STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		8/24/17

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/15/2017

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.

F 157 Continued From page 1
as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews the facility failed to report a significant medication error to the physician for 1 of 7 sampled residents with medications reviewed. (Resident #20)

The findings included:

Resident #20 was admitted to the facility 05/19/12 with diagnoses which included dementia with behavioral disturbances, hypertensive chronic kidney disease, chronic congestive heart failure, atherosclerotic heart disease, left bundle branch block, atrial fibrillation, mitral valve disorder, cardiomyopathy and presence of implantable cardiac defibrillator.

The most recent Minimum Data Set (MDS) dated 05/08/17 assessed Resident #20 with severe cognitive deficit.

Review of physician orders from June and July 2017 noted Resident #20 had prescribed 125 micrograms of Lanoxin (a medication to treat congestive heart failure as well as heart rhythm problems) every day except Monday and Thursday. Review of the Medication Administration Records (MARs) for Resident #20

F 157

1) On 7/26/2017, Director of Clinical Services (DCS) notified the Medical Director (MD) of the medication error for Resident #20 for Lanoxin. A medication error report was completed on 8/14/2017 by the Director of Clinical Services.

2) The Director of Clinical Services and/or Nursing Supervisor reviewed the last 30 days of nursing notes in the medical record and the medication administration records of the current residents to determine if the physician required notification. Any further areas identified were addressed by the DCS.

3) The Director of Clinical Services and/or Nursing Supervisor re-educated all licensed nurses on notifying the Director of Clinical Services of medication errors and notifying the physician for medication errors and change in condition. Completed 8/24/17. Licenses nurses on leave or vacation will be re-educated before returning to work.
The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 2 noted the facility utilized a paper system for medication administration and staff initialed the MAR when a medication was administered. The 2017 June and July MARs for Resident #20 were reviewed and the following concerns were identified: -The order for Lanoxin was printed on the June 2017 MAR with directions to "Take 1 tab by mouth every day. Hold Monday and Thursday." Included on the MAR directly under the order for Lanoxin was a notation to record the resident's pulse. Review of a calendar noted Monday and Thursday dates for June 2017 included 1, 5, 8, 12, 15, 19, 22, 26 and the 29th. Handwritten on the June 2017 MAR next to the order for Lanoxin was an "X" on the following dates 1, 5, 12, 15, 16, 17, 18, 19, 21, 27 and 29. There were no initials or pulse recorded for June 3, 4 or 7th to indicate if the Lanoxin had been given. In addition, an "X" was indicated on the MAR on the 20, 23, 24, 25 and 28 though there were initials documented over the "X" along with a pulse recorded. -The order for Lanoxin was printed on the July 2017 MAR with directions to "Take 1 tab by mouth every day. Hold Monday and Thursday." Included on the MAR directly under the order for Lanoxin was a notation to record the resident's pulse. Review of a calendar noted Monday and Thursday dates for July 2017 included 1, 6, 10, 13, 17, 20, 24, 27 and 31st. Handwritten on the July 2017 MAR next to the order for Lanoxin was an "X" on the following dates 1, 2, 5, 11, 14, 15, 16, 17, 19, 21, 22, 23, 25, 26, 28, 29, 30. In addition, an "X" was indicated on the MAR on the 3, 4, 7, 8, 9, 12 and 18 though there were initials documented over the "X" along with a pulse recorded. On 7/19/17 "see other" was handwritten on the MAR and a new entry for Lanoxin was written for the remainder of the	F 157	Administration Records and Nursing Notes to determine if notification warranted will occur 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter. 4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/18 /2017. The Director of Clinical Services or designee in DCS absence will present the results of the Quality Improvement Monitoring to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule modified based on findings.	

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F 157	Continued From page 3	F 157		

month with 20, 24, 27 and 31 blocked off as days not to administer the Lanoxin

On 07/26/17 at 3:45 PM the Director of Nursing (DON) stated there had been no medication errors reported to her for the month of June or July 2017. In a follow-up interview on 7/27/17 at 12:03 PM the DON explained an "X" on a MAR was used to denote not to administer medication. The DON reviewed the 2017 June and July MAR for Resident #20 and stated she could not explain what happened. The DON verified the days "X" out were not consistent with the physician's order. The DON stated it did not appear the Lanoxin had been given as ordered and that she was not aware of the problem. The DON stated it appeared someone had identified the concern on 07/19/17 and corrected the MAR but had failed to report the error to her so that she could inform the resident's physician as well as put systems in place to correct the problem. The DON stated it was not clear who had put the "X" on the June and July MAR for Resident #20.

On 7/27/17 at 2:00 PM the physician of Resident #20 stated he was not aware of the issues with administration of the Lanoxin in June and July for Resident #20 until today. The physician stated he expected medication to be administered as ordered and to be informed of any medication errors. The physician explained Resident #20 was on the lowest dose of Lanoxin and there had been no harm noting that Resident #20's recent heart rates averaged 85, which was fine. The physician stated the Lanoxin order was confusing as written and planned on rewording the order to make it easier to understand.

On 07/27/17 at 3:00 PM Nurse #2 stated she

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	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

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F 157	Continued From page 4 routinely worked with Resident #20. Nurse #2 stated she was working with Resident #20 on 07/19/17 and recalled the consultant pharmacist was reviewing the current MARs and identified the Lanoxin was not administered to Resident #20 as ordered. Nurse #2 stated she overheard the consultant pharmacist report the concern to the unit manager and the unit manager asked her to change the entry on the MAR to reflect the actual order. Nurse #2 stated she reviewed the Lanoxin on the July 2017 MAR for Resident #20 and saw many mistakes and rewrote it and "X" off the remaining days of July consistent with the order to hold the medication on Monday and Thursday. Nurse #2 stated she did not think the DON was in the building at the time and did not report the error to the DON or to the resident's physician. Nurse #2 stated she thought the unit manager or consultant pharmacist would have reported the medication error to the DON and physician. On 07/27/17 at 3:40 PM the unit manager stated the consultant pharmacist routinely came to the facility and would look at MARs to see if there were any discrepancies. The unit manager recalled on 07/19/17 the consultant pharmacist reported a concern with administration of Lanoxin to Resident #20. The unit manager stated she shared the concern with Nurse #2 and asked her to rewrite the order on the MAR. The unit manager stated she didn't recall if she reported the concern to the DON and physician but would have expected Nurse #2 to report the medication error. The unit manager reviewed the June and July MAR for Resident #20 and stated there was no way to determine who handwrote the "X" on the Lanoxin administration record entries.	F 157		

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F 157	Continued From page 5 On 07/27/17 at 4:35 PM the consultant pharmacist stated as part of her monthly review she looked at MARs when in the facility to see if there were any issues. The consultant pharmacist recalled seeing the concern with the administration of Lanoxin to Resident #20 on 07/19/17 and spoke with the unit manager about the concern. The consultant pharmacist stated she suggested they make a new entry and thought she instructed the nurses to follow their policy in terms of calling the MD and notifying the DON.	F 157		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to give a choice in frequency and bath type to 2 of 3 residents reviewed for choices (Resident #43, Resident #52).	F 242	1) On 7/31/17 Residents #43 bathing preference was obtained by an Interdisciplinary Team (IDT) member. Care plan and kardex were updated by Nursing Supervisor on 8/14/17 to reflect choice.	8/24/17

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CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

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F 242

Continued From page 6

The findings included:

1. Resident #43 was admitted to the facility on 07/05/17 with diagnoses of heart failure, end stage renal disease and diabetes.

Review of the admission Minimum Data Set (MDS) dated 07/12/17 revealed Resident #43 was cognitively intact and was totally dependent for bathing.

Review of the facility shower schedules revealed Resident #43 received showers on Wednesday and Friday.

An interview conducted on 07/24/17 at 11:38 AM with Resident #43 revealed she received two showers a week but she would prefer to have at least three showers per week. She stated no one had ever asked her how many showers she wanted a week.

An interview conducted on 07/27/17 at 10:47 AM with the Admission Coordinator and the Admissions Director revealed the nurses that admit the resident to the floor discussed preferences regarding baths and showers with the resident or their family. The stated they did not discuss bathing preferences during their part of the admission.

An interview conducted on 07/27/17 at 10:52 AM with Nurse Aide (NA) #1 revealed she made the shower schedule for the halls. She stated residents received two showers per week unless they requested more and then she added those to schedule. She stated she nor the shower team asked residents how many showers a week they wanted but they could request more.

F 242

On 7/31/17 Residents # 52 bathing preference was obtained by IDT member. Care plan and kardex were updated by Nursing Supervisor on 8/14/17 to reflect choice.

2) The Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor interviewed current residents on bathing preference, completed on 8/4/17. Care plans and kardex were updated to reflect choices. Future residents will be asked upon admission for the bathing preference by admissions.

3) The Director of Clinical Services and/or Nursing Supervisor in serviced Licensed Nurses and Certified Nurse Assistant on honoring residents right to choice the type of bathing completed by 8/24/17. Licensed staff on leave or vacation will be in serviced before returning to work. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of bathing preferences 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year.

4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/18 /2017. The Director of Clinical Services or designee in DCS absence will report the results of the Quality Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

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F 242

Continued From page 7

An interview conducted on 07/27/17 at 2:35 PM with the Unit Manager revealed the nurses did not discuss bathing preferences with residents or their families during the admission process. She stated residents received two showers a week unless they requested more.

An interview conducted with the Director of Nursing on 07/27/17 at 4:43 PM revealed it was her expectation for residents to be asked about their bathing preference and frequency and their preferences should be accommodated.

2. Resident #52 was admitted to the facility on 01/11/17 and readmitted on 07/05/17 with diagnoses of hypertension, diabetes, arthritis and dementia.

Review of the quarterly Minimum Data Set (MDS) dated 06/22/17 revealed Resident #52 was cognitively intact and was totally dependent for bathing.

Review of the facility shower schedules revealed Resident #52 received showers on Tuesday and Friday.

An interview conducted on 07/26/17 at 2:38 pm with Resident #52 revealed she was scheduled for two showers per week but she would prefer a tub bath because she gets too cold during a shower. She stated no one had ever asked her if she preferred a tub bath to a shower.

An observation of the two shower rooms on 07/26/17 at 3:57 pm revealed there was a functional bath tub in each room. One shower room had a walk in whirlpool tub and the other

F 242

Monitoring to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule modified based on findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 8	F 242		

shower room had a large step in tub.

An interview conducted on 07/27/17 at 10:47 am with the Admissions Coordinator and Admissions Director revealed the nurses that admit the resident to the floor discuss preferences regarding baths and showers with the resident or their family. They stated they did not discuss bathing preferences during their part of the admission process.

An interview conducted on 07/27/17 at 10:52 am with Nurse Aide (NA) #1 revealed she made the shower schedule for the halls. She stated residents received two showers per week unless they requested more and then she added those to the schedule. She stated she nor the shower team asked residents about their preference for a bed bath, tub bath or shower.

An interview conducted on 07/27/17 at 11:39 am with NA #2 who is on the shower team revealed Resident #52 had not mentioned to her that she preferred a tub bath to a shower. NA #2 stated if the resident had mentioned it, they would have accommodated her request.

An interview was conducted on 07/27/17 at 2:35 pm with the Unit Manager revealed the nurses did not discuss bathing preferences with residents or their families during the admission process. She stated residents received two showers a week unless they requested otherwise.

An interview conducted on 07/27/17 at 4:43 pm with the Director of Nursing (DON) revealed it was her expectation for residents to be asked about their bathing preference and frequency and their preferences should be accommodated.

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	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

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F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to keep a scheduled appointment for 1 of 1 resident reviewed for social services (Resident #92). The findings included: Resident #92 was admitted to the facility on 07/12/17 with diagnoses of end stage renal disease, non-Alzheimer's dementia, and chronic obstructive pulmonary disease. Review of the admission Minimum Data Set dated 07/19/17 revealed Resident #92 was moderately cognitively impaired. Review of the hospital discharge summary dated 07/12/17 revealed Resident #92 had a neurology appointment scheduled for 07/26/17. An interview conducted on 07/27/17 at 8:35 AM with Resident #92's family member revealed he called the facility last week to remind them of the neurology appointment and make sure they were going to transport Resident #92 to and from his appointment. He stated he spoke to the Business Office Manager who stated he would give the message to the Transporter. Resident #92's family member never received a call from the Transporter that she couldn't take the resident to his appointment but he received a call from the	F 250	1) Resident #92s missed a doctors appointment due to a scheduling conflict. The appointment was rescheduled and he was seen by the neurologist on 8/10/17. 2) On 8/5/2017 the Executive Director and Transporter reviewed all scheduled appointments for the rest of the year and no other conflicts were identified. Any further areas identified were addressed by the DCS. 3) On 7/31/17 the Executive Director re-educated the transportation aide, central supply and Unit Coordinators on procedure for scheduling appointments and/or following up with existing appointments. Daily copies of the appointment schedule will be posted in the staffing book and given to the Dietary Manager (DM) and Director of Rehab (DOR). The Director of Clinical Services and/or Nursing Supervisor to perform Quality improvement Monitoring of physician appointments to determine if proper arrangements have occurred 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year.	8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 250	Continued From page 10 neurology office on 07/26/17 asking him where the resident was. The family member stated when he called the Transporter she informed him she meant to cancel the appointment and reschedule it due to a conflict in her schedule. The family member stated if he had been called he would have taken Resident #92 to his appointment that they had waited two months for. An interview conducted on 07/27/17 at 9:05 AM with the facility Transporter revealed she meant to call and reschedule Resident #92's neurology appointment when he was admitted because her transport schedule was full for 07/26/17. She stated she totally forgot to reschedule the appointment and did not have it in her book for 07/26/17. The Transporter stated it was her responsibility to schedule all of the resident's outside appointments and no one checked behind her to make sure the appointments were kept or scheduled. She stated she should have called the family to see if they could have taken Resident #92 to his appointment and if not she should have rescheduled the appointment. An interview conducted on 07/27/17 at 11:56 AM with the Director of Nursing revealed it was her expectation for the Transporter to reschedule appointments as necessary and inform the family when she did so. She stated all appointments should be written in the book even if they needed to be rescheduled.	F 250	4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/18 /2017. The Director of Clinical Services or designee in DCS absence will report the results of the Quality Improvement Monitoring to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule modified based on findings.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 253		8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

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F 253

Continued From page 11

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews, the facility failed to maintain the environment in a clean and comfortable manner on 2 of 2 halls affecting 21 out of 34 rooms. Door skins were cracked, peeled and jagged, personal care equipment was not labeled and covered, wheelchair arm rests were worn and rough, the caulking around the commode bases were stained, floors were stained, a sink drain was rusty, a seat extender was soiled and a bathroom maintained a very strong urine odor (Rooms 104, 105, 107, 108, 110, 112, 114, 202, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217 and 218).

The findings included:

1. The doors in resident rooms and bathrooms were rough and jagged as follows:

a. Room 216: On 07/24/17 at 11:58 AM, the bedroom door's plastic sleeve was observed chipped, and peeling away from the wood door and was curled with jagged edges sticking away from the door. This remained the same during observations on 07/25/17 at 8:55 AM, on 07/25/17 at 4:10 PM, on 07/26/17 at 3:54 PM and on 07/27/17 at 5:32 PM.

b. Room 215: On 07/24/17 at 3:14 PM the bedroom door's plastic sleeve was observed to be rough and torn and the bathroom had splintered gouges on the door edges. This remained the same during observations on 07/25/17 at 8:43 AM and at 4:07 PM, on 07/26/17 at 3:52 PM and on 07/27/17 at 5:35 PM.

F 253

1) The door sleeves for rooms 108, 206, 207, 208, 210, 213, 215, 216 were removed by contractor by 8/18/2017. New door sleeves were special ordered and will be installed by maintenance staff when they arrive. Rough spots or splinters were sanded and/or patched. The bathroom floors in 104, 105, 107, 108, 110, 112, 114, 202, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, and 218 were replaced by contractor by 8/24/17. Remaining bathroom floors on 100 and 200 hall replaced by contractor to be completed 8/24/17. The caulk around the toilets in 208 & 210, 207 & 209 and 212 & 214 and on the remaining 100 and 200 halls was replaced when toilets reset after floors refinished, completed 8/24/17. Seat extender was cleaned by housekeeping on 7/27/2017. Unlabeled items were discarded and replaced with labeled items on 7/27/2017 by the Director of Clinical Services.

2) Observations of resident area doors, bathroom floors, personal items unlabeled and not bagged and seat extenders was completed 8/4/17 by the Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping.

3) The Director of Clinical Services and the Maintenance Director re-educated staff on reporting issues with resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 253

Continued From page 12

c. Room 213: On 07/24/17 at 11:56 AM the sleeve on the door was observed chipped, jagged and curled outward in three places. This remained the same during observations made on 07/25/17 at 8:40 AM and 4:05 PM, on 07/26/17 at 3:51 PM and on 07/27/17 at 5:32 PM.

d. Room 210: On 07/25/17 at 3:58 PM, on 7/26/17 at 3:48 PM and on 07/27/17 at 5:26 PM the plastic sleeve covering the lower half of the bedroom door was observed chipped, jagged and curling away from the door.

e. Room 208: On 07/24/17 at 2:53 PM the plastic door sleeve had 2 gouged areas which were rough and splintered wood was exposed. This remained jagged and curled when observed on 07/25/17 at 9:17 AM and at 3:57 PM, on 07/26/17 at 3:46 PM and on 07/27/17 at 5:24 PM.

f. Room 207: On 07/25/17 at 10:51 AM the plastic sleeve on the bedroom door was observed gouged and curling at the edges leaving sharp edges. This remained the same when observed on 07/5/17 at 3:53 PM, 07/26/17 at 3:43 PM and on 07/27/17 at 5:20 PM.

g. Room 206: On 07/25/17 at 9:18 AM the door sleeve had a gouge with a rough edge. This remained the same when observed on 07/25/17 at 3:49 PM and on 07/27/17 at 5:18 PM.

h. Room 108: The plastic door sleeve was observed chipped and jagged on 07/26/17 at 3:25 PM and on 07/27/17 at 5:08 PM.

On 07/27/17 at 5:08 PM, the maintenance supervisor stated that the facility has been replacing the old door sleeves with new gray

F 253

doors, bathroom floors, caulking around toilets and unlabeled, non bagged personal items in resident rooms 8/14/2017- 8/24/2017. The Maintenance Director and/or Housekeeping supervisor and Executive Director to perform Quality Improvement Monitoring of resident rooms, bathrooms and hall ways to identify items in need of repair 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of unlabeled/non bagged items in residents rooms 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year.

4) The Executive Director will introduce the plan of correction to the QAPI committee on 8/18/17. The Executive Director or designee will report the results of the Quality Improvement Monitoring to the QAPI Committee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 13	F 253		

colored ones for the past 5 to 6 months. He stated the plan was to replace 3 to 5 door sleeves each month.

On a final observation round on 07/27/17 at 5:36 PM it was noted that out of a total of 34 resident rooms on 2 halls, there were 7 door sleeves that had been replaced. No other doors to closets or shower rooms had been changed.

2. The caulking around the commode bases and floors were observed as follows:

a. Bathroom shared by Rooms 208 and 210: Observations on 07/24/17 at 2:53 PM revealed the caulking at the base of the commode was cracked and discolored. This remained the same during observations on 07/25/17 at 3:57 PM, on 07/26/17 at 3:46 PM and on 07/27/17 at 5:24 PM.

b. Bathroom shared by Rooms 207 and 209: On 07/24/17 at 12:02 PM the caulking around the base of the commode was observed brown stained. This remained the same when observed on 07/26/17 at 3:43 PM and on 07/27/17 at 5:20 PM. In addition, the floors around the commode were stained and discolored at these same observations.

c. Bathroom shared by Rooms 110 and 112: On 07/24/17 at 12:26 PM there was no caulking around the base of the commode. This remained the same on 07/25/17 at 9:14 AM. On 07/25/17 at 4:35 PM around the base of the commode was dark brown stains. This remained the same when observed on 07/26/17 at 3:14 PM and on 07/27/17 at 5:09 PM.

d. Bathroom shared by Rooms 105 and 107: On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 14	F 253		

07/24/17 at 11:33 AM the caulking around the commode was observed soiled and dark. This remained the same during observations on 07/25/17 at 4:34 PM, on 07/26/17 at 3:21 PM and on 07/27/17.

e. Bathrooms shared by Rooms 212 and 214: On 07/26/17 at 3:53 PM and on 07/27/17 at 5:29 PM the floor behind the commode was observed soiled.

f. The bathroom in Room 202 was observed to have a rust colored stain on the floor by the commode on 07/24/17 at 11:11 AM, on 07/25/17 at 9:32 AM, on 07/25/17 at 3:47 PM and on 07/27/17 at 5:16 PM.

During interview with the maintenance supervisor on 07/27/17 at 5:02 PM, he stated that maintenance spot checks rooms every couple of weeks and the caulking around the commodes needed to be pulled up and replaced.

On 07/27/17 at 5:16 PM, the housekeeping supervisor stated they have not tried anything to get the stain up from room 201 but the normal cleaning products. The administrator stated at this time that the floor would have to be replaced.

On 07/27/17 at 5:29 PM, the housekeeping supervisor stated the floor in the bathroom shared by rooms 212 and 214
had some rust but could be cleaner.

3. Unlabeled, uncovered personal care equipment were observed as follows:

a. Bathroom shared by Rooms 216 and 218: On 07/24/17 at 11:58, an unlabeled covered gray

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 15	F 253		

wash basin was in the bathroom which was shared by 4 male residents. This remained uncovered and unlabeled during observations on 07/25/17 at 8:55 AM. On 07/25/17 at 4:10 PM the unlabeled wash basin was covered. On 07/27/17 at 5:32 PM the wash basin was observed not covered or labeled in the bathroom.

b. Bathroom shared by Rooms 215 and 217: On 07/24/17 at 3:21 PM, an unlabeled, uncovered urinal with yellow wet residue was observed in the shared bathroom. The urinal remained unlabeled and uncovered when observed on 07/25/17 at 8:54 AM. The urinal was unlabeled in a bag with a labeled urine specimen container during observations on 07/25/17 at 4:07 PM.

c. Bathroom shared by Rooms 212 and 214 and shared by 4 residents: On 07/24/17 at 10:53 AM a bagged urinal was not labeled. Observations revealed the urinal remained bagged and not labeled on 07/25/17 at 9:44 AM. When observed on 07/25/17 at 4:05 PM, the urinal remained unlabeled and a fracture pan was not labeled. When observed on 07/26/17 at 3:52 PM the urinal remained unlabeled and bagged and on 07/27/17 at 5:29/17 the urinal was soiled and remained bagged and not labeled.

d. Bathroom shared by Rooms 211 and 213: On 07/25/17 at 8:41 AM and at 4:06 PM, on 07/26/17 at 3:52 PM and on 07/27/17 at 5:27 PM an unlabeled covered fracture pan was observed in the shared bathroom. In addition, on 07/27/17 at 5:27 PM an unlabeled uncovered bed pan with a dark brown smear on the side was observed along with a second uncovered labeled fracture pan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 16	F 253		

e. Room 210 by the sink: an unlabeled emesis basin was observed by the shared sink on 07/24/17 at 4:15 PM, on 07/25/17 at 8:56 AM and at 3:58 PM, on 07/26/17 at 3:48 PM (containing some dried sparkle material), and on 07/27/17 at 5:26 PM.

f. Bathroom in Room 208: On 07/24/17 at 2:54 PM a urine collection hat was observed unlabeled and contained debris and dried brown matter. On 07/25/17 at 3:57 PM the urine hat was observed gone and a clear urine cylinder was observed bagged and unlabeled. This remained bagged and unlabeled during observations on 07/26/17 at 3:46 PM.

g. Shared bathroom for Rooms 207 and 209, shared by 4 residents: On 07/25/17 at 10:52 AM an unlabeled covered wash basin was in the bathroom. On 07/26/17 at 3:43 PM observations revealed an unlabeled bagged urinal and an unlabeled bagged wash basin. During observations on 07/27/17 at 5:20 PM there were an unlabeled urinal and an unlabeled wash basin.

h. Room 207: Observations revealed that there were 2 stacked gray wash basins on the floor under the sink in this room on 07/24/17 at 12:00 PM, on 07/25/17 at 10:52 AM and at 3:53 PM, on 07/26/17 at 3:43 PM and on 07/27/17 at 5:20 PM.

i. Room 206: On 07/24/17 at 11:36 AM an unlabeled denture cup was observed at the sink shared by 2 residents. The unlabeled denture cup remained when observed on 07/25/17 at 9:20 AM and at 3:49 PM and on 07/27/17 at 5:18 PM.

j. Shared bathroom Rooms 110 and 112: On 07/24/17 at 12:26 PM observations revealed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 17	F 253		

uncovered graduate cylinder on the floor and a urinal and cylinder uncovered on the shelf above the commode. On 07/25/17 at 4:35 PM the personal care equipment was bagged and labeled. Then on 07/26/17 at 3:14 PM, there was a wash basin observed in the room with the name of another resident who had discharged.

k. Shared bathroom for Rooms 105 and 107, shared by 4 residents: On 07/24/17 at 11:32 AM observations revealed a labeled, uncovered bed pan and wash basins over the commode. On 07/25/17 at 3:36 PM all personal care equipment was labeled and covered. On 07/26/17 at 3:12 PM there was an unlabeled covered wash basin. On 07/27/17 at 5:05 PM a labeled but uncovered fracture pan was observed in the bathroom.

Interview with the Director of Nursing on 07/27/17 at 5:18 PM revealed she expected personal care equipment to be covered and labeled to the resident using the item.

4. The wheelchair arm rests on Resident #66's wheelchair were observed to have multiple tears covering both arm rests which were rough to the touch on 07/24/17 at 3:02 PM, on 07/25/17 at 3:35 PM, and on 07/26/17 at 3:11 PM.

Interview with the Housekeeping Supervisor on 07/27/17 at 5:04 PM revealed all wheelchairs were cleaned monthly and arm rests that needed replacing should be identified then.

5. A personal fan in room 114 was observed with a heavy build up of dust on blades and grill during observations on 07/24/17 at 11:20 AM, on 07/25/17 at 4:37 PM, on 07/26/17 at 3:18 PM and on 07/27/17 at 5:12 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 18	F 253		

Interview with the Housekeeping Supervisor on 07/27/17 at 5:12 PM revealed housekeeping staff had not ben cleaning the personal fan in this room but they would start.

6. Observations revealed a brown smear on the side of the extended toilet seat in the bathroom shared by Rooms 110 and 112 on 07/24/17 at 12:26 PM, on 07/25/17 at 9:14 AM and 4:35 PM, on 07/26/17 at 3:14 PM and 07/27/17 at 5:09 PM.

On 07/27/17 at 5:09 PM, the Housekeeping Supervisor was able to clean the brown smear off with a paper towel. He stated he expected his staff to thoroughly clean the sides of the commode seat.

7. There was a rusty drain in the sink of the bathroom in room 104 during observations made on 07/24/17 at 11:32 AM, on 07/25/17 at 4:34 PM, on 07/26/17 at 3:21 PM and on 07/27/17 at 5:02 PM.

Interview with the Maintenance Director on 07/27/17 at 5:02 PM revealed the sink needed to be reglazed.

8. The bathroom shared shared by rooms 207 and 209 was observed to have a very strong odor of urine on 07/24/17 at 12:02 PM. On 07/25/17 at 9:23 AM housekeeping was observed to clean the bathroom. On 07/25/17 at 10:51 AM, on 07/25/17 at 3:53 PM, on 07/26/17 at 3:43 PM and on 07/27/17 at 5:20 PM, the bathroom remained with a very strong urine odor.

On 07/27/17 at 5:20 PM, the Housekeeping Supervisor stated that this was a problem

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 19 bathroom and the floor needed to be stripped. He stated the staff mop the floor about 3 times a day. He stated about 2 to 3 weeks ago he stripped the bedroom floor and was planning on stripping the bathroom floor. It had been on the plans for about a month.	F 253		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews facility nursing staff failed to administer a cardiac medication as ordered by the physician for 1 of 7 sampled residents with medications reviewed. (Resident #20) The findings included: Resident #20 was admitted to the facility 05/19/12 with diagnoses which included dementia with behavioral disturbances, hypertensive chronic kidney disease, chronic congestive heart failure, atherosclerotic heart disease, left bundle branch block, atrial fibrillation, mitral valve disorder, cardiomyopathy and presence of implantable cardiac defibrillator. The most recent Minimum Data Set (MDS) dated 05/08/17 assessed Resident #20 with severe cognitive deficit. The current care plan dated 05/31/17 included a problem area that, Resident	F 333	1) On 7/26/2017, Director of Clinical Services (DCS) notified the Medical Director (MD) of the medication error for Resident #20 for Lanoxin. A medication error report was completed on 8/14/2017 by the Director of Clinical Services. 2) The Director of Clinical Services and/or Nursing Supervisor reviewed the last 30 days of nursing notes in the medical record and the medication administration records of the current residents to determine if the physician required notification. Any further areas identified were addressed by the DCS. 3) The Director of Clinical Services and/or Nursing Supervisor re-educated all licensed nurses on notifying the Director of Clinical Services of medication errors and notifying the physician for medication	8/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 333 Continued From page 20

#20 had cardiovascular problems and resident at risk for bleeding/bruising due to diagnoses of hypertension, arrhythmia, use of anticoagulant and atrial fibrillation. Approaches to this problem area included to provide medications as ordered.

Review of physician orders from June and July 2017 noted Resident #20 had prescribed 125 micrograms of Lanoxin (a medication to treat congestive heart failure as well as heart rhythm problems) every day except Monday and Thursday. Review of the Medication Administration Records (MARs) for Resident #20 noted the facility utilized a paper system for medication administration and staff initialed the MAR when a medication was administered. The 2017 June and July MARs for Resident #20 were reviewed and the following concerns were identified:
-The order for Lanoxin was printed on the June 2017 MAR with directions to "Take 1 tab by mouth every day. Hold Monday and Thursday." Included on the MAR directly under the order for Lanoxin was a notation to record the resident's pulse. Review of a calendar noted Monday and Thursday dates for June 2017 included 1, 5, 8, 12, 15, 19, 22, 26 and the 29th. Handwritten on the June 2017 MAR next to the order for Lanoxin was an "X" on the following dates 1, 5, 12, 15, 16, 17, 18, 19, 21, 27 and 29. There were no initials or pulse recorded for June 3, 4 or 7th to indicate if the Lanoxin had been given. In addition, an "X" was indicated on the MAR on the 20, 23, 24, 25 and 28 though there were initials documented over the "X" along with a pulse recorded.
-The order for Lanoxin was printed on the July 2017 MAR with directions to "Take 1 tab by mouth every day. Hold Monday and Thursday." Included on the MAR directly under the order for

F 333

errors and change in condition. Completed 8/24/17. Licenses nurses on leave or vacation will be re-educated before returning to work.
The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of Medication Administration Records and Nursing Notes to determine if notification warranted will occur 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter.

4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/18 /2017. The Director of Clinical Services or designee in DCS absence will present the results of the Quality Improvement Monitoring to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule modified based on findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 21	F 333		

Lanoxin was a notation to record the resident's pulse. Review of a calendar noted Monday and Thursday dates for July 2017 included 1, 6, 10, 13, 17, 20, 24, 27 and 31st. Handwritten on the July 2017 MAR next to the order for Lanoxin was an "X" on the following dates 1, 2, 5, 11, 14, 15, 16, 17, 19, 21, 22, 23, 25, 26, 28, 29, 30. In addition, an "X" was indicated on the MAR on the 3, 4, 7, 8, 9, 12 and 18 though there were initials documented over the "X" along with a pulse recorded. On 7/19/17 "see other" was handwritten on the MAR and a new entry for Lanoxin was written for the remainder of the month with 20, 24, 27 and 31 blocked off as days not to administer the Lanoxin

Review of labs for Resident #20 noted the last Digoxin/Lanoxin level was drawn 06/05/17 with a level of .3. Labwork from 06/05/17 indicated the normal range of Digoxin/Lanoxin was .8-2.0.

On 07/26/17 at 3:45 PM the Director of Nursing (DON) stated there had been no medication errors reported to her for the month of June or July 2017. In a follow-up interview on 7/27/17 at 12:03 PM the DON explained the pharmacy printed the individual resident monthly MARs based on physician orders. The DON explained the monthly MARs were reviewed for accuracy by 2 separate nurses before they went into circulation and, if there were any medications ordered to be given anytime other than every day, it was up to the nurses to indicate that on the MAR. The DON stated this could be done by the nurses checking the MAR or by the nurse administering the medication and would include an "X" to denote not to administer the medication. The DON reviewed the 2017 June and July MAR for Resident #20 and stated she could not explain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 22	F 333		

what happened. The DON verified the days "X" out were not consistent with the physician's order. The DON stated it did not appear the Lanoxin had been given as ordered and that she was not aware of the problem. The DON stated it appeared someone had identified the concern on 07/19/17 and corrected the MAR but had failed to report the error to her so that she could inform the resident's physician as well as put systems in place to correct the problem. The DON stated it was not clear who had put the "X" on the June and July MAR for Resident #20.

On 07/27/17 at 12:30 PM Nurse #1 stated she worked with Resident #20 on a regular basis. Nurse #1 reviewed the 2017 June and July MAR for Resident #20 and stated she couldn't explain what happened. Nurse #1 stated she circled the words Monday and Thursday on the Lanoxin order on the MAR for Resident #20 to remind staff not to give the Lanoxin those days. Nurse #1 stated the adminstration of the Lanoxin for June and July appeared to be a mess and she couldn't interpret the MAR to know when the Lanoxin was actually given to Resident #20. Nurse #1 indicated she did administer the Lanoxin on some of the days it had been "X" out in June and July (if the "X" was entered incorrectly) and stated she did not know who put the "X" on the June and July MAR for the Lanoxin.

On 7/27/17 at 2:00 PM the physician of Resident #20 stated he was not aware of the issues with administration of the Lanoxin in June and July for Resident #20 until today. The physician stated he expected medication to be administered as ordered and to be informed of any medication errors. The physician explained Resident #20

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	345385	A. BUILDING ______ B. WING ______	C 07/27/2017

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F 333 Continued From page 23 F 333

was on the lowest dose of Lanoxin and there had been no harm noting that Resident #20's recent heart rates averaged 85, which was fine. The physician stated the Lanoxin order was confusing as written and planned on rewording the order to make it easier to understand.

On 07/27/17 at 3:00 PM Nurse #2 stated she routinely worked with Resident #20. Nurse #2 stated she was working with Resident #20 on 07/19/17 and recalled the consultant pharmacist was reviewing the current MARs and identified the Lanoxin was not administered to Resident #20 as ordered. Nurse #2 stated she overheard the consultant pharmacist report the concern to the unit manager and the unit manager asked her to change the entry on the MAR to reflect the actual order. Nurse #2 stated she reviewed the Lanoxin on the July 2017 MAR for Resident #20 and saw many mistakes and rewrote it and "X" off the remaining days of July consistent with the order to hold the medication on Monday and Thursday. Nurse #2 stated she did not think the DON was in the building at the time and did not report the error to the DON. Nurse #2 stated she thought the unit manager or consultant pharmacist would have reported the medication error to the DON.

On 07/27/17 at 3:40 PM the unit manager stated the consultant pharmacist routinely came to the facility and would look at MARs to see if there were any discrepancies. The unit manager recalled on 07/19/17 the consultant pharmacist reported a concern with administration of Lanoxin to Resident #20. The unit manager stated she shared the concern with Nurse #2 and asked her to rewrite the order on the MAR. The unit manager stated she didn't recall if she reported

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F 333	Continued From page 24 the concern to the DON but would have expected Nurse #2 to report the medication error. The unit manager reviewed the June and July MAR for Resident #20 and stated there was no way to determine who handwrote the "X" on the Lanoxin administration record entries. On 07/27/17 at 4:35 PM the consultant pharmacist stated as part of her monthly review she looked at MARs when in the facility to see if there were any issues. The consultant pharmacist recalled seeing the concern with the administration of Lanoxin to Resident #20 on 07/19/17 and spoke with the unit manager about the concern. The consultant pharmacist stated she suggested they make a new entry and thought she instructed the nurses to follow their policy in terms of calling the MD and notifying the DON. The consultant pharmacist reported she did check the record and saw the last lab work (for the Lanoxin) was okay and that the resident's heart rate was okay. If they were not okay, the consultant pharmacist said she would have done something about it right away.	F 333		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		8/24/17

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F 520	Continued From page 25 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification and complaint survey of 09/15/16. This was for one deficiency that was originally cited in September of 2016 and was subsequently recited on the current recertification	F 520	1) Facility has QAPI committee in place and implements plans for improvement and monitors and revises as needed through the QAPI process. 2) The Regional Director of Clinical Services Joanna Ingermann re-educated the interdisciplinary team members on regulation F520 and the facility□s policy	

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F 520	Continued From page 26 and complaint survey of 07/27/17. The two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 242: Choices: Based on record review and resident and staff interviews the facility failed to give a choice in frequency and bath type to 2 of 3 residents reviewed for choices (Resident #43, Resident #52). During the recertification survey of 09/15/16 the facility was cited at F 242 for failing to provide 2 of 2 sampled residents assessed as safe smokers the choice to smoke whenever they wanted to smoke (Residents #49 and #90). An interview with the Administrator on 07/27/17 at 5:45 PM revealed the facility audited resident choices for the time period designated in their plan of correction and did not have any concerns so they had discontinued the monitoring.	F 520	and procedures for Quality Assurance Performance Improvement on 8/14/17. The Interdisciplinary Team including but not limited to Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor interviewed current residents on bathing preference, completed 8/4/17. Care plans and kardex were updated to reflect choices. Future residents will be asked upon admission for the bathing preference by admissions. 3) The Director of Clinical Services and/or Nursing Supervisor in serviced Licensed Nurses and Certified Nurse Assistant on honoring residents right to choice the type of bathing 8/14/2017-8/23/2017. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of bathing preferences 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. 4) The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 8/18 /2017. The Director of Clinical Services or designee will report on the Quality Improvement Monitoring to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical	

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F 520	Continued From page 27	F 520	Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. Quality Improvement Quality Monitoring schedule modified based on findings.	