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	345159	A. BUILDING _____ B. WING _____	C 04/11/2019

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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
E 000	Initial Comments A recertification survey was conducted 4/8/2019 through 4/11/2019. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID# 1JLK11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# 1JLK11.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurate code the Minimum Data Set (MDS) related to prognosis of life for 4 of 4 sampled residents who received hospice care (Residents #5, #37, #67 and #68). The findings included: 1. Resident #5 was readmitted to the facility on 07/13/18 under hospice care. Review of Resident #5's significant change Minimum Data Set (MDS) dated 07/26/18 revealed the MDS indicated Resident #5 received hospice care. The MDS indicated Resident #5 did not have a prognosis of life expectancy of less than 6 months. Review of Resident #5's quarterly MDS dated 10/12/18 revealed Resident #5 received hospice care. The MDS indicated Resident #5 did not	F 641	The following residents significant change Minimum Data Set (MDS) was updated by the Resident Care Specialist RN (RCS RN) on 4/10/2019 to reflect that the resident(s) had prognosis of life expectancy of less than 6 months to reflect the need for hospice care. Resident #5 significant change MDS dated 07/26/2018 Resident #37 significant change MDS dated 08/21/2018 Resident #67 significant change MDS dated 03/07/2019 Resident #68 significant change MDS dated 02/28/2019 Root cause analysis reflected that the RCS RN could not locate the hospice certification in the charts and did not follow up with hospice to obtain the	5/8/19

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

Electronically Signed | 05/03/2019

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F 641	Continued From page 1 have a prognosis of life expectancy of less than 6 months. Review of Resident #5's quarterly MDS dated 01/08/19 revealed Resident #5 received hospice care. The MDS indicated Resident #5 did not have a prognosis of life expectancy of less than 6 months. Review of Resident #5's quarterly MDS dated 04/03/19 revealed Resident #5 received hospice care. The MDS indicated Resident #5 did not have a prognosis of life expectancy of less than 6 months. Interview with the MDS Coordinator on 04/10/19 at 10:04 AM revealed Resident #5 received hospice care which indicated a prognosis of life expectancy of less than 6 months. The MDS Coordinator explained the physician's hospice certification which documented a life expectancy of six months or less was not available for review. The MDS Coordinator reported the MDS should indicate Resident #5's prognosis of less than 6 months. Interview with the Director of Nursing (DON) on 04/10/19 at 10:20 AM revealed the MDS should be accurate and reflect Resident #5's prognosis of life. 2. Resident #37 was readmitted to the facility on 08/21/18 under hospice care. Review of Resident #37's significant change Minimum Data Set (MDS) dated 09/03/18 revealed the MDS indicated Resident #37 received hospice care. The MDS indicated Resident #37 did not have a prognosis of life	F 641	certification that the residents' prognosis of life expectancy was 6 months or less when receiving hospice services. On 4/12/2019 both of the RCS RNs were provided with education on the need for accuracy of assessment with residents receiving hospice services and how to certify that the resident(s) had a prognosis of life expectancy of less that 6 months. The education was done by the Director of Nursing (DON) by 4/19/2019. All residents who receive hospice services would be at risk for the same deficient practice. On 4/10/2019 an audit was completed by the RCS RN of all residents receiving Hospice services and updates to the MDS sent for all discrepancies on 4/10/2019. On 4/12/2019 education was completed by the DON on accuracy of assessment and certifying that residents receiving hospice services had a prognosis of life expectancy of less than 6 months. Education was provided to both of the RCS RNS and the Social Worker. Systemic Change: As of 4/12/2019 and moving forward, the RCS RNs have been educated on process to certify the need for hospice services and the need for accurate assessments. The significant change for resident starting to receive hospice services will be reviewed for accuracy by the other RCS RN. A random audit of 2 significant changes for hospice services (if available) will be	

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F 641	Continued From page 2 expectancy of less than 6 months. Review of Resident #37's quarterly MDS dated 11/19/18 revealed Resident #37 received hospice care. The MDS indicated Resident #37 did not have a prognosis of life expectancy of less than 6 months. Review of Resident #37's quarterly MDS dated 02/05/19 revealed Resident #37 received hospice care. The MDS indicated Resident #37 did not have a prognosis of life expectancy of less than 6 months. Interview with the MDS Coordinator on 04/10/19 at 11:32 AM revealed Resident #37 received hospice care which indicated a prognosis of life expectancy of less than 6 months. The MDS Coordinator explained the physician's hospice certification which documented a life expectancy of six months or less was not available for review. The MDS Coordinator reported the MDS should indicate Resident #37's prognosis of less than 6 months. Interview with the Director of Nursing (DON) on 04/10/19 at 11:33 AM revealed the MDS should be accurate and reflect Resident #37's prognosis of life. 3. Resident #67 was readmitted to the facility on 02/22/19 under hospice care. Review of Resident #67's significant change Minimum Data Set (MDS) dated 03/07/19 revealed the MDS indicated Resident #5 received hospice care. The MDS indicated Resident #67 did not have a prognosis of life expectancy of less than 6 months.	F 641	reviewed weekly x 4, then 5 monthly x 2 months by the DON for compliance. Monitoring the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit results to the QAPI Committee. Results will be tracked and trended and submitted to the QAPI Committee. Base on the information received the QAPI Committee will determine the need for ongoing auditing.	

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F 641	Continued From page 3	F 641		

Interview with the MDS Coordinator on 04/10/19 at 11:32 AM revealed Resident #67 received hospice care which indicated a prognosis of life expectancy of less than 6 months. The MDS Coordinator explained the physician's hospice certification which documented a life expectancy of six months or less was not available for review. The MDS Coordinator reported the MDS should indicate Resident #67's prognosis of less than 6 months.

Interview with the Director of Nursing (DON) on 04/10/19 at 10:20 AM revealed the MDS should be accurate and reflect Resident #5's prognosis of life.

4. Resident #68 was admitted to the facility on 07/19/16.

A review of the hospice physician's verbal orders revealed Resident #68 was admitted to hospice on 02/28/19.

A review of the hospice certification narrative note dated 02/28/19 which was electronically signed by the physician on 03/01/19 indicated Resident #68 had a life expectancy of less than 6 months.

The significant change Minimum Data Set (MDS) assessment dated 03/08/19 indicated Resident #68 had a diagnosis of cancer and had not been coded under Section J1400 Prognosis as having a condition or chronic disease that could result in a life expectancy of less than 6 months.

On 04/10/19 at 11:04 AM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Resident #68's

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F 641	Continued From page 4	F 641		

significant change MDS assessment dated 03/08/19. The MDS Coordinator stated she should have coded under Section J1400 Prognosis that Resident #68 had a life expectancy of less than 6 months. The MDS Coordinator verified in the medical record that the documentation from hospice dated 02/28/19 indicated Resident #68 had a prognosis of less than 6 months. The MDS Coordinator stated she overlooked the hospice documentation and did not accurately code the significant change MDS assessment dated 03/08/19 to reflect Resident #68 had a life expectancy of less than 6 months. The MDS Coordinator stated she would need to submit a modification to the significant change MDS assessment dated 03/08/19 to accurately reflect Resident #68 had life expectancy of less than 6 months.

On 04/10/19 at 11:13 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that significant change MDS assessment dated 03/08/19 would have been coded under Section J1400 Prognosis to accurately reflect Resident #68 had a life expectancy of less than 6 months. The DON stated her expectation was that the MDS Coordinator would submit a modification to the significant change MDS assessment dated 03/08/19 to accurately reflect Resident #68 had a life expectancy of less than 6 months.

On 04/10/19 at 11:17 AM an interview was conducted with the Administrator who stated it was his expectation that the significant change MDS assessment dated 03/08/19 would have been accurately coded to reflect Resident #68 had a life expectancy of less than 6 months. The Administrator stated it was his expectation that

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F 641	Continued From page 5 the MDS Coordinator would submit a modification to the significant change MDS assessment dated 03/08/19 to accurately reflect Resident #68 had life expectancy of less than 6 months.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		5/8/19

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F 656	Continued From page 6 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to develop an individualized plan of care for a right resting hand splinting device recommended by Occupational Therapy to be worn daily for up to 6 hours for 1 of 3 residents (Resident #4) reviewed for range of motion. Findings included: Resident #4 admitted to the facility on 9/12/2017 with most recent readmission being 9/29/2017. Resident #4 had diagnoses which included muscle weakness and contracture of the right hand. Review of the Quarterly Minimum Data Set (MDS) dated 1/7/2019 revealed Resident #4 was severely cognitively impaired. Resident #4 required total assistance with activities of daily living (ADL). Resident #4 was coded as having impairment to upper and lower extremities on one side. Review of Resident #4's plan of care revised on 1/9/2019 revealed no care plan in place for a right resting hand splinting device. Review of the April 2019 monthly physician orders	F 656	The root cause analysis reveled that the SDC was, responsible for completing the Care plan for resident #4 and she missed adding the use of the right resting hand splinting devise to his 15 page care plan. The splint was being applied to Resident #4 as ordered but the use was not care planned. The SDC and both of the RCS RNs were provided with education on documentation and creation of the individualized care plan. This education was done on April 12, 2019 by the DON. Interventions for the affected resident: The comprehensive Care plan was updated to include the use of the right resting hand splinting device the day the deficient practice was found on April 9, 2019. Interventions for resident identified as having the potential to be affected: Current resident(s) with splints, care plans were audited 100% by the RCS RNS and the SDC one instance was found and immediately corrected. Audited was completed by 4/26/2019.	

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F 656	Continued From page 7 read in part: don/ doff (place on/ take off) Resident #4's right resting hand splint for up to 6 hours or as tolerated. An interview was completed on 4/9/2019 at 3:21 PM with the MDS Coordinator. The MDS Coordinator stated she was aware Resident #4 had a splinting device. The MDS Coordinator stated Resident #4's resting hand splint should have been developed into a plan of care for mobility or functioning by the Staff Development Coordinator (SDC). The MDS Coordinator stated she was not certain as to why the resting hand splint was omitted and not care planned for Resident #4. An interview was completed on 4/9/2019 at 3:57 PM with the SDC. The SDC stated she was aware Resident #4 had a right resting hand splinting device. The SDC explained that the right resting hand splint should have been developed into a plan of care for Resident #4. The SDC was not certain as to why the right resting hand splint was omitted from the plan of care. The SDC stated she was going to develop a plan of care at this time to reflect Resident #4's right resting hand splinting device. An interview was completed on 4/10/2019 at 9:50 AM with the Director of Nursing (DON). The DON stated she expected splinting devices to be care planned by the SDC and doubled checked by the MDS department to capture all resident care needs per policy and regulation.	F 656	As of 4/12/2019 and moving forward: Care plans will be updated accurately and timely upon receipt of splint orders from therapy and checked for accuracy by the RCS RN with in 3 working days. Systemic Change: Education was completed by the DON on updating the individualized care plans to reflect the use of any splinting devise. Education was completed to both RCS RNs and the SDC on 4/12/2019 by the DON. A random audit of 2 orders for splinting devices (if available) will be reviewed weekly x 4, then 5 monthly x 2 months by the DON for compliance. Monitoring the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit results to the QAPI Committee. Results will be tracked and trended and submitted to the QAPI Committee. Base on the information received the QAPI Committee will determine the need for ongoing auditing.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		5/8/19

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F 657	Continued From page 8 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to revise a care plan regarding splint application and pressure sore prevention boot for 1 of 3 sampled residents with contractures (Resident #5). The findings included: Resident #5 was readmitted to the facility on 07/13/18 with diagnoses which included traumatic brain injury and hemiplegia.	F 657	The root cause analysis reveled that the resident□s care plan was not updated timely and accurately to reflect changes to his orders after returning to the care center upon his return from an extended stay at the hospital. RCS RN and Unit managers were educated on the importance of ensuring that care plans are updated timely and accurately to reflect any new orders. This education was done on April 12, 2019 by the DON.	

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F 657	Continued From page 9 Review of Resident #5's significant change Minimum Data Set (MDS) dated 07/26/18 revealed an assessment of severely impaired cognition. The MDS indicated functional impairment on one side of Resident #5's upper and lower extremities with no pressure sores. Review of physician's orders dated 01/22/19 revealed daily application of a brand specific boot to Resident #5's left foot used to prevent pressure sores. Review of Resident #5's quarterly MDS dated 04/03/19 revealed an assessment of severely impaired cognition. The MDS indicated functional impairment on one side of Resident #5's upper and lower extremities with no pressure sores. Review of Resident #5's care plan dated 04/03/19 revealed interventions related to functional range of motion impairment included application of a hand splint on the left hand. The care plan did not contain an intervention regarding boot application on the left foot. Observation on 04/08/19 at 9:49 AM and at 2:52 PM revealed Resident #5 seated in a wheel chair with a boot on the left foot. Resident #5's left hand contracture did not have a splint. Observation on 04/09/19 at 10:42 AM and at 1:22 PM revealed Resident #5 seated in a wheel chair with a boot on the left foot. Resident #5's left hand contracture did not have a splint. Interview with Nurse Aide (NA) #1 on 04/10/19 revealed Resident #5 did not use a hand splint.	F 657	Interventions for the affected resident: Therapy screening and evaluation was performed and new orders for the hand splint was obtained. The comprehensive Care plan was updated to include the use of the hand splinting device beginning on 4/11/2019. Additionally the Care plan was updated to reflect the use of the provalon boot as an off loading device as of 4/13/2019 Interventions for resident identified as having the potential to be affected: Current resident(s) with splints, care plans were audited 100% by the RCS RNS and the SDC one instance was found and immediately corrected. Audit was completed by 4/26/2019. As of 4/12/2019 and moving forward: Care plans will be updated accurately and timely upon receipt of splint orders from therapy and checked for accuracy by the RCS RN with in 3 working days. Systemic Change: Education was completed by the DON on updating the individualized care plans to reflect the use of any splinting devise. Education was completed to both RCS RNs and the SDC on 4/12/2019 by the DON. A random audit of 2 orders for splinting devices (if available) will be reviewed weekly x 4, then 5 monthly x 2 months by	

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F 657	Continued From page 10 Interview with the Staff Development Nurse (who supervised splint applications) on 04/10/19 at 9:52 AM revealed Resident #5 no longer used a splint and received passive range of motion. Interview with the MDS Coordinator on 04/10/19 at 10:04 AM revealed Resident #5's care plan did not contain current interventions for range of motion and pressure sore prevention. The MDS Coordinator reported the care plan required revision related to boot application and splint application. The MDS Coordinator explained she was not aware of the order for the boot application and nonuse of the hand splint. Interview with the Director of Nursing (DON) on 04/10/19 at 10:20 AM revealed Resident #5's care plan should be accurate and revised as needed. The DON reported Resident #5's care plan should contain the boot application and omit the hand splint.	F 657	the DON for compliance. Monitoring the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit results to the QAPI Committee. Results will be tracked and trended and submitted to the QAPI Committee. Base on the information received the QAPI Committee will determine the need for ongoing auditing.	