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 08/30/2018

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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and Medical Director (MD) interviews, the facility failed to obtain an order to give an antiplatelet (medication that prevents platelets from forming together to create a clot) prior to the medication being administered beginning 06/01/18 for 1 of 3 residents (Resident #32) reviewed for unnecessary medications related to anticoagulants. The findings included: Resident #32 was admitted to the facility on 05/13/13 and was readmitted on 05/19/18. His diagnoses included myocardial infarction (MI), muscle weakness, Parkinson's disease, aortic stenosis, coronary artery disease, chest pain, and others. Review of Resident #32s most recent quarterly Minimum Data Set (MDS) dated 07/26/18 revealed he was severely cognitively impaired for daily decision making and required limited to full assistance of 1 to 2 staff with his activities of daily living (ADL). An observation of Resident #32 on 08/29/18 at 1:03 PM revealed him up in his wheelchair in the dining room and wheeling in his wheelchair back to his room. The resident is alert to name and	F 658	After an internal root cause analysis was completed by facility, it was determined that the nurse failed to clarify readmission orders which were conflicting. Resident #32 had his Plavix started on 6/1/2018. On August 30, 2018 -September 14, 2018, the Director of Nursing and/or Nursing Supervisor performed Quality Improvement Monitoring of May 2018 - September 2018 physician orders containing anticoagulants to validate accurate transcription to medication administration record. Follow up based on findings. Licensed nurses were re-educated on accurate transcribing of physician orders August 30, 2018 - September 14, 2018 by the Director of Nursing and/or Nursing Supervisor. The Director of Nursing and/or Nursing Supervisor to perform Quality Improving Monitoring of written physician orders to medication administration record for accurate transcription five times a week for twelve weeks, then monthly and as needed thereafter for one year. The Director of Nursing is responsible for	9/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/13/2018

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.

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F 658	Continued From page 1 was not understood when he talked. Review of Resident #32s medical record revealed he was hospitalized 05/15/18 through 05/19/18 for a myocardial infarction. Review of his discharge summary dated 05/19/18 with medications listed revealed he had conflicting orders regarding his Plavix. In one section of the summary there was an order to continue the Plavix 75 milligrams (mg) - 1 tablet by mouth (po) daily. Then in another section there was an order to discontinue the Plavix. The receiving nurse called the Nurse Practitioner and verified with her the Plavix should be stopped. Review of the May 2018 Medication Administration Record (MAR) revealed Resident #32 was not receiving Plavix; however, the June, July and August MARs revealed the resident was receiving Plavix 75 mg - 1 tablet po daily. An interview on 08/29/30 at 4:26 PM with the unit manager revealed Resident #32 was scheduled for dental extractions and was taken off his Plavix and Aspirin and then was admitted to the hospital on 05/15/18 with an MI. The unit manager stated the cardiologist stated he should not be taken off his Plavix and Aspirin. She also stated she was not sure where the order was for the Plavix to be re-started on 06/01/18 but staff were trying to locate the order. An interview on 08/30/18 at 8:30 AM with the interim Director of Nursing (DON) revealed they had looked through Resident #32s thinned chart and were still looking for the order. An interview on 08/30/18 at 3:00 PM with the DON and Administrator revealed they had not	F 658	implementing this plan. The Director of Nursing introduced the plan of correction to the QAPI committee on September 13, 2018. Results of the Quality Improvement Monitoring to be reviewed at monthly QAPI Committee Meeting. 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. Quality Improvement Monitoring schedule is modified based on findings.	

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F 658	Continued From page 2 been able to find an order to re-start the Plavix on 06/01/18 for Resident #32 and were not sure why the medication was re-started. An interview on 08/30/18 at 3:05 PM with the Medical Director (MD) revealed the resident had had no outcome from being on the medication. The MD stated he did not consider it to be a major medical error that the resident had been given Plavix because he actually needed to be on the medication. The MD also stated Resident #32 was on Palliative care and if switched to Hospice he would likely be taken off Plavix. An interview on 08/30/18 at 3:18 PM with the unit manager revealed she had received a verbal order from the MD for the resident to receive Plavix 75 mg po 1 tablet daily to continue indefinitely starting on 06/01/18. An interview on 08/30/18 at 4:14 PM with the interim DON revealed she would have expected there to be an order in place prior to the staff administering the medication.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide 2 showers per week as scheduled for 1 of 2 residents sampled for activities of daily living (Resident #51).	F 677	After an internal root cause analysis was completed by the facility, it was determined that the facility failed to reassign staff to offer/perform showers when the shower aides were absent or	9/14/18

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F 677 Continued From page 3

The findings included:

Resident #51 readmitted to the facility on 08/08/17 with diagnoses that included: acquired absence of right leg, hypothyroidism, hypertension, vitamin B12 deficiency and vitamin D deficiency.

Review of the comprehensive minimum data set (MDS) dated 08/07/18 revealed that Resident #51 was cognitively intact and required limited assistance with bathing.

Review of the facility's shower schedule on 08/28/18 revealed that Resident #51 was scheduled showers on Monday and Friday on first shift.

Review of the facility's bath detail report for Resident #51 dated 08/28/18 revealed the following:

Friday 08/10/18: shower was given

Monday 08/13/18: no shower or bed bath was given

Friday 08/17/18: no shower or bed bath was given

Monday 08/20/18: no shower was given but a bed bath was given.

An interview was conducted with Resident #51 on 08/28/18 at 10:47 AM. Resident #51 stated that she was not consistently receiving her scheduled showers each week. She stated that she was scheduled showers on Monday and Friday on first

F 677

reassigned based on identified resident needs/acuity. Resident #51 refused showers August 20, 2018 - August 24, 2018 to the Director of Nursing. Resident #51 consented to have a shower on August 27, 2018.

The Director of Nursing and/or Nursing Supervisor completed Quality Improvement Monitoring of residents receiving showers as scheduled on August 30, 2018. Follow up based on findings.

Certified Nurse Aides and Licensed Nurses were re-educated by the Director of Nursing between August 30, 2018 - September 14, 2018 on providing showers to residents even when the shower team isn't present.
The Director of Nursing/Designee to facilitate reassigning/reallocating staff to ensure resident showers are offered/completed. The Director of Nursing and/or Nursing Supervisor to perform Quality Improving Monitoring of residents receiving showers five times a week for twelve weeks, then monthly and as needed thereafter for one year.

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F 677	Continued From page 4 shift and that was fine if she received them but the last 2 weeks she had not been receiving them. Resident #51 stated that one member of the shower team was on vacation and the other shower team member had been pulled to the floor and no one had made arrangements for other staff to fill in and give showers. Resident #51 stated that she had voiced her concerns to facility management and they told her that they were working on fixing the problem, so she could receive her showers as scheduled. An interview was conducted with Nursing Assistant (NA) #1 on 08/29/18 at 10:35 AM. NA #1 confirmed that she was responsible for Resident #51 on 08/13/18. She stated that she had not showered her because NA #2 was in the shower room that day and she assumed she would shower her. An interview was conducted with NA #3 on 08/29/18 at 10:39 AM. NA #3 confirmed that she was responsible for Resident #51 on 08/17/18 and 08/20/18. She stated she did not shower Resident #51 on 08/17/18 or 08/2018 because she did not have time and there was no one on the shower team on those days. NA #3 stated that the schedule on 08/17/18 indicated that Restorative Aide (RA) #1 was going to do showers that day but for some reason she did not. An interview was conducted with RA #1 on 08/29/18 at 10:40 AM. RA #1 stated that on 08/17/18 she was directed to go to the hall for a short time but ended up staying on the hall until 1:30 PM and then was directed to complete her documentation and was never able to go to the shower room and give showers on that day. RA	F 677		

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F 677	Continued From page 5 #1 confirmed that she had not showered Resident #51 on 08/17/18. An interview was conducted with NA #2 on 08/29/18 at 12:17 PM. NA #2 confirmed that she was a member of the shower team and gave showers Monday through Friday on first shift. NA #2 confirmed that Resident #51 was scheduled for a shower on Monday and Friday on first shift. She added that most days they did between 24 and 25 showers. NA #2 stated that recently the other member of the shower team was on vacation and during that week she only gave showers 2 days and the other days she was pulled to the floor to do other duties. NA #2 stated when she got pulled to the floor it did put the showers behind and if there was only 1 person on the shower team then it is hard to get all the showers completed for that day. NA #2 stated that if there was no one in the shower room giving showers then the residents generally did not get their showers because the staff did not have the time to do them all. She added that the facility tried to replace them in the shower room if they were off or got pulled to the floor but unfortunately that did not always happen. NA #2 confirmed that on 08/13/18 she was in the shower room by herself and was only able to get about half of the scheduled showers done and Resident #51 was not one of those residents and therefore she did not receive her shower that day. An interview was conducted with the Interim Director of Nursing (DON) on 08/30/18 at 3:45 PM. The DON stated that on 08/20/18 she was invited to attend the resident council meeting and she went and was made aware that the previous week residents had not been provided their scheduled showers due to some staffing	F 677		

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F 677	Continued From page 6 challenges. The DON stated that following the resident council meeting she had went and talked to Resident #51 and offered to give her a shower and at that time Resident #51 declined because she was already up and dressed. The DON stated that after looking into the incident she identified that the one member of the shower team had been on vacation and the other team member had been pulled several days to the floor and no one was replaced to give showers. She added that she immediately started making arrangements for staff to fill in for the shower team while they were off and checked in with Resident #51 daily the next week to make sure that she was getting her scheduled showers with no concerns were voiced from her. The DON stated that she expected showers to be given as scheduled even if the shower team was off as the NA ' s were able to give showers as were the nurses.	F 677		