

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

PRINTED: 10/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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	E 000			
	An unannounced COVID-19 Focused Survey was completed on-site 10/06/2020 through 10/07/2020 and the survey team exited on 10/07/2020. Additional information was obtained on 10/08/20. Therefore, the exit date was changed to 10/08/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Facilities. Event ID# 34N911.				
F 000	INITIAL COMMENTS	F 000			
	An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was completed on-site 10/06/2020 through 10/07/2020 and the survey team exited on 10/07/2020. Additional information was obtained on 10/08/20. Therefore, the exit date was changed to 10/08/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One (1) of the twenty-nine (29) complaint allegations was substantiated and cited. Event ID # 34N911.				
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		10/22/20	
	The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, family member interview, staff interviews and Nurse Practitioner interview the facility failed to follow a physician order for Insulin and monitor a		Resident #1 discharged against medical advice on 7/24/2020 A quality review/observation was		

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

TITLE

(X6) DATE

Electronically Signed

10/21/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 1</p> <p>resident's blood glucose level after admission to the facility for 1 of 3 residents reviewed for medication administration (Resident #1).</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility after a hospital admission for acute renal failure on 07/23/20. Resident #1's diagnosis included diabetes mellitus type 2.</p> <p>Review of an admission assessment revealed Resident #1 arrived at the facility on 07/23/20 at 5:30 PM. The assessment revealed Resident #1 was alert and oriented.</p> <p>Review of Resident #1's discharge summary from the hospital on 07/23/20 revealed an order for Insulin glargine 100 units per milliliter solution for injection (Lantus) inject 34 units by subcutaneous injection daily at bedtime. The discharge summary also revealed an order to monitor Resident #1's blood glucose level 4 times daily before meals and at bedtime.</p> <p>A Physician Order was placed by the facility on 07/23/20 at 10:58 PM for Insulin glargine 100 units per milliliter solution (Lantus) inject 34 units subcutaneously at bedtime related to diabetes mellitus type 2.</p> <p>Resident #1's July 2020 Medication Administration Record (MAR) revealed an order for Resident #1 to receive 34 units of Insulin subcutaneously at bedtime initiated on 07/24/20 at 9:50 AM. The review revealed no documentation of Resident #1 receiving Insulin glargine 100 units per milliliter solution (Lantus) 34 units subcutaneously at bedtime on 07/23/20.</p>	F 760	<p>completed on 10/21/2020 by the Director of Nursing to ensure all current resident medication orders are accurate and up to date as prescribed by the Medical Director and / or Nurse Practitioner. An additional quality review/observation was also completed on 10/21/2020 by the Director of Nursing to ensure all current residents prescribed medications are being administered by the nurse as ordered and all current residents with orders for blood glucose level monitoring are being monitored as ordered.</p> <p>Current facility Licensed Nursing Staff were re-educated from 10/8/2020 – 10/15/2020 by the Director of Nursing/Assistant Director of Nursing on timeliness of admission orders and ensuring that all resident medications and supplies are available and if they are not available the process to receive them in a timely manner. All newly hired licensed nurses will be educated by the Director of Nursing / Assistant Director of Nursing during new hire orientation.</p> <p>The Director of Nursing/Assistant Director of Nursing will complete a quality review to ensure the following: Is the resident a new admission/readmission to the facility? Were all medications available per the MD order? If medication not available, did the nurse use Omnicell or call pharmacy or call physician? Did the resident receive their medications on time per MD order? If not, was the physician notified with documentation in the medical record with new orders received, as applicable. If the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 2</p> <p>Review of Resident #1's July 2020 MAR revealed an order to monitor the residents blood glucose level 4 times daily before meals and at bedtime initiated on 07/24/20 at 6:30 AM. Resident #1's blood glucose levels were the following:</p> <ul style="list-style-type: none"> · 07/24/20 at 6:30 AM: 222 · 07/24/20 at 11:30 AM: 437 · 07/24/20 at 4:30 PM: 257 <p>Review of Resident #'s July 2020 MAR revealed she was administered Humalog sliding scale insulin solution initiated on 07/24/20 at 6:30 AM. She received 2 units at 6:30 AM, 10 units at 11:30 AM and 4 units at 4:30 PM.</p> <p>On 10/07/20 at 2:00 PM an interview was conducted with Resident #1. She stated she was admitted to the facility on 07/23/20 at 5:30 PM. The interview revealed she was insulin dependent and considered herself a "brittle diabetic". She stated she did not receive any insulin the night of 07/23/20 nor did staff check her blood sugar. The interview revealed she had asked a staff member, who's name she could not recall, multiple times for her insulin however they stated to her it was unavailable. She stated the next day on 07/24/20 her blood glucose levels remained elevated and she was afraid to remain in the facility. The interview revealed she left the facility against medical advice due to her blood glucose levels not being maintained properly.</p> <p>On 10/07/20 at 2:00 PM an interview was conducted with Resident #1's family member. She stated Resident #1 had left the facility against medical advice due to lack of care regarding her Insulin. The interview revealed</p>	F 760	<p>resident has orders for blood sugars and/or insulin, were the medications and supplies available? These quality reviews will be completed on 5 residents 3 x weekly for 1 month, then 1x weekly for two months, then 1 x monthly for 3 months. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met.</p> <p>Date of compliance: October 22, 2020</p>		

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

PRINTED: 10/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 3</p> <p>Resident #1 had not received Insulin on the night of 07/23/20 despite having a diagnosis of diabetes and her blood glucose level was not checked until 07/24/20 at 6:30 AM.</p> <p>On 10/06/20 at 3:00 PM an interview was conducted with Nurse #1. She stated she was working on the night of 07/23/20 and had assisted with Resident #1's admission. She stated when a resident is admitted from the hospital the nurses are responsible for taking the discharge summary and completing a medication reconciliation with the Nurse Practitioner. She stated the nurse will then verify the orders and place them into the system. The interview revealed Insulin was not located in back up medication in the facility and the nurse was responsible for calling Pharmacy and receiving a STAT delivery at night. She stated she did not recall ordering a STAT delivery from Pharmacy on 07/23/20 nor did she remember any issues with the admission. She stated she was helping Nurse #2 and was not assigned to Resident #1's care. The interview revealed it would have been Nurse #2's responsibility to administer Insulin to Resident #1.</p> <p>On 10/06/20 at 3:15 PM an interview was conducted with Nurse #2. She stated she would have been responsible for the 300 hall which Resident #1 was admitted to on 7/23/2020 however could not recall the resident. She stated the first shift nurses would usually complete the medication reconciliation prior to her getting to the facility at 7:00 PM for third shift. The interview revealed she did not recall having issues obtaining Insulin in July 2020 or remember anything regarding Resident #1's orders. When asked why her name would be listed with portions of Resident #1's admission she stated she may</p>	F 760			

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

PRINTED: 10/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 4</p> <p>have completed them but could not recall the resident or recall completing her admission. She stated she did not remember Resident #1 asking for her blood sugar to be checked or stating to her that she needed insulin.</p> <p>On 10/07/20 at 12:01 PM an interview was conducted with Nurse #3. She stated she was working on 07/23/20 from 7:00 AM to 7:00 PM on the 300 hall in which Resident #1 was admitted. The interview revealed she had completed Resident #1's skin assessment but could not recall anything information about the resident. She stated, "it depends on the day whether or not I'm able to complete a medication reconciliation prior to third shift arriving". The interview revealed she could not recall if she had completed it on 07/23/20 or asked third shift to.</p> <p>On 10/07/20 at 8:40 AM an interview was conducted with the facilities former Social Worker. She stated on 07/24/20 Resident #1 had stated to her the nurses were not monitoring her blood glucose levels properly and administering her insulin correctly so she wanted to leave. She stated on 07/24/20 Resident #1's blood glucose level was high, and she was saying it was due to not receiving Insulin the night before on 07/23/20. The interview revealed Resident #1's family member came on 07/24/20 and removed her from the facility. She stated she documented the information into a progress note in the resident's chart.</p> <p>On 10/06/20 at 4:44 PM an interview was conducted with the Director of Nursing (DON). She stated she had been in the facility since 08/31/20 so she was not the active DON during the time period Resident #1 was admitted. She</p>	F 760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	<p>Continued From page 5</p> <p>stated once a resident was admitted from the hospital the orders should be taken from the discharge summary and verified by the nurse with the facility Nurse Practitioner. She stated the Nurse Practitioner for the facility had changed since July 2020. The interview revealed if a resident was admitted with nighttime Insulin orders then they should receive the Insulin as ordered on the first night of their stay. The nurses could call pharmacy for a STAT medication to be delivered. She stated since the order was put into the computer charting system on 07/23/20 at 10:58 PM the system may have automatically scheduled it to be administered on the following day.</p> <p>On 10/07/20 at 4:30 PM an interview was conducted with the Administrator. He stated he had been the interim Administrator since late August 2020. The interview revealed nurses should follow orders regarding a residents Insulin. He stated if a resident had an order to receive Insulin at night, they should be receiving it the first night they were admitted to the facility and their blood glucose levels should be monitored.</p> <p>On 10/08/20 at 1:57 PM an interview was conducted with the facility's former Nurse Practitioner. She stated she had given orders for Resident #1 to receive Lantus 34 units at bedtime on 07/23/20. The interview revealed when she came into the facility on 07/24/20 she evaluated Resident #1 due to her having concerns because she didn't receive insulin the night before or have her blood sugar checked. She stated her documents showed Resident #1 had a diagnosis of type 2 diabetes mellitus with out of control glucose levels. She stated Resident #1 had a blood glucose level of 437 prior to lunch on</p>	F 760			

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

PRINTED: 10/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2020
NAME OF PROVIDER OR SUPPLIER CARDINAL HEALTHCARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760	Continued From page 6 7/24/20 and was extremely upset. The interview revealed she expected the nurse on duty when Resident #1 was admitted to ensure her orders were carried through and to have administered the insulin as ordered. She stated she did not know why it hadn't been done but it had resulted in Resident #1 having increased blood glucose levels the next day on 07/24/20. She stated the resident ended up leaving against medical advice due to this issue.	F 760			