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 10/28/2021

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/25/21 through 10/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# D4BW11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 10/25/21 through 10/28/21. There were three complaint allegations investigated and they were all unsubstantiated. Event ID# D4BW11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/7/21

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

Electronically Signed | 11/22/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews, and resident interviews the facility failed to maintain residents' dignity by delaying incontinence care affecting 1 of 1 resident (Resident #26) reviewed for dignity. The resident expressed feelings of being uncomfortable, upset, mad and embarrassed. The findings included: 1.Resident #26 was admitted to the facility on 4/28/17 with diagnosis which included heart failure. Review of the quarterly Minimum Data Set (MDS) dated 9/17/21 revealed Resident #26 was cognitively intact and dependent upon staff members for assistance with toilet use and transfers. Resident #26 was coded as being incontinent of bowel and bladder. Resident #26	F 550	On 10/26/2021 at 9:04am certified nursing assistant #3 provided incontinent care to resident #26. On 11/15/2021 certified nursing assistant #3 was provided a one on one education plan regarding patient incontinence care, meal service and resident rights. On 11/16/2021 and 11/18/2021 the Director of Nursing and/or designee completed a QA (quality assurance) monitoring of resident’s rights as it relates to incontinent care of all interview able residents. No issues noted with current care being provided. On 11/23/2021 through 11/30/2021 the Director of Nursing and/or designee provided education to all staff about not turning off a call light until the service	

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F 550	Continued From page 2 was coded as having adequate vision. Review of Resident #26's care plan dated 9/28/20 with a target date of 10/27/21 revealed a focus area for bowel incontinence related to immobility. The goal was for Resident #26 to experience less episodes of incontinence through the review date. Interventions included providing peri care after each incontinent episode. An interview and observation conducted with Resident #26 on 10/26/21 at 8:54 AM revealed she was upset stating to the surveyor, "I'm having a bad day and you don't want to know why". She stated she had a bowel movement at 7:30 AM and she used her call light for assistance. The interview revealed at 7:45 AM Nurse Aide (NA) #3 entered her room, and she told the NA that she had went to the restroom and needed to be changed. She was told by NA #3 that she would have to wait because she needed to assist residents in the dining room for the breakfast meal. NA #3 turned off her call light and left the room. Resident #26 stated she had since been sitting in a bowel movement and had to eat her breakfast meal without being changed. She stated it made her feel mad, upset and embarrassed that other residents were more important. The interview revealed she knew the exact times of the incidents because she had been looking at the clock. An observation conducted on 10/26/21 at 8:54 AM revealed a foul odor coming from Resident #26's room while the surveyor entered the room with Nurse #1 during her medication pass. The surveyor informed Nurse #1 that Resident #26 needed to be changed. Nurse #2 went down the hall to find NA #3 and asked her to change	F 550	requested is provided. Also to include if the staff member is unable to complete the request from the resident they alert someone who can. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee to complete Quality Improvement monitoring of resident's rights as it relates to incontinent care. Monitoring to include if the call light was on and if a staff member provided the care per the facility policy and to be completed on 5 residents three times a week for four weeks, then one time a week for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a	

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F 550	Continued From page 3 Resident #26. An observation conducted on 10/26/21 at 8:59 AM revealed NA #3 picking up resident's breakfast meal trays. An interview conducted with Nurse #1 on 10/26/21 at 9:00 AM revealed it was expected for incontinence care to be completed every two hours but took longer due to staffing shortage. Nurse #1 further revealed multiple residents had complained about having to wait for long periods of time for incontinence care. She stated she was not aware Resident #26 had not been changed but could smell the foul odor when she entered the room with the resident's medication. An observation was conducted on 10/26/21 at 9:04 AM with NA #3 providing incontinence care to Resident #26. NA #3 entered the room with a full bed change including top sheet, fitted sheet and bed pad. When NA #3 removed the loose-fitting top bed sheet there was a brown substance noted to be on the resident s top sheet, gown, bed pad and bottom sheet. NA #3 cleaned Resident #26 using wash clothes and soap with water to rinse. When finished removing the soiled items she provided Resident #26 with a clean gown, top sheet, fitted sheet, bed pad and brief. NA #3 was observed scrubbing a brown substance from the resident's mattress which had soaked through the bed sheet. An interview conducted with Nurse Aide (NA) #3 on 10/26/21 at 9:15 AM revealed she had not provided incontinence care to Resident #26 since coming on shift at 7:00 AM. She stated she normally started getting residents up in the mornings for breakfast and took them to the	F 550	minimum. AOC Date: 12/07/2021	

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F 550	Continued From page 4	F 550		

dining room for their breakfast meal. NA #3 stated she was assisting a resident to the dining room when she saw Resident #26's call light on. She entered the room and Resident #26 stated she had a bowel movement and needed to be changed. NA #3 stated she turned off the residents call light and told her she would return after the breakfast meal to change her. She stated she thought Resident #26 was okay with waiting to be changed and did not tell the other NA working on the hall. NA #3 stated she went ahead a brought in bed change linens because she figured she would need them.

An interview conducted with NA #4 revealed she was working on the 100 hall with NA #3. She stated when she came onto shift at 7:00 AM her and NA #3 immediately start getting residents up for the breakfast meal because the facility was short staffed, and third shift wasn't getting all of the residents up. NA #4 stated they did not have time to complete an incontinence round until after breakfast because one NA went to the dining room to assist and one stayed on the hall. NA #4 stated she had remained on the 100 hall while NA #3 went to the dining room and didn't know Resident #26 needed to be changed. She stated she had been assisting other residents on the hall with their breakfast meals.

An interview conducted on 10/28/21 at 3:34 PM with the Director of Nursing (DON) revealed she had provided education to staff regarding call lights and turning them off without providing care. She stated NA #3 should not have turned off the residents call light until care had been provided. The interview revealed a lot of the NAs in the building thought they did not have to provide incontinence care during meal times. The DON

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F 550	Continued From page 5 stated she would speak to staff again on the issue and make sure they knew incontinence care still had to be provided. She stated she had residents complain of not being changed during meal times. An interview conducted on 10/28/21 at 5:45 PM with the Administrator revealed he expected for nursing staff to be providing incontinence care as needed to the residents. The interview revealed staff were expected to not turn off a resident call light unless care had been provided.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interview, and record review, the facility failed to place a call light within reach for 1 of 1 resident (Resident #208) reviewed for accommodation of needs. Findings included: Resident #208 admitted to the facility on 10/20/21 with diagnoses that included displaced fracture of right femur, anxiety, and chronic obstructive pulmonary disease. Review of the most current Minimum Data Set (MDS) dated 10/20/21 revealed Resident #208	F 558	On 10/26/2021 at 12:20 PM Regional Nurse Consultant place call bell within reach and clipped the bell to the bed covering for resident #208. On 10/26/2021 at 12:30 PM the Director of Nursing and/or designee completed a QA (quality assurance) monitoring of resident's call bell locations and being clipped so they will stay within reach of the resident. No issues noted with current call bell locations. On 11/23/2021 through 11/30/2021 the Director of Nursing and/or designee	12/7/21

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F 558	Continued From page 6 had moderately impaired cognition. Resident #208 was coded as not having behavioral symptoms or refusing care. Resident #208 required one-to-two-person assistance from staff for bed mobility, transfers, and personal hygiene. Review of the care plan dated 10/20/21 revealed Resident #208 had an activity of daily living (ADL) self-care deficit with a goal identified to maintain her current level of function. The interventions included Resident #208 to use her call bell to call for assistance. On 10/26/21 at 10:48 AM Resident #208 was observed in bed wringing her hands. She was calling out for someone to help her. Resident #208's call bell was observed to the left of her bed, on the floor. Resident stated that her call bell had been on the floor for 2 hours and she could not call for the nurse to inform her that she needed her nerve medication. On 10/26/21 at 11:05 AM observed Resident #208's call bell lying on the floor on the left side of the bed. An interview was conducted on 10/26/21 at 11:06 AM with Resident #208, she stated that she needed help with ambulating and her call bell was lying in the floor. Resident #208 stated that she became extremely anxious once she noticed the call bell was on the floor. An interview was completed on 10/26/21 at 11:20 AM with Nurse Aide (NA) #7. She stated when she delivered Resident #208 breakfast tray she was observed resting in bed and the call bell was within reach.	F 558	provided education to all staff about resident's call bell locations and being clipped so they will stay within reach of the resident. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee to complete Quality Improvement monitoring of resident's call bell locations and being clipped so they will stay within reach of the resident and to be completed on 10 residents five times a week for four weeks, then one time a week for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 558	Continued From page 7 On 10/26/21 at 11:15 AM an interview with Nurse #4 was completed. Nurse #4 stated that she had just gotten to the 300 halls (which is also the isolation hall). Nurse #4 further explained she did not observe Resident #208's call bell placement when she worked with her in the room. On 10/26/21 at 12:23 PM an interview with the Regional Nurse Consultant was completed. He stated he went to Resident #208's room and placed the call bell back onto the bed. He further stated that he clipped the call bell closer to the resident so that it was within her reach. On 10/26/21 at 4:00 PM an interview was completed with the Director of Nursing (DON). The DON stated her expectation of staff would be to ensure that the resident's call bells were within reach.	F 558	AOC Date: 12/07/2021	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(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. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		12/7/21

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F 561	Continued From page 8 facility that are significant to the resident. §483.10(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. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to provide showers for 1 resident (Resident #23) at least 2 times per week as scheduled for 1 of 3 residents reviewed for choices. The findings included: Resident #23 was admitted to the facility on 05/01/06 and readmitted on 01/16/20 with diagnoses which included Parkinson's disease, heart failure, hypertension diabetes mellitus type II and dementia among others. Resident #23's Care Area Assessment (CAA) summary for Activities of Daily Living (ADL) and Rehab Potential dated 03/01/2021 revealed Resident #23 had a significant change in status related to her continued decline and increase debility related to her medical diagnoses that had contributed to her requiring more extensive assistance with her ADL. The CAA summary further revealed she could make her needs known and healthcare staff were to monitor the resident to ensure her needs were being met and	F 561	On 10/26/2021 resident #23 shower has been provided per preference. Resident #23 was scheduled for Tuesday and Saturday on first shift according to her preference. On 11/15/2021 – 11/17/2021 all residents/responsible party were questioned regarding shower preference by the Unit Manger. On 11/18/2021 a shower schedule was developed by the Director of Nursing to reflect the current shower preferences. On 11/23/2021 – 11/30/2021 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding showers, shower schedules and documentation on the daily bathing list/PCC. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee will conduct Quality improvement monitoring of	

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F 561	Continued From page 9	F 561		

she remained safe in her environment.

Resident #23's most current quarterly Minimum Data Set (MDS) assessment dated 09/10/21 revealed she was cognitively intact for daily decision making and required total assistance of one staff with bathing, extensive assistance of 1 staff with dressing and limited assistance of 1 staff with personal hygiene.

Resident #23's care plan dated 09/17/21 revealed she had a care plan for ADL self-care performance deficit. The interventions included the resident required extensive assistance of 1-2 staff with bathing/showering, bathing/showering per resident choice, resident preferred showers in the morning and provide sponge bath when a shower cannot be tolerated.

Observation and interview on 10/25/21 at 10:53 AM with Resident #23 revealed her sitting up in her room in her wheelchair dressed for the day. The resident was dressed neatly in matching clothing appropriate for the weather and stated she was not getting her 2 showers per week and was only getting one per week most of the time. Resident #23 further stated she preferred 2 showers per week later in the morning or early afternoon.

Review of the shower/bath log for Resident #23 revealed she was scheduled for showers on Tuesday and Saturday from 7:00 AM to 3:00 PM. The shower log for August 2021 revealed she received a shower on 08/03/21, 08/10/21, 08/17/21, 08/24/21 08/28/21 and 08/31/21. Showers were not documented as given on 08/07/21 and 08/14/21. The shower log for September 2021 revealed she received a bed

resident showers two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months.

The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

AOC Date: 12/07/2021

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F 561	Continued From page 10	F 561		

bath (not her preference) on 09/04/21, shower on 09/11/21 and shower on 09/18/21. Showers were not documented as given on 09/07/21, 09/14/21, 09/21/21, 09/25/21 and 09/28/21. The shower log for October 2021 revealed she received showers on 10/03/21, 10/12/21, 10/16/21, 10/19/21 and 10/26/21. Showers were ot documented as given on 10/05/21, 10/09/21 and 10/23/21.

Interview on 10/25/21 at 11:13 with Nurse #1 revealed Resident #23 was correct about only getting one shower per week instead of the 2 showers per week she was supposed to be given. Nurse #1 stated the nurse aides (NAs) were not able to complete all their showers done as scheduled especially when they worked with only 3 NAs on day shift.

Interview on 10/27/21 at 1:48 PM with Nurse Aide (NA) #5 revealed she had cared for Resident #23 and stated she preferred a shower to a bed bath and did not like to get her showers early in the morning. NA #5 stated they used to have a shower team, but the staff member assigned to showers was now working on the floor and it was up to the NAs to give all the showers and bed baths. She further stated it was sometimes difficult to get all the showers done on 1st shift if there was not enough help.

Interview on 10/27/21 at 2:01 PM with NA #4 revealed she had cared for Resident #23 and stated the resident received showers when she worked on the hall. She indicated the resident did not like to get her showers in the morning, so she showered her in the afternoon right after lunch.

Interview on 10/28/21 at 3:45 PM with the Director of Nursing (DON) revealed she expected

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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 561	Continued From page 11 the residents to get their showers as preferred on their scheduled days. She further revealed if staff were having difficulty getting their tasks done, she would want them to ask the nurses, Unit Manager, or herself for assistance in getting showers done. The DON stated if the showers were not documented in the record, she would assume they were not done for the resident on that day.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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	F 580		12/7/21

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 10/28/2021

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F 580	Continued From page 12 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and Physician Assistant (PA) interviews, the facility failed to notify the Physician/Physician's Assistant of a resident's breakthrough pain for 1 of 2 residents (Resident #46) reviewed for notification of pain. The findings included: Resident #46 was admitted to the facility on 09/05/21 and was readmitted on 09/20/21 with diagnoses which included peripheral vascular disease, acute embolism, chronic pain, and depression. During the resident's hospitalization from 09/09/21 to 09/20/21 she had an above the knee amputation (AKA) of the right leg.	F 580	On 10/27/2021 a phone conversation between the Unit Manager and the Nurse Practitioner was held regarding pain medication regiment for Resident #46. Order changes noted from Morphine 15mg PO Q 12hrs scheduled to Morphine 15mg PO Q 6hrs. as needed for pain. On 10/20/2021 Depakote 125mg PO BID was started for mood stabilizer. On 11/12/2021 and 11/13/2021 the Director of Nursing and/or designee completed a QA (quality assurance) monitoring of resident's pain assessments. No issues noted and no need to notify MD/NP of any changes in	

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F 580	Continued From page 13 Resident #46's admission Minimum Data Set (MDS) assessment dated 09/20/21 revealed she was moderately cognitively impaired for daily decision making but could make her needs known. The MDS further revealed she had no rejection of care behaviors, and Resident #46 received scheduled and as needed (prn) pain medication for occasional pain at a level of 4 which was assessed prior to her right AKA. Resident #46's Care Area Assessment (CAA) summary dated 10/03/21 for pain revealed she recently had a right above the knee amputation (AKA) and had increased pain, due to phantom pain of the right leg. The summary further indicated Resident #46 had verbal behaviors directed at staff related to care and was associated with her increased pain. Observation and interview on 10/25/21 at 4:13 PM revealed Resident #46 lying in bed crying and stated her pain level was a 10 on a scale of 1-10. Resident #46 was noted to be moving in her bed trying to find a comfortable position. She stated it was "unbearable pain" as she pointed to her right AKA. Resident #46 further stated she still had staples in her incision to her right stump and said they were "very uncomfortable." Interview on 10/25/21 at 4:30 PM was conducted with Nurse #4 who confirmed she was caring for Resident #46. Nurse #4 was made aware of Resident #46's pain in her right AKA stump and that she verbalized pain on a scale of 10. Nurse #4 stated she would check to see what medication she could administer to the resident. Follow up interview on 10/26/21 at 9:30 AM with	F 580	condition related to increase in pain or uncontrolled pain. On 11/23/2021 through 11/30/2021 the Director of Nursing and/or designee provided education to licensed nurses about notification to the Medical Doctor and/or Nurse Practitioner related to change in condition to include increase in pain or uncontrolled pain. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee to complete Quality Improvement monitoring for notification to Medical Doctor and/or Nurse Practitioner related to change in condition to include increase in pain or uncontrolled pain. Monitoring to include pain assessments and/or questionnaire to be completed on 5 residents three times a week for four weeks, then one time a week for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human	

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F 580	Continued From page 14 Nurse #4 revealed when she checked on Resident #46's medication she had given a dose of Oxycodone at 2:00 PM and the resident was not due for another dose until 6:00 PM because it was ordered every 4 hours as needed for pain. Nurse #confirmed she had not notified the PA the resident was having severe pain and had not called the doctor to report the resident's pain. Observation and interview on 10/26/21 at 11:42 AM revealed Resident #46 lying in bed crying with tears running down her face and stated her pain was beyond a 10 and she had just received her 9:00 AM pain medication along with her prn pain medication. Resident #46 stated she had been screaming in pain and begging for her medication since 9:30 AM and had just received it. Resident #46 stated the "pain was unbearable." Resident #46 indicated NA #9 had been in to see what she needed and went to let the nurse know she needed pain medication. Follow up interview on 10/26/21 at 12:15 PM with Nurse #4 revealed she had not notified the PA or the MD about the resident's severe pain. Interview on 10/26/21 at 1:43 PM with the Unit Manager revealed Nurse #4 should have called the NP or the MD regarding the resident's pain and obtained orders for additional medication or a change in medication. The Unit Manager stated she had verified the order for Morphine as being scheduled and not prn and said she had not contacted the PA or MD because Nurse #4 had not asked her to call them for her. Interview on 10/27/21 at 8:16 AM with the Director of Nursing (DON) revealed she was aware of Resident #46's complaints of break	F 580	Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. AOC Date: 12/07/2021	

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F 580	Continued From page 15 through pain and stated she would have expected Nurse #4 or the Unit Manager to have called the PA or MD for additional orders on 10/25/21 or 10/26/21 when the resident had break through pain. The DON further stated if they had notified her of the resident's pain she would have called the PA or MD as well. Interview on 10/28/21 at 4:26 PM with the PA revealed she had been made aware on 10/26/21 around 8:00 PM of Resident #46's unrelieved pain and had made some changes in Resident #46's medication orders to try to better control her pain. She further indicated she would expect the nurses to notify her if the pain medications were not working for Resident #46 so she could make more adjustments.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other	F 583		12/7/21

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F 583	Continued From page 16	F 583		

materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interviews, and staff interviews, the facility failed to ensure 1 of 6 residents (Resident #212) was covered and provided privacy during care.

The findings included:

Resident #212 was admitted to the facility on 10/18/21.

Review of the most recent comprehensive Minimum Data Set (MDS) dated 10/18/21 revealed that Resident #212 was cognitively intact and required extensive assistance with bed mobility, transfers, toileting, and personal hygiene.

A continuous observation from 10:30 am through 11:00 am from outside of Resident #212's room on 10/25/21 revealed she was laying on the bed on her back with no covering, adult brief, or clothing on. Nursing Assistant (NA) #7 was in

On 11/15/2021 certified nursing assistant #7 was provided a one on one education plan regarding patient personal privacy to include privacy while providing bathing.

On 11/16/2021 and 11/17/2021 the Maintenance Director and/or designee completed a QA (quality assurance) monitoring of resident's rooms to ensure all doors will shut to provide privacy and also all privacy curtains are in proper working order to provide privacy.

On 11/23/2021 through 11/30/2021 the Director of Nursing and/or designee provided education to all staff about resident's personal privacy to include all resident's room doors will shut to provide privacy and also all privacy curtains are in proper working order to provide privacy. If the staff have any issues they are to report these issues to their supervisor

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F 583	Continued From page 17 the room performing care. Resident #212's door was cracked open approximately 2 feet and Resident #212's unclothed body was visible from the hallway by the surveyor. On 10/25/21 at 12:45 PM an interview and observation of Resident #212 were conducted with Nursing Assistant (NA) #7. NA #7 confirmed Resident #212's door was left cracked open while performing a bed bath. During the interview NA #7 stated she normally left the door cracked open if she was the only NA on the hall. She stated that she would pull the privacy curtains in the room and that she failed to pull the privacy curtain when performing the bed bath. An interview obtained on 10/25/21 12:50PM with Resident #212 she stated that she wasn't aware the NA had left the door cracked. She stated this embarrassed her and she wished the NA would have closed the door. An interview with the Director of Nursing (DON) on 10/27/21 at 3:48 pm revealed that she expected the NA to provide privacy to the resident by always closing the resident's door and pulling the curtain around the resident's bed before beginning care. She stated that the NA must always maintain resident's privacy throughout the procedure, by keeping the exposed areas draped or covered with a sheet, blanket, or towel. During an interview with the Administrator on 10/27/21 at 4:40 pm, he stated Resident #212's door should had been closed or the privacy curtain pulled to ensure her unclothed body was not visible from the hall to maintain her privacy.	F 583	immediately. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee to complete Quality Improvement monitoring of resident's rooms to ensure all doors will shut to provide privacy and also all privacy curtains are in proper working order to provide privacy to include staff interviews. Monitoring will be completed on 5 residents five times a week for four weeks, then one time a week for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 583	Continued From page 18	F 583	AOC Date: 12/07/2021	
F 658 SS=E	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 observations, record reviews, resident, staff and Physician's Assistant (PA) interviews, the facility failed to follow a Physicians order for one of one resident reviewed for Dialysis (Resident #6) and one of two residents reviewed for wound care (Resident #56). Findings included: 1. Resident #6 was admitted to the facility on 7/16/21 with diagnoses which included renal insufficiency requiring dialysis. Review of Resident #6's admission Minimum Data Set (MDS) dated 7/16/21 revealed she was cognitively intact requiring extensive assistance of one staff member for most activities of daily living. Resident #6 was coded under special treatments as receiving dialysis. Review of a Physicians progress note dated 9/28/21 revealed Resident #6 was evaluated for chronic conditions such as hypertension and gastroesophageal reflux disease (GERD). Resident#6's blood pressure was within the goal range and her GERD was stable. The Physician stated he would like her thyroid level monitored	F 658	On 11/5/2021 a new order for Resident #6 was received and noted from dialysis to discontinue order for holding morning medications on dialysis days. On 10/25/2021 Resident #56 had a clarification order noted to wipe posterior cervical incision bid with alcohol prep and continue collar whenever out of bed. Resident #56 was discharged on 11/16/2021. On 11/17/2021 – 11/18/2021 all residents receiving dialysis were reviewed to ensure dialysis orders are accurate and complete. On 11/17/2021 – 11/18/2021 all residents with wound care orders were reviewed to ensure they were transcribed to the medication administration record and/or the treatment administration record. On 11/23/2021- 11/30/2021 The Director of Nursing and/or designee re-educated Licensed Nurses on accurate orders for dialysis residents to include holding or not holding medications prior to dialysis as directed by the Medical Doctor. Also to	12/7/21

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F 658	Continued From page 19 every 6 months. Review of an active physician's order initiated on 7/29/21 revealed the following: Hemodialysis on Tuesday, Thursday and Saturday at 9:45 AM. Review of active physician's order initiated on 7/19/21 by Nurse #9 revealed the following: Medication not to be given on dialysis days prior to dialysis. The order was not transcribed to the Medication Administration Record. Review of Resident #6's Medication Administration Record for October 2021 revealed the resident had received 6:00 AM medication prior to dialysis on the following dates: 10/2, 10/5, 10/7, 10/12,10/14, 10/16, 10/19, 10/21, 10/23, 10/26, 10/28. The medication received included: · Levothyroxine Sodium Capsule 125 micrograms once daily for hypothyroidism · Tums 500mg tablet for Gastroesophageal reflux disease (GERD) Resident #6 received the following 9:00 AM medication prior to dialysis on 10/5, 10/7, 10/12, 10/14, 10/16, 10/19, 10/21, 10/23, 10/26, 10/28: · Colace 100mg for constipation · Duloxetine delayed release 30 milligram capsule for depression · Famotidine 40 mg tablet for GERD · Hydralazine 100mg 1 tablet for hypertension · Tums 500 mg tablet for GERD Review of a Dialysis communication form dated 10/9/21 revealed they had no recommendations to the facility. Resident #6's blood pressure was 133/55.	F 658	include transcription of orders to ensure they are on the medication administration record and/or the treatment administration record. Newly hired staff will be educated upon hire. Starting on 11/29/2021 The Director of Nursing and/or designee will conduct Quality improvement monitoring of residents receiving dialysis were reviewed to ensure dialysis orders are accurate and complete and residents with wound care orders were reviewed to ensure they were transcribed to the medication administration record and/or the treatment administration record three times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, 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 658	Continued From page 20 Review of a Dialysis communication form dated 10/26/21 revealed their recommendation was to administer Resident #6's medication as scheduled. Resident #6's documented blood pressure was 198/68 after dialysis. Review of Resident #6's most recent thyroid stimulating hormone (TSH) level dated 11/5/21 revealed her TSH level was 1.41 (normal range 0.45- 5.33). An interview could not be conducted with Nurse #9. She no longer worked in the facility An interview conducted on 10/27/21 at 4:18 PM with Resident #6 revealed some of the nurses had given her medication prior to going to dialysis. She stated the Nurse yesterday morning on 10/26/21 had stopped her and administered her 9:00 medication prior to going to dialysis. The interview revealed Resident #6 was not having any negative effects from receiving her medication prior to dialysis. She stated the facility always provided her with breakfast prior to leaving for dialysis and sent her with a snack because the dialysis facility would not allow the residents to eat lunch there. An interview conducted on 10/27/21 at 4:29 PM with Nurse #7 revealed she had administered Resident #6's prior to dialysis on 10/5/21 because she was able to give the resident her medication first on that day. Nurse #7 stated she was not aware of any orders to not administer her medication prior to dialysis. The interview revealed the order should have been transcribed onto the MAR so the nurses would know because the order was not on the MAR for them to see.	F 658	AOC DATE: 12/07/2021	

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F 658	Continued From page 21	F 658		

An interview conducted with Nurse #1 on 10/28/21 at 8:34 AM revealed she had administered Resident #6's medication prior to dialysis on 10/7/21, 10/12/21 and 10/25/21. She stated she knew there was an order to not administer Resident #6's medication prior to dialysis however she thought she remembered the resident asking for her medicine, so she decided to give it.

An interview conducted on 10/28/21 at 9:10 AM with Nurse #8 revealed she had administered Resident #6's medication prior to dialysis on 10/21/21. She stated she was an agency nurse working in the facility and had stopped Resident #6 in the hallway on her way to leave the building for dialysis and administered her medication. Nurse #8 stated she did not know there was an order to not administer the resident's medication prior to dialysis but she had not checked the resident's orders.

An interview conducted on 10/28/21 at 9:34 AM with the Director of Nursing (DON) revealed Resident #6 shouldn't have received any medication prior to going to dialysis per Physician's order. She stated she would speak to the nurses to ensure they knew about the order. She stated the order had not been transcribed onto the MAR due to a mistake by Nurse #9 when she originally put in the order.

An interview conducted on 10/28/21 at 4:25 PM with the facility Physician's Assistant (PA) revealed she had reviewed Resident #6's medication and agreed the nurses should have held her morning medication on dialysis days because she was getting blood pressure

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

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F 658	Continued From page 22	F 658		

medication and taking that prior to dialysis could cause hypotension (low blood pressure) when the resident came back from dialysis. After reviewing Resident #6's vital signs she stated the resident had not experienced a low blood pressure as a result of receiving the medication prior to dialysis however she stated her expectation was for the nursing staff to follow her orders. The interview revealed Resident #6 was in a stable condition and had experienced no negative outcomes from receiving her medication prior to dialysis.

2. Resident #56 was admitted to the facility on 10/7/21. Her diagnoses included displaced fracture of the cervical vertebrae, fracture of the lumbar vertebrae.

Review of Resident #56's most recent quarterly minimum data set (MDS) dated 10/7/21 revealed she was cognitively intact and required one person assistance with dressing, toileting, personal hygiene and bathing.

Review of a physician order written on 10/7/21 revealed the physician had written the following order "May use Aspen collar when out and bed and during activities. Clean incision with alcohol daily, may shower." This order was never transcribed to the medication administration record (MAR).

Review of a physician order written 10/21/21 written at 2:14 PM revealed the physician had written the following order for wound care: "Wipe posterior cervical incision twice a day with alcohol

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 10/28/2021

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	Continued From page 23	F 658		

prep, continue collar whenever out of bed."

Review of medication administration record (MAR) from 10/1/21 through 10/31/21 revealed the wound care order was not transcribed to the MAR until 10/25/21.

An interview on 10/25/21 at 10:34 AM with Resident #56 revealed she had been at the facility for approximately 3 weeks, resident stated that she had a wound on the back of her neck, and she wears a neck collar. Resident #56 stated that she had no wound care done to her neck since she was admitted. She stated that she had complained about this to the nurses, but no one had done any wound care.

An observation on 10/25/21 at 10:56 AM revealed Nurse #4 performing wound care to Resident #56 neck. She wiped the area with an alcohol wipe per physician order. Incision to back of neck was covered with a scab, edges were approximated. No signs or symptoms of infection observed.

An interview on 10/26/21 at 11:54 AM with Nurse #4 revealed that she remembered transcribing and entering the order to perform daily wound care to the medication administration record (MAR). Nurse #4 stated she failed to select the area on the MAR that makes the orders flow over to the electronic medication administration record (eMAR). She stated therefore the wound care was never performed because it never showed up on the electronic medication administration record.

An interview on 10/26/21 at 12:23 PM with the Regional Nurse Consultant revealed he was unaware that Nurse #4 was so overwhelmed with

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 10/28/2021

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	Continued From page 24 the amount of work assigned to her. He stated that he expects all physician orders to transcribed and entered onto the medication administration record once the nurse or unit manager receives them. On 10/28/21 at 2:20 PM an interview with the Director of Nursing (DON) was conducted. She stated that she expects the Unit Manager and/or the nurses to transcribe and enter all physicians' orders to the medication administration record once they receive them. An interview was conducted on 10/28/21 at 4:25 PM with the Physician's Assistant (PA) which revealed that she expected the staff to follow the physician orders. She expected the staff to notify the physician if the orders were not followed. She stated she was unaware that wound care had not been performed until 10/21/21, once she was aware, she initiated another order for the wound care.	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 reviews, resident, and staff interviews the facility failed to provide showers or complete bed baths for 1 of 3 residents (Resident #46) reviewed for activities of daily living (ADL) for dependent residents. The findings included:	F 677	On 10/31/2021 resident #46 bed bath has been provided. On 11/3/2021 Resident #46 had a bathing preference completed and was scheduled for Thursday and Sunday on 7-3 shift according to her preference.	12/7/21

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 10/28/2021

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 677	Continued From page 25 Resident #46 was admitted to the facility on 09/05/21 and was readmitted on 09/20/21 with diagnoses which included coronary artery disease, peripheral vascular disease, multiple sclerosis, and depression. During the resident ' s hospitalization from 09/09/21 to 09/20/21 she had an above the knee amputation (AKA). Resident #46's admission Minimum Data Set (MDS) assessment dated 09/20/21 revealed she was moderately cognitively impaired for daily decision making but could make her needs known. The MDS further revealed she had no rejection of care behaviors, and her bathing was assessed as activity did not occur. Resident #46's Care Area Assessment (CAA) summary dated 10/03/21 for ADL and rehab potential revealed she was able to make her needs/concerns/preferences known. Resident #46 was documented as requiring extensive assistance with ADL and staff were to encourage resident participation in ADL. Resident #46's care plan dated 10/04/21 revealed she had a care plan for ADL self-care performance deficit related to right AKA, pain, and decreased mobility among others. The interventions included the resident required extensive assistance of 1-2 staff with bathing/showering, bathing/showering per resident choice (no choice was indicated on the care plan) and provide sponge bath when a shower cannot be tolerated. Observation and interview on 10/25/21 at 4:13 PM revealed the resident lying in bed crying and stated her pain level was at a 10 on a scale of	F 677	On 11/15/2021 – 11/17/2021 all residents/responsible party were questioned regarding shower preference by the Activities Director. On 11/18/2021 a shower schedule was developed by the Director of Nursing to reflect the current shower preferences. On 11/23/2021 – 11/30/2021 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding showers, shower schedules and documentation on the daily bathing list/PCC. Newly hired staff will be educated upon hire. Starting on 11/29/2021 The Director of Nursing and/or designee will conduct Quality improvement monitoring of resident showers five times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human	

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 10/28/2021

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 677	Continued From page 26 1-10. Resident #46 was noted to be moving in her bed trying to find a comfortable position. She stated they had increased her pain medication, but it had not helped with her pain, and she stated it was "unbearable pain." There was a strong odor in the room and the resident's hair was greasy and disheveled. Resident #46 stated she had not had a shower since she was admitted to the facility. She stated she had staples in her stump still and was not sure she could shower but stated she had not had a bed bath since admission either. Review of Resident #46's physician orders revealed there was no indication she could not shower with staples in her incision and there was no dressing applied over the staples. Review of the shower log for September 2021 revealed Resident #46 had 2 bed baths and no showers and missed 2 showers for the month. The shower log for October 2021 for Resident #46 revealed she had 3 bed baths on 10/06/21, 10/07/21 and 10/08/21 and refused a bed bath on 10/18/21 and refused a bed bath on 10/23/21 but there was no other documentation for the rest of the month. Showers were not documented as given on 10/05/21, 10/10/21, 10/12/21, 10/19/21, and 10/26/21. Interview on 10/27/21 at 1:52 PM with Nurse Aide (NA) #5 revealed she often cared for Resident #46 and stated she had refused her bed bath for her once before because she was in pain and did not want to get a bed bath. NA #5 stated they were not always able to get all their showers done each day with all the other duties they had especially when someone called out for the day.	F 677	Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. AOC Date: 12/07/2021	

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 10/28/2021

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 677	Continued From page 27 Interview on 10/27/21 at 2:12 PM with NA #8 revealed she had taken care of Resident #46 several days and stated had given her a bed bath but had not offered her a shower due to her staples in her wound. NA #8 further stated there was not always enough staff available to give everyone's shower on the days scheduled. Interview on 10/28/21 at 3:45 PM with the Director of Nursing (DON) revealed she expected the residents to get their showers as preferred on their scheduled days. She further revealed if staff were having difficulty getting their tasks done, she would want them to ask the nurses, Unit Manager, or herself for assistance in getting showers done. The DON stated if the showers were not documented in the record, she would assume they were not done for the resident on that day.	F 677		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and Physician's Assistant (PA) interviews, the facility failed to manage a resident's complaints of pain for 1 of 2 residents (Resident #46) reviewed for pain management. The findings included:	F 697	On 11/6/2021 Resident #46 had new orders for Morphine 15mg PO every 12 hours scheduled, Oxycodone 10mg PO every 6 hours as needed for pain and on 11/4/2021 Gabapentin 300mg one PO at bedtime. On 10/20/2021 Resident #46 had new orders for Depakote 125mg PO BID was started for mood stabilizer. On	12/7/21

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 10/28/2021

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 697	Continued From page 28 Resident #46 was admitted to the facility on 09/05/21 and was readmitted on 09/20/21 with diagnoses which included peripheral vascular disease, acute embolism, chronic pain, and depression. During the resident's hospitalization from 09/09/21 to 09/20/21 she had an above the knee amputation (AKA) of the right leg. Resident #46's admission Minimum Data Set (MDS) assessment dated 09/20/21 revealed she was moderately cognitively impaired for daily decision making but could make her needs known. The MDS further revealed she had no rejection of care behaviors, and Resident #46 received scheduled and as needed (prn) pain medication for occasional pain at a level of 4 which was assessed prior to her right AKA. Review of Resident #46's Medication Administration Record for September 2021 revealed the following orders for pain medication: 1. Morphine sulfate extended release (ER) 15 milligram (mg) tablet - take 1 tablet by mouth every 12 hours with maximum daily amount 30 mg. (scheduled at 9:00 AM and 9:00 PM) effective 09/20/21. 2. Oxycodone Hydrochloride (HCl) tablet 10 mg - 1 tablet by mouth every 8 hours as needed for pain effective 09/28/21. 3. Cymbalta Capsule delayed release particles (DRP) 60 mg - give 1 capsule by mouth once daily for neuropathy effective 09/06/21. Review of Resident #46's Medication Administration Record for October 2021 revealed the following orders for pain medication: 1. Morphine sulfate extended release (ER) 15	F 697	11/17/2021 Medical Doctor completed a pain assessment for Resident #46. On 11/12/2021 and 11/13/2021 the Director of Nursing and/or designee completed a QA (quality assurance) monitoring of resident's pain assessments. No issues noted to include no increase in pain or uncontrolled pain. On 11/23/2021 through 11/30/2021 the Director of Nursing and/or designee provided education to licensed nurses about notification to the Medical Doctor and/or Nurse Practitioner related to increase in pain or uncontrolled pain. Newly hired staff will be educated upon hire. Starting on 11/29/2021 the Director of Nursing and/or designee to complete Quality Improvement monitoring for resident increase in pain or uncontrolled pain. Monitoring to include pain assessments and/or questionnaire related to pain to be completed on 5 residents three times a week for four weeks, then one time a week for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee	

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	345385	A. BUILDING _____ B. WING _____	C 10/28/2021

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 697	Continued From page 29 milligram (mg) tablet - take 1 tablet by mouth every 12 hours with maximum daily amount 30 mg. (scheduled at 9:00 AM and 9:00 PM) 2. Oxycodone immediate 10 mg tablet - take 1 tablet by mouth every 4 hours as needed for pain. (An increase from every 8 hours as needed for pain) 3. Cymbalta Capsule delayed release particles (DRP) 60 mg - give 1 capsule by mouth once daily for neuropathy effective 09/06/21. Resident #46's Care Area Assessment (CAA) summary dated 10/03/21 for pain revealed she recently had a right above the knee amputation (AKA) and had increased pain, due to phantom pain of the right leg. The summary further indicated Resident #46 had verbal behaviors directed at staff related to care and was associated with her increased pain. Resident #46's care plan dated 10/04/21 revealed she had a care plan for pain related to right AKA, chronic pain, and decreased mobility among others. The interventions included assessing resident's pain level every shift, utilize pain scale 0-10, medicate resident as ordered and evaluate effectiveness of pain medication, monitor for non-verbal signs of pain, and document/report any changes in pain characteristics to PA or MD. Review of the MAR for September 2021 and October 2021 revealed the resident ' s pain level was being assessed 2 times per day and the documented ranges were 5 to 10 most shifts and when pain medication was administered the ranges were recorded as 7 to 10 on a scale of 0 to 10. Observation and interview on 10/25/21 at 4:13	F 697	consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. AOC Date: 12/07/2021	

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	345385	A. BUILDING _____ B. WING _____	C 10/28/2021

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 697	Continued From page 30	F 697		

PM revealed Resident #46 lying in bed crying and stated her pain level was a 10 on a scale of 1-10. Resident #46 was noted to be moving in her bed trying to find a comfortable position. She stated it was "unbearable pain" as she pointed to her right AKA. Resident #46 further stated she still had staples in her incision to her right stump and said they were "very uncomfortable."

Interview on 10/25/21 at 4:30 PM was conducted with Nurse #4 who confirmed she was caring for Resident #46. Nurse #4 was made aware of Resident #46's pain in her right AKA stump and that she verbalized pain on a scale of 10. Nurse #4 stated she would check to see what medication she could administer to the resident.

Resident #46's Medication Administration Record (MAR) was reviewed and the resident according to the MAR, received Oxycodone on 10/25/21 at 2:00 AM and 10:06 PM. There was no entry on the MAR by Nurse #4 that she had given the Oxycodone at 2:00 PM.

Review of the narcotic sheets revealed Resident #46 received Morphine Sulfate ER 15 mg 1 tablet by mouth at 9:08 AM (as ordered), Oxycodone 10 mg by mouth at 2:00 PM and Morphine Sulfate ER 15 mg 1 tablet by mouth at 3:00 PM on 10/25/21. The resident received an extra dose of Morphine Sulfate 15 mg 1 table by mouth at 3:00 PM. The resident reported at 4:00 PM her pain level was down to a 4 from a 10.

Follow up interview on 10/26/21 at 9:30 AM with Nurse #4 revealed when she checked on Resident #46 ' s medication she had given a dose of Oxycodone at 2:00 PM and the resident was not due for another dose until 6:00 PM because it

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 10/28/2021

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 697	Continued From page 31	F 697		

was ordered every 4 hours as needed for pain. Nurse #4 confirmed she had not notified the PA the resident was having severe pain and had not called the doctor to report the resident's pain. Nurse #4 stated Resident #46 was not still crying with pain when she checked on her yesterday at 4:00 PM and stated the Morphine seemed to have helped with her severe pain.

While observing a medication pass on 10/26/21 at 11:19 AM, another surveyor revealed Resident #46 was screaming out in pain and could be heard in the hallway. Nurse #4 heard the resident screaming and asked, "what is that noise?" The surveyor explained it was Resident #46 screaming for her pain medication. Nurse #4 administered her pain medication at 11:30 AM.

Observation and interview on 10/26/21 at 11:42 AM revealed Resident #46 lying in bed crying with tears running down her face and stated her pain was beyond a 10 and she had just received her 9:00 AM pain medication along with her prn pain medication. Resident #46 stated she had been screaming in pain and begging for her medication since 9:30 AM and had just received it. Resident #46 stated the "pain was unbearable." Resident #46 indicated NA #9 had been in to see what she needed and went to let the nurse know she needed pain medication.

Interview on 10/26/21 at 12:00 PM with NA #9 revealed she had gone to the 300 hall to find Nurse #4 to let her know the resident needed pain medication around 11:00 AM. NA #9 stated the resident had been complaining of pain for over an hour and she had reported it to Nurse #4.

Review of Resident #46's Medication

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 10/28/2021

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 697	Continued From page 32	F 697		

Administration Record revealed Resident #46 had not received Morphine Sulfate ER 15 mg 1 tablet by mouth at 9:00 AM as ordered. The MAR also revealed Resident #46 had received oxycodone 1 tablet by mouth at 10:00 PM on 10/25/21 and at 11:30 AM on 10/26/21.

Interview on 10/27/21 at 7:31 AM with Nurse #6 who typically cared for Resident #46 on night shift revealed Resident #46 did have pain sometimes at night but not like during the day. Nurse #6 stated the resident took Trazadone at night for sleep and she typically was able to sleep through the night once she was medicated with her prn pain medication and Trazadone.

Review on 10/26/21 at 12:00 PM of Resident #46's narcotic sheets for 10/26/21 revealed at 8:00 AM Resident #46 had received Morphine Sulfate ER 15 mg 1 tablet by mouth (as ordered), Oxycodone Immediate 10 mg tablet 1 tablet by mouth at 11:30 AM and Morphine Sulfate ER 15 mg 1 tablet by mouth at 11:30 AM. The resident received an extra dose of Morphine Sulfate 15 mg 1 tablet by mouth at 11:30 AM.

Follow up interview on 10/26/21 at 12:15 PM with Nurse #4 revealed she had given Resident #46 an extra dose of Morphine Sulfate ER 15 mg 1 tablet by mouth on 10/25/21 and on 10/26/21. She stated she had given the medication because she had misread the order and thought it said prn (as needed). Nurse #4 further stated Resident #46 was in so much pain she administered the medication to help alleviate her pain. Nurse #4 indicated she had consulted with the Unit Manager about giving the resident another dose of the Morphine Sulfate and said the Unit Manager told her she thought the order

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 10/28/2021

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 697	Continued From page 33	F 697		

was prn (as needed), but she needed to verify it before she gave an extra dose. Nurse #4 further indicated she misread the order and gave the extra doses.

Interview on 10/26/21 at 1:43 PM with the Unit Manager revealed Nurse #4 should have called the NP or the MD regarding the resident's pain and obtained orders for additional medication or a change in medication.

Follow up interview on 10/27/28 at 11:45 AM with the Unit Manager revealed she had spoken with the PA over the phone last evening and obtained new orders for Resident #46's pain medication. She stated the new medications would begin today and they would see how well it worked to manage her pain.

Interview on 10/28/21 at 4:26 PM with the PA revealed she had been made aware on 10/26/21 around 8:00 PM of Resident #46's unrelieved pain and had made some changes in Resident #46's medication orders to try to better control her pain. She stated it was difficult to manage her pain and find the right combination of medications that worked for her because of her systemic disease. The PA stated it was a matter of finding the right balance of pain control without causing sedation and affecting her function. She further stated she had changed her pain medications and added Neurontin to help with her phantom pain in her right AKA stump. The new orders given on the evening of 10/26/21 for medications were as follows:

1. Oxycodone Hydrochloride tablet 10 mg - give 1 tablet by mouth every 8 hours as needed for pain.

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 10/28/2021

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 697	Continued From page 34 2. Morphine Sulfate 15 mg tablet - give 1 tablet by mouth every 6 hours as needed for pain. 3. Neurontin capsule 300 mg (Gabapentin) - give 1 capsule by mouth at bedtime for pain effective 10/27/21. The PA indicated she would be monitoring Resident #46 to determine the effectiveness of the new orders for her pain medication and to see if the Neurontin helped with her phantom pain in her right leg.	F 697		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		12/7/21

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 10/28/2021

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 725	Continued From page 35 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to provide sufficient nursing staff for the provision of incontinence care to a resident (Resident #26) who had a bowel movement, failed to provide showers as scheduled for 1 resident (Resident #23) and failed to provide showers or complete bed baths for 1 dependent resident (Resident #46). This affected 3 of 7 residents reviewed for sufficient nursing staff. The findings included: This tag is cross referred to: F550: Based on observation, record reviews, staff interviews, and resident interviews the facility failed to maintain residents' dignity by delaying incontinence care affecting 1 of 1 sampled resident (Resident #26). The resident expressed feeling of being uncomfortable, upset, mad and embarrassed. F561: Based on observations, record reviews, resident, and staff interviews, the facility failed to provide showers for one resident at least two times per week as scheduled for 1 of 3 residents reviewed for choices (Resident #23). F677: Based on record reviews, resident, and staff interviews the facility failed to provide showers or complete bed baths for 1 of 3 residents (Resident #46) reviewed for activities of daily living (ADL) for dependent residents.	F 725	Resident #26 was provided incontinent care on 10/26/2021 at 9:04AM. Resident #23 was provided a shower on 10/26/2021. Resident #46 was provided a shower on 10/31/2021. On 11/17/2020, the Executive Director met with the Director of Nursing and Human Resources to ensure recruiting efforts for open positions were in place along with approved incentives for new hires and referrals. Additionally, bonus structure reviewed by the Executive Director for staff who work additional shifts as needed. Agency contracts in place to meet staffing needs. The Executive Director, Director of Nursing and the Human Resources Person reviewed staffing levels on 11/17/2021 to ensure adequate staffing levels based on residents' needs and acuity. No inadequacies noted. On 11/17/2021 the Executive Director and the Director of Nursing reviewed the nursing staffing schedule was completed and if there was sufficient staff scheduled to care for the residents. Additionally, the staffing assignment sheets were reviewed to ensure adequate staffing to the residents as per the schedule on 11/17/2021 and no issues were identified.	

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	345385	A. BUILDING _____ B. WING _____	C 10/28/2021

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 725	Continued From page 36 An interview conducted with Nurse #1 on 10/26/21 at 9:00 AM revealed it was expected for incontinence care to be completed every two hours but took longer due to staffing shortage. Nurse #1 further revealed multiple residents had complained about having to wait for long periods of time for incontinence care due to staffing and the showers were not being completed as scheduled. An interview conducted with Nurse Aide (NA) #4 on 10/26/21 at 2:36 PM revealed in the mornings when she came on shift at 7:00 AM she had to immediately start getting residents out of bed and dressed for the morning meal. She stated one NA went to the dining room and one stayed on the hall with the residents. The interview revealed there was no time for incontinence care rounding prior to breakfast. NA #4 stated it was "touch and go" getting tasks completed during the day with the number of staff members they had working in the facility. She stated she hadn ' t taken a lunch break yet due to trying to get showers completed on the hall. An interview conducted on 10/27/21 at 7:00 AM with Nurse #3 revealed she always worked on third shift with one other nurse. She stated on 10/26/21 the facility had 2 nurses and 3 NAs to provide care to 58 residents. The interview revealed she had been working since 4:30 PM the previous day because the facility could not find anyone else to come in and needed a nurse. Nurse #3 stated the facility sometimes only had 2 NAs working on the hall during third shift which made it hard for them to get their task completed such as incontinence rounding.	F 725	On 11/15/2021 through 11/17/2021, the Activities Director interviewed interview-able (BIMS of 8 and above) residents on bathing preferences. Bathing preferences were utilized by the Director of Nursing to establish a bathing schedule for current residents on 11/17/2021. The Interdisciplinary Team then updated the residents' plans of care and Kardexes accordingly by 11/19/2021. Beginning on 11/23/2021 through 11/30/2021 the Director of Nursing/Assistant Director of Nursing/RN Nurse Manager educated Nursing Staff on regulation F-725 and to directly notify the ED, DCS, or ADCS for any call outs, so that facility leadership is aware of and can intervene with any staffing needs that could lead to inadequate staffing to meet residents' needs. The ED, DCS, ADCS or Scheduler will attempt to replace the staff member who is calling out by calling on facility staff to stay over or come into work, using a current nursing staff roster/phone list and/or by notifying contracted agency of staffing needs. If staffing needs cannot be met using these means, the ED, DCS, ADCS may enforce mandating for staff member (s) currently working. Facility Nursing Staff has been educated on waiting for their relief to arrive prior to leaving the facility at the end of their shifts. Facility Nursing Staff was also educated on giving a shift to shift resident report to the oncoming employee relieving them of their job duties. This shift to shift report should encompass the	

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 10/28/2021

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 725	Continued From page 37 An interview conducted on 10/27/21 at 7:15 AM with NA#6 she worked the 7:00 PM to 7:00 AM (third) shift during which showers were scheduled from 7:00PM to 11:00 PM. The interview revealed she was unable to complete those showers due to residents wanting to go to bed, residents wanting snacks and not enough staff to complete all of the tasks. An interview on 10/27/21 at 3:45 PM with NA #8, a first shift NA, revealed there was not always enough staff available to give everyone ' s shower on the days scheduled. An interview conducted on 10/28/21 at 3:27 PM with the Director of Nursing revealed the facility was staffed with two licensed practical nurses (LPN) during the day and they sometimes had a Medication Aide. The DON stated she and the facility transporter were in charge of staffing. She stated the goal for Nurse Aides (NA) during the day was 6 however the facility normally had 4-5 NAs for day shift and 3-4 on night shift. The interview revealed the facility was using agency staffing for nurses and NAs since July 2021 however had been experiencing issues with the agency staff calling out or not showing up. She stated the facility had started a program to train their own NAs and pay for their courses, but staff were leaving once they completed the course. The DON stated the facility could not compete with COVID-19 pay offered by other facilities and had lost a lot of staff since COVID-19. She stated she had received a lot of complaints from NAs due to staffing and not being able to get their incontinence rounding or showers completed. She stated the week before she had given 3 showers herself due to the NAs on the hall not being able to do so. The interview revealed the	F 725	status of the residents on their staff assignment to include any baths, refusals of baths, or baths that were not completed, so that they can be followed up to completion. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing/Assistant Director of Nursing will conduct QI monitoring of regulation F-725 to ensure sufficient direct care nursing staff to meet the needs of residents and to ensure residents are bathed per their preferences. QI monitoring will be conducted five times a week for four weeks, then three times a week for four weeks, once weekly for four weeks, then monthly for three months utilizing a sample size of five random residents. The Director of Nursing/Assistant Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for 6 months or until substantial compliance is met. AOC Date: 12/07/2021	

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 10/28/2021

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 725	Continued From page 38 facility had 2 open Registered Nurse positions, 6 open Licensed Practical Nurse positions, 2-unit manager positions open, two medication aide positions open and several Nurse Aide positions open for day and night shift. She stated the facility was offering incentives for new staff and was hoping this would help. An interview conducted with the Administrator on 10/28/21 at 5:30 PM revealed he did not feel the facility had a staffing issue. He stated they were using agency Nurses and Nurse Aides to assist with staffing and felt the NAs had enough time to complete their assigned task if they used their time wisely.	F 725		
F 880 SS=E	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 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/7/21

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 10/28/2021

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 880	Continued From page 39	F 880		

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.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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 10/28/2021

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 880	Continued From page 40 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 follow CDC guidelines for the use of Personal Protective Equipment (PPE) when 6 out of 6 staff members (Nurse #1, NA #6, NA #3, Speech Therapist, Nurse #4 and Laundry Assistant #1) were observed not wearing eye protection while providing resident care. This occurred during a global pandemic. The findings included: A review of the Centers for Disease Control and Prevention (CD*C) COVID-19 Data Tracker on 10/25/21 indicted the county where the facility was located had a high level of community transmission for COVID-19. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 09/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): *If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below	F 880	On 10/25/2021 all current staff were provided verbal education by the Regional Director of Nursing and/or designee on the use of eye protection in counties with high or substantial rate of transmission. All current staff on 10/25/2021 were provided eye protection and all employees coming into work were educated and provided eye protection prior to working their shift. On 10/25/2021 □ 10/27/2021 all staff were questioned about their use of eye protection with all residents while working in a county with high or substantial rate of transmission. Education provided to all staff members starting on 10/25/2021. On 10/25/2021 all current staff were provided verbal education by the Regional Director of Nursing and/or designee on the use of eye protection in counties with high or substantial rate of transmission. Prior to the employees□ next shift education was provided by the Director of Nursing and/or designee on the use of eye protection in counties with high or substantial rate of transmission. On 11/23/2021 □ 11/30/2021 all staff were re-educated on the use of eye protection in counties with high or substantial rate of transmission. Newly hired staff will be	

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 10/28/2021

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 880	Continued From page 41 including: Eye protection (i.e. goggles or a face shield that covers the front and sides on the face) should be worn during all patient care encounters. A review of the facility policy entitled, "Consulate Healthcare Emergency Procedure - Pandemic COVID-19," revised on 10/04/2021 indicated: 16. Initiate Transmission based precautions per the CDC (Standard, Contact and Droplet) including PPE - respirator, eye protection, gown and gloves. 1. a. Observation on 10/25/21 at 10:36 AM revealed Nurse #1 going into room 114-A to administer morning medications to Resident #158 without eye protection. The nurse was observed within 3 feet of the resident assisting her with medications and providing water for the resident to take her medications. Interview on 10/25/21 at 11:39 AM with Nurse #1 revealed she had not been informed by the Director of Nursing or the Unit Manager she needed to wear eye protection on the general unit while providing medication pass. Nurse #1 stated she would have to find some goggles to wear over her glasses or a face shield. Interview on 10/25/21 at 11:41 AM with the Regional Nurse Consultant revealed the staff on the general unit did not need to wear eye protection, only the staff working on the isolation unit for new admissions. The Regional Nurse Consultant stated he was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19.	F 880	educated upon hire. Starting on 11/29/2021 The Director of Nursing and/or designee will conduct Quality improvement monitoring of staff□s use of PPE to include the use of eye protection for five times a week for four weeks, then three times a week for eight weeks, and then one time weekly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/29/2021. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. AOC Date: 12/07/2021	

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 10/28/2021

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 880	Continued From page 42	F 880		

Interview on 10/28/21 at 3:16 PM with the Director of Nursing (DON) who is also the Infection Preventionist (IP) revealed she was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19 until informed on Monday by the Regional Nurse Consultant.

b. Observation on 10/25/21 at 10:43 AM revealed Nurse Aide (NA) #6 going into room 102 passing ice to Resident #33 without eye protection. The NA was observed within 3 feet of the resident adjusting items on his overbed table to get his cup within his reach.

Observation on 10/25/21 at 11:29 AM revealed NA #6 coming out of room 106 with bagged dirty linen and trash after providing care to Resident #5 without eye protection.

Interview on 10/25/21 at 11:33 AM with NA #6 revealed she had not been informed by the nurse or the DON she needed to wear goggles or a face shield while providing resident care on the general unit.

Interview on 10/25/21 at 11:41 AM with the Regional Nurse Consultant revealed the staff on the general unit did not need to wear goggles, only the staff working on the isolation unit for new admissions. The Regional Nurse Consultant stated he was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19.

Interview on 10/28/21 at 3:16 PM with the Director of Nursing (DON) who is also the Infection Preventionist (IP) revealed she was not

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 10/28/2021

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 880	Continued From page 43	F 880		

aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19 until informed on Monday by the Regional Nurse Consultant.

c. Observation on 10/25/21 at 10:45 AM revealed NA #3 coming out of room 112 with bagged linen and trash after completing care for Resident #3 without eye protection.

Interview on 10/25/21 at 11:33 AM with NA #3 revealed she had not been informed by the nurse or the DON she needed to wear goggles or a face shield while providing resident care on the general unit.

Interview on 10/25/21 at 11:41 AM with the Regional Nurse Consultant revealed the staff on the general unit did not need to wear eye protection, only the staff working on the isolation unit for new admissions. The Regional Nurse Consultant stated he was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19.

Interview on 10/28/21 at 3:16 PM with the Director of Nursing (DON) who is also the Infection Preventionist (IP) revealed she was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19 until informed on Monday by the Regional Nurse Consultant.

d. Observation on 10/25/21 at 11:31 AM revealed the Speech Therapist in room 101 interviewing and working with Resident #29 within 3 feet of the resident without eye protection.

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 10/28/2021

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 880	Continued From page 44	F 880		

Interview on 10/25/21 at 11:39 AM with the Speech Therapist revealed she had not been informed by the DON she needed to wear goggles or a face shield while providing care to residents on the general unit. She stated it was her understanding she only needed to wear goggles or a face shield on the isolation unit.

Interview on 10/25/21 at 11:41 AM with the Regional Nurse Consultant revealed the staff on the general unit did not need to wear eye protection, only the staff working on the isolation unit for new admissions. The Regional Nurse Consultant stated he was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19.

Interview on 10/28/21 at 3:16 PM with the Director of Nursing (DON) who is also the Infection Preventionist (IP) revealed she was not aware of the guidelines requiring staff to wear eye protection in counties with high or substantial rate of transmission of COVID-19 until informed on Monday by the Regional Nurse Consultant.

e. On 10/25/2021 at 11:30 AM observed Nurse #4 passing medications on the 200 hall without wearing a face shield and/or goggles.

During an interview on 10/25/21 at 11:40 AM Nurse #4 indicated that she was instructed to only wear eye protection on the 300 hall (which is the isolation hall). She further stated that she was instructed that she did not have to wear eye protection anywhere else in the facility because the pandemic for their area was over.

f. An observation on 10/25/21 at 11:40 AM

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 10/28/2021

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 880	Continued From page 45 revealed Laundry Assistant #1 going in and out of resident rooms on the 200 hall without eye protection. An interview was conducted on 10/25/21 at 11:38 AM with Laundry Assistant #1. When asked what the facility policy was for wearing eye protection, indicated that she was informed to only wear eye protection when on the 300 hall. On 10/25/21 at 11:47 AM the Director of Nursing (DON) indicated staff wearing eye protection in the facility was mandatory at this time. She further stated that all staff had been instructed at the monthly staff meetings.	F 880		