident to receive tirzepatide in the facility. The DON was interviewed on 7/21/26 at 2:26 PM. The DON explained she had been in her position for 3 weeks and had no idea that Resident #77 was not receiving her prescribed tirzepatide until the Unit Manager told her on 7/6/26. The DON reported the facility suspected someone was taking the tirzepatide. The DON reported a refrigerator that locked had been ordered and the medication was to be kept in the Unit Manager's office and either she or the Unit Manager would provide the medication to the nurse for administration. The DON reported there was not a camera in the medication room to capture images of which nurse accessed the refrigerator and prior to this, there had been no process in place for tracking medications that were not narcotics. The DON reported she expected high value medications to be locked up and distributed by the Unit Manager during the day when the administration of the medication could be supervised. The facility Physician was interviewed by phone on 7/21/26 at 3:49 PM. The Physician reported he was not aware of the missing doses of tirzepatide for Resident #77. The Physician reported Resident #77 was not harmed by the missed medications. A phone interview was conducted with the Nurse Practitioner on 7/22/26 at 11:09 AM. The Nurse Practitioner explained she was not aware Resident #77 had not been receiving doses of tirzepatide and Resident #77 had not mentioned this to her during her visits with the resident. The Nurse Practitioner reported she did not believe Resident #77 was harmed by the missed tirzepatide doses. The Administrator was interviewed on 7/22/26 at 2:50 PM. The Administrator reported the medications were usually delivered by pharmacy at night and the receiving nurse was responsible for securing the medications, but there was no process in place for medications that were not narcotics. The Administrator reported because there was not a process in place for non-narcotic medications, someone felt they could take the tirzepatide. The Administrator reported the management team became aware of the missing medications when the Unit Manager discovered the tirzepatide pens were missing on 7/6/26. The Administrator reported the Unit Manager had attempted to discover who took the medication by interviewing the nurses who had access to the medication room during that weekend, but the Unit Manager was not able to identify anyone. The Administrator reported she expected a process to be put in place to secure high value medications and that no medications were taken by nursing staff.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident and staff, the facility failed to report an allegation of misappropriation of property to the State Agency, Adult Protective Services and law enforcement for suspicion of diversion of a resident's medication for 1 of 3 residents reviewed for misappropriation of property (Resident #77).The findings included:Review of the facility Abuse Policy dated 1/23/20 indicated misappropriation of property included the theft of a resident's medication and the facility reported incidents or allegations to the State Agency with an initial report for occurrences of alleged or reasonably suspected crime against a resident, including misappropriation of resident property.Resident #77 was admitted to the facility on [DATE] with diagnoses including diabetes and sleep apnea. A physician order dated 7/4/26 indicated tirzepatide (a medication used for the treatment of elevated blood glucose levels, sleep apnea and weight management) 12.5 milligrams (mg) to be injected every Saturday.Resident #77 was interviewed on 7/19/26 at 11:18 AM and she reported she had been missing doses of tirzepatide for months. Resident #77 explained she was told by nursing staff that the medications had not been delivered from the pharmacy, but she felt like it happened at least once per month, and the doses had not been replaced. Resident #77 said she did not recall all the specific dates she did not receive the medication other than Saturday, 7/18/26.Review of the facility's initial and investigation reports revealed no report had been submitted for Resident #77 related to missing tirzepatide.The Unit Manager was interviewed on 7/21/26 at 2:09 PM. The Unit Manager reported on 7/6/26 she counted the doses of Resident #77's tirzepatide and found that a tirzepatide pen was missing from the medication refrigerator. The Unit Manager stated she suspected someone had taken the tirzepatide and reported this information to the Director of Nursing (DON). The Unit Manager reported they attempted to determine which nurse was taking the medication, but they were unable to because there were too many nurses assigned to work with that medication cart. The Unit Manager reported when the tirzepatide dose was missing on 7/18/26, she was certain a nurse was taking the medication. The Unit Manager reported Resident #77 was the only resident to receive tirzepatide in the facility. The DON was interviewed on 7/21/26 at 2:26 PM. The DON reported the facility suspected someone was taking the tirzepatide, but she and the Unit Manager were unable to identify any staff responsible for the missing medications. The DON explained when the tirzepatide dose for 7/18/26 was not available, they were certain a nurse was taking the medication. The Administrator was interviewed on 7/27/26 at 4:31 PM by phone. The Administrator reported when the tirzepatide was discovered as missing on 7/6/26 the facility was not investigating it as misappropriation and did not file a report with the State, notify Adult Protective Services or notify law enforcement because they did not think a crime had been committed. The Administrator reported the Unit Manager had attempted to discover who took the medication by interviewing the nurses who had access to the medication room during that weekend, but the Unit Manager was not able to identify anyone.		

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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 observation, record review, and interviews with staff, resident, and the resident's Responsible Party, the facility failed to provide incontinence care when needed for 1 of 8 dependent residents reviewed for activities of daily living (ADL) (Resident #23). Findings included: Resident #23 was readmitted to the facility on [DATE] with diagnoses including Alzheimer's dementia, congestive heart failure, and stroke. A physician order dated 4/2/25 specified to give furosemide (a diuretic medication used to remove excess fluid by increased urination) 40 milligrams by mouth twice daily. The annual Minimum Data Set (MDS) dated [DATE] documented that Resident #23 had moderate cognitive impairment and was fully dependent on staff for all ADL, including hygiene, dressing, transfers to and from her wheelchair, and bed mobility when turning side to side, or changing position in the bed or chair. Resident #23 was always incontinent of urine and stool, had an unstageable pressure ulcer (skin pressure injury with an undetermined depth and stage) and moisture-associated skin damage (inflammation and erosion of the skin caused by prolonged exposure to moisture from sources such as urine, stool, sweat, and wound exudate). The care plan dated 7/6/26 documented that Resident #23 had a pressure ulcer and incontinence associated dermatitis (reddened raw areas of skin to the groin caused by prolonged contact with urine or stool). Interventions included to provide prompt incontinence care, maintaining clean and dry skin, and turn and reposition the resident often to prevent further skin injury. The care plan documented that Resident #23 required a two person assist for bed mobility. Review of the Wound Care note dated 7/15/26 at 2:27 PM by the Wound Nurse Practitioner indicated that resident #75's left and right ischium and peri wound were denuded (skin rubbed off), erythematous (reddened), excoriated (scraped skin), fragile (easily torn), macerated (overly wet), and had non-blanchable (persistently red) dark red discoloration with induration (firm swelling). There was a moderate amount of serosanguinous drainage. The wounds were described as stable. On 7/19/26 at 10:35 AM, Resident #23 was observed asleep with the head of bed elevated to approximately 30 degrees. Resident #23 wore a silk nightcap and hospital gown. Her linens appeared clean, and no staff were observed providing care. There was no urine odor detected upon entry. On 7/19/26 at 11:20 AM, Resident #23 remained asleep with the head of bed near 30 degrees. Her gown, cap, blanket, and linen arrangement remained unchanged. No staff were observed providing care. There was no urine odor detected upon entry. On 7/19/26 at 1:30 PM, Resident #23 was observed in bed with the head of bed elevated at approximately 30 degrees. A urine odor was noted upon entering the room. During an observation and interview on 7/19/26 at 2:35 PM with Nursing Assistant (NA) #9, the NA was observed preparing to complete a full bed bath and linen change for Resident #23. NA #9 indicated that she was changing the bed linens due to a large amount of urinary incontinence. A strong urine odor was present. The hospital gown Resident #23 wore was wet and the fitted sheet under Resident #23 was wet and had a yellow-colored ring that extended out to the side of the mattress. NA #9 reported she first rounded on Resident #23 at approximately 9:00 AM and washed her hands and face after breakfast and provided incontinence care at that time. NA #9 stated Resident #23 required incontinence care at least every two hours and more often if drinking fluids. NA #9 stated she did not return to provide incontinence care after lunch trays were delivered and acknowledged she had not provided any care since the 9:00 AM round. NA #9 reported that she delivered the lunch tray to Resident #9 and had to return to the meal cart to deliver other residents' lunch trays. NA #9 stated she then had to pick the trays back up after lunch was over. When asked why she hadn't provided care before lunch, or after lunch, NA #9 replied she got busy with other residents and didn't (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make it back to Resident #23. On 7/19/26 at 3:30 PM during an interview with Resident #23's Responsible Party (RP), she reported that she arrived on 7/19/26 around 1:30 PM and observed Resident #23's gown and bed linens were wet with urine. The RP stated she used the call light and asked NA #9 who was assigned to Resident #23 and requested the NA provide incontinence care. She reported that NA #9 stated she was assigned to Resident #23 and was preparing to change all of the bed linens and provide a bed bath. The RP reported NA #9 left the room and returned after approximately 20 to 30 minutes with a stack of linens to provide care. The RP stated she frequently visited for 6 to 8 hours per day and had observed periods of four or more hours without care or repositioning. The RP stated she often found the resident wet and smelling of urine and expressed concern that staff were not checking the resident every couple of hours. The RP reported she had expressed her care concerns to the nursing leadership previously on multiple occasions but was unable to provide exact dates. Resident #23 was interviewed on 7/20/26 at 11:15 AM, immediately after wound care was provided, and reported that staff had not changed her or gotten her dressed for the day on 7/19/26 until well after lunch. Resident #23 reported it was an issue that her RP talked to the nursing leadership about. Resident #23 stated she had bathing products and clothing that were provided by her family and there were always clean linens for her to have so did not know why the staff ignored her. She reported that she asked to be changed on 7/19/26 when they brought her lunch tray in and NA #9 said she would be back to do it and she did not. Resident #23 could not recall who picked up her lunch tray or if she asked again to be changed and get dressed. Multiple attempts to conduct a telephone interview with Nurse #9 who was assigned to Resident #23 on 7/19/26 were unsuccessful. An observation of the Wound Nurse providing wound care to Resident #23 and interview were conducted on 7/20/26 at 10:30 AM. Resident #23 had non-blanchable maroon discoloration, redness, maceration, and excoriation to her peri area that extended from the mid-line of the right buttock to the inner groin folds, and upwards from her buttocks towards her left and right ischium (part of your pelvis that you sit on). Her inner thighs were reddened and excoriated. There were remnants of thick white barrier cream present in skin folds between her thigh and groin. The Wound Nurse indicated that the peri wounds were improving and she had notified the RP of the improvement. The Wound Nurse indicated that the right and left ischium wound and peri wounds could potentially be negatively impacted by any delay in providing incontinence care. The Wound Nurse indicated she provided wound treatments to Resident #75 every day, Monday through Friday. The Wound Nurse indicated she did not work on 7/19/26 and the agency nurse would have provided the prescribed daily wound care. The Wound Nurse reported that Resident #23's wounds looked better than the week prior. On 7/21/26 at 10:34 AM, the Assistant Director of Nursing (ADON) was interviewed and stated she was not aware that Resident #23 had not been provided with incontinence care for several hours on 7/19/26 from NA #9 or another staff member. The ADON stated that the care Resident #23 received on 7/19/26 did not follow her care plan and was not consistent with staff training. She stated the lack of incontinence care for Resident #23 from 9:00 AM to 2:30 PM was unacceptable. The ADON reported she met with Resident #23's RP approximately one month prior to address the concerns regarding nursing staff not providing incontinence care. The ADON stated NAs should make rounds on residents every 2 hours and provide incontinence care, if needed. The ADON reported that residents who were on medications that make them urinate or move their bowels more frequently should be checked more frequently. The ADON indicated she was disappointed that Resident #75 did not receive incontinence care for several hours and NA #9 was not trained to provide care in that manner. The ADON reported she planned to follow up with NA #9 on her next scheduled workday. On 7/20/26 at 1:50 PM, the Director of Nursing (DON) was interviewed. The DON stated she was not (continued on next page)		

Department of Health & Human Services
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware that NA #9 reported that she did not provide the care to Resident #23 between 9:00 AM and 2:00 PM on Sunday 7/19/26 because she needed to pass lunch trays and then pick them up afterward. The DON stated that NAs were expected to prioritize resident needs and that residents who were incontinent must be attended to promptly. She reported that staff should always change a resident's incontinence brief when the resident requests to prevent skin breakdown and to provide good customer service. The DON reported that what happened with Resident #23 on 7/19/26 was unacceptable. On 7/21/26 at 12:24 PM, the Administrator was interviewed and reported that staff were expected to round every two hours and notify the nurse if they were unable to provide required care. She stated there were no staffing or system issues that should have prevented timely incontinence care for Resident #23.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with staff and the Nurse Practitioner, the facility failed to apply a right`hand C`grip splint (a hand orthosis designed to support the wrist and fingers) as ordered by the physician for 1 of 1 residents (Resident #10) reviewed for contractures and range of motion (ROM).Findings included:Record review showed Resident #10 was admitted to the facility on [DATE] with diagnoses including stiffness of the right hand, hemiplegia (paralysis of one side of the body), and hemiparesis (severe weakness affecting one side of the body) following cerebrovascular disease affecting the dominant right side, muscle weakness, and dementia.Review of the care plan revealed the facility care`planned Resident #10 as requiring assistance with activities of daily living (ADLs) due to chronic health conditions and cerebrovascular accident with hemiplegia (revision date 3/29/26). Interventions included the resident wearing a right`hand C`grip splint during nighttime hours for 8 hours or as tolerated, and referring to therapy as needed.Review of the Occupational Therapy Discharge summary dated [DATE] showed Resident #10 received Occupational Therapy services from 4/14/26 through 5/27/26. The long`term goal was for Resident #10 to safely wear a C`grip splint on the right hand, wrist, and fingers for up to 8 hours with minimal signs or symptoms of redness, swelling, discomfort, or pain. At discharge, the resident was able to tolerate the splint for 8 hours. Therapy discharged the resident due to achieving maximum potential. Discharge recommendations directed the resident to wear the C`grip splint 8 hours daily or as tolerated.Review of orders dated 5/27/26 indicated: Patient to wear RIGHT C`grip SPLINT during nighttime hours for 8 hours or as tolerated.Review of the Splint/Orthotic Wear and Care instructions from the Occupational Therapist dated 5/27/26 documented the splint was intended to prevent further contractures of the hands, wrists, and fingers. The resident was to wear the right C`grip splint during nighttime hours for 8 hours daily or as tolerated. The document indicated that the nursing staff had been trained on splint application on 5/27/26. The nurse who signed the document that nursing staff was trained was not in the facility during the survey and was not interviewed.Review of the most recent comprehensive Minimum Data Set (MDS) assessment, a Significant Change dated 6/30/26, showed Resident #10 was severely cognitively impaired, did not exhibit behaviors or rejection of care, and had impairment in both upper and lower extremities. The resident required substantial to maximum assistance with most ADLs and was not on therapy services.Review of Resident #10's medication administration record (MAR), treatment administration record (TAR), and Point`of`Care (POC) documentation which were a part of the Electronic Medical Record (EMR) for June and July 2026 showed no documentation that staff applied or removed splints. Observations on 7/21/26 at 6:30 AM revealed Resident #10 in his wheelchair without splint.During an interview on 7/21/26 at 7:10 AM, Nurse #12 stated that she had been assigned to Resident #10 and worked the 7 PM to 7 AM shift. Nurse #12 stated she was not aware that Resident #10 had splint. Nurse #12 stated she had not applied splints and had not observed the resident wearing splint at night. After reviewing Resident #10's MAR and TAR in resident's EMR, she stated she did not see any splint orders. She was unsure where the resident's splints were located in his room.During an interview on 7/21/26 at 9:50 AM, the Rehabilitation Director stated Resident #10 had contractures in his right hand. He said the resident could move and open his right hand, and therapy recommended the C`grip splint be applied at night. He stated the resident had been under Occupational Therapy services a few months prior because his splint was misplaced. The therapist verified proper fit, comfort, and skin integrity, and confirmed the resident (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tolerated the splint for 8 hours. After discharge, the Occupational Therapist educated nursing staff on hand exercises and splint application. Occupational Therapist provided the splint recommendations and orders to the unit nurse. In an interview on 7/21/26 at 9:50 AM, Unit Manager #1 stated the therapist entered a splint order on 5/27/26 into the EMR, but this order was not transcribed by the nurse into the MAR or TAR in the EMR. As a result, staff could not see the order or document application and removal of the splints. Unit Manager #1 stated she did not believe staff were applying the splints at night. Unit Manager #1 was unsure who was responsible for splint application. She indicated depending on the type of splint to be applied to the resident, Nurses and Nurse Aides were trained by therapy. Some splints could be easily applied by the Nurse Aides when trained and some required Nurses to apply the splint. An observation of the resident's room with Unit Manager #1 on 7/21/26 at 10:00 AM revealed Resident #10's splint was stored in the bottom drawer of the nightstand. During an interview on 7/21/26 at 1:55 PM, Nurse Practitioner #1 stated Resident #10 had right hand contractures and that the C-grip splints would prevent the contractures from worsening. She stated the resident should wear the splints at night per therapy recommendations. She stated she should be notified if the resident refused the splints or if any concerns related to the splints or skin integrity arose. During an interview on 7/21/26 at 1:30 PM, the Director of Nursing (DON), stated that for any resident with splint ordered by therapy, the nurses must enter the splint order and transcribe it on to the MAR in resident's EMR. Once in the MAR, Nurses could see the order, apply the splint as directed, and document application or refusal. The DON stated if a resident repeatedly refused the splint application, had skin integrity concerns, or could not tolerate the recommended duration, then therapy and the DON should be notified.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with resident, pharmacist, physician, Nurse Practitioner, and staff, the facility failed to administer tirzepatide (a medication used for the treatment of elevated blood glucose levels, sleep apnea and weight management) as ordered for 1 of 7 residents reviewed for significant medication errors (Resident #77).The findings included:Resident #77 was admitted to the facility on [DATE] with diagnoses including diabetes and sleep apnea. A physician order dated 11/19/25 ordered tirzepatide (a once weekly injectable medication) 10 milligrams (mg) once weekly on Thursdays for diabetes.Resident #77 weighed 362 pounds on 9/5/25.Resident #77 weighed 384 pounds on 6/9/26. Lab results for Resident #77 included a hemoglobin A1C (labs used to measure average blood glucose results over the past 3 months) dated 9/11/25 of 6.8 (normal 4.0-6.0). Lab results dated 5/29/26 for Resident #77 included a hemoglobin A1C of 7.1. The Medication Administration Record (MAR) revealed Resident #77 received tirzepatide 10 mg on Thursday 2/26/26.A physician order dated 2/27/26 indicated Resident #77's tirzepatide dose increased from 10 mg to 12.5 mg to be injected every Thursday.The MAR revealed on Thursday 3/5/26, Resident #77 did not receive tirzepatide 12.5 mg. There was no progress note written by Nurse #2 to explain why she did not receive the medication.A phone interview with Nurse #2 was conducted on 7/21/26 at 3:08 PM. Nurse #2 reported she did not remember why Resident #77 did not receive the tirzepatide on 3/5/26. Nurse #2 reported if the medication was not given, the medication was not available. The MAR indicated Resident #77 received tirzepatide 12.5 mg on Thursday 3/12/26 and Thursday 3/19/26.The MAR indicated Resident #77 received tirzepatide 12.5 mg on Thursday 3/26/26.On Thursday 4/2/26 tirzepatide was documented as not given and the progress note written by Nurse #3 indicated waiting on pharmacy.A phone interview was conducted with Nurse #3 on 7/21/26 at 10:24 AM. Nurse #3 reported she was aware that a lot of the time the tirzepatide was not available for administration, and she did not know why. Nurse #3 was unable to report the specific dates.The MAR revealed Resident #77 received tirzepatide 12.5 mg on the following Thursdays: 4/9/26, 4/16/26, 4/23/26, 4/30/26, 5/7/26 and 5/14/26. On 5/21/26 there was a notation by Nurse #4 that the medication was not in stock and was not administered.Attempts were made to contact Nurse #4 for interview, and those attempts were unsuccessful.A physician order dated 5/22/26 indicated tirzepatide 12.5 mg to be injected on Friday 5/22/26.The MAR indicated Resident #77 was administered tirzepatide 12.5 mg on Friday 5/22/26.The quarterly Minimum Data Set assessment dated [DATE] assessed Resident #77 to be cognitively intact. The assessment coded her to have received one injection during the look-back period, and she was taking hypoglycemic medications (medications used to control blood glucose levels).The MAR revealed on Thursday 5/28/26 and Thursday 6/4/26 Resident #77 received 12.5 mg of tirzepatide. On Thursday 6/11/26 tirzepatide 12.5 mg was not administered and Nurse #5 documented medication reorder in a progress note.A phone interview was conducted with Nurse #5 on 7/21/26 at 12:45 PM. Nurse #5 reported she remembered the tirzepatide was not available for Resident #77 on 6/11/26 and she called the pharmacy to request a refill. Nurse #5 did not know why the medication was not available. The MAR indicated Resident #77 received tirzepatide 12.5 mg on 6/18/26 and 6/25/26. Resident #77 did not receive tirzepatide on 7/2/26. A progress note written by Nurse #6 on 7/2/26 documented medication unavailable, awaiting order. Nurse #6 was interviewed on 7/21/26 at 11:49 AM. Nurse #6 reported she attempted to administer the medication to Resident #77 on 7/2/26 and the tirzepatide was not available. Nurse #6 explained she called the on-call provider and received an order to move the administration day to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Cabarrus Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Brookwood Avenue NE Concord, NC 28025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Saturday and then reordered the medication from the pharmacy. A physician order dated 7/4/26 discontinued the order to administer tirzepatide 12.5 mg on Thursday and indicated tirzepatide 12.5 mg to be injected every Saturday. The MAR revealed Resident #77 received tirzepatide 12.5 mg on Saturday 7/4/26 and Saturday 7/11/26. Resident #77 did not receive tirzepatide on Saturday 7/18/26. A progress note written by Nurse #7 documented waiting on pharmacy delivery. Attempts were made to contact Nurse #7 for interview and those attempts were unsuccessful. A phone interview was conducted with the Pharmacist on 7/21/26 at 9:46 AM. The Pharmacist indicated that some tirzepatide pens had multiple doses and some had one dose per pen. The Pharmacist reviewed the packing slips for 2/24/26, 3/10/26, 3/20/26, 4/2/26, 5/21/26, 6/12/26, and 7/4/26 and explained the doses of tirzepatide and number of pens that had been delivered. The Pharmacist explained the medication could be refilled early with an override from the facility, but he did not know if an override had been completed for Resident #77's tirzepatide. The medication refrigerator was observed on 7/21/26 at 2:00 PM with Nurse #8. There were no doses of tirzepatide for Resident #77. Resident #77 was interviewed on 7/19/26 at 11:18 AM and she reported she had been missing doses of tirzepatide for months. Resident #77 explained she was told by nursing staff that the medications had not been delivered from the pharmacy, but she felt like it happened at least once per month, and the doses had not been replaced. Resident #77 said she did not recall all the specific dates she did not receive the medication other than yesterday, 7/18/26. Resident #77 described feeling nauseated and fatigued when she missed a dose and then received the full dose a week later. It's almost like I'm starting all over with the medication. Resident #77 described the day after tirzepatide as a day where she didn't feel like she could do much because of fatigue and nausea and reported skipping a dose made the nausea and fatigue more intense. The DON was interviewed on 7/21/26 at 2:26 PM. The DON explained she had been in her position for 3 weeks and had no idea that Resident #77 was not receiving her prescribed tirzepatide until the Unit Manager told her on 7/6/26. The DON reported the facility suspected someone was taking the tirzepatide. The facility Physician was interviewed by phone on 7/21/26 at 3:49 PM. The Physician reported he was not aware of the missing doses of tirzepatide for Resident #77. The Physician reported Resident #77 was not harmed by the missed medications, her increase in Hemoglobin A1c and weight were not significant. A phone interview was conducted with the Nurse Practitioner on 7/22/26 at 11:09 AM. The Nurse Practitioner explained she was not aware Resident #77 had not been receiving doses of tirzepatide and Resident #77 had not mentioned this to her during her visits with the resident. The Nurse Practitioner reported she did not believe Resident #77 was harmed by the missed tirzepatide doses.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Cabarrus Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 430 Brookwood Avenue NE Concord, NC 28025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, the facility failed to ensure that the required privacy curtain was in place and maintained in a shared resident room for 1 of 6 residents reviewed for privacy (Resident #73). Findings included: Resident #73 was admitted to the facility on [DATE] with diagnoses including stroke, vascular dementia with agitation, speech and language deficits, and cognitive communication deficit. The annual MDS dated [DATE] documented severe cognitive impairment and total dependence on staff for all activities of daily living. On 7/19/26 at 11:09 AM, surveyor observed that the privacy curtain normally hung between Resident #73's bed and his roommate's bed was missing, with only approximately 12 inches of torn curtain remaining attached to the track. No curtain separated the two beds. On 7/19/26 at 11:13 AM, Nurse #17 reported she was unaware of a missing privacy curtain and indicated that a work order must be entered for the missing privacy curtain in Resident #73's room. On 7/20/26 at 9:30 AM the room still had no privacy curtain in place. On 7/21/26 at 9:43 AM, Nursing Assistant (NA) #6 reported that she was assigned to Resident #73 on 7/21/26 from 7:00 AM to 7:00 PM. She stated she was not aware that the privacy curtain was missing and noted that all shared rooms should have privacy curtains between the beds. NA #6 stated that if there was any issue with a privacy curtain (such as being broken, ripped, or soiled), she would report the concern to the nurse, who would then enter an emergency work order into the computer. On 7/21/26 at 10:34 AM, the Associate Director of Nursing (ADON) confirmed multiple nursing assistants (NA #7 and NA #8) had been assigned to Resident #73 over the dates the curtain had been missing and stated that staff were expected to notify the supervisor immediately when a privacy curtain was missing. The ADON reported a work order had been entered on 7/20/26 at 7:30 AM and that the curtain was not replaced until 7/21/26 at 10:30 AM. Attempts to contact NA #7 were unsuccessful. On 7/22/26 at 10:22 AM, during a telephone interview, NA #8 stated that the privacy curtain should be drawn before care is provided. NA #8 stated she did not report the missing curtain in resident #73's room to the nurse because she was unaware it was missing. On 7/20/26 at 7:10 AM, Nurse #14 stated she had been unaware the curtain was missing and explained that NA staff should have notified her so that she could enter a work order. Nurse #14 confirmed she submitted a work order on 7/20/26 at 7:30 AM. On 7/21/26 at 12:14 PM, the Housekeeping Director reported he had not been notified by housekeeping staff that the curtain was missing on 7/19/26 or 7/20/26. He explained he was informed only on 7/21/26 around 9:30 AM by nursing leadership and replaced the curtain by 10:30 AM. On 7/21/26 at 1:09 PM, the Maintenance Director reported that privacy curtain work orders were considered critical. He explained the first work order dated 7/20/26 at 7:30 AM had been closed prematurely because maintenance staff believed housekeeping had already installed the replacement curtain. A second work order later the same day was not recognized as a duplicate, contributing to the delay. The Maintenance Director stated this was a breakdown in communication between maintenance and housekeeping. On 7/21/26 at 12:24 PM, the Administrator stated she had been unaware that the curtain was missing and reported it was her expectation that every shared room maintain a functioning privacy curtain. She indicated the delay resulted from communication breakdown between departments.		