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	07/24/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 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, resident representative, staff, dialysis staff, and manager of the transport company interviews, the facility failed to send a lift pad with the resident causing the resident to miss their dialysis appointment for 1 of 3 resident reviewed for dialysis (Resident #32). Findings included:Resident #32 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, diabetes, and dependence on renal dialysis.Review of Resident #32's initial nursing assessment dated [DATE] revealed Resident #34 was alert and oriented and required extensive assistance with one person staff for transfers.Review of Resident #32's Kardex (quick reference tool that summarizes essential patient information for nurses) dated 07/18/25 revealed the resident was supposed to have a lift pad under her on dialysis days Monday, Wednesday, and Fridays and was a lift transfer on dialysis days only. Review of Resident #32's physician orders dated 07/18/25 revealed the resident was ordered to have a lift pad under her on dialysis days Monday, Wednesday, and Friday.Observation and interview conducted with Resident #32 and Resident Representative (RR) on 07/21/25 at 2:40 PM revealed both the resident and RR were upset and frustrated due to the resident missing her dialysis appointment 07/21/25. The RR further revealed the facility failed to send Resident #32 with a lift pad which the dialysis center must have to transfer Resident #32 to receive her treatment. The RR stated Resident #32 would have to be sent out to the hospital to receive her dialysis treatment because the dialysis center was unable to schedule her back in. The RR and Resident #32 indicated this has happened multiple times and was an ongoing issue when she was a prior resident.A phone interview conducted with Resident #32's Dialysis Nurse #1 on 07/23/25 at 8:30 AM revealed she had cared for Resident #32 for a couple years at the dialysis center. Dialysis Nurse #1 indicated on 07/21/25 Resident #32 arrived at the dialysis center without a lift pad. Dialysis Nurse #1 stated she contacted the transporter that brought the resident, and they went back to the facility to retrieve the pad and brought it back to the dialysis center. The transporter returned and placed the lift pad on the back of Residents #32's wheelchair and failed to notify the dialysis employees. Dialysis Nurse #1 revealed by the time the pad arrived Resident #32 had missed majority of her sitting time and was unable to receive her treatment. It was further revealed the dialysis center expected for residents to have the lift pad under the resident when they arrived. Dialysis Nurse #1 indicated this had also happened on 03/24/25 and 05/19/25 when Resident #32 was a resident at the facility previously.A phone interview conducted with the manager of the transport company on 07/23/25 at 2:50 PM revealed a driver took Resident #32 to her dialysis appointment on 07/21/25 without a lift pad. The transporter drove back to the facility and retrieved the lift pad and once the driver arrived at the dialysis center the dialysis staff refused to transfer the resident onto the pad. The manager of the transport company indicated nursing staff from the facility needed to place the lift pad under the resident before arriving at the dialysis center. Resident #32 was unable to receive her dialysis treatment and was sent back to the facility. The interview further revealed the facility had sent Resident #32 without her lift pad to dialysis appointments before.An interview was conducted with Nurse Aide (NA) #1on 07/24/25 at 10:20 AM revealed she had assisted Resident #32 with getting ready for her dialysis appointment on 07/21/25. NA #1 indicated 7/21/25 was the first time she had cared for Resident #32 and was not aware she required a lift pad for her appointment and failed to put it under the resident on this date. NA #1 indicated Resident #32 was a sit-to-stand one person assist for transfers and was not aware she was a total lift at her dialysis appointment. An interview conducted with the Director of Nursing (DON) on 07/23/25 at 11:30 AM revealed she was aware Resident #32 went to her dialysis appointment on 7/21/25 and the lift pad was not sent. the DON indicated nursing staff was responsible for ensuring the resident's lift pad was under her when she went out to the appointment. The DON stated Resident #32 was unable to be re-scheduled at the dialysis center and was sent out to the hospital to receive her dialysis treatment. The DON revealed Resident #32 was not a total lift for transfers in the facility but was at dialysis appointments. The DON stated she expected nursing staff to get the residents to all appointments with all needed accessories.