STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345342	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Elm Retirement and Nursing Centers	1285 West A Street Kannapolis, NC 28081

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 and staff interviews, the facility failed to afford the resident the right to participate in the care planning process for 2 of 2 residents reviewed for care plans (Resident #31, and Resident #21). The findings included: a. Resident #31 was admitted to the facility on [DATE] with diagnosis of hypertension, diabetes mellitus and respiratory failure. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #31 was cognitively intact. Resident #31’s care plan was last updated on 7/2/25. An interview with Resident #31 on 8/25/25 at 11:45 AM was conducted and the Resident stated she had not been invited to a care plan meeting, and that there was not a family member that would have been invited instead of her. She stated that she would like to be invited to care plan meetings. An interview on 8/28/25 10:25 AM with the Social Worker (SW) was conducted. The SW indicated she had been employed since May 2024. She further indicated that the former Administrator never told her that care plan meetings were to be held for every resident on a quarterly basis. The SW stated she was trained to have care plan meetings only if the family or residents ask for one. The SW added the only care plan meetings conducted were for short-term rehabilitation residents only. The SW stated for the long-term Residents, care plan meetings were done by request, for change in condition, wounds or falls. An interview with the MDS Nurse on 8/28/25 at 10:25 AM was conducted. The MDS Nurse indicated that she was told by the former Administrator not to be involved with the Social Worker’s task to invite the Resident or Responsible Party for a care plan meeting, so she did not intervene when the meetings were not being held. She further indicated that care plan updates were completed quarterly, as needed and annually. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 8/28/25 at 10:54 AM was conducted. The DON stated that care plan meetings were happening, but the invitation letters or phone calls to invite residents and/or Responsible Parties were not being made. The DON indicated that he dropped the ball in following up on the care plan meetings due to the position changes that had taken place. He explained he had stepped down as Administrator to the DON position until a new DON could be hired. The DON stated the care plan meeting process was that Residents that were alert and oriented were invited to attend and residents that were not alert and oriented had their Responsible Party invited. He further stated that the SW was very involved but did not know that she was supposed to conduct care plan meetings by inviting residents and/or the Responsible Party. He further stated that his expectation was that all Residents and Responsible Parties were invited to the care plan meetings and that documentation of the invitation be it phone call, letter or in person be uploaded into the medical record. b. Resident #21 was admitted to the facility on [DATE] with diagnoses of hypertension, chronic pain, muscle weakness, and lack of coordination. Review of Resident #21’s quarterly Minimum Data Set, dated [DATE] revealed the resident was cognitively intact. Resident #21’s revised care plan was completed on 07/23/25. Review of Resident #21’s medical record revealed no documentation that a care plan meeting had been completed with Resident #21 or the Resident Representative (RR). An interview conducted with Resident #21 on 8/27/25 at 11:17 AM revealed that she had not been invited to her care plan meetings. Resident #21 further revealed she would have attended the care plan meetings if she had been invited. An interview with Resident #21 on 8/25/25 at 2:05 PM was conducted and the Resident stated she had not been invited to a care plan meeting. The resident further revealed she would like to be invited to care plan meetings to discuss goals and plans of possible discharge. An interview on 8/28/25 10:25 AM with the Social Worker (SW) was conducted. The SW indicated she had been employed since May 2024. She further indicated that the former Administrator never told her that care plan meetings were to be held for every resident on a quarterly basis. The SW stated she was trained to have care plan meetings only if the family or residents ask for one. The SW stated for the long-term Residents, care plan meetings were done by request, for change in condition, wounds or falls. An interview with the MDS Nurse on 8/28/25 at 10:25 AM was conducted. The MDS Nurse indicated that she was educated to not be involved in care plan meetings per the prior Administrator. She further indicated that care plan meetings were conducted by the SW. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 8/28/25 at 10:54 AM was conducted. The DON stated that care plan meetings were happening, but the invitation letters or phone calls to invite residents and/or Responsible Parties were not being made. The DON indicated that he dropped the ball in following up on the care plan meetings due to the position changes that had taken place. He explained he had stepped down as Administrator to the DON position until a new DON could be hired. The DON stated the care plan meeting process was that Residents that were alert and oriented were invited to attend and residents that were not alert and oriented had their Responsible Party invited. He further stated that the SW was very involved but did not know that she was supposed to conduct care plan meetings by inviting residents and/or the Responsible Party. He further stated that his expectation was that all Residents and Responsible Parties were invited to the care plan meetings and that documentation of the invitation be it phone call, letter or in person be uploaded into the medical record.

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to provide 1 of 3 residents with quarterly statements of their personal trust fund account managed by the facility (Resident #21). The findings included:Resident #21 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #21 was cognitively intact.Interview with Resident #21 on 08/25/25 at 2:05 PM revealed she had not received any statements since admission but had money in a resident trust fund account. The Resident further revealed she wanted to receive quarterly statements to know how much money she had to spend in her account. Resident #21 stated no staff in the facility had ever discussed the resident's available funds with her.Interview with the Business Office Manager (BOM) on 08/27/25 at 1:20 PM revealed Resident #21 had not received any quarterly statements since admission. The BOM further revealed the facility had been mailing the quarterly statements to the resident's former home address and the resident should have been receiving them. The Business Office Manager indicated Resident #21 had money in a resident trust fund account that was managed by the facility. The BOM stated she was not sure how it was missed but would speak to Resident #21 and would start giving quarterly statements to Resident #21.An interview with the Director of Nursing (DON) on 08/28/25 at 12:30 PM revealed he was not aware Resident #21 had not received quarterly statements. The DON further revealed Resident #21 should receive quarterly statements and be knowledgeable of the money in her account.

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F 0689 Level of Harm - Minimal harm or potential for 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)

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F 0689 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 Nurse Practitioner (NP) interviews, the facility failed to maintain safety for a severely cognitively impaired resident in a wheelchair when the Activities Director was assisting residents out the double doors at the front entrance of the facility to smoke. After assisting Resident #9 outside, the Activities Director failed to lock the brakes of Resident #9's wheelchair and Resident #9 rolled down the pavement in front of the facility approximately 31 feet and fell out of her wheelchair landing on her left side. Resident #9 sustained skin tears to the left elbow and left AKA (above the knee amputation) stump. Resident #9 also sustained abrasions to the chin, left cheek, lips, and the bridge of the nose with visible bleeding from the nostrils. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #9).The findings included:Resident #9 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, lack of coordination, tobacco use, chronic pain, anxiety and depression.The quarterly MDS dated [DATE] revealed Resident #9 had severe cognitive impairment, rejected care daily, had bilateral lower extremity impairment and used a wheelchair. Resident #9 required substantial to maximal assistance with toileting hygiene, bathing, upper body dressing, rolling left to right and sitting to lying. Resident #9 was dependent on staff for lower body dressing and chair to bed to chair transfers. Resident #9 required supervision or touching assistance with propelling her wheelchair 50 feet with two turns and was dependent on staff for propelling her wheelchair 150 feet.Review of Resident #9's Focused Care Plan for Smoking dated 5/5/2025 indicated the resident would be assessed for smoking and required supervision at all times. The goal stated Resident #9 would abide by the smoking policy and would be supervised during smoking times through the review period. The interventions included to assess Resident #9's compliance with the smoking policy, staff to go out with Resident #9 at smoking intervals per facility protocol, smoking per facility protocol and supervision with all smoking activity.The Focused Care Plan for Risk of Falls related to bilateral above the knee amputation (AKA) dated 5/5/2025 indicated Resident #9 was at risk for falls due to weakness, deconditioning and decreased mobility. The goal stated Resident #9 would have reduced risk for fall injuries through staff assessment and interventions through the review period. The interventions included to anticipate resident needs, educate resident to allow staff to assist her when outside in her wheelchair for safety and to educate resident, family and caregivers about safety reminders and what to do if a fall occurs. An interview with the Activities Director was conducted on 8/26/25 at 3:06 PM. The Activities Director stated on 7/21/2025 she was assisting three (3) residents outside the front entrance of the building to smoke. She stated she positioned Resident #9 next to a garbage can outside the second set of double doors to avoid her wheelchair from rolling and quickly turned to assist the other two (2) residents and to avoid the door from hitting one of the residents. She stated when she turned back around, she observed Resident #9 laying on her left side with her head facing the parking lot yelling help get me up with blood observed around her nose. She notified Nurse #1 who assessed the resident and assisted her back to her wheelchair. She admitted she did not lock the brakes to Resident #9's wheelchair because everything happened so fast. She further stated she was in-serviced the following day by the Administrator (the current Director of Nursing).A progress note from Nurse #1 dated 7/21/2025 at 4:38 PM revealed Resident #9 was found by staff outside of the facility lying on the sidewalk on her left side bleeding from the nose. In addition, the note indicated Resident #9 sustained skin tears to her left elbow, left above the knee amputation (AKA) stump, an abrasion to the left cheek, lips and nose. Nurse #1 indicated the bleeding from the resident's nose was controlled and the resident was assisted back to her wheelchair and to her bed. Nurse Practitioner #1 assessed the resident and placed orders for the resident to be transferred to the hospital for further evaluation. Emergency Medical Service (EMS) arrived at the facility on 7/21/2025 at 5:59 PM to transport Resident #9 to the hospital. On 8/27/2025 at 9:44 AM Nurse #1 was interviewed. She stated she was notified by a Nurse Assistant (NA) that Resident #9 fell outside. She stated that she observed Resident #9 laying on the pavement. She assessed Resident #9 and noted skin tears the left elbow and left above the knee (AKA) stump. Resident #9 was also observed to have blood coming from the nose. Pressure was applied to control the bleeding. Nurse #1 stated Resident #9 was crying in pain but could not recall where the pain was. Nurse #1 assisted Resident #9 back to her wheelchair and escorted the resident to her room for further assessment. The assessment found no additional injuries, resident cognition was at baseline and range of motion (ROM) was intact. Nurse Practitioner #1 was notified, assessed the resident and placed an order for the resident to be transferred to

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with resident and staff, the facility failed to post cautionary signs for oxygen in use for 1 of 3 residents reviewed for respiratory care (Resident #28). The findings included:Resident #28 was admitted to the facility 07/28/25 with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure,. Review of Resident #28's admission Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact and was coded for oxygen use. A physician order for Resident #28 dated 08/15/25 read oxygen at 2 liters per minute via nasal canula to maintain oxygen above 90%.An observation conducted on 08/25/25 at 3:05 PM revealed there was no cautionary signage for oxygen use found anywhere near the entrance of Resident # 28's room. Resident #28 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident #28's room.An observation conducted on 08/27/25 at 9:25 AM revealed there was no cautionary signage for oxygen use found anywhere near the entrance of Resident # 28's room. Resident #28 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident # 28's room.An interview conducted with Unit Manager #1 on 08/28/25 at 11:00 AM revealed she was not aware Resident #24, Resident #23, and Resident #28 did not have an oxygen sign posted outside their rooms but should have. UM #1 stated she and nursing were responsible for hanging cautionary oxygen signs.An interview conducted with the Director of Nursing (DON) dated 08/28/25 at 12:30 PM revealed the facility had recently had renovations and the signs were not put back up. The DON stated he was not aware the signs were not posted, and cautionary oxygen signs were expected to be posted for any residents with oxygen orders.