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	345162	A. BUILDING _____ B. WING _____	C 12/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 12/15/2017. Intake # NC00133245 and NC00131487.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to maintain residents' dignity by failing to knock on doors or ask permission to enter the rooms for 1 of 7 residents reviewed for dignity which resulted in the resident's feelings of undignified treatment (Resident #48). Findings included: 1. Record review revealed Resident #48 was admitted to the facility on 11/22/2014 with diagnoses which included Parkinson's disease and Anemia. The Annual Minimum Data Set dated 7/4/2017 indicated Resident #48 was moderately cognitively impaired and required extensive to total assist with all Activities of Daily Living.	F 557	This was corrected by the DON performing a written coaching and education with employee #1 regarding the facility policy of knocking prior to entering resident rooms, resident privacy, dignity and residents rights on 1/9/18. To ensure others are not affected by the same practice education was provided to all staff members employed by the facility on 12/15/17 - 1/10/17 by the acting SDC concerning the facility policy of Knocking on doors, resident privacy and dignity and resident rights. All new employees will receive training on knocking during orientation. The measures put into place to ensure systematic changes are the use of a monitoring tool to be completed daily with 5 residents for 1 week then weekly with 4 residents for 3 weeks, then monthly with 3	1/12/18

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

Electronically Signed | 01/12/2018

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F 557	Continued From page 1 An observation and interview were conducted with Resident #48 on 12/12//2017 at 11:16 AM. During the interview the resident was in bed and the door to the room was closed. Nursing Assistant (NA) #1 entered the room at 11:21 AM, walked in to the bathroom and exited the room. NA #1 did not knock or ask permission to enter, and did not speak to the resident. The resident reported the staff knocked at times but not all the time. The resident indicated at times when she woke from a nap and a staff member was in her room, it startled her. Observations were made on 12/12/2017 at 12:05 PM, 12:40 PM and 2:10 PM of NA #1 entering the resident's room without knocking or asking permission to enter. An interview was conducted with NA #1 on 12/15/2017 at 9:15 AM. NA #1 reported she was aware staff needed to knock and announce prior to entering residents' rooms. NA #1 stated she was very busy on certain halls and forgot to knock. NA #1 stated she knew it was important to knock and did not know why she was in the habit of just walking in the rooms. An interview was conducted with the Administer (ADM) on 12/15/2017 at 9:59 AM. The ADM stated the expectation was for every employee to knock and announce themselves when entering resident's rooms. The ADM stated all employees were expected to respect residents' dignity at all times.	F 557	residents for 11 months by the Quality of Life Director or Department Managers. Any non compliance will be corrected immediately and communicated to the Administrator. Results of the findings will be compiled and a report presented to QAPI for 12 months the committee will revise or develop new measures as necessary.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family	F 565		1/12/18

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F 565	Continued From page 2 group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances that were reported in the resident council meetings for 3 of 3 consecutive months. Findings included:	F 565	The Administrator reviewed the grievances expressed in resident council September, October, November and December. The results were compiled and root causes were determined. The results suggest issues with failure to	

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F 565	Continued From page 3 Observation of a Resident Council Meeting was conducted on 12/13/2017 at 10:14 AM and revealed an issue with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there were no explanations given as to the reason the grievances were not resolved. The Resident Council president explained that during each meeting the issues from the prior month were discussed by the council members to see if the issues were still a concern. The Resident Council president reported the Activities Director (AD) documented the issues and discussed the ongoing concerns during each meeting. Several of the members indicated the AD explained during the meetings that the issues were passed along to the appropriate staff to ensure resolution of the issues. Review of the Resident Council Meeting minutes from September 2017, October 2017 and November 2017 were reviewed. Review of the Resident Council minutes dated September 21, 2017 indicated the residents voiced concerns of new nursing staff not knocking before entering residents' rooms. Review of a facility Grievance Report dated September 25, 2017 revealed the facility nursing staff was in-serviced by the Staff Development Coordinator (SDC) on knocking before entering resident rooms, and staff understood if the issue continued to problematic, disciplinary actions would be initiated. There were no signatures of employees in attendance of the in-service.	F 565	knock on doors before entering residents rooms, personal clothing issues, call lights not answered timely and meal delivery. the Administrator apologized for the failure to follow up on 12/21/17. To ensure that others are not affected All staff members received education on the grievance policy and procedure along with prompt and follow up By the Acting SDC on 1/10 and 1/12/17. The Administrator met with the resident council on again on 01/11/17 to reviewed the facilities plan of correction with the elders and ask permission to check with them periodically to ensure the compliance. The system put into place is to list all grievances on the grievance log, discuss grievances daily with the Administrator and follow progress by asking 3 residents about the progress daily for 1 week by the Administrator or Admissions Coordinator then monthly thereafter for 11 months in Resident council by the Quality of Life Director. Any issues will be discussed immediately with the Administrator and corrected by educating, applying new interventions and measuring progress. To ensure the system remains and is effective a report will be compiled from the resident interviews and presented to QAPI for review and recommendations monthly for 1 year.	

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F 565	Continued From page 4	F 565		

Review of the Resident Council minutes dated October19, 2017 indicated the residents reported the concerns from the previous month's meeting were not improved and voiced continued issues with new nursing staff not knocking before entering residents' rooms. The minutes reported the issue was not resolved. The minutes also reported the Administrator (ADM) was present during the meeting and informed the residents the nursing staff should be knocking before entering rooms.

Review of the Resident Council minutes dated November 16, 2017 indicated the residents reported continued issues with staff not knocking before entering rooms.

Review of a Facility Grievance Report dated 11/16/2017. The report indicated the residents in the Resident Council Meeting continued to report the staff were not knocking before entering rooms. The report revealed all nursing staff were in-serviced during the in-service fair and acknowledged written actions would be issued for failure to knock prior to entering rooms. The report indicated the issue had not been observed by the quality zone managers and there would be continued monitoring. The report also indicated the resolution was reported to the Resident Council. The report was dated 11/23/2017 and signed by the ADM. There were no signatures of employees in attendance of the in-service or the in-service fair.

An interview was conducted with the AD on 12/15/2017 at 8:44 AM. The AD indicated the grievances from the Resident Council meetings were forwarded to the specific departments for

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F 565	Continued From page 5 resolution. The AD reported she was aware there was an ongoing issue with the staff not knocking on residents' doors prior to entering the room. The AD stated there were times she witnessed staff not knocking, and she told the staff they needed to knock. The AD also stated she informed the staff during the morning meeting of the ongoing issue with knocking and was told the staff had been in-serviced. An interview was conducted with the ADM on 12/15/2017 at 9:59 AM. The AD revealed the SDC was no longer employed at the facility, and they were unable to locate sign in sheets for in-services or any audits that may have been completed. The ADM stated the facility grievance resolution system was under review. The ADM stated the expectation was all grievances would be investigated when reported and the actions of the investigations be documented and reported to ensure resolution.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to accurately assess dental status for one of eighteen residents reviewed for dental status (Res. #39). Findings included: A review of the medical record revealed Resident #39 was admitted 1/25/2010 and readmitted 2/1/2017 with diagnoses of Diabetes, dementia	F 641	Corrective action for the alleged action is accomplished by correct coding of the assessment and transmission on 1/08/18 by MDS coordinator. To ensure that others are not affected by the same issue all resident's dental status was reviewed for accuracy on 1/8/18-1/11/18 by Nurse Managers including the ADON, DON. MDS	1/12/18

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F 641	Continued From page 6 and hemiplegia. The Annual Minimum Data Set (MDS) dated 5/30 2017 noted Resident #39 was severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living, with the help of one person. In section L0200 of the Dental Assessment, Resident #39 was noted to have "No natural teeth or tooth fragments (edentulous)." There was Care Area Assessment documentation and a care plan was in place for risk of dental problems. On 12/12/2017 at 10:26 AM Resident #39 was observed sitting in a wheelchair near the nurse's station. Resident #39 was observed to have his lower canine teeth and some tooth fragments between those two teeth. Resident #39 stated he did not have any problems with his teeth and did not have tooth pain. In an interview with the MDS nurse on 12//14/2017 at 2:30 PM, the nurse stated she was not sure if she had observed Resident #39 or not, but she stated she usually did look at the residents when assessing them. The MDS nurse stated she had not done the assessment in question and had not been working at the facility long. On 12/14/2017 at 5:10 PM, in an interview, the Director of Nursing stated she expected the MDS to be accurate for all residents.	F 641	Coordinators(not responsible for the deficiency) and Wound care nurse. Education was performed by the MDS Consultant on 12/16/17with current coordinators and again on 1/10/18 by the DON. MDS Coordinators will attend rolling co-horts for education ongoing as offered. The system put into place is ensure compliance is that all comprehensive assessments will be reviewed for 1 week by their MDS counterpart then 10% monthly for 11 months. any issues will be reported to the DON immediately and addressed. An audit tool will be completed of the findings and a report compiled and presented to QAPI for 1 year for revision and recommendation.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		1/12/18

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F 688	Continued From page 7 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide consistent application of hand splints as ordered for 1 of 1 residents which resulted in the possibility of an increased risk of further decreased range of motion/contractures (Resident #48). Findings included: Record review revealed Resident #48 was admitted to the facility on 11/22/2014 with diagnoses which included Parkinson's disease and contractures of left and right hands. Review of Resident #48's Care Plan updated on 7/4/2017 indicated the resident was at risk for a self-care deficit related to bilateral (both sides) hand contractures. Included in the interventions was to provide range of motion (ROM) to bilateral hands as tolerated and to apply carrot splints as	F 688	Corrective action for the hand splint of resident #48 was accomplished by placing the devise on 12/15/17 by the restorative aide. To ensure that others are not affected an in service was conducted with the clinical staff regarding our restorative policy, splinting and contracture management on 1/11/2018 by the acting Staff development Coordinator. A list of all additional residents with splint orders were obtained and residents were monitored to ensure appropriate placement on 1/11/2018. The system put into place was to ensure that all orders were on the MAR and the nurse was responsible to ensure compliance. An audit tool was implemented which included all residents with splint orders daily for 1 week, weekly for 3 weeks then monthly for 3 months by the MDS Coordinator.	

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F 688	Continued From page 8 ordered. Review of the most recent Minimum Data Set dated 11/3/2017 indicated Resident #48 was cognitively intact, required extensive to total assist with all Activities of Daily Living and had functional limitation impairments to both upper extremities. An observation was conducted of Resident #48 on 12/11/2017 at 11:16 AM. The resident was in bed and observed with contractures to both hands with no splints present. An interview was conducted with Resident #48 on 12/11/2017 at 3:44 PM. The resident was resting in bed and no splints were observed on the resident's hands. The resident stated the staff put the carrot splints in her hands sometimes but not every day. The resident further stated the splints were kept in the top drawer of the bedside table. Observations were conducted on 12/12/2017 at 9:36 AM and 12/14/2017 at 1:08 PM of Resident #48 without splints on her hands. An interview was conducted on 12/14/17 03:55 PM with the facility Occupational Therapist (OT). The OT indicated Resident #48 was not currently treated by the therapy department for her hand contractures. The OT revealed the resident was treated on admission and periodically since admission. The OT indicated the resident was treated in in September 2017 and was discharged from OT to Restorative Therapy on 9/29/2017. The OT indicated the therapists worked with the resident for the hand contractures. The OT indicated the resident was admitted with the contractures and when she was treated in	F 688	A report of the findings will be compiled and presented to QAPI for review and revision as needed	

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F 688	Continued From page 9	F 688		

September the contractures were basically the same with no worsening observed.
The OT revealed when Resident #48 was discharged from therapy services on 9/29/2017, orders were written for the resident to receive Restorative Therapy for Range of Motion and splint application to her hands. The OT provided a copy of the orders which specified Restorative Therapy was to wash/dry bilateral hands daily, provide ROM to bilateral hands daily, and apply inflatable carrot splints to bilateral hands for at least 2 hours a day as tolerated. The OT stated the Restorative Therapy Aides were responsible for the orders and they were instructed to attempt to splint the resident's hands for at least 4 hours daily if the resident could tolerate them. The OT reported she did not recall the resident refusal of the splints.

An interview was conducted with the Restorative Therapy Aide (RTA) on 12/15/2017 at 8:12 AM. The RTA reported Resident #48 was treated by Restorative Therapy daily for the contractures of her hands. The RTA explained the treatment consisted of washing and drying the resident's hands, providing ROM and then applying the carrot splints. The RTA reported the splints usually were on the resident for at least 4 hours. The RTA reported the resident did not refuse the splints. The RTA revealed Restorative Therapy may not have been provided on days the RTAs worked as a nursing assistant on the halls because the other aides may not apply them. The RTA presented the monthly documentation of application of the splints. There were numerous days observed with no initials for application of the hand splints. The RTA stated if there were no initials documented the splints were not applied.

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F 688	Continued From page 10 An interview was conducted with the Director of Nursing (DON) on 12/15/2017 at 9:38 AM. The DON stated the expectation was for ROM and splints to be applied as ordered. The DON also stated if the RTA was unavailable, the expectation was for the nursing assistants assigned to the residents to provide the ROM and application of splints.	F 688		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of 10/6/2016. This was for one deficiency that was originally cited at the regulatory grouping of 483.20 in October of 2016 and subsequently recited on the current recertification survey of 12/15/2017. The repeated deficiency was in the area of accurate assessment. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This citation is cross referenced to: F641 (483.20) Based on observations, staff interviews and record review the facility failed to	F 867	Corrective action was accomplished by compiling a list of all deficiencies from 10/6/2016 to current and create a tool for auditing for compliance by the facility Administrator on 1/09/2018. To ensure that the same practice does not recur all Administrative staff were in serviced on Former and existing grievances, plans of corrections, audit tools and monitoring by the acting SDC on 1/09/2018 by the acting SDC and Administrator. An audit tool was compiled to ensure compliance is attained and ongoing on 1/09/18 by the Administrator. The Administrative staff will be responsible for completion of the tool once weekly on weekends as assigned Weekend manager for three months. The tool will	1/12/18

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F 867	Continued From page 11 accurately assess dental status for one of eighteen residents reviewed for dental status (Resident #39). The facility was cited during the 10/6/2016 survey at 483.20, for failure to accurately assess a resident for fall history and another resident for eating ability. During the current recertification survey the facility continued to fail to accurately assess residents. In an interview on 12/15/2017 at 4:00 PM, the facility Administrator stated the QAA committee met monthly and identified issues and developed and implemented plans of action to correct deficiencies. The Administrator stated the Minimum Data Set Nurse was new to the position and that was the reason for the inaccurate assessments.	F 867	be completed once Monthly by the administrator for 9 months. Any issues will be discussed with the Administrator immediately and corrected. A report of the findings will be compiled by the Administrator and taken to QAPI monthly for 1 year to ensure compliance is achieved and is ongoing.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		1/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASTONIA CARE AND REHABILITATION	416 N HIGHLAND STREET GASTONIA, NC 28052

(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 880	Continued From page 12	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 13 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain infection control procedures when a staff member did not clean an insulin vial top before drawing up the insulin for one of one residents observed receiving insulin (Resident #70). Findings included: Observation of a medication pass was conducted on 12/13/2017 at 4:14 PM with Nurse #1. Resident #70 was to receive 6 units of insulin per sliding scale. Nurse #1 took the box from the top drawer of the medication cart and stated each resident had their own insulin vial. Nurse #1 removed the multi-use vial of insulin from its box labeled with Resident #70 ' s name, checked the vial with the order and proceeded to insert the needle into the vial without cleaning the vial top. Nurse #1 drew up 6 units of insulin, entered the room, and administered the insulin. When questioned as to why she did not clean the top of the vial, Nurse #1 stated she thought she did clean the vial top. Nurse #1 stated the protocol for using any vial of medication was to clean the top of the vial with alcohol before drawing up the medication. On 12/13/2017 at 5:00 PM, in an interview, the	F 880	Nurse # 1 was educated on 12/13/17 by the nurse consultant regarding policy and procedure for cleaning the top of the vial with alcohol swab prior to drawing up the insulin from the vial. Resident #70 was assessed on 12/13/17 by the unit coordinator and observed no sings and symptoms of infection at the injection site. Any resident has the potential to be affected by this issue therefore all residents who receive insulin from a multi dose vial were observed on 12/14/17 for signs and symptoms of infection with no negative outcomes noted by Unit Coordinator. Licensed nurses were In serviced on Medication administration and infection control policy and procedures 12/14/17-01/11/18 by Facility Nursing consultant, DON and Acting SDC. the system put into place to ensure ongoing compliance is to monitor 1 nurse each week for 4 weeks using the medication administration tool then then one nurse monthly for 11 months to include all nurses annually. Any issues will be reported to the DON and corrected immediately a report of the findings will be compiled	

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F 880	Continued From page 14 Director of Nursing stated Nurse #1 knew the proper procedure for cleaning any medication vial before drawing up medication. The Director of Nursing stated the expectation was all medication vials would be cleaned with alcohol before medications were drawn up.	F 880	and submitted to QAPI monthly for review and revision	