

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLNTON REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1410 EAST GASTON STREET</b> <b>LINCOLNTON, NC 28092</b>		
(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	F 000			
F 557 SS=D	<p>A complaint investigation survey was completed on 12/29/19 through 12/30/19. There were a total of 34 allegations investigated and 12 were substantiated and cited. Event ID# GQGE11.</p> <p>Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide dignity for a cognitively intact resident who waited over 2 hours for incontinent care to be provided and preferred to wear her own underwear at night instead of a brief for 1 of 3 resident sampled for dignity and respect (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on 04/24/19 with diagnoses included hydronephrosis (swelling of the kidney due to a build-up of urine).</p> <p>An undated urinary care plan with a 07/17/19 last review date revealed Resident #6 to have a history of urinary tract infection and interventions included check at least every 2 hours for</p>	F 557	<p>1 Root Cause: The staff did not understand that timely incontinence care is a dignity issue, and we provided re-education on resident rights and dignity.</p> <p>Interventions for affected resident; Resident 6 was checked by the DON and found to be dry and clean. Resident 6 was interviewed by MDS on 1/17/2020 to care plan her preference for either wearing brief or her own underwear at night and educated on her right to make that determination. Care plan was updated by MDS on 1/17/2020. Resident 6 was informed staff would continue to check on her every 2 hours at night and she would be offered a bed pan at night if she requested to be toileted or she would</p>	1/20/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/17/2020

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 557	<p>Continued From page 1</p> <p>incontinence and wash, rinse, and dry soiled areas. A fall care plan that included an intervention to assist with toileting and incontinence care, bed mobility, and transfers. A self-care deficit care plan with interventions that included provide extensive assistance with personal hygiene and toileting.</p> <p>A quarterly Minimum Data Set (MDS) dated 10/13/19 indicated Resident #6 was cognitively intact and able to make her needs known. It further indicated she required extensive assistance for transfers, toilet use, and personal hygiene. Resident #6 was frequently incontinent of urine.</p> <p>A continuous observation on 12/29/19 at 11:52 am revealed Resident #6 to be very upset and agitated after requesting to speak to a surveyor. She was up in her wheelchair and dressed. Her call light was on at the time. The resident room had a slight urine smell during the interview. At 11:55 am on 12/29/19, NA #2 entered the room and asked the resident what she needed. When the resident told her she needed to go to the bathroom, NA #2 told her she would get someone to assist her and turned the call light off. Resident #6 turned the light back on. At 12:05 pm, an unidentified staff member entered the room and asked Resident #6 if she was ready for lunch and Resident #6 again said she needed to go to the bathroom. An unidentified female staff member, while standing on the opposite side of the curtain as Resident #6, told her she needed to wait now because the lunch meal trays were being passed and turned and walked out of the room. At 12:20 pm, no staff member had assisted Resident #6 with toileting before an activity staff member served her lunch tray.</p>	F 557	<p>be changed if she was soiled. Resident 6 was educated on the grievance process on 1/17/2020 by the Administrator.</p> <p>All nursing staff was re-educated on the rights of residents to dignity and respect, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night. Performed by the DON 12/31/2019.</p> <p>2 All residents had the potential to be affected. The facility performed an audit of continent residents to determine their preference to use an incontinence product or their own underwear at bed time.</p> <p>All nursing staff was re-educated on the rights of residents to dignity and respect, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night. Performed by the DON 1/2/2020 All staff was re-educated on the grievance process Performed by the DON completed 1/2/2020</p> <p>3 Systemic Changes</p> <p>Nursing Assistants and all licensed staff will be educated during orientation and at least annually on the need to provide timely incontinence care and the residents' rights to be treated with dignity and respect including the right to retain and use personal possessions including</p>		

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F 557	Continued From page 2  During an interview on 12/29/19 at 3:15 pm, NA #1 revealed she worked 12 hour shifts on the weekend and was usually assigned to the 200 hall where Resident #6 resides. She stated she was familiar with Resident #6 and she was usually one of the first residents gotten up at the start of her shift but she had been instructed to begin getting the residents up at the opposite end of the hallway as Resident #6 that morning because several had families coming to take them to church services. She stated while she and the other NAs on day shift began getting residents on the hall up for the day, she noticed Resident #6's light on. She recalled Resident #6 asking to get up beginning at approximately 07:30 am, maybe a little earlier. She entered the room and Resident #6 asked to get up and she had told her she would have to wait because other residents had to get up before her. She reported she returned to Resident #6's room about 09:30 am or a little after to get her up and Resident #6 was irritated for having to wait, she was also soaked in urine and she had to strip the linen and give Resident #6 a bed bath before getting her up and dressed. She stated residents were normally toileted every 2 hours but acknowledged Resident #6 waited over 2 hours after asking to get up and use the toilet on the morning of 12/29/19. She further indicated she was aware that Resident #6 wore briefs at night and had said she wished she could wear her own underwear while getting her up on occasion, but various NAs on night shift had told her they did not have enough help to toilet her at night and she would have to wear the briefs even if wearing them was not her preference.  An interview with Nurse #1 on 12/30/19 at 6:34	F 557	clothing and determining if they want to use an incontinence product or not at bed time.  All staff will be educated during orientation and at least annually on the grievance process and how to help residents voice any concerns they have.  4 Monitoring Random audits of ADL care and incontinence checks will be performed by the DON/licensed staff designee will be performed on 10 residents weekly for 4 weeks and then 2x monthly for 3 months to ensure proper and timely ADL care. The audits will be reviewed weekly in the clinical focus meeting times one month and monthly there after. The DON will report finding of the ADL and incontinence checks to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times four months to ensure ongoing compliance and to determine the need for further monitoring.		

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F 557	Continued From page 3 am revealed she worked the 200 hall on 12/29/19 and was familiar with Resident #6. She stated she knew Resident #6 would usually ask to be toileted during the day, wore her own underwear, and was typically able to stay continent during the day time. She indicated staffing had been a struggle recently, but on 12/29/19, she had an adequate number of NAs to provide care needs. She further indicated she was not aware that Resident #6 was not gotten up first as usual and Resident #6 should not have sat in urine for 2 hours after asking to be toileted.  An interview with the Director of Nursing (DON) on 12/30/19 at 06:49 am revealed the 200 hall was staffed with 3 NAs on day shift on 12/29/19 and was not aware that Resident #6 had been asked to wait 2 hours to be toileted and how much it upset her. She further indicated she was not aware staff had told Resident #6 she had to wear a brief during the night instead of her own panties because they did not have time to toilet her frequently enough. She stated she did not believe the resident should have been told to wait for 2 hours to be toileted nor that she should have to wear a brief if she can remain continent in her own underwear. She further indicated Resident #6 should be checked and offered the bedpan during the night if she requested to toilet or brief be changed if she was soiled.	F 557			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of	F 676		1/20/20	

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F 676	<p>Continued From page 4</p> <p>daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:</p> <p>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...</p> <p>§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interview, the facility failed to provide toileting assistance for 1 of 3 resident sampled for activities of daily living (ADL) (Resident #6).</p>	F 676	<p>Root Cause: The staff thought that because Resident 6 had agreed to wear a brief in the past that she was supposed to continue wearing one. They did not understand that it was her choice to make and would help her maintain her ADLs.</p>		

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F 676	<p>Continued From page 5</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on 04/24/19 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD-lung disease), muscle weakness, diabetes, hydronephrosis (swelling of the kidney due to a build-up of urine) and acquired absence of the left leg above the knee.</p> <p>Monthly physician orders for Resident #6 included an ongoing order for Nystatin cream 100,000 units per gram to buttocks/peri-area every shift for redness dated 04/25/19.</p> <p>An undated urinary care plan with a 07/17/19 last review date revealed Resident #6 to have a history of urinary tract infection and interventions included check at least every 2 hours for incontinence and wash, rinse, and dry soiled areas. A fall care plan that included an intervention to assist with toileting and incontinence care, bed mobility, and transfers. A self-care deficit care plan with interventions that included provide extensive assistance with personal hygiene and toileting.</p> <p>A quarterly Minimum Data Set (MDS) dated 10/13/19 indicated Resident #6 was cognitively intact and able to make her needs known. It further indicated she required extensive assistance for transfers, toilet use, and personal hygiene. Resident #6 was frequently incontinent of urine.</p> <p>Review of Nurse Aide (NA) charting for the December 2019 revealed Resident #6 was continent of bladder on first and second shift with 3 days of bladder incontinence on day shift and</p>	F 676	<p>1 Interventions for affected resident; Resident 6 was checked by the DON and found to be dry and clean. Resident 6 was interviewed by MDS on 1/17/2020 to care plan her preference for either wearing brief or her own underwear at night and educated on her right to make that determination. Care plan was updated by MDS on 1/17/2020. Resident 6 was informed staff would continue to check on her every 2 hours at night and she would be offered a bed pan at night if she requested to be toileted or she would be changed if she was soiled. Resident 6 was educated on the grievance process on 1/17/2020 by the Administrator.</p> <p>All nursing staff was re-educated on the rights of residents to retain ADLs, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night. Performed by the DON 12/31/2019.</p> <p>2 All residents had the potential to be affected. The facility performed an audit of continent residents to determine their preference to use an incontinence product or their own underwear at bed time.</p> <p>All nursing staff was re-educated on the rights of residents to retain ADLs, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night.</p>		

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F 676	<p>Continued From page 6</p> <p>one day on evening shift. The documentation indicated Resident #6 was primarily incontinent of her bladder with only 3 days of bladder continence on night shift for the month.</p> <p>Therapy evaluation and plan notes revealed Resident #6 was evaluated on 12/19/19 and currently being treated by Occupational Therapy 5 times per week to increase independence with ADL to allow Resident #6 to safely perform her own toileting with no more than supervision assistance.</p> <p>NA Kardex indicated Resident #6 required a slide board for transfer with extensive assistance of one staff member and to check resident every 2 hours for incontinence to include wash, rinse, and dry soiled areas with incontinence. The Kardex did address assisting resident to the toilet.</p> <p>Nursing progress notes included a note written on 12/17/19 that indicated excoriation to the groin region with treatment ordered and on 12/24/19 that included reddened areas on groin, groin folds, and abdominal folds reddened with treatment ordered.</p> <p>A continuous observation on 12/29/19 beginning at 11:52 am revealed Resident #6 to be very upset and agitated after requesting to speak to a surveyor. She was up in her wheelchair and dressed and her call light was on at the time. At 11:55 am on 12/29/19, NA #2 entered the room, asked the resident what she needed. When the resident told her, she needed to go to the bathroom the staff member told her she would get someone to assist her and turned the call light off. Resident #6 turned the light back on. At 12:05 pm, an unidentified staff member entered the</p>	F 676	<p>Performed by the DON 1/2/2020 All staff was re-educated on the grievance process Performed by the DON completed 1/2/2020</p> <p>3 Systemic Changes Nursing Assistants and all licensed staff will be educated during orientation and at least annually on the need to provide timely incontinence care and the residents' rights to be treated with dignity and respect including the right to retain ADLs this includes being able to use their own underwear or an incontinence product at bed time. All staff will be educated during orientation and at least annually on the grievance process and how to help residents voice any concerns they have.</p> <p>4 Monitoring Random audits of ADL care and incontinence checks will be performed by the DON/licensed staff designee will be performed on 10 residents weekly for 4 weeks and then 2x monthly for 3 months to ensure proper and timely ADL care. The audits will be reviewed weekly in the clinical focus meeting times one month and monthly thereafter. The DON will report finding of the ADL and incontinence checks to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times four months to ensure ongoing compliance and to determine the need for further monitoring. Interventions for affected resident; Resident 6 was checked by the DON and</p>		

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F 676	<p>Continued From page 7</p> <p>room and asked Resident #6 if she was ready for lunch and Resident #6 again said she needed to go to the bathroom. An unidentified female staff member, while standing on the opposite side of the curtain as Resident #6, told her she needed to wait now because the lunch meal trays were being passed and turned and walked out of the room. At 12:20 pm, no staff member had assisted Resident #6 with toileting before an activity staff member served her lunch tray.</p> <p>During an interview on 12/29/19 at 11:52 am, Resident #6 stated she was always told to wait when she asked to use the toilet and she further indicated she had been told she has to wear briefs at night because staff do not have time to toilet her. She stated they began making her wear a brief during the night shortly after being admitted. She indicated she could wear her personal underwear during the day and evening shifts and remain continent most of the time. She stated she had turned on the light on the morning of 12/29/19 at 7:00 am to get out of bed and use the bathroom. Resident #6 stated she had to lay in urine all morning because they did not come in to get her up until almost 10:00 am because they had told her they had to get residents up for family visitors and church first. She further stated she did not eat breakfast on the morning of 12/29/19 even though she knew she was a diabetic because she refused to eat while laying in urine. Resident #6 reported night shift had come in between 5:00-6:00 am to check on her before leaving at the end of the shift. The interview further revealed she was concerned she would develop sore places from sitting in urine for long periods of time and get another bladder infection. Resident #6 stated she felt staff were tired of taking care of her and that made her sad.</p>	F 676	<p>found to be dry and clean. Resident 6 was interviewed by MDS on 1/17/2020 to care plan her preference for either wearing brief or her own underwear at night and educated on her right to make that determination. Care plan was updated by MDS on 1/17/2020. Resident 6 was informed staff would continue to check on her every 2 hours at night and she would be offered a bed pan at night if she requested to be toileted or she would be changed if she was soiled.</p> <p>All nursing staff was re-educated on the rights of residents to dignity and respect, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night. Performed by the DON 12/31/2019.</p> <p>2 All residents had the potential to be affected. The facility performed an audit of continent residents to determine their preference to use an incontinence product or their own underwear at bed time.</p> <p>All nursing staff was re-educated on the rights of residents to dignity and respect, to include the need to provide timely incontinence care and that continent residents have the right to wear their own underwear at night if they chose and the need to toilet continent residents at night. Performed by the DON 12/31/2019 All staff was re-educated on the grievance process and shown how to fill one out and where they are so</p>		

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F 676	Continued From page 8  During an interview on 12/29/19 at 3:15 pm, NA #1 revealed she worked 12 hour shifts on the weekend and was usually assigned to the 200 hall where Resident #6 resides. She stated she was familiar with Resident #6 and she is usually one of the first residents gotten up at the start of her shift. She indicated she had been instructed to begin getting the residents up at the opposite end of the hallway as Resident #6 that morning because several had families coming to take them to church services. She stated while her and the other NAs on day shift began getting residents on the hall up for the day, she noticed Resident #6's light on. She recalled Resident #6 asking to get up and go to the bathroom beginning at approximately 07:30 am, maybe a little earlier, but could not recall the resident if Resident #6 stated she was incontinent at that time. NA #1 revealed Resident #6 asked to get up she had told her she would have to wait because other residents had to get up before her. She further revealed she returned to Resident #6's room about 09:30 am or a little after to get her up and Resident #6 was irritated for having to wait. She stated when she started getting her up, she noticed her bed was soaked in urine and she had to strip the linen and give Resident #6 a bed bath before getting her up and dressed. She stated Resident #6 was normally toileted every 2 hours but acknowledged Resident #6 waited over 2 hours after asking to get up and use the toilet on the morning of 12/29/19 because of the order residents were gotten up that morning.  An additional interview was conducted with NA #1 on 12/29/19 at 3:40 pm. She revealed the hall usually has 2 NAs and an NA that floats between two halls during first shift on the weekends, but	F 676	residents may express any concern they have.  3 Systemic Changes Nursing Assistants and all licensed staff will be educated during orientation and at least annually on the need to provide timely incontinence care and the residents' rights to be treated with dignity and respect including the right to retain and use personal possessions including clothing and determining if they want to use an incontinence product or not at bed time.  All staff will be educated during orientation and at least annually on the grievance process and how to help residents voice any concerns they have.  4 Monitoring Random audits of ADL care and incontinence checks will be performed by the DON/licensed staff designee will be performed on 10 residents weekly for 4 weeks and then 2x monthly for 3 months to ensure proper and timely ADL care.  The audits will be reviewed weekly in the clinical focus meeting times one month and monthly there after. The DON will report finding of the ADL and incontinence checks to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times four months to ensure ongoing compliance and to determine the need for further monitoring.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345159</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLNTON REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1410 EAST GASTON STREET</b> <b>LINCOLNTON, NC 28092</b>		
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F 676	<p>Continued From page 9</p> <p>that on 12/29/19 there was not a NA to float, but an NA orientee was scheduled. She stated the NAs on 200 usually round together to allow residents to be provided quicker.</p> <p>An interview with NA #2 on 12/29/19 at 4:01 pm revealed she worked the 200-hall unit on 12/29/19. She stated she and her co-workers were able to get everyone up. She confirmed NA #1's statement that they started at the bottom of the hall opposite of Resident #6 that morning to get residents ready for church. She stated she was aware Resident #6 was told she had to wait a little bit because there was a resident that needed to get up before her on the morning of 12/29/19 but was not aware that Resident #6 sat in urine for a couple of hours after asking to get up and use the toilet.</p> <p>An interview with NA #3 on 12/30/19 at 6:06 am revealed she worked during night shift and had previously worked with Resident #6. She stated staffing can be rough at times and Resident #6 did wear a brief during the night to help her to stay dry because there was usually only 2 NAs at night, and they are usually only able to make 2 to 2.5 rounds during the shift.</p> <p>An interview with Nurse #1 on 12/30/19 at 6:34 am revealed she worked 200 hall and was familiar with Resident #6. She stated she knew Resident #6 would usually ask to be toileted during the day and was typically able to stay continent during the day time. She indicated staffing had been a struggle recently, but on 12/29/19, she had an adequate number of NAs to provide care needs. She further indicated she was not aware that Resident #6 was not gotten up first as usual and Resident #6 should not have</p>	F 676			

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F 676	Continued From page 10 sat in urine for 2 hours after asking to be toileted.  An interview with the Director of Nursing (DON) on 12/30/19 at 06:49 am revealed the 200 hall was staffed with 3 NAs on day shift on 12/29/19 and was not aware that Resident #6 had been asked to wait 2 hours to be toileted. She further indicated she was not aware she did not eat her breakfast because of sitting in the urine. She further indicated she was aware briefs were used on Resident #6 at night since admission, but was not aware it was because staff had told Resident #6 she had to wear a brief during the night instead of her own underwear because they did not have time to toilet her frequently enough. She stated she did not believe the resident should have been told to wait for 2 hours to be toileted nor that she should have to wear a brief if she can remain continent in her own underwear. She further indicated Resident #6 should be checked and offered the bedpan during the night if she requested to toilet or brief be changed if she was soiled.	F 676			