STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 9/8/19 through 9/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9GUH11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 9/8/19 through 9/11/19. A total of 21 allegations were investigated and 2 allegations were substantiated. There was one citation as a result of the complaint investigation. Event ID# 9GUH11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		10/7/19

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

Electronically Signed | 10/03/2019

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F 656	Continued From page 1 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 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 record reviews and staff interviews, the facility failed to develop a comprehensive, individualized, and person- centered care plan in the area of anti-psychotics for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #62). The findings included: 1. Resident #62 was re-admitted to the facility on 07/09/19 with a diagnoses that included psychotic disorder, non-Alzheimer's dementia, anxiety and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated 08/21/19 indicated Resident #62 was severely cognitively impaired. The assessment further revealed she was coded as	F 656	The care plan for resident #62 was corrected by Minimum Data Set (MDS) Coordinator on 9/10/19. Care plans for residents receiving antipsychotics were reviewed by MDS on 9/11/19 to ensure accuracy. Issues identified were addressed at that time. MDS was re-educated on 9/11/19 by Administrator to ensure care plans for residents receiving antipsychotics were accurate. The education will be included in Orientation for new hires. Beginning 10/7/19, MDS will audit 5 care plans 3 times weekly for 4 weeks, then 1 time weekly for 2 months and then 1 time	

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F 656	Continued From page 2 receiving anti-psychotic medication daily during the assessment period. Review of the care plan dated 07/19/19 revealed no focus area for anti-psychotic medication use. On 09/10/19 at 10:19 AM an interview was conducted with MDS Nurse #1. She stated she was responsible for creating care plans and was aware of Resident #62 received an anti-psychotic medication on a daily basis. She stated Resident #62 should have been care planned for antipsychotic medication use. The interview revealed the error of no antipsychotic care plan for Resident #62 had occurred while the facility was transitioning over to point click care a computerized system. MDS Nurse #1 stated she would include the care plan for antipsychotic medication use for Resident #62 immediately. On 09/10/19 at 11:03 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #62 did not have a focus area on her care plan for receiving anti-psychotic medication. The interview revealed her expectation would be for this area to be included into the care plan. The interview revealed it was the responsibility of MDS Nurse #1 and hadn't been completed due to a transition into point click care a computerized system. On 09/11/19 at 10:33 AM an interview was conducted with the Administrator. The Administrator stated the care plan had been missed by mistake and her expectation was for the MDS Nurse to create a care plan for anti-psychotic medication for Resident #62.	F 656	monthly for 3 months (March 30, 2020) to ensure care plans are accurate. MDS will provide information regarding audits to the Quality Assurance Performance Improvement (QAPI)committee until April 30, 2020, at which time the QAPI committee will determine if further auditing is needed. Completion Date 10/07/2019	
F 657	Care Plan Timing and Revision	F 657		10/7/19

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F 657 SS=D	Continued From page 3 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §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 medical record reviews and staff interviews the facility failed to review and revise the care plan for 1 of 2 sampled residents reviewed for unsupervised smoking (Resident #16). The findings included:	F 657	The care plan for Resident #16 was corrected by Minimum Data Set (MDS) Coordinator on 9/10/19. Care plans for residents who smoke were reviewed by MDS on 9/11/19 to ensure accuracy. Issues identified were addressed.	

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F 657	Continued From page 4 Resident #16 was admitted to the facility on 09/10/18 with a diagnoses that included anemia, heart failure and thyroid disorder. Review of the annual Minimum Data Set (MDS) assessment dated 07/08/19 indicated Resident #16 was cognitively intact requiring extensive assistance of two staff members for most activities of daily living (ADL). The review revealed Resident #16 was coded for tobacco use. Review of the care plan dated 07/11/19 revealed a focus area for unsafe smoking. The goal was for Resident #16 to not smoke without supervision or not suffer any injury from unsafe smoking through the next review date on 11/30/19. Interventions included providing supervision for smoking. Review of a safe smoking assessment dated 08/02/19 completed by the Director of Nursing (DON) revealed Resident #16 was assessed as a safe smoker, requiring no supervision for smoking. On 09/10/19 at 10:19 AM an interview was conducted with MDS Nurse #1. She stated to her knowledge Resident #16 had last been evaluated for smoking in July in which she was determined to be an unsafe smoker. The interview revealed the care plan should have been based from the most recent smoking assessment which was 08/02/19. She stated based on the assessment the care plan should have stated the resident was a safe smoker requiring no supervision and would be immediately updated. The interview revealed MDS Nurse #1 reviewed the assessments on a	F 657	MDS was re-educated on 9/11/19 by Administrator to ensure care plans for residents who smoke are updated timely when there is a change. Changes for smokers status will be discuss during clinical morning meeting as well as during weekly clinical risk meeting, to ensure care plans are updated timely. The education will be included in Orientation for new hires. Beginning 10/7/19, MDS will audit 5 care plans 3 times weekly for 4 weeks, then 1 time weekly for 2 months and then 1 time monthly for 3 months (March 30, 2020) to ensure care plans are accurate. MDS will provide information regarding audits to the Quality Assurance and Performance Improvement (QAPI)committee until April 30, 2020, at which time the QAPI committee will determine if further auditing is needed. Completion date 10/7/2019	

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F 657	Continued From page 5 quarterly basis. On 09/10/10 at 11:05 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #16 was a safe smoker and her care plan should reflect that. The interview revealed it was the responsibility of MDS Nurse#1 to update the care plans and this had not occurred because MDS Nurse #1 had not seen the smoking assessment from 08/02/19. The interview revealed following her assessment on 08/02/19 she had not relayed the information to MDS Nurse #1 regarding the updated smoking assessment for Resident #16. On 09/11/19 at 10:26 AM an interview was conducted with the Administrator. She stated Resident #16's care plan should have been updated based on her most recent smoking evaluation.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and Physician Assistant (PA) interviews the facility failed to follow Physician orders for treatment of an arterial ulcer for 1 of 1 resident reviewed for	F 684	The dressing for resident #55 was corrected on 9/10/19 by the charge nurse and assessed by the Physician's Assistant.	10/7/19

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F 684	Continued From page 6 arterial ulcers (Resident #55). Findings included: Resident #55 was admitted to the facility with diagnoses including non-Alzheimer's dementia and peripheral vascular disease (a circulation disorder in which narrowed blood vessels reduce blood flow to the limbs). Review of the quarterly Minimum Data Set (MDS) dated 07/23/19 revealed Resident #55 was moderately cognitively impaired and required extensive assistance with bed mobility and transfers. The MDS further revealed Resident #55 had 1 arterial ulcer (a wound caused by poor blood flow to the lower extremities). Review of the skin breakdown care plan last updated 08/30/19 revealed Resident #55 had an arterial ulcer of the right heel related to vascular disease. Interventions included wearing an off-loading boot as ordered and receiving treatments as ordered. Review of the medical record revealed Resident #55 had a Physician's order dated 09/01/19 to clean the right medial (to the middle of the body) heel with normal saline, pat dry, apply Dakin's 0.5% solution (an antiseptic which kills most bacteria) moistened gauze, pack to the depth of the wound, apply calcium alginate (a dressing that absorbs wound drainage), and cover with a dry dressing daily. Resident #55 also had a Physician's order to apply compression wraps to both lower extremities in the morning and remove the compression wraps at night. Review of the Treatment Administration Record	F 684	Residents with wounds were assessed by the Director of Nursing on 9/10/19 to ensure physician's orders were being followed with proper dressings in place . Issues identified were addressed. Director of Nursing will educate licensed nurses by 10/7/19 to ensure dressings are applied according to physician orders and if dressings are found not applied correctly to correct immediately. The education will be included in Orientation for new hires. Beginning 9/16/19, Director of Nursing and/or Unit Manager began auditing 3 dressings 3 times weekly for 4 weeks, then 1 time weekly for 2 months and then 1 time monthly for 3 months (March 30, 2020) to ensure dressings are applied according to physician orders. DON/UM will provide findings of the weekly audits to the Quality Assurance and Performance Improvement (QAPI) committee until April 30, 2020, at which time the QAPI committee will determine if further auditing is needed. Completion date 10/07/2019	

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F 684	Continued From page 7	F 684		

(TAR) for 09/09/19 revealed the dressing to Resident #55's right heel was initialed as being changed by Nurse #3 on the 7:00 AM to 7:00 PM shift.

An observation of Resident #55's right foot on 09/10/19 at 8:54 AM revealed it was wrapped in a compression wrap from his toes to his knee. Nurse #6 removed the compression wrap from Resident #55's lower leg and revealed a wound to his right heel. No dressing was observed to be on Resident #55's right heel upon removal of the compression wrap. The Physician's Assistant (PA) was present in the room at the time Nurse #6 removed the compression wrap from Resident #55's right leg.

During an interview on 09/10/19 at 9:12 AM Nurse #6 confirmed Resident #55 did not have a dressing in place to his right heel when she removed the compression wrap.

An interview with Nurse #3 on 09/10/19 at 9:22 AM revealed she cared for Resident #55 for the 7:00 AM to 7:00 PM shift on 09/09/19. Nurse #3 stated she removed the old dressing from Resident #55's right heel and re-applied a new dressing per Physician's order approximately 6:30 PM on 09/09/19. Nurse #3 stated she removed the compression wrap to Resident #55's right heel when she changed his dressing and did not re-apply the compression wrap to the right heel after changing the dressing. Nurse #3 stated she initialed the TAR for 09/09/19 as completing the dressing change as ordered.

An interview with Nurse #4 on 09/10/19 at 3:56 PM revealed she cared for Resident #55 on 09/09/19 for the 7:00 PM to 7:00 AM shift. Nurse

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F 684	Continued From page 8 #4 stated she applied the compression wraps to Resident #55's lower legs approximately 6:30 AM on 09/10/19. Nurse #4 stated there was no dressing in place to Resident #55's right heel the morning of 09/10/19 and she applied the compression wrap directly over the wound. Nurse #4 stated she did not replace the right heel dressing before applying the compression wrap because the dressing was going to be applied on day shift. An interview with the Director of Nursing (DON) on 09/10/19 at 5:56 PM revealed she expected Resident #55's wound to have been covered with a dressing before the compression wrap was applied. An interview with the Physician's Assistant (PA) on 09/10/19 at 9:20 AM revealed there was no dressing on Resident #55's right heel when the compression wrap was removed the morning of 09/10/19. The PA stated Resident #55's wound increased in size since her assessment 09/03/19 and a contributing factor to the wound increasing in size could be the fact there was no dressing on the right heel and the compression wrap was directly on the right heel wound. The PA stated if Resident #55's dressing came off a new dressing should have been applied as soon as possible. The PA stated the compression wrap should not have been applied directly over Resident #55's right heel wound. An interview with the Administrator on 09/11/19 at 10:27 AM revealed she expected a dressing to have been re-applied to Resident #55's right heel before the compression wrap was applied.	F 684		
F 693	Tube Feeding Mgmt/Restore Eating Skills	F 693		10/7/19

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F 693 SS=D	Continued From page 9 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to date a resident's tube feeding formula and tubing per facility policy for 1 of 2 residents reviewed for tube feeding (Resident #18). The findings include: Resident #18 was admitted to the facility on 02/02/12 and readmitted on 01/25/18 with diagnoses which included dysphagia. Review of Resident #18's most recent quarterly	F 693	Nurse #4 was re-educated by the Director of Nursing on 9/8/19 to ensure tube feeding formula bottle is dated correctly when hanging the bottle and tubing is dated. Residents who receive tube feeding were assessed by Director of Nursing on 9/8/19 to ensure completion of proper dating/timing are provided on the label on the formula bottle and tubing dated. Issues identified were addressed.	

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F 693	Continued From page 10 Minimum Data Set (MDS) dated 07/10/19 revealed he was severely cognitively impaired and was dependent upon two staff members for activities of daily living (ADL). Resident #18 was coded for receiving tube feeding. Review of Resident #18's physician orders revealed an order initiated on 03/18/19 for Jevity 1.5 calories via G-tube at 60 milliliters (ml) per hour for a duration of 16 hours, off at 8:00 AM and on at 4:00 PM for a diagnosis of dysphagia. Review of Resident #18's medication administration record (MAR) revealed an order for Jevity 1.5 calories via G- tube at 60 ml per hour. The review revealed on 09/07/19 the Jevity formula was documented as administered at 4:00 PM by Nurse #4. An observation conducted on 09/08/19 at 10:00 AM revealed a bottle of Jevity tube feeding formula with tubing attached hanging on an intravenous (IV) pole at Resident #18's bedside. On the partially empty bottle of Jevity was a label for the nurse to fill in the date and time the feeding was started. Further observations revealed the only information documented on the label was 4:00 PM. In addition, the tubing was not labeled with a date. . On 09/08/19 at 10:24 AM an interview was conducted with Nurse #1. Nurse #1 indicated she was the charge nurse for Resident #18 and stated nurses were expected to date and time the bottle of tube feeding formula and date the tubing with each administration. Nurse #1 observed Resident #18's tube feeding formula during the interview and confirmed the bottle of tube feeding formula and tubing were not dated.	F 693	Director of Nursing/Unit Manager will re-educated licensed nurses by 10/7/19 on ensuring labels are completed correctly with time and date on the bottle when hanging a bottle of formula and to date tubing. The education will be included in Orientation for new hires. Beginning September 16, 2019 Director of Nursing /Unit Manager began auditing 2 residents who receive tube feeding 3 times weekly for 4 weeks, then 1 time week for 2 months and then 1 time monthly for 3 months(March 30, 2020) to ensure labels are completed correctly on tube feeding formula and tubing is dated. Director of Nursing/Unit Manager will provide findings of the weekly audits to Quality Assurance and Performance Improvement(QAPI) committee until April 30, 2020,at which time the QAPI committee will determine if further auditing is needed. Completion date 10/07/2019	

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F 693	Continued From page 11 On 09/08/19 at 10:31 AM an interview was attempted with Nurse #4 with no success. A voicemail was left by the surveyor with no return phone call. On 09/10/19 at 11:33 AM an interview was conducted with the Director of Nursing (DON). The DON stated she had spoken with Nurse #4 who initiated the bottle of tube feeding formula for Resident #18 on 09/07/19 at 4:00 PM. She stated Nurse #4 told her she did not date the bottle when she administered it. The DON stated her expectation was for all her nurses to enter the date and time on the tube feeding formula label and date the tubing per the facility policy. The interview revealed she was going to provide an in-service to all nursing staff. On 09/11/19 at 10:32 AM an interview was conducted with the Administrator. She stated Resident #18's formula and tubing should have been dated when it was initiated.	F 693		