STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Cabarrus	250 Bishop Lane 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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 Nurse Practitioner (NP) and staff interviews, the facility failed to write an order to resume warfarin (an anticoagulant medication used to thin blood after a stroke) after laboratory results were received which resulted in a resident missing 3 consecutive doses of warfarin. This was for 1 of 4 residents reviewed for professional standards (Resident #1).The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including stroke, left-sided hemiplegia (paralysis on one side of the body) and heart disease. The admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 was cognitively intact. The MDS documented Resident #1 was taking anticoagulant medications. A care plan dated 10/30/25 addressed Resident #1's use of anticoagulant medication with interventions including administering the anticoagulant medications as ordered and observe for adverse reactions including bruising, blood in the urine or stool, or changes in vital signs. Review of the facility warfarin protocol (no date) signed by the facility physician revealed laboratory blood draws for Protime/International Normalized Ratio (PT/INR) (blood work to test blood clotting time in response to the medication warfarin), revealed that residents taking warfarin were to have PT/INR lab draws on Monday and Thursday of every week and orders were as follows depending on results: - INR results less than 2.0: increase the daily dose of warfarin by 0.5 mg and recheck the PT/INR on the next scheduled date- INR results 2.0-3.0: no dose change, recheck the PT/INR next scheduled day- INR results 3.01-3.50: decrease the dose by 0.5 mg, recheck PT/INR next scheduled day- INR results 3.51-4.0: hold warfarin for 1 day, decrease the dose by 0.5 mg, recheck PT/INR the next scheduled day- INR results 4.01-6.0: hold warfarin for 2 days, decrease the dose by 1 mg, recheck the PT/INR the next scheduled day- INR results 6.01-7: hold warfarin, recheck the PT/INR next scheduled day, and notify the physician/NP immediately if active bleeding present- INR results more than 7.01: hold warfarin, give Vitamin K (a vitamin that promotes blood clotting) 5 mg intramuscularly immediately, notify the physician/NP if active bleeding present and repeat the INR the next day. Review of the physician orders for Resident #1 revealed an order dated 11/7/25 for warfarin 11.5 milligrams (mg) to be administered daily at 8:00 PM. Review of the medication administration record for Resident #1 revealed he received warfarin 11.5 mg daily at 8:00 PM from 11/7/25 until 11/10/25. PT/INR lab results for Resident #1 dated 11/10/25 were 1. 18. Further review of the physician orders for Resident #1 revealed the order for warfarin 11.5 mg to be administered daily was discontinued on 11/11/25.Review of the physician orders revealed no order had been written to resume warfarin for Resident #1 after it was discontinued on 11/11/25. Review of the medication administration record revealed no doses of warfarin were administered to Resident #1 from 11/11/25 to 11/13/25. Unit Manager #1 (a nurse) was interviewed on 11/14/25 at 12:12 PM. Unit Manager #1 explained she was responsible for reviewing all PT/INR results, adjusting the medication doses, and notifying the physician/NP if necessary. Unit Manager #1 reported she received the PT/INR results for Resident #1 on 11/11/25 and she used the warfarin protocol to increase his dose to 12 mg. Unit Manager #1 explained she believed she wrote a physician order to increase his dose to 12 mg, but upon reviewing the physician orders, reported she had not written the order. Unit Manager #1 explained Resident #1 should have received 12 mg of warfarin on 11/11/25, 11/12/25, and 11/13/25. The Unit Manager #1 reported the lab was unable to obtain the blood sample for the PT/INR on 11/13/25 and she had written an order to have an immediate PT/INR lab drawn 11/14/25. A follow-up interview was conducted with Unit Manager #1 on 11/14/25 at 1:00 PM and she reported Resident #1's PT/INR results was 2.8 and he would resume warfarin 12 mg at 8:00 PM on 11/14/25. The NP was interviewed on 11/14/25 at 12:48 PM and she reported Resident #1 had been difficult to get to a therapeutic PT/INR level which would be 2.0-3.0, and he required frequent warfarin dosage adjustments. The NP reported the lab results were sent to the facility, and the Unit Managers used the physician approved warfarin protocol to adjust the warfarin dose. The NP explained that missing the 3 doses of warfarin did not harm Resident #1. The NP reported when she was notified of the missed warfarin, she checked on Resident #1 and he was fine. The NP concluded that she expected the staff to follow the warfarin protocol for all residents receiving warfarin. The Director of Nursing (DON) was interviewed on 11/14/25 at 2:48 PM. The DON reported on 11/14/25 Unit Manager #1 was reviewing the PT/INR results from 11/13/25 and noticed that the PT/INR for Resident #1 was not obtained. The DON explained the facility ordered for an immediate PT/INR lab draw and notified the NP of the missed medication. The DON reported Unit Manager #1 reported she thought she put in the new warfarin order, but it was not in the system. The