STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING _____ B. WING _____	C 07/12/2023

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GASTONIA HEALTH & REHAB CENTER	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(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 and complaint investigation survey was conducted on 07/10/23 through 07/12/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 4Q4D11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/10/23 through 07/12/23. Event ID# 4Q4D11. The following intakes were investigated NC00204423, NC00201760, and NC200801. 7 of 7 complaint allegations did not result in a deficiency.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		8/7/23

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

Electronically Signed | 08/02/2023

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F 690	Continued From page 1 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 3 residents (Resident #40) reviewed with indwelling catheters. The findings included: Resident #40 was admitted to the facility on 02/10/2023. Resident #40 was currently being followed by Hospice and had an indwelling urinary catheter for comfort. A review of Resident #40's care plan dated 03/21/2023 revealed a focus area for indwelling urinary catheter. The interventions included check tubing for kinks each shift, and position catheter bag and tubing below the level of the bladder and provide a privacy cover. A review of Resident #40's significant change	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI The facility did not follow policies and procedures by failing to keep a urinary catheter from touching the floor to reduce the risk of infection or injury for 1 or 3 residents that was observed with indwelling catheters. Immediate Action Nurse #1(PM) educated July 17, 2023 by Administrator on Indwelling Urinary Catheter Care Procedure. Resident #40 order were reviewed and validated by physician no change needed. Larger trash can was placed in room on July 12, 2023 to eliminate urinary catheter touching the floor. July 18, 2023 a catheter bag container was put in place to eliminate	

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F 690	Continued From page 2 Minimum Data Set (MDS) assessment dated 03/31/23 revealed the resident was cognitively intact, required extensive to total assistance with all activities of daily living (ADL) except eating and had an indwelling urinary catheter. A review of the physician orders for Resident #40 dated 07/01/23 revealed an order for an indwelling urinary catheter size 16 French with a 5 cubic centimeter (cc) bulb (the part of the catheter used to prevent the catheter from sliding out of the urinary bladder) for comfort in a Hospice patient. There were orders to change the catheter every 4 weeks on Monday, catheter care every shift and as needed for preventive measures and an order to drain the catheter every shift and as needed. An observation was conducted of Resident #40 on 07/10/23 at 10:47 AM. Resident #40 was observed sitting in a chair in her room with her urinary catheter bag with a privacy cover that was open on the bottom hanging on the outside of her trash can and the bottom of the bag was touching the floor and the tubing to empty the catheter bag was in direct contact with the floor surface. An observation was conducted of Resident #40 on 07/11/23 at 4:45 PM. Resident #40 was observed sitting in a chair in her room with her urinary catheter bag hanging on the outside of her trash can and the tubing and bottom of the bag were in direct contact with the floor surface. An interview was conducted on 07/12/23 at 11:04 AM with Nursing Assistant (NA) #1 which revealed she was assigned to care for Resident #40 from 7:00 AM to 7:00 PM. She stated she had placed Resident #40's catheter on the side of	F 690	urinary catheter from touching the floor. Identification of Others All residents are at risk for the deficient practice therefore a 100 percent audit was completed on July 17, 2023 by administrator on catheter orders, leg straps in place, catheter bags in place and tubing below the level of the bladder, check kinks per shift, and privacy cover provided. To validate tubing not touching the floor, liked residents□ catheter tubing is placed in privacy bag which is stored on resident's bedframe and/or underneath resident□s wheelchair/gerichair. If any residents were identified corrective action was implemented immediately. Systemic Change Effective July 17, 2023, 100% of nursing (including agency) and therapy was in-serviced on Indwelling Urinary Catheter Care Policy. While providing care to residents with urinary catheter staff will validate that catheter bag is in place and tubing is below the level of the bladder and not touching the floor. Any employees on leave must receive education before returning to work. This education will also be provided during orientation for new hires and agency staff. Orders will be review daily (Monday through Friday) during clinical meeting of any new orders received. New admissions and/or readmissions orders will be reviewed during clinical meeting	

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F 690	Continued From page 3 her chair but that she often moved it to the outside of her trash can because she moved from her chair to her recliner during the day. NA #1 indicated she had been educated to keep a catheter bag off the floor due to infection control and prevention of urinary tract infection. She further stated when the bag was hooked to her chair, the bag and tubing did not touch the floor. An observation was conducted of Resident #40 on 07/12/23 at 11:33 AM. Resident #40 was observed sitting in a chair in her room with her urinary catheter bag hanging on the outside of her trash can and the tubing and bottom of the bag were in direct contact with the floor surface. An interview was conducted with Nurse #1 on 07/12/23 at 11:04 AM in Resident #40's room. Nurse #1 stated she was assigned to care for Resident #40 from 7:00 AM to 7:00 PM on 07/12/23. Nurse #1 observed the resident's urinary catheter bag and tubing resting on the floor. She stated she had seen the bag on the floor and knew it shouldn't be touching the floor but the resident liked to hook it to her trash can. Nurse #1 indicated it was concerning to her that the catheter bag and tubing were in contact with the floor because this placed the resident at greater risk for urinary tract infections. Nurse #1 proceeded to move the catheter bag and tubing and hooked it on the bottom of the chair so the tubing and bag were no longer in contact with the surface of the floor. She further stated she would talk with NA #1 to make sure she kept the bag and tubing off the floor. An interview was conducted with the Director of Nursing (DON) on 07/12/23 at 2:17 PM and she revealed it was her expectation that catheter bags	F 690	which is conducted daily Monday - Friday the clinical team with review physician orders to validate if resident is being admitted with catheter. New admissions and/or readmissions with catheter orders will have the following interventions put in place and validated by director of nursing and/or designee of the following: order to check for kinks per shift, leg strap in place, tubing below the level of the bladder, privacy cover and/or leaf bag provided, and tubing not touching the floor. Monitoring The Administrator and/or designee with monitor urinary catheter tubing to ensure it is not touching the floor. This monitoring will be conducted x4 weeks, then biweekly x4 weeks, and them monthly thereafter for 3 months. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until compliance is achieved. Completion Date August 7, 2023	

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F 690	Continued From page 4 and tubing be placed below the level of the resident's bladder and that they both clear the floor to prevent the resident contracting a urinary tract infection. An interview was conducted with the Administrator on 07/12/23 at 3:30 PM and she revealed that it was her expectation that a urinary catheter bag and tubing be kept below the level of the urinary bladder and off the floor. She added a catheter bag should never be in contact with the floor.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		8/7/23

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F 692	Continued From page 5 Based on observations, record review, resident and staff interview the facility failed to follow a physician order for a nutritional supplement for 2 of 2 sampled residents reviewed (Resident #20 and Resident #7). The findings included: 1. Resident #20 was admitted into the facility on 08/18/22. A quarterly Minimum Data Set (MDS) dated 05/17/23 revealed Resident #20 was alert and oriented. The resident was coded as receiving a therapeutic diet. Resident #20 was not coded for weight loss or weight gain. A care plan dated 05/25/23 had a focus area for increased nutrition/hydration due to poor by mouth intake. The goal was for the resident to be adequately nourished within limits of her end stage illness. Interventions included providing supplements per order. Resident #20's Medication Administration Record (MAR) dated July 2023 revealed a physician order dated 12/01/22 which read, "Nutritional supplement three times a day 90 milliliter's three times daily". On 07/12/23 Nurse #1 documented Resident #20 had refused the supplement at 9:00 AM. On 07/12/23 at 8:55 AM an observation was conducted of Nurse #1 administering medication to Resident #20. During the observation Nurse #1 did not provide Resident #20 with the nutritional supplement. Nurse #1 was observed documenting refusal for the ordered supplement.	F 692	F692 Nutrition/Hydration Status Maintenance The facility did not follow polices and procedures by not following physician orders and providing Resident #7 (MB) and Resident #20 (DC) a boost with medication pass as ordered by physician which was identified as failure to provide hydration. Immediate Action Nurse #1(PM) educated July 12, 2023 by Unit Coordinator on Resident Hydration Policy. Resident #7 and #20 hydration/supplement order were reviewed and validated by physician no change needed. Identification of Others All residents are at risk for the deficient practice therefore a 100 percent audit was completed on July 12, 2023 by unit coordinator on supplements orders to identify any residents not receiving hydration with medication pass and/or on meal trays. If any resident were identified of not receiving supplement an invention was put in place and registered dietitian made aware. Systemic Change Effective July 17, 2023 100% of nursing (including agency) and dietary staff was in-serviced on resident hydration policy.	

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F 692	Continued From page 6 On 07/12/23 at 11:16 AM an interview was conducted with Resident #20. She stated she did not refuse to take her morning nutritional supplement, but Nurse #1 had not asked. The interview revealed she did not like the vanilla flavor the facility often provided and wanted to try chocolate or strawberry instead. She stated staff had not asked her to try another flavor they just assumed because she did not like vanilla that she would refuse for the day. On 07/12/23 at 11:28 AM an interview was conducted with the Dietary Manager. During the interview she stated the facility had several different flavors of nutritional supplements such as strawberry, chocolate and vanilla. She stated the supplements were provided to the residents by the nurses on the hall unless specified on the dietary card. The Dietary manager reviewed Resident #20's dietary card and stated the kitchen did not send her supplement out with the meal tray, the nurses on the hall provided it to her. On 07/12/23 at 2:30 PM an interview was conducted with Nurse #1. During the interview she stated she knew Resident #20 didn't like the vanilla nutritional supplement, so she went ahead and documented refused. Nurse #1 stated she thought that was the only flavor in the facility. The interview revealed Nurse #1 had not asked Resident #20 if she would like to try another flavor or if she wanted to take her supplement on 07/12/23. On 07/12/23 at 1:46 PM an interview was conducted with the Registered Dietitian (RD). She stated she normally prescribed a nutritional supplement to residents that she felt needed	F 692	Residents will be offered/administered sufficient fluid intake to maintain hydration. A variety of fluids will be offered to residents, depending on preferences and nutritional/diagnosis considerations. This education was provided by Unit Coordinator. Any employees on leave must receive education before returning to work. This education will also be provided during orientation for new hires and agency staff. New admissions and/or readmissions orders will be reviewed during clinical meeting which is conducted daily Monday - Friday the clinical team with review physician orders to ensure supplement orders clarifies if supplements are to be provided with medication pass or on meal trays. Effective July 26, 2023, supplement orders will be reviewed weekly during resident review to validate any changes with supplement orders. Any changes noted, registered dietitian will be made aware for clarification. Monitoring The Unit Coordinator and/or designee with monitor weekly observation of medication pass and/or delivery of trays to ensure supplements are being provided as ordered by physician. This monitoring will be conducted x4 weeks, then biweekly x4 weeks, and them monthly thereafter. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for	

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F 692	Continued From page 7 additional calories in between meals. The interview revealed she wanted the nurses on the halls to provide the residents with the supplemental drinks she ordered to ensure the residents did not have a weight loss. On 07/12/23 at 2:10 PM an interview was conducted with the Director of Nursing (DON). She stated she had been working with the nurses on orders. She stated Nurse #1 should have given the resident the supplement as ordered or at least have asked if she wanted to take it for the day. 2. Resident #7 was admitted into the facility on 03/03/23. A quarterly MDS dated 06/09/23 revealed Resident #7 was moderately cognitively impaired. The resident was coded as not having a weight loss or weight gain. A care plan dated 03/22/23 had a focus area for increased nutrition/hydration due to a history of significant weight loss. The goal was for Resident #7 to remain free of significant weight changes through the next review. Interventions included providing supplements per orders. On 07/12/23 at 8:58 AM an observation was conducted of Nurse #1 administering Resident #7's medication. During the observation Nurse #1 was not observed administering Resident #7's ordered nutritional supplement. An observation was conducted of Resident #7's breakfast tray sitting on her bedside table. The resident did not have a nutritional supplement on the tray.	F 692	recommendations or modifications until compliance is achieved. Completion Date August 7, 2023	

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F 692	Continued From page 8	F 692		

Resident #7's Medication Administration Record (MAR) dated July 2023 revealed a physician order dated 05/21/23 which read, "Nutritional supplement two times a day 90 milliliter's." On 07/12/23 Nurse #1 documented she had administered the prescribed supplement at 8:00 AM.

On 07/12/23 at 2:30 PM an interview was conducted with Nurse #1. During the interview she stated she documented she had given Resident #7 her nutritional supplement because she thought it had come out on her breakfast tray. When the surveyor stated the tray had been observed with no supplement Nurse #1 stated she didn't know why it wasn't on there she thought the resident had received it.

On 07/12/23 at 11:28 AM an interview was conducted with the Dietary Manager. She stated the supplements were provided to the residents by the nurses on the hall unless specified on the dietary card. The Dietary manager reviewed Resident #7's dietary card and stated the kitchen did not send her supplement out with the meal tray, the nurses on the hall provided it to her.

On 07/12/23 at 1:46 PM an interview was conducted with the Registered Dietitian (RD). She stated she normally prescribed a nutritional supplement to residents that she felt needed additional calories in between meals. The interview revealed she wanted the nurses on the halls to provide the residents with the supplemental drinks she ordered to ensure the residents did not have a weight loss.

On 07/12/23 at 2:10 PM an interview was conducted with the Director of Nursing (DON).

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F 692	Continued From page 9 She stated she had been working with the nurses on orders. The interview revealed Nurse #1 should have given Resident #7 the boost supplement during the medication pass.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews the facility failed to maintain a continuous supply of supplemental oxygen for 1 of 1 resident reviewed for oxygen therapy (Resident #246). The findings included: Resident #246 was admitted to the facility on 07/03/23 with diagnoses which included chronic obstructive pulmonary disease (COPD) with exacerbation and abnormalities of breathing. A physician order dated 07/03/23 revealed Resident #246 was ordered supplemental oxygen at 2 liters per minute continuously every day and night shift. The admission evaluation dated 07/05/23 revealed Resident #246 was alert and oriented	F 695	F695 Respiratory/Tracheostomy Care and Suctioning The facility did not follow policies and procedures by failing to maintain a continuous supply of supplemental oxygen for a resident that received oxygen therapy. Immediate Action NA #2, #3, and #4 educated July 17, 2023 by Director of Nursing on Safe Oxygen Handling Practices and Competency for Oxygen Administration. Resident #246 was discharged home on July 12, 2023. Identification of Others All residents are at risk for the deficient	8/7/23

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F 695	Continued From page 10 and required one person assist for majority of activities of daily living (ADL). The admission evaluation further revealed Resident #246 was coded for oxygen use. An observation and interview conducted with Resident #246 on 07/10/23 at 11:50 AM revealed Resident #246 was sitting in her bed with oxygen running through nasal cannula. Resident #246 stated she had told staff on 07/10/23 at 7:00 AM during breakfast that her oxygen tank was empty, and she was unable to go to the dining room for meals and attend activities. It was observed the oxygen tank on her wheelchair was empty by the gauge. Resident #246 indicated staff had not been back into the room to put a new tank on her wheelchair. During the observation of Resident #246 she did not report being short of breath or appear to have signs or symptoms of respiratory distress. An observation and interview was conducted with the Director of Nursing (DON) on 07/10/23 at 12:05 PM. The DON observed Resident #246's oxygen tank on her wheelchair was empty. Resident #246 explained to the DON that she had told staff it was empty while staff had passed tray at an estimated time of 7:00 AM. The DON indicated the tank was empty and should have been replaced immediately once staff was made aware. An interview conducted with Nurse Aide (NA) #3 on 07/11/23 at 2:50 PM revealed on 07/10/23 around 7:00 AM she had assisted passing out breakfast trays and delivered Resident #246's meal. NA #2 further revealed Resident #246 had reported to her and NA #4 her oxygen tank on her wheelchair was empty. NA #3 stated the tank was	F 695	practice therefore a 100 percent audit was completed on July 18, 2023 by director of nursing. Audit consisted of verifying oxygen orders by physician and validating oxygen availability present in resident's rooms. If any residents were identified corrective action was implemented immediately. Systemic Change Effective July 17, 2023, 100% of nursing (including agency) and therapy was in-serviced on Safe Oxygen Handling Practices and Competency for Oxygen Administration. While providing care for residents that's receiving oxygen therapy staff including therapy will ensure resident has continuous supply of supplemental oxygen, by checking oxygen concentrator and/or tank to ensure availability of oxygen supply. Any employees on leave must receive education before returning to work. This education will also be provided during orientation for new hires and agency staff. Orders will be review daily (Monday – Friday) during clinical meeting of any new orders received. New admissions and/or readmissions orders will be reviewed during clinical meeting which is conducted daily Monday - Friday the clinical team with review physician orders to validate if resident is being admitted with oxygen therapy. New admissions and/or readmissions with oxygen orders will have the following interventions put in place and validated by director of nursing and/or	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASTONIA HEALTH & REHAB CENTER	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

(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 695	Continued From page 11 empty and advised NA #4 to change her tank out. An interview conducted with NA #4 on 07/11/23 at 3:05 PM revealed he assisted NA #3 with passing trays around 7:00 AM. NA #4 further revealed Resident #246 had stated her oxygen tank was empty on her wheelchair. NA #4 indicated he was busy passing trays and had forgotten to get a new tank. An interview conducted with Nurse #2 on 07/12/23 at 2:35 PM revealed she was not aware Resident #246's oxygen tank was empty. Nurse #2 further revealed oxygen tanks were supposed to be checked each shift and Resident #246's tank should have been changed when she had reported to nursing staff. Nurse #3 indicated Resident #246 had enjoyed being out in the dining room for meals and to attend activities. Nurse #3 stated Resident #246 was ordered to have oxygen continuously and when she is not getting oxygen, she was short of breath. A follow up interview with the DON on 07/12/23 at 2:20 PM revealed oxygen tanks were supposed to be checked every shift and anytime nursing staff were in the resident's room. The DON indicated Resident #246 needed to remain on oxygen continuously and her oxygen tank should have never been empty. An interview with the Nurse Practitioner (NP) on 07/12/23 at 2:30 PM revealed Resident #246 had history of chronic obstructive pulmonary disease and respiratory issues that required her to be on oxygen continuously. The NP further revealed Resident #246 was a newer admit, but assumed she would be short of breath without oxygen.	F 695	designee of the following: oxygen signage on resident's door, oxygen in place (concentrator and/or tank), oxygen tubing, and prefill water. Monitoring The Director of Nursing and/or designee with monitor oxygen therapy by assuring signage on resident's door and observing oxygen availability. This monitoring will be conducted x4 weeks, then biweekly x4 weeks, and them monthly thereafter for 3 months. Findings will be reported monthly to the Quality Assurance Performance Improvement (QAPI) committee for recommendations or modifications until compliance is achieved. Completion Date August 7, 2023.	