STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 03/11/2021

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LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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E 000	Initial Comments An unannounced Recertification survey was conducted 03/08/21 through 03/11/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# V91311.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and complaint investigation survey was conducted 03/08/21 through 03/11/21. One complaint allegation was investigated and was unsubstantiated. Event ID# V91311.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		4/2/21

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

Electronically Signed | 04/02/2021

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement a care planned intervention for a protective boot for 1 of 3 residents (Resident # 25) reviewed for developing and implementing the comprehensive care plan. The findings included: Resident # 25 was admitted to the facility on June 6, 2020 with diagnoses of left-hand contracture, right hand contracture, muscular incoordination, lack of muscle control, muscle wasting and atrophy, and displaced spiral fracture of right tibia. The quarterly Minimum Data Set (MDS) assessment dated January 2, 2021 revealed the resident was severely cognitively impaired for	F 656	We got cited for not implementing the Care-plan as it relates to the soft boot not being placed on the resident by the Staff who stated they were not aware-even though it was on the care-plan. The staff members were noted to be familiar with the resident but did not know that this boot was supposed to be on. The root cause is that the floor nurse got clarification regarding the order and it was communicated verbally that the order was to discontinue the use of the soft boot as of 8.4.20. The clarification of the order was not written in the resident's chart and therefore was not able to be reviewed as part of the facility's daily clinical meeting. Staff will be educated on the importance	

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F 656	Continued From page 2 daily decision making. She was totally dependent on two persons for all activities of daily living (ADL). Review of Resident #25's physician's orders revealed an order dated May 17, 2020 for a soft boot while in bed for protection from friction and pressure. A review of the care plan dated May 17, 2020 and revised on June 20, 2020 revealed Resident # 25 was to have a soft offloading boot to left foot for protection while in bed. Observations of Resident # 25 were as follows: o March 9, 2021 at 5:05 PM. The resident was lying on her back in bed with head of bed elevated to approximately 40 degrees. No soft boot to Left foot. o March 10, 2021 at 8:45 AM. The resident was on her back in bed. No soft boot to Left foot. o March 10, 2021 continuous observation from 9:30 AM through 10:20 AM. When the bath was initiated, the resident was lying on her back in bed with a pillow under her head with no soft boot to the left lower extremity. There was no redness, dryness, or broken skin to the left foot. o March 11, 2021 at 8:45 AM. The resident was in bed on her back. No soft boot to left foot. o March 11, 2021 at 9:30 AM. The resident was in bed on her back. No soft boot to left foot. o March 11, 2021 at 11:58 AM. The resident was in bed on her back. No soft boot to left foot. o March 11, 2021 at 1:43 PM. The resident was in bed on her back. No soft boot to left foot. An interview with Nurse Aide (NA) # 1 and Nurse	F 656	of documenting communication of changes in plans of care in the resident's medical record. These changes can then be reviewed and the care-plan. verified during the daily clinical meeting. Orders will be reviewed Monday to Friday by the Inter Disciplinary Team (IDT) to determine if any Care Plans for assistive devices need to be initiated or updated. Training on the process for review of orders by IDT team was performed by the Director of Nursing (DON) on 3/30/2021. Interventions for the affected resident: On 3/11/2021 the order was changed to reflect the soft boot while in bed was discontinued on 8/4/2020 by the physician. The resident's Comprehensive Care Plan was updated by the Resident Care Specialist RN (RCS RN) on 3/12/2021 to reflect that the soft offloading boot to the left foot while in bed was discontinued. No sign of skin breakdown due to pressure or friction noted during skin check of the left foot by the wound nurse on 3/30/2021. Interventions for resident(s) identified as having the potential to be affected: Current resident(s) who use an appliance or splint would be at risk for the same deficient practice. On 3/29/2021 an audit was completed by the Rehab Program Manager (RPM) Staff Development Coordinator (SDC) and or the RCS RE of	

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F 656	Continued From page 3 Aide # 2 on March 10, 2021 at 10:30 AM revealed Nurse Aide # 1 had been working at the facility since November 2020. Nurse Aide # 2 had been employed at the facility for eight months. NA # 1 and NA # 2 were asked if they were aware of a soft boot to be worn by the resident while in bed. Both NA # 1 and NA # 2 stated they were not aware of a soft boot to be applied while the resident was in bed. An interview with Nurse # 1 on March 11, 2021 at 11:00 AM revealed she was familiar with Resident # 25 was aware the resident was to wear a soft boot when in bed. Nurse # 1 stated it was the responsibility of the nurse to ensure devices were donned, applied correctly, and signed for on the TAR. During the interview Nurse #1 confirmed Resident #25's soft boot was not in her room and she had checked this off on the Treatment Administration Record in error that day. Nurse # 1 was observed on March 11, 2021 at 11:10 AM to search the resident's room for the boot. There was no soft boot located during the search. An interview with the Director of Nursing (DON) on March 11, 2021 at 4:01 PM revealed her expectation that nurses follow orders. The DON stated she did not know why the soft boot was not being applied for Resident #25 as ordered. She could not explain why NAs were not aware of the devices.	F 656	100% of residents who use an appliance or splint to verify the order and care plan for the splint was accurate. Those found to be non-compliant were correct at the time of the audit. Audit was completed on 3/31/2021. Systemic Change: The floor nurses were educated on communicating clarification of orders r/t splints and ensuring that these changes are reflected on the resident's care plan. Going forward all orders related to splints needing clarification will be handled by the therapy department. Once confirmed, therapy will review information in the morning clinical, at which time the care plan will be reviewed for accuracy. Therapy will be educated on this new systemic change no later than 4/3/2021. Monitoring the change to sustain compliance ongoing: A random audit of 3 separate care plans with splints/assistive devices (if available) will be reviewed weekly for 3 months by the DON or designee for compliance. For a minimum of 3 months, the DON/Designee will report audit t results to the QAPI Committee. Results will be tracked and trended and submitted the QAPI Committee. Based on the information received the QAPI Committee will determine the need for on going monitoring of the system.	
F 684 SS=D	Quality of Care	F 684		4/2/21

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F 684	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to apply an ankle foot orthosis (AFO) ordered by the orthopedic physician to prevent a re-fracture of the right tibia for 1 of 3 residents (Resident # 25) reviewed for range of motion. The findings included: Resident # 25 was admitted to the facility on June 6, 2020 with diagnoses of left-hand contracture, right hand contracture, muscular incoordination, lack of muscle control, muscle wasting and atrophy, and displaced spiral fracture of right tibia. The quarterly Minimum Data Set (MDS) assessment dated January 2, 2021 revealed the resident had severely impaired cognitive skills for daily decision making. She was totally dependent on two persons for all activities of daily living (ADL) including transfers. A review of the Resident # 25's medical record revealed the following orthopedic Physician orders dated November 4, 2020 - "obtain AFO	F 684	Root Cause Analysis reflected that the order for orthotic assistive device was not transcribed correctly and not caught by the order review process so orthotic assistive device was not placed on resident per written order. Orders will be reviewed Monday to Friday by the Inter Disciplinary Team (IDT) to ensure written orders are accurately transcribed. Training on the process for review of orders by IDT team was performed by the Director of Nursing (DON) on 3/30/2021. Interventions for the affected resident: On 3/11/2021 the order was changed to reflect the soft boot while in bed was discontinued on 8/4/2020 by the physician. The resident's Comprehensive Care Plan was updated by the Resident Care Specialist RN (RCS RN) on 3/12/2021 to reflect that the soft offloading boot to the left foot while in bed was discontinued. No sign of skin breakdown due to pressure or friction noted during skin check of the left foot by the wound nurse on 3/30/2021.	

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F 684	Continued From page 5 brace from orthotist, wear AFO during transfer, follow up in six months." The orthopedic physician notes indicated the brace was to be used to prevent a re-fracture of the right tibia. A review of Resident # 25's physician's orders dated November 4, 2020 revealed transcription of "obtain brace right lower extremity." There was no transcription of "wear AFO during transfer." Resident # 25's Treatment Administration Record (TAR) from November 2020 to March 2021 had no record of the order to wear the AFO brace during transfer. A continuous observation of Resident # 25 on March 10, 2021 from 9:30 AM through 10:20 AM revealed Nurse Aide (NA) #1 and NA#2 provided a bed bath, oral care, incontinence care, hair care, foot care, and transfer from bed to chair via mechanical lift. The resident's right lateral ankle had intact pink scar tissue without drainage. No brace was placed on the resident's right lower extremity prior to transfer. NA #1 and NA #2 were asked after the resident was transferred out of bed if they were aware of a brace required during transfers. Both NA# 1 and NA #2 stated they were not aware a brace was to be applied prior to transfers. An interview with Nurse # 1 on March 11, 2021 at 11:00 AM revealed she was familiar with Resident # 25 and was consistently assigned to Resident # 25 on day shift, Monday through Friday. The nurse was asked to review the order written on November 4, 2021 for the AFO brace to be worn during transfers. Nurse #1 stated she was unaware of the order. Nurse #1 was observed to search Resident # 25's room for the AFO brace	F 684	Interventions for resident(s) identified as having the potential to be affected: Current resident(s) who use an assistive device would be at risk for the same deficient practice. On 3/9/2021 an audit of 100% of orders for appliances was performed by the DON, SDC and the RCS RE and updated in Point Click Care (PCC) as appropriate. Audit was completed on 3/9/2021. Re-Education was provided to the floor nurses related to proper order entry and transcription. Education completed by the DON on 4/2/2021. Systemic Change: As of 4/3/2021 and moving forward, the previous days orders will be reviewed by the IDT team to ensure orders are entered correctly. Therapy will train nursing staff to don and doff assistive devices as ordered. A random audit of 3 separate orders will be reviewed 5x weekly for 2 weeks then 3x week for 2 weeks then weekly for 2 months by the DON or designee for compliance. Monitoring the change to sustain compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit audit results to the QAPI Committee. Results will be tracked and trended and submitted the QAPI Committee. Based on the	

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F 684	Continued From page 6 and located it the top back of the resident's closet under an uncased yellow pillow. An interview with the Unit Nurse Manager on March 11, 2021 at 1:47 PM, revealed she was not able to explain why the order for Resident #25's AFO brace had not been transcribed to the TAR. She stated on receipt of the order, a nurse should have reviewed and transcribed the brace to the TAR. Since the process for reviewing and transcribing orders was not followed, she did not know the brace was ordered. An interview was conducted with the Director of Nursing (DON) on March 11, 2021 at 4:01 PM and she reviewed the order written for Resident #25's AFO brace dated November 4, 2020 at that time. The DON stated she expected nursing staff to follow the process for reviewing orders and verifying orders were listed in the appropriate places in the medical record. The DON stated she did not know where the failure in the process had occurred.	F 684	information received the QAPI Committee will determine the need for on going auditing.	
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	F 880		4/2/21

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F 880	Continued From page 7 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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.	F 880		

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F 880	Continued From page 8 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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 record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 6 staff members on the quarantine hall did not wear a mask (Nurse Aide #3) while providing care to 1 of 10 residents (Resident #123) reviewed for infection control and did not wear a gown and gloves (Housekeeper #1) when entering 1 of 10 resident rooms (Resident #120) on the quarantine hall. These failures occurred during a COVID-19 pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Responding to Coronavirus (COVID-19) in Nursing Homes," last reviewed and updated on 4/30/20 indicated the following statements: *All recommended COVID-19 PPE should be worn during care of residents under observation,	F 880	Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 6 staff members on the quarantine hall did not wear a mask (Nurse Aide #3) while providing care to 1 of 10 residents (Resident #123) reviewed for infection control and did not wear a gown and gloves (Housekeeper #1) when entering 1 of 10 resident rooms (Resident #120) on the quarantine hall. These failures occurred during a COVID-19 pandemic. Intervention for resident affected: No residents were affected by the alleged deficient practice. The C.N.A#3 was assigned to another unit during the survey, that did not require him/her to use a N95 or KN95. CNA will not be placed in a position to give personal care to a	

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F 880	Continued From page 9 which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. A review of the facility ' s COVID-19 policy entitled, Isolation - Categories of Transmission-Based Precautions During COVID Pandemic revealed the following: Enhanced Droplet Precautions: 1. Enhanced Droplet Precautions may be implemented for an individual documented or suspected to be infected with microorganisms (example includes but is not limited to: COVID-19) transmitted by droplets (particle droplets (less than 5 microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning and nebulizer treatments). 2. Equipment will include: gown, eye protection, gloves and facemask and don equipment in appropriate PPE sequence; when available, N95 or higher level respirator will be worn; if available. Facemask AND eye protection is acceptable if N95 is not available. During the entrance conference on 3/8/21 at 10:11 AM, the Administrator indicated the 100 hall was designated as the quarantine hall for new admissions and readmissions. 1. The CDC guideline entitled, "How to Wear Masks," updated on 1/30/21 indicated the following: *Wear a mask over your nose and mouth to help prevent getting and spreading COVID-19. *Wear a mask correctly for maximum protection. *Don ' t put the mask around your neck or up on	F 880	resident who requires the use of a N95/KN95 despite the C.N.A's physician clearance to use a surgical. Staff member was educated on mask use and to exit the facility if a mask break is needed. One on One re-education completed by Infection Control Prevention Officer on 3/9/2021. Root Cause Analysis reflected that Housekeeper #1 was blatantly non-compliant as he did not follow training which he was given or read and follow signage he saw posted. Disciplinary action was initiated and Housekeeper #1 is no longer employed at the facility. Interventions for resident(s) identified as having the potential to be affected: All residents would be at risk for the same alleged deficient practice. Failure to follow transmission based precautions guidelines has the potential to affect all residents and staff. To ensure residents and staff are protected from communicable disease the following corrections will be made: • The Transmission Based Precautions guidelines for the Observational Intake Unit (OIU) were reviewed with no changes made. Completed by IPCO on 3/9/21. • All signage on OIU was audited and found to be in compliance with company policy/CDC guidelines: completed by IPCO on 3/9/21.	

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F 880	Continued From page 10 your forehead. 1. During a continuous observation on the quarantine hall on 3/8/21 from 11:40 AM to 12:18 AM, Nurse Aide (NA) #3 was seen coming out of Resident #123's room with a surgical mask down below her chin and a face shield while holding a bag of soiled linen in her hand. NA #3 placed the soiled bag in the soiled utility room and walked up back to the quarantine hall with her surgical mask still under her chin. Before NA #3 entered another room in the quarantine hall, she repositioned her surgical mask back over her mouth and nose. An interview with NA #3 on 3/8/21 at 3:20 PM revealed she usually worked as a restorative aide but had been pulled to work on the quarantine hall for about one and half weeks. NA #3 stated she had been short of breath ever since she had COVID-19 and could only wear a surgical mask even when working on the quarantine hall. NA #3 further stated she had difficulty breathing while providing care to Resident #123 in her room, so she had to take her mask off. NA #3 added that she had received several education related to the use of PPE and knew that she was supposed to keep her nose and mouth covered with her mask but had to take if off because she couldn ' t breathe. An interview with the Infection Preventionist (IP) on 3/8/21 at 3:29 PM revealed she had been aware of NA #3 ' s difficulty with wearing an N95 or a KN95 mask and had allowed her to wear a surgical mask and a face shield when working on the quarantine hall. The IP stated she was unable to assign NA #3 to another hall because of the heavier workload but NA #3 should have kept	F 880	• The IPCO will complete one-on-one education with staff on appropriate use of PPE in rooms on transmission based precautions to include mask competencies, PPE usage and reading of signage. To be completed by April 2, 2021. • Quality, Safety and Education Portal (QSEP) training entitled CMS Targeted COVID-19 Training for Front-line Nursing Home Staff and Nursing Home Management to be completed by 100% of staff. To be completed by 3/30/2021. Monitoring the change to sustain compliance ongoing: • Observation of all rooms on transmission based precautions will occur to ensure compliance with Personal Protective Equipment (PPE) to be completed by the Infection Prevention and Control Officer (IPCO)/designee. This will be done 5 times a week for 4 weeks, then 1 time a week x 1 month, then 2 times monthly x 1 month then monthly x 3 months. Audit to be completed by August 23, 2021. • If employees are noted to be non compliant with use of appropriate PPE corrective action will be taken. These finding will be reviewed in QAPI and by Administrator for trends to determine if further monitoring and/or education is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 03/11/2021

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F 880	Continued From page 11 her mask on while providing care to Resident #123. An interview on 3/8/21 at 4:01 PM with the Director of Nursing (DON) revealed she had been aware that NA #3 was having trouble breathing with either N95 mask or KN95 mask and that NA #3 had obtained a note from her doctor that she could come back to work and wear a surgical mask. A second interview with the DON on 3/11/21 at 4:02 PM revealed she expected NA #3 not to remove her mask in Resident #123's room while providing care and that NA #3 should not have come out of the room and go up and down the quarantine hall with her mask under her chin and both nose and mouth exposed. 2. During a continuous observation on the quarantine hall on 3/8/21 from 11:40 AM to 12:18 AM, Housekeeper #1 was seen entering Resident #120's room without putting on a gown and gloves prior to going into the room. Housekeeper #1 was observed delivering clean laundry to the resident. When Housekeeper #1 exited Resident #120's room, he was observed rubbing hand sanitizer to both hands. An interview conducted with Housekeeper #1 on 3/10/21 at 10:35 AM revealed he went inside Resident #120's room without wearing a gown and gloves because he had not been told he needed to wear one when going into the room. Housekeeper #1 stated he had delivered laundry on the quarantine hall several times and had never worn a gown and gloves when going into the rooms. He acknowledged that he had seen the sign on the door but had never paid attention	F 880	For a minimum of 6 months, the IPCO/Designee will report audit audit results to the QAPI Committee. Results will be tracked and trended and submitted the QAPI Committee. Based on the information received the QAPI Committee will determine the need for on going auditing.	

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F 880	Continued From page 12 to it. An interview conducted with the Housekeeping/Laundry Manager (HLM) on 3/10/21 at 10:29 AM revealed they received education every month about infection control procedures and any updates related to COVID-19. The HLM stated Housekeeper #1 had been educated on what PPE to use when going into the rooms on the quarantine hall and was not sure why he did not follow the signs on the doors. An interview was conducted on 3/11/21 at 4:02 PM with the Director of Nursing (DON). The DON stated it was unacceptable for Housekeeper #1 to not wear a gown and gloves when going into the rooms on the quarantine hall. The DON added that Housekeeper #1 had been educated on proper use of PPE and that she had seen him gown up prior to entering rooms on the quarantine hall before.	F 880		