STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING ______ B. WING ______	C 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON 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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #4BLQ11.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility neglected to provide oral care and showers for a resident who required extensive assistance with activities of daily living causing the resident to feel unclean and unkempt for 1 of 1 residents (Resident #19). The findings included: Resident #19 was admitted to the facility on 11/25/15 with diagnoses which included cerebral vascular accident (stroke), hemiplegia, and respiratory disease. Review of the quarterly Minimum Data Set (MDS) dated 02/19/16 coded Resident #19 as cognitively intact and capable of making her needs known. The MDS indicated Resident #19 required extensive physical assistance of 1 person with her activities of daily living (ADLs) which included bed mobility, transfers, dressing, toileting,	F 224	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident: Resident #19 was assisted with a shower, dentures were removed and cleaned and placed back in her mouth on April 22, 2016.	5/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/13/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 personal hygiene, and bathing. Further review of the MDS indicated Resident #19's preferences for showers and hygiene was very important with no documented behaviors or refusal of care. Review of a care plan dated 02/25/16 revealed Resident #19 had an ADL self-care deficit related to weakness and hemiplegia with approaches for staff to provide the assistance with ADLs to level needed and assist with mouth care/denture care daily and as needed (prn). On 04/18/16 at 4:10 PM Resident #19 was interviewed and asked if staff helped her to clean her teeth and the resident answered, "No, they do not help me get my dentures out at night for them to soak." Resident #19 explained that she was unable to remove her dentures on her own due to her paralysis and that she had not had her dentures soaked or oral care provided in a "long time" and could not recall when the last time a staff member assisted her with oral care. Resident #19 dentures were observed to be visibly dirty, dull in color, with thick accumulation of food matter along the teeth and gum line. Resident #19 had a blue colored denture cup on the shelf above the sink and a box of denture soaking packets on the sinks vanity in her room. On 04/19/16 at 10:43 AM Resident #19 was observed in her room disheveled. Resident #19's hair was unclean, uncombed, greasy looking, and matted to her head with her scalp visible. On 04/20/16 at 9:30 AM Resident #19 was observed lying in bed and reported that she had received her morning care but that no one had taken her dentures out during the night to soak them. Her teeth were observed and were visibly	F 224	Interventions for residents identified as having the potential to be affected: A facility audit was performed on April 28, 2016 by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to ensure that resident's requiring assistance with denture/oral hygiene received assistance. Dentures were cleaned for those resident's identified as indicated. Oral hygiene was provided for those residents identified as needing oral hygiene. Director of Nursing and Assistant Director of Nursing performed an audit on April 28, 2016 of scheduled showers to ensure all residents were receiving and or offered showers at least twice weekly. Residents identified as needing a shower or requesting a shower was assisted with a shower. Licensed Nurses and Certified Nursing Assistants across all shifts including full time, part time and as needed staff will be educated by May 18, 2016 on ensuring oral hygiene is provided with morning and bedtime care and as needed. Dentures are removed and soaked at bedtime, cleaned and placed back in mouth prior to breakfast. This education will be provided by the facility Staff Development Coordinator(SDC). By May 18th, 2016, the facility SDC will provide education to Licensed Nurses and Certified Nurses Assistants across all	

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dirty with thick accumulation of food matter along the teeth and gum line and her hair was observed to be greasy looking.

On 04/21/16 at 11:45 AM Resident #19 was observed to be self-propelling in the hall and disheveled. Resident #19's hair was greasy looking, matted to her head on the left side with her scalp visible, her shoes were not fastened with the Velcro tabs flopping and her shoes flopping up and down on her feet. Resident #19 reported no one had assisted her with removing her dentures to soak and that she was supposed to have a shower.

On 04/21/16 at 2:50 PM Resident #19 was observed setting in her wheelchair in her room. Resident #19's hair was greasy looking, matted to her head, and her dentures were visibly dirty with thick accumulation of food matter along the teeth and gum line.

On 04/22/16 at 9:20 AM a follow-up interview was conducted with Resident #19. She stated she had not received a shower all week and her shower days were on Saturday and Wednesday. She reported she had a shower on Saturday 04/16/16 but had not received a shower since then. Resident #19 indicated she was told on Wednesday 04/20/16 by the nurse aide (NA) #2 she would take her to the shower later that day but the NA did not take her. Resident #19 explained that on Thursday NA #2 was supposed to give her a shower but had not. Resident #19 stated "well here it is Friday and I still do not have a shower and no one has helped me with soaking my dentures either." The resident was observed to have greasy looking hair, disheveled, unclean, and her dentures were visibly dirty.

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shifts including full time, part time and as needed staff. This education will focus on ensuring showers are given as scheduled and upon request from a resident.

Systemic Change:

Director of Nursing (DON), Staff Development Coordinator (SDC), Unit Manager (UM) or Designee will randomly audit ten (10) residents twice weekly for 12 weeks, then ten (10) residents weekly for 12 weeks, then twice monthly for 6 months across all shifts. Audit will include ensuring that dentures are removed at bedtime, placed in a denture cup with cleanser to soak and showers are completed as scheduled.

Newly hired Licensed Nurses and Certified Nurses Assistants will be educated by the facility SDC on ensuring oral hygiene and/or denture care is provided with morning and bedtime care as as needed. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the SDC on ensuring residents receive showers as scheduled and upon request of the resident.

Monitoring of the change to sustain system compliance ongoing:

Monthly for a minimum of twelve months, the DON, SDC, or UM will present results of the oral hygiene, denture care and shower audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and

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F 224	Continued From page 3 On 04/22/16 at 10:00 AM, NA #1 was interviewed and reported Resident #19 was supposed to have a shower on Wednesday 04/20/16 and that she was unaware if the resident had a shower. NA #1 observed and stated "her hair is greasy looking and matted to her head and she does not look like she has had a shower." NA #1 further stated she was not responsible for the care of Resident #19 and was unaware of why she had not had a shower or her dentures cleaned during the week. On 04/22/16 at 10:05 AM, Nurse #1 was interviewed and stated she would have expected Resident #19 to have had a shower on Wednesday. Nurse #1 stated she was unaware Resident #19 had not received a shower on Wednesday or during the week. Nurse #1 further stated she was unaware that Resident #19 was not being assisted with oral care or soaking of her dentures. She indicated it was her expectation for the residents to be assisted with showers and oral care. On 04/22/16 at 12:45 PM, a telephone interview was conducted with NA #2. NA #2 stated she was responsible for the care of Resident #19 on Wednesday 04/20/16 and Thursday 04/21/16 from 7:00 AM until 3:00 PM. NA #2 confirmed she had not given Resident #19 a shower on Wednesday or Thursday and that she had gotten behind and had forgotten to give the resident a shower. NA #2 also stated she had not soaked the resident's dentures or provided oral care. On 04/22/16 at 12:50 PM, a telephone interview was conducted with NA #3. She confirmed she was responsible for the care of Resident #19 from 11:00 PM until 7:00 AM. NA #3 stated she	F 224	Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the 12 months.	

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F 224	Continued From page 4 had not assisted the resident with soaking her dentures or provided oral care. NA #3 further stated she was unaware Resident #19 required assistance with her dentures. On 04/22/16 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that ADL care be provided to a resident as required or needed. She further stated she would have expected a resident to have a shower on their scheduled shower days and any other day should it be requested. The DON stated she would have expected the nursing staff to have assisted the resident with soaking her dentures and assist a resident with oral care as needed.	F 224		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide residents dignity during dining observations by calling clothing protectors "bibs" with the possibility of causing the residents to feel like children for 3 of 3 residents sampled for dignity (Resident #1, #76, and #85). The findings included: 1) Resident #1 was re-admitted to the facility on	F 241	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's	5/20/16

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03/06/13 with diagnoses which included dementia, hemiplegia, seizures, and depression. Review of the quarterly Minimum Data Set (MDS) dated 03/03/16 coded Resident #1 with severe cognitive impairment and was totally dependent on staff for her activities of living (ADLs) which included bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Resident #1 also required extensive assistance of 1 person physical assist with eating.

On 04/18/16 at 12:19 PM during the dining observation on hall 400 nurse aide (NA) #1 was observed to knock on the resident's door and asked "can I come in and bring you a bib?" NA #1 was observed to drape the clothing protector over Resident #1's clothes and fastened it around her neck.

On 04/21/16 at 12:15 PM during the dining observation on hall 400 NA #1 was observed to knock on Resident #1's door and stated "here let me put on your bib." NA #1 was again observed to drape the clothing protector over the resident's clothes and fastened it around her neck.

On 04/21/16 at 2:42 PM NA #1 was interviewed. She stated it was her normal routine to go around to the resident's rooms, washed their hands, and give them a "bib." She further stated she had always called the clothing protectors "bibs" and that she should not have been calling them that. NA #1 had no further explanation for calling the clothing protectors "bibs."

On 04/21/16 at 2:49 PM Nurse #1 was interviewed. She stated she would not have expected the clothing protectors to be called bibs.

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allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated.

Interventions for affected residents:

The Staff Development Coordinator (SDC) provided education to NA #1 on April 10, 2016 related to providing care to residents in a manner that maintains or enhances each resident's dignity. The education placed emphasis on proper terminology such as clothing protectors rather than bibs.

Interventions for residents identified as having the potential to be affected:

Education will be provided to Licensed Nurses (LN) and Certified Nursing Assistants (CNA's) (across all shifts including full time, part time and as needed staff) by May 18, 2016. The education will be provided by the facility SDC. Education will include ensuring resident's are provided care in a manner that maintains or enhances each resident's dignity.
Staff will be instructed to use the terminology, clothing protectors rather than bibs.

Systemic Change:

Director of Nursing (DON), Staff Development Coordinator (SDC), Unit Manager (UM), or Designee will randomly observe different meal service times in resident rooms and/or the dining area

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On 04/22/16 at 1:30 PM the Director of Nursing (DON) was interviewed. She stated she would not have expected the clothing protectors to be called "bibs."

2) Resident #76 was re-admitted to the facility on 05/22/14 with diagnoses which included Parkinson's disease, osteoarthritis, tremors, and heart failure. Review of the quarterly Minimum Data Set (MDS) dated 03/02/16 coded Resident #76 as cognitively intact and capable of making his needs known. Further review of the MDS indicated Resident #76 required extensive assistance of staff for transfers, and was totally dependent on staff for bed mobility, dressing, toileting, personal hygiene, and bathing, and was independent for eating.

On 04/18/16 at 12:19 PM during the dining observation on hall 400 nurse aide (NA) #1 was observed to knock on the resident's door and asked "can I come in and bring you a bib?" NA #1 was observed to drape the clothing protector over Resident #76's clothes and fastened it around his neck.

On 04/21/16 at 12:15 PM during the dining observation on hall 400 NA #1 was observed to knock on Resident #76's door and stated "here let me put on your bib." NA #1 was again observed to drape the clothing protector over the resident's clothes and fastened it around his neck.

On 04/21/16 at 2:30 PM Resident #76 was interviewed. He stated "they call them bibs all the time." The resident stated he wore a clothing protector "most of the time at lunch and only sometimes at dinner." Resident #76 further stated "I don't know how it makes me feel or if it bothers

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three times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks to ensure staff maintain resident's dignity by using the terminology clothing protectors rather than bibs.

Newly hired Licensed Nurses and certified Nursing Assistants will be educated by the facility SDC on ensuring resident's receive care in a manner that maintains or enhances their dignity. The education will include using the terminology clothing protectors rather than bibs.

Monitoring of the change to sustain compliance ongoing:

Monthly for a minimum of three months, the DON, SDC, or UM will report results of the dignity audits to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.

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me because I didn't know what they were supposed to be called other than bibs." Resident #76 indicated he would have preferred them to be called clothing protectors instead of bibs.

On 04/21/16 at 2:42 PM NA #1 was interviewed. She stated it was her normal routine to go around to the resident's rooms, washed their hands, and give them a "bib." She further stated she had always called the clothing protectors "bibs" and that she should not have been calling them that. NA #1 had no further explanation for calling the clothing protectors "bibs."

On 04/21/16 at 2:49 PM Nurse #1 was interviewed. She stated she would not have expected the clothing protectors to be called bibs.

On 04/22/16 at 1:30 PM the Director of Nursing (DON) was interviewed. She stated she would not have expected the clothing protectors to be called "bibs."

3) Resident #85 was admitted to the facility on 11/10/15 with diagnoses which included dementia, depressive disorder, and muscle weakness. Review of the quarterly Minimum Data Set (MDS) dated 02/03/16 coded Resident #85 with mild to moderate cognitive impairment and required extensive to total assistance on staff for bed mobility, transfers, dressing, toileting, and bathing. Further review of the MDS revealed Resident #85 was independent with eating.

On 04/18/16 at 12:19 PM during the dining observation on hall 400 nurse aide (NA) #1 was observed to knock on the resident's door and asked "can I come in and bring you a bib?" NA #1 was observed to drape the clothing protector over

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F 241	Continued From page 8 Resident #85's clothes and fastened it around her neck. On 04/21/16 at 12:15 PM during the dining observation on hall 400 NA #1 was observed to knock on Resident #85's door and stated "here let me put on your bib." NA #1 was again observed to drape the clothing protector over the resident's clothes and fastened it around her neck. On 04/21/16 at 2:15 PM Resident #85 was interviewed. She stated she had heard the nurse aides (NAs) call the clothing protectors "bibs" since she had resided at the facility. Resident #85 further stated it made her feel like she was a child and that she preferred them to be called clothing protectors and not bibs. On 04/21/16 at 2:42 PM NA #1 was interviewed. She stated it was her normal routine to go around to the resident's rooms, washed their hands, and give them a "bib." She further stated she had always called the clothing protectors "bibs" and that she should not have been calling them that. NA #1 had no further explanation for calling the clothing protectors "bibs." On 04/21/16 at 2:49 PM Nurse #1 was interviewed. She stated she would not have expected the clothing protectors to be called bibs. On 04/22/16 at 1:30 PM the Director of Nursing (DON) was interviewed. She stated she would not have expected the clothing protectors to be called "bibs."	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		5/20/16

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A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and staff interviews the facility failed to evaluate a resident's ability to use a call light and failed to place a call light within reach of the resident with the possibility of causing the resident to feel unable to get the help or assistance needed for 1 of 1 resident sampled for accommodation of needs (Resident #133).

The findings included:

Resident #133 was admitted to the facility on 03/30/15 with diagnoses which included history of lower leg fracture, degenerative disc disease, difficulty in walking, and muscle weakness.

Review of the annual Minimum Data Set (MDS) dated 02/02/16 coded Resident #133 with severe cognitive impairment for daily decision making, usually understood, and sometimes understands. The MDS revealed Resident #133 required total assistance of 1 person for bed mobility, dressing, eating, toileting, personal hygiene, and bathing. Further review of the MDS indicated Resident #133 had severely impaired vision.

Review of a care plan dated 02/18/16 revealed Resident #133 had a self-care deficit with

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The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated.

Interventions for affected residents:

On 04/22/2016, Resident #133's call light was changed from a button style to a pancake style (flat) call light. Call light was placed within reach and Resident #133 demonstrated the ability to press the call light. Resident #133 care plan was updated to reflect use of a pancake style (flat) call light in lieu of a button style call light.

Interventions for residents identified as

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approaches for staff to provide assistance with activities of daily living and to place call light within reach.

On 04/21/16 at 9:55 AM Resident #133 was observed sitting in a high back wheelchair beside the foot of the bed with the right front wheel of the wheelchair against the gray colored fall mat on the floor and the resident's call light was observed to be stretched across the head of the bed approximately 2 inches below the pillow. Resident #133 was asked if she could reach her call light. Resident #133 was observed to uncover her head and stated, "What call light?"

On 04/22/16 at 9:25 AM Resident #133 was observed again sitting in the wheelchair beside the foot of the bed and the resident's call light was observed to be stretched across the pillow at the head of the bed. Resident #133 was asked if she could reach her call light and she stated, "What call light? What are you talking about? I just want to lay down."

On 04/22/16 at 10:00 AM an interview was conducted with nurse aide (NA) #1. NA #1 confirmed that Resident #133 was unable to reach her call light and stated "she is blind and unable to use the call light at all." NA #1 was asked should the resident need assistance how would the staff know. NA #1 indicated Resident #133 was checked on frequently and that she could yell out for assistance or help.

On 04/22/16 at 10:05 AM an interview was conducted with Nurse #1. Nurse #1 confirmed Resident #133 was unable to use her call light due to blindness. Nurse #1 stated should the resident need help or assistance she was

F 246 (Provider's Plan of Correction)

having the potential to be affected:

A facility audit of the current resident population was performed on 04/28/2016 by the facility Director of Nursing (DON) and Assistant Director of Nursing (ADON) to assess residents□ ability to utilize the call light. Upon audit completion, call lights were changed to the pancake style for all residents identified as being unable to use the push button style call light. These residents performed a return demonstration to ensure they were able to use the pancake style call light. Identified residents care plan was updated to reflect use of pancake style call light. Newly admitted residents will be educated upon admission on the button style call bell. A return demonstration will be required to validate ability to use as applicable.

All resident rooms were audited on 04/28/2016 to ensure call lights were within reach of the resident.

Licensed Nurses (LN) and Certified Nursing Assistants (CNA) across all shifts (including full-time, part-time and as needed) will be provided education by 05/18/2016 by the facility Staff Development Coordinator (SDC). Education will include completing maintenance request forms to change call light styles for any resident identified as unable to use push button style call light. Education will also include completing therapy referrals for residents noted with a functional decline resulting in a decrease in their ability to use the call light as well

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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

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capable of yelling out. Nurse #1 further stated she had never thought about the resident being unable to use her call light and would put in an order for her to be evaluated for a pancake type call light.

On 04/22/16 at 10:15 AM an interview was conducted with the Rehabilitation Manager. He stated Resident #133 was on the rehab therapy case load from 09/28/15 through 11/10/15. He further stated he was unaware of the resident's capability for the use of a call light.

On 04/22/16 at 1:30 PM an interview was conducted with the Director of Nursing (DON). She stated she expected all call lights to be within the reach of the resident. The DON further stated it was everyone's responsibility to ensure call lights were within reach and that the residents were capable of using them.

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as monitoring to assure call lights are within reach of residents.

Systemic Change:

Director of Nursing, Assistant Director of Nursing, Unit Manager (UM) or Designee will audit ten (10) residents three times weekly for 4 weeks, then ten (10) residents twice weekly for 4 weeks, then ten (10) residents weekly for 4 weeks to ensure call lights are within reach and residents have the ability to press the call lights with corrections made as indicated.

Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the SDC during their orientation period. Education will include completing maintenance request forms to change call light styles for any resident identified as unable to use push button style call light. Education will also include completing therapy referrals for residents noted with a functional decline resulting in a decrease in their ability to use the call light as well as monitoring to assure call lights are within reach of residents.

Monitoring of the change to sustain system compliance ongoing:

Monthly for a minimum of three months, the Director of Nursing, Assistant Director of Nursing and/or Unit Manager will present results of the call light audits to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will review the

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F 246	Continued From page 12	F 246	audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to implement an activity program for a cognitively impaired resident with the possibility of causing the resident to feel unaccepted and socially isolated for 1 of 3 resident's sampled for meeting activity needs (Resident #133). The findings included: Resident #133 was admitted to the facility on 03/30/15 with diagnoses which included dementia, degenerative disc disease, difficulty in walking, and muscle weakness. Review of the annual Minimum Data Set (MDS) dated 02/02/16 coded Resident #133 with severe cognitive impairment for daily decision making, usually understood, and sometimes understands. The MDS revealed Resident #133 required total assistance of 1 person for bed mobility, dressing, eating, toileting, personal hygiene, and bathing.	F 248	The statements included are not an admission and do not constitute agreement with the alleged deficiencies here in. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations set fourth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: An additional activities assessment will be completed by the Activities Director by May 18th, 2016 on Resident #133. To assist with completing a comprehensive activities assessment, information will be gathered from the resident□s family in	5/20/16

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Further review of the MDS indicated Resident #133 had severely impaired vision.

Review of a care plan, originally dated 09/15/15, and updated on 02/01/16 and 04/18/16, addressed the problem that Resident #133 had dementia, was in the facility long term, and severe cognitive impairment, problems with communicating and was not able to make her needs known. She was also noted totally dependent on staff for decision making. Goals included Resident #133 would participate in social interaction with 1 on 1 visits at least 2 times per week and would participate in self-directed activities daily which included that she enjoyed working with her hands. The approaches included for staff to provide assistance to and from all out of room activities 3 times per week and promote verbal and social interaction among staff and peers.

The most recent activity note in the medical record was dated 02/18/16 which indicated Resident #133 "has some confusion, shows little interests in group events, and enjoys in room."

Review of the activity attendance sheets revealed for the month of February 2016 Resident #133 was provided one on one (1:1) in room activities which included exercise on 02/01/16, reality orientation on 02/02/16, wiped the resident's hands before lunch on 02/05/16, and other 1:1 in room activities which the particular activities were not identified on 02/07/16, 02/08/16, 02/14/16, 02/17/16, 02/20/16, 02/22/16, 02/26/16, and 02/29/16. The activities director was unable to provide activity attendance sheets for the dates of 02/27/16 or 02/28/16.

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order to establish an activities plan of care designed to appeal to Resident #133 interests and to enhance the resident�s highest practicable level of physical, mental and psychosocial well-being. Resident #133 activities plan of care will be updated by the facility Activities Director to reflect activities that meet the resident�s interests by May 18th, 2016.

Interventions for residents with potential to be affected:

Facility residents will be assisted by Facility Staff to out of room activities and/or offered 1 to 1 activities by the Activities Director as per the resident activity assessment/plan of care.

On May 13th, 2016, the facility Activities Director was educated by the Regional Clinical Director on the expectation of providing activities that appeal to the residents interests and to enhance the resident�s highest practicable level of physical, mental and psychosocial well-being. Education focused on ensuring activities are offered as per the resident activity assessment/plan of care.

The Staff Development Coordinator or Director of Nursing will provide education to facility staff (across all shifts including full-time, part-time and as needed staff). This education will be completed by May 18th, 2016 and emphasize the importance of the facility activities program and the facility staff responsibility in assisting

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Review of the attendance sheets for the month of March 2016 revealed Resident #133 was provided 8 in room activities. The record indicated the resident was provided conversation and/or ice cream on the following days: 03/08/16, 03/09/16, 03/12/16, 03/14/16, 03/19/16, 03/20/16, 03/21/16, and 03/30/16.

Further review of the activity attendance sheets for Resident #133 revealed she was provided two 1:1 in room activities during the month of April 2016 (dated from 04/01/16 through 04/22/16). The activity provided was that Resident #133's mail was read to her on 04/01/16 and again on 04/06/16.

Resident #133 was observed alert and awake as follows:
· On 04/21/16 at 9:55 AM she was in her room sitting in her wheelchair that was positioned at the foot of the bed. The television was on.
· On 04/21/16 at 10:35 AM she was in her room, in the wheelchair which was positioned at the foot of her bed.
· On 04/21/16 at 2:20 PM she was in her room, sitting in her wheelchair which was positioned at the foot of her bed and the television was playing.
· On 04/22/16 at 10:15 AM she was in her room, sitting in her wheelchair, at the left side of her bed with a throw over her head, and the television playing on a news type channel.

On 04/22/16 at 1:25 PM an interview was conducted with the Activity Director (AD). She stated she collected information relating to the resident's interest from family members when a resident was cognitively impaired. The AD described Resident #133 as alert, attentive, and a "challenge." The AD indicated she was unaware

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residents to group activity programs of their choice and/or as outlined in their activities plan of care.

Systematic Change:

Effective May 20th, 2016, announcements will be made over the facility intercom system 30 minutes and 15 minutes prior to the start of any group activity to alert facility staff to begin assisting residents to the scheduled activity.

The facility Administrator and Activities Director will review the activities attendance record weekly for twelve (12) weeks for group activities to ensure optimal resident attendance to group activities.

The facility Administrator and Activities Director will review (10) residents monthly to ensure 1 to 1 in-room activities are provided as per care plan.

Monitoring of the change to sustain system compliance ongoing:

The Administrator and Activity Director will report the completed activities participation and 1 to 1 audit results to the Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing

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F 248	Continued From page 15 Resident #133 liked watching "The Andy Griffith Show" until "one day last week." The AD further indicated Resident #133 had not liked the activity of putting lotion of her hands and that they were starting a prayer meeting activity on Wednesday 04/27/16 and was hoping Resident #133 would participate in that activity. The AD indicated 1:1 in room activities included playing checkers with the men, playing scrabble, rubbing lotion on the females' hands, and reminiscing. The AD further indicated the group activities included bingo, church services, music/singing events, and an exercising for which approximately 27 out of 100 resident's attended these activities. The AD further indicated she had approximately 3 hands on activities per month for the resident's which included crafts, stringing beads, and painting. The AD stated there have only been 2 activity staff members and the volunteers which come to the facility and assist were the relatives of the AD and ladies from her church. The AD further stated "some weeks a resident may have only 2 activities but never do they have 3." On 04/22/16 at 2:20 PM an interview was conducted with the Administrator. He stated he was unaware that 27 out of 100 residents' was all that attended the facility's biggest activity events. He further stated the staff needed to assist more residents' to the activity events.	F 248	and determine the need for further auditing beyond the three months.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		5/20/16

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F 253	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep in good repair resident equipment and the walls in resident rooms on 2 of 4 halls (Halls 300 and 400). The findings included: During a facility tour on 04/22/16 from 8:55 AM to 9:30 AM with the Maintenance Director (MD) the following environmental concerns were observed: a) In Room 309, around the heating/cooling unit was observed approximately 2 to 3 inch crack between the unit and the wood framed molding, peeling of paint and crumbling plaster at the bottom of the unit, and black staining, rotten wood, and crumbling plaster underneath the unit on the left side. b) In Room 313 Bed A, the white colored chair railing around the middle of the wall was observed to be separated with gashes in the paint and uneven. c) In Room 401 Bed A, gashes were observed in the plaster on the wall behind the head board of the bed which had been chalked and repainted. d) In the bathroom between Rooms 407 and 409 the portable raised toilet seat frame was observed with numerous rusted areas on the metal frame. e) In Room 408 Bed B, gashes were observed in the plaster on the wall behind the head board of the bed which had been chalked and repainted. f) In Room 412 Bed B, the tall deep back cushion of the wheelchair was observed to have peeling, torn, and tattered vinyl.	F 253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies here in. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations set forth in the following plan of correction . The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Interventions for affected resident: In room 309 the Maintenance Director replaced the rotten wood around the heating/cooling unit and replastered and painted underneath the unit on the left side on May 10, 2016. In Room 313 Bed A, Room 401 Bed A and 408 Bed B the chair rail will be removed and walls will be completely painted by the Maintenance Director / Designee by May 20th, 2016. In Room 407 and Room 409 the portable raised toilet seat frame in the bathroom was replaced on May 10, 2016 with a new toilet seat frame. In room 412 B the tall deep back cushion of the wheelchair was replaced on April 29, 2016 with a new cushion.	

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On 04/22/16 at 9:30 AM and during part of the facility tour the MD was interviewed. He stated that each room observed was not homelike and needed to be repaired. The MD further stated the facility was in the process of remodeling resident rooms. He indicated Room 115 had been remodeled approximately 2 months ago for the corporate office and interior decorator to observe and make changes or give the approval to continue with the other resident rooms. The MD stated he was unaware of a schedule as to when the remodeling of the resident rooms would begin. He further stated the offices, the dayroom, and the hallway walls had been either remodeled and/or repainted. He also indicated the rooms on the 100 and 200 halls had been repainted and remodeled with new light fixtures, bedspreads, curtains, furniture, and sink vanities. The MD reiterated that he was unaware of when the resident rooms would be repainted or remodeled.

On 04/22/16 at 2:20 PM the Administrator was interviewed. He stated the facility had spent approximately 80,000 dollars already in remodeling or repairs. He further stated he expected the other resident rooms to be repainted and/or remodeled in the next year or so. The Administrator confirmed the rooms were not homelike and were in need of repair.

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Interventions for residents with potential to be affected:

A facility wide audit will be performed by the Maintenance Director by May 20, 2016 around all heating/cooling units to ensure that there is no rotten wood, crakes, crumbling plaster, peeling of paint or black staining underneath any resident's heating/cooling units for all of the rooms once weekly for three months.

A facility wide audit will be performed by the Maintenance Director by May 20, 2016 to ensure that the chair railing is not separated with gashes in the paint / plaster on the wall and not even behind the headboard of the beds or in the middle of the wall for all of the rooms once weekly for three months.

A facility wide audit will be performed by the Maintenance Director / Designee by May 20, 2016 to ensure that all raised toilet seat frame have no rust areas on the metal frame for all the rooms once weekly for three months.

A facility wide audit will be performed by the Maintenance Director / Designee by May 20, 2016 to ensure that all tall deep back cushions of the wheelchair are not peeling, torn or has tattered vinyl for all the rooms once weekly for three months.

On May 9th, 2016, The Administrator re-educated the Maintenance Director on

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F 253	Continued From page 18	F 253	ensuring a home like environment. Systematic Change: By May 20th, 2016, Staff Members (across all shifts including full-time, part-time and as needed staff) will be educated by the Staff Development Coordinator and/or Designee on completing maintenance request forms to replace or repair around heating/cooling units, repair or replace chair railing in the middle of the wall or behind the head board of the beds, replace raised toilet seats that have rust areas on the metal frame or repair/replace back cushions that are peeling, torn and tattered vinyl. As follow-up, the facility Administrator will conduct facility audits (tours) with the Maintenance Director monthly for 3 months to ensure the facility exhibits a homelike environment. Monitoring of the change to sustain system compliance ongoing: The Administrator and Maintenance Director will report audit results monthly in the Quality Assurance and Performance Improvement Committee for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond the three months.	

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F 282	Continued From page 19	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to follow the care plan for providing showers and oral care for 1 of 3 residents sampled for activities of daily living (Resident #19). The findings included: Resident #19 was admitted to the facility on 11/25/15 with diagnoses which included cerebral vascular accident (stroke), hemiplegia, and respiratory disease. Review of the quarterly Minimum Data Set (MDS) dated 02/19/16 coded Resident #19 as cognitively intact and capable of making her needs known. The MDS indicated Resident #19 required extensive physical assistance of 1 person with her activities of daily living (ADLs) which included bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Further review of the MDS indicated Resident #19's preferences for showers and hygiene were very important with no documented behaviors or refusal of care. Review of a care plan dated 02/25/16 revealed Resident #19 had an ADL self-care deficit related to weakness and hemiplegia with approaches for	F 282	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident: Resident #19 was assisted with a shower, dentures were removed and cleaned and placed back in her mouth on April 22, 2016. Interventions for residents identified as having the potential to be affected: A facility audit was performed on April 28, 2016 by the Director of Nursing (DON) and Assistant Director of Nursing (ADON)	5/20/16

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staff to provide the assistance with ADLs to level needed and assist with mouth care/denture care daily and as needed (prn).

On 04/18/16 at 4:10 PM Resident #19 was interviewed and asked if staff helped her to clean her teeth and the resident answered, "No, they do not help me get my dentures out at night for them to soak." Resident #19 explained that she was unable to remove her dentures on her own due to her paralysis and that she had not had her dentures soaked or oral care provided in a "long time" and could not recall when the last time a staff member assisted her with oral care. Resident #19 dentures were observed to be visibly dirty, dull in color, with thick accumulation of food matter along the teeth and gum line. Resident #19 had a blue colored denture cup on the shelf above the sink and a box of denture soaking packets on the sink vanity in her room.

On 04/19/16 at 10:43 AM Resident #19 was observed in her room disheveled. Resident #19's hair was unclean, uncombed, greasy looking, and matted to her head with her scalp visible.

On 04/20/16 at 9:30 AM Resident #19 was observed lying in bed and reported that she had received her morning care but that no one had taken her dentures out during the night to soak them. Her teeth were observed and were visibly dirty with thick accumulation of food matter along the teeth and gum line and her hair was observed to be greasy looking.

On 04/21/16 at 11:45 AM Resident #19 was observed to be self-propelling in the hall and disheveled. Resident #19's hair was greasy looking, matted to her head on the left side with

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to ensure that resident's requiring assistance with denture/oral hygiene received assistance. Dentures were cleaned for those resident's identified as indicated. Oral hygiene was provided for those residents identified as needing oral hygiene. DON & ADON performed an audit on April 28, 2016 of scheduled showers to ensure all residents were receiving and or offered showers at least twice weekly. Residents identified as needing a shower or requesting a shower was assisted with a shower.

Licensed Nurses (LN) and Certified Nursing Assistants (CNA's) across all shifts including full time, part time and as needed staff will be educated by May 18, 2016. Education will be provided by the Staff Development Coordinator (SDC) on ensuring oral hygiene is provided with morning and bedtime care. Dentures are removed and soaked at bedtime, cleaned and placed back in mouth prior to breakfast.

LN's & CNA"s across all shifts including full time, part time and as needed staff will be educated by May 18, 2016, on ensuring that showers are given as scheduled and upon request from a resident. This education will be provided by the facility SDC. The education will include assuring that assistance with activities of daily living is provided as outlined in the resident care plan.

Systemic Change:

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	345159	A. BUILDING ______ B. WING ______	C 04/22/2016

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LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON 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 282	Continued From page 21 her scalp visible, her shoes were not fastened with the Velcro tabs flopping and her shoes flopping up and down on her feet. Resident #19 reported no one had assisted her with removing her dentures to soak and that she was supposed to have a shower. On 04/21/16 at 2:50 PM Resident #19 was observed setting in her wheelchair in her room. Resident #19's hair was greasy looking, matted to her head, and her dentures were visibly dirty with thick accumulation of food matter along the teeth and gum line. On 04/22/16 at 9:20 AM a follow-up interview was conducted with Resident #19. She stated she had not received a shower all week and her shower days were on Saturday and Wednesday. She reported she had a shower on Saturday 04/16/16 but had not received a shower since then. Resident #19 indicated she was told on Wednesday 04/20/16 by nurse aide (NA) #2 that she would take her to the shower later that day and NA #2 had not taken her. Resident #19 stated on Thursday NA #2 was supposed to give her a shower and had not. Resident #19 stated "well here it is Friday and I still do not have a shower and no one has helped me with soaking my dentures either." The resident was observed to have greasy looking hair, disheveled, unclean, and her dentures were visibly dirty. On 04/22/16 at 10:00 AM, NA #1 was interviewed and reported Resident #19 was supposed to have a shower on Wednesday 04/20/16 and that she was unaware if the resident had a shower. NA #1 observed and stated "her hair is greasy looking and matted to her head and she does not look like she has had a shower." NA #1 further stated	F 282	Director of Nursing (DON), Staff Development Coordinator (SDC), Unit Manager (UM) or Designee will randomly audit ten (10) residents twice weekly for 12 weeks, then ten (10) residents weekly for 12 weeks, then twice monthly for 6 months across all shifts to ensure oral hygiene and showers are provided. Audit will include ensuring that showers are received as scheduled and as requested, dentures are removed at bedtime, placed in a denture cup with cleanser to soak and assistance is provided by staff for those residents identified and care planned as requiring assistance. Newly hired Licensed Nurses and Certified Nurses Assistants will be educated By the facility SDC on ensuring oral hygiene and/or denture care is provided with morning and bedtime care. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the facility SDC to ensure residents receive showers as scheduled and upon request of the resident. Education will include ensuring assistance with activities of daily living is provided for residents identified and care planned as requiring assistance. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 12 months, the DON, SDC, or UM will present results of the audits ensuring residents receive assistance with activities of daily living as indicated, oral hygiene, denture care, and	

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F 282	Continued From page 22 she was not responsible for the care of Resident #19 and was unaware of why she had not had a shower or her dentures cleaned during the week. On 04/22/16 at 10:05 AM, Nurse #1 was interviewed and stated she would have expected Resident #19 to have had a shower on Wednesday. Nurse #1 stated she was unaware Resident #19 had not received a shower on Wednesday or during the week. Nurse #1 further stated she was unaware that Resident #19 was not being assisted with oral care or soaking of her dentures. She indicated it was her expectation for the residents to be assisted with showers and oral care. On 04/22/16 at 12:45 PM, a telephone interview was conducted with NA #2. NA #2 stated she was responsible for the care of Resident #19 on Wednesday 04/20/16 and Thursday 04/21/16 from 7:00 AM until 3:00 PM. NA #2 confirmed she had not given Resident #19 a shower on Wednesday or Thursday and that she had gotten behind and had forgotten to give the resident a shower. NA #2 also stated she had not soaked the resident's dentures or provided oral care. On 04/22/16 at 12:50 PM, a telephone interview was conducted with NA #3. She confirmed she was responsible for the care of Resident #19 from 11:00 PM until 7:00 AM. NA #3 stated she had not assisted the resident with soaking her dentures or provided oral care. NA #3 further stated she was unaware Resident #19 required assistance with her dentures. On 04/22/16 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that ADL care	F 282	showers to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the 12 months.	

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F 282	Continued From page 23 be provided to a resident as required or needed. She indicated she expected the NAs to follow the care plan for each resident. The DON stated she would have expected the nursing staff to have assisted Resident #19 with soaking her dentures and assisted the residents with oral care as needed.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observations, record review, resident, and staff interviews the facility failed to provide oral care and showers for a resident who required extensive assistance with activities of daily living causing the resident to feel unclean and unkempt for 1 of 3 residents sampled for activities of daily living (Resident #19). The findings included: Resident #19 was admitted to the facility on 11/25/15 with diagnoses which included cerebral vascular accident (stroke), hemiplegia, and respiratory disease. Review of the quarterly Minimum Data Set (MDS) dated 02/19/16 coded Resident #19 as cognitively intact and capable of making her needs known. The MDS indicated Resident #19 required	F 312	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected residents: Resident #19 was assisted with a shower; dentures were removed, cleaned and put	5/20/16

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F 312 Continued From page 24

extensive assistance with 1 person physical assist with her activities of daily living (ADLs) which included bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Further review of the MDS indicated Resident #19's preferences for showers and hygiene was very important with no documented behaviors or refusal of care.

Review of a care plan dated 02/25/16 revealed Resident #19 had an ADL self-care deficit related to weakness and hemiplegia with approaches for staff to provide the assistance with ADLs to level needed and assist with mouth care/denture care daily and as needed (prn).

On 04/18/16 at 4:10 PM Resident #19 was interviewed and asked if staff helped her to clean her teeth and the resident answered, "No, they do not help me get my dentures out at night for them to soak." Resident #19 explained that she was unable to remove her dentures on her own due to her paralysis and that she had not had her dentures soaked or oral care provided in a "long time" and could not recall when the last time a staff member assisted her with oral care. Resident #19 dentures were observed to be visibly dirty, dull in color, with thick accumulation of food matter along the teeth and gum line. Resident #19 had a blue colored denture cup setting on the shelf above the sink and a box of denture soaking packets setting on the sinks vanity in her room.

On 04/19/16 at 10:43 AM Resident #19 was observed in her room disheveled. Resident #19's hair was unclean, uncombed, greasy looking, and matted to her head with her scalp visible.

F 312

back in resident's mouth on April 22, 2016.

Interventions for residents identified as having the potential to be affected:

A facility audit was performed on April 22, 2016 by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) to identify those residents requiring assistance with the Activities of Daily Living. The resident care card were updated to reveal those resident's identified as needing assistance with Activities of Daily Living.

Licensed Nurses and Certified Nursing Assistants across all shifts including full time, part time and as needed staff will be educated by May 18, 2016. Education will be provided by the Staff Development Coordinator. Education will include providing resident's with assistance with activities of daily living (ADL's) including denture care, showers and oral hygiene as needed.

Systemic Change:

Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager (UM),will randomly audit ten (10) residents twice weekly for 12 weeks, then ten (10) residents weekly for 12 weeks, then twice monthly for 6 months across all shifts to ensure residents are assisted with denture care, oral hygiene and showers as scheduled and indicated.

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F 312	Continued From page 25 On 04/20/16 at 9:30 AM Resident #19 was observed lying in bed and reported that she had received her morning care but that no one had taken her dentures out during the night to have soaked them. Her teeth were observed and were visibly dirty with thick accumulation of food matter along the teeth and gum line and her hair was observed to be greasy looking. On 04/21/16 at 11:45 AM Resident #19 was observed to be self-propelling in the hall and disheveled. Resident #19's hair was greasy looking, matted to her head on the left side with her scalp visible, her shoes were not fastened with the Velcro tabs flopping and her shoes flopping up and down on her feet. Resident #19 reported no one had assisted her with removing her dentures to soak and that she was supposed to have a shower. On 04/21/16 at 2:50 PM Resident #19 was observed setting in her wheelchair in her room. Resident #19's hair was greasy looking, matted to her head, and her dentures were visibly dirty with thick accumulation of food matter along the teeth and gum line. On 04/22/16 at 9:20 AM a follow-up interview was conducted with Resident #19. She stated she had not received a shower all week and her shower days were on Saturday and Wednesday. She reported she had a shower on Saturday 04/16/16 but had not received a shower since then. Resident #19 indicated she was told on Wednesday 04/20/16 by the nurse aide (NA) #2 she would take her to the shower later that day but the NA did not take her. Resident #19 explained that on Thursday NA #2 was supposed to give her a shower but had not. Resident #19	F 312	Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the Staff Development Coordinator on ensuring resident's receive assistance with activities of daily living including denture care, oral hygiene and showers as indicated. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 12 months, the DON, ADON or UM will report results of the denture care, oral hygiene and shower audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 312	Continued From page 26	F 312		

stated "well here it is Friday and I still do not have a shower and no one has helped me with soaking my dentures either." The resident was observed to have greasy looking hair, disheveled, unclean, and her dentures were visibly dirty.

On 04/22/16 at 10:00 AM, NA #1 was interviewed and reported Resident #19 was supposed to have a shower on Wednesday 04/20/16 and that she was unaware if the resident had a shower. NA #1 observed and stated "her hair is greasy looking and matted to her head and she does not look like she has had a shower." NA #1 further stated she was not responsible for the care of Resident #19 and was unaware of why she had not had a shower or her dentures cleaned during the week.

On 04/22/16 at 10:05 AM, Nurse #1 was interviewed and stated she would have expected Resident #19 to have had a shower on Wednesday. Nurse #1 stated she was unaware Resident #19 had not received a shower on Wednesday or during the week. Nurse #1 further stated she was unaware that Resident #19 was not being assisted with oral care or soaking of her dentures. She indicated it was her expectation for the residents to be assisted with showers and oral care.

On 04/22/16 at 12:45 PM, a telephone interview was conducted with NA #2. NA #2 stated she was responsible for the care of Resident #19 on Wednesday 04/20/16 and Thursday 04/21/16 from 7:00 AM until 3:00 PM. NA #2 confirmed she had not given Resident #19 a shower on Wednesday or Thursday and that she had gotten behind and had forgotten to give the resident a shower. NA #2 also stated she had not soaked the resident's dentures or provided oral care.

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F 312	Continued From page 27 On 04/22/16 at 12:50 PM, a telephone interview was conducted with NA #3. She confirmed she was responsible for the care of Resident #19 from 11:00 PM until 7:00 AM. NA #3 stated she had not assisted the resident with soaking her dentures or provided oral care. NA #3 further stated she was unaware Resident #19 required assistance with her dentures. On 04/22/16 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that ADL care be provided to a resident as required or needed. She further stated she would have expected a resident to have a shower on their scheduled shower days and any other day should it be requested. The DON stated she would have expected the nursing staff to have assisted the resident with soaking her dentures and assist a resident with oral care as needed.	F 312		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by:	F 412		5/20/16

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F 412	Continued From page 28 Based on observations, medical record review, staff interviews, and family interviews the facility failed to provide routine dental services for 1 of 2 residents (Resident #62). The findings included: Resident #62 was originally admitted to the facility on 07/11/14. She was recently discharged to the hospital and readmitted on 03/24/16. The most recent annual Minimum Data Set (MDS) dated 04/06/16 revealed the resident had diagnoses which included non-Alzheimer's dementia, diabetes, heart disease and macular degeneration among others. The MDS also revealed Resident #62 required extensive assistance with bed mobility and transfers, and total assistance with dressing, eating, personal hygiene, toileting, and bathing. The MDS further indicated Resident #62 had some tooth fragments. The MDS's reviewed for the past year indicated the payor source for Resident #62 was Medicaid unless she had a qualifying hospitalization and had been Medicare for a brief time. During an observation of Resident #62 on 04/19/16 at 10:28 AM the resident was noted to have 3 teeth in her bottom jaw and what appeared to be a full upper plate. On 04/21/16 at 9:40 AM the Social Services Director (SSD) was interviewed. The SSD stated there was a hygienist at the facility once a month and the dentist was there every other month along with the hygienist. The SSD further stated the responsible party or resident sign a consent form to see the dentist on admission and residents are usually seen twice a year. A review of the medical record for Resident #62	F 412	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected residents: Resident #62 received a Comprehensive Oral Examination by Long Term Care Professional Dental Services on May 2, 2016 with no current restorative dental needs and/or recommendations. Interventions for residents identified as having the potential to be affected. A facility audit of the current resident population was performed 04/21/2016 - 05/06/2016 by the facility Social Services Director (SSD) and a representative from Long Term Care Professional Dental Services to ensure dental services has been offered at least annually. Resident's identified as being affected were offered dental services and those accepting will be assessed by Long Term Dental Associates on May 20, 2016. Re-education was provided with the	

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revealed no documentation of dental consults or referrals or routine periodic dental examinations since the resident's original admit date of 07/11/14.

During an observation of Resident #62 on 04/21/16 at 10:55 AM the resident was noted to have 3 teeth in her bottom jaw and what appeared to be a full upper plate.

During a phone interview with a Family Member (FM) for Resident #62 on 04/21/16 at 12:38 PM, the FM stated he remembered signing a consent for Resident #62 to be seen by a dentist in the facility but was unsure if she had actually seen one or not.

On 04/21/16 at 12:45 PM the Medical Records Director was interviewed. She verbalized that Resident #62 had no documentation that could be found where she had ever been seen by a dentist.

On 04/22/16 at 12:50 PM the SSD was interviewed. The SSD stated that she should have audited the building when she started in 2015 to see who had and had not seen the dentist. The SSD further stated that somehow this had slipped through the cracks for being followed up on.

On 04/22/16 at 12:57 PM the DON was interviewed. The DON stated her expectation was that each resident is offered dental services they need and to make sure that dental services are provided for them.

F 412

facility Social Services Director on 05/13/2016 by the facility Director of Nursing on the expectation of ensuring dental services are offered yearly and as needed.

Systemic Change:

The facility will ensure dental services are offered yearly and as needed. Facility Social Services Director will communicate new admission information to Long Term Care Professional Dental Services for enrollment into the dental program. If a resident and/or responsible party decline dental servcies, declination letters will be sent to the facility from Long Term Care Professional Dental Associates. Long Term Care Professional Dental Associates will continue to follow-up and offer dental services annually.

Social Services Director will audit quarterly with Minimum Data Set (MDS) schedule to ensure dental services have been offered to all residents.

Monitoring of the change to sustain system compliance ongoing:

Quarterly for a minimum of twelve months, the Social Services Director will present results of the dental audit to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the

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F 412	Continued From page 30	F 412	need for further auditing beyond the twelve months.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520	.	5/20/16

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by:
Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2015. This was for 2 deficiencies which were originally cited in May of 2015 on a recertification and complaint survey. The deficiencies in the areas of failure to follow a resident's written plan of care and activities of daily living were recited on the current recertification and complaint survey. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referred to:

1a. F282: Failure to follow a resident's written plan of care: Based on observations, record review, resident, and staff interviews the facility failed to follow the care plan for providing showers and oral care to 1 of 3 residents sampled for activities of daily living (Resident #19).

On the recertification survey in May of 2015, the facility was cited a deficiency at F 282 for failure to follow the care plan intervention for the use of a pull/tab alarm. On the current survey the facility again failed to follow a resident's care plan for providing showers and oral care.

b. F312: Activities of Daily Living: Based on observations, record review, resident, and staff

F 520

The statements included are not an admission and do not constitute agreement with the alleged deficiencies here in. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations set forth
in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

Interventions for affected resident:

On 4/22/16, Resident #19 was assisted with a shower, dentures were removed and cleaned and placed back into her mouth.

Interventions for residents with potential to be affected:

Licensed Nurses (LN) and Certified Nursing Assistants (CNA's) across all shifts including full time, part time and as needed staff will be educated by May 18, 2016. Education will be provided by the Staff Development Coordinator (SDC) on ensuring oral hygiene is provided with morning and bedtime care. Dentures are removed and soaked at bedtime, cleaned and placed back in mouth prior to breakfast.

LN's & CNA''s across all shifts including full time, part time and as needed staff will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING ______ B. WING ______	C 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON 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

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interviews the facility failed to provide oral care and showers for a resident who required extensive assistance with activities of daily living causing the resident to feel unclean and unkempt for 1 of 3 residents sampled for activities of daily living (Resident #19).

On the recertification survey in May of 2015, the facility was cited a deficiency F 312 for failure to wash resident's hands before every meal who required assistance with activities of daily living. On the current survey the facility failed to provide oral care and showers to a resident.

During an interview on 04/22/16 at 2:20 PM the Administrator indicated he was unaware there was a problem and the past action plans were not followed through to improve the systems. The Administrator stated the Quality Assessment and Assurance Committee had monthly meetings and it was his plan to correct the issues presented in this survey and develop systems to keep the issues from reoccurring.

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be educated by May 18, 2016, on ensuring that showers are given as scheduled and upon request from a resident. This education will be provided by the facility SDC. The education will include assuring that assistance with Activities of Daily Living is provided as outlined in the resident care plan.

Re-education was provided to the facility Quality Assessment and Assurance Committee (QA & A Committee) by the Regional Clinical Director. Education included importance of maintaining an effective QA & A Committee. Education emphasized ensuring the QA & A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities.

Systematic Change:

Random audits will be completed by the Director of Nursing / Designee to validate that oral hygiene is provided during morning and bedtime care and scheduled showers are offered at least twice weekly and upon request from any resident. Audits will be performed randomly on ten (10) residents twice weekly for 12 weeks, then ten (10) residents weekly for 12 weeks, then twice monthly for 6 months across all shifts to ensure residents are assisted with Activities of Daily Living care as outlined in the resident care plan for

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F 520	Continued From page 33	F 520	denture care, oral hygiene and showers as scheduled and indicated. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 12 months, the Director of Nursing / Designee will report audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement committee will review the audits to make recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond the twelve months.	