| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LINCOLNTON REHABILITATION CENTER** | **1410 EAST GASTON STREET LINCOLNTON, NC 28092** |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite complaint investigation survey was conducted on 1/30/2024 to 2/1/2024. Additional information was obtained offsite on 2/12/2024 to 2/15/2024. Therefore, the exit date was changed to 2/15/2024. The following intakes were investigated NC00211829 and NC00212472. Event ID #4D8N11. 3 of the 7 allegations resulted in deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen | F 550 | | 3/14/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/29/2024

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 550

Continued From page 1
or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff and resident interview the facility failed to treat a resident (Resident #6) in a dignified manner when Nurse Aide (NA) #2 was rough and pushing on her during a transfer. This made Resident #6 feel "unsafe" during the transfer and she stated this was a dignity issue. Additionally, the facility failed to assist a resident at eye level during a meal (Resident #3) for 2 of 4 residents reviewed for dignity.

The findings included:

1. Resident #6 was admitted to the facility on 1/27/23 with multiple diagnoses which included muscle wasting and atrophy, muscle weakness, and difficulty in walking.

The annual Minimum Data Set (MDS) dated 12/27/23 indicated Resident #6 was cognitively intact. She required substantial/maximal assistance with transfers from chair to bed. Resident #6 had no behavior or refusal of care indicated.

F 550

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
Resident #6 was interviewed on 1/30/2024 by the Regional Clinical Director and stated that she did not want certified nurse aide #2 to care for her. On 1/31/2024, certified nurse aide #2 was provided education on customer service and ensuring residents feel safe during transfers by the Director of Nursing.
Certified nurse aide #2 was removed from the staffing schedule on 1/30/2024 pending further investigation.
On 1/31/2024, certified nurse aide #8 was provided immediate education by the Director of Nursing on the proper guidelines for assisting residents during meals by being positioned at eye level.
2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice
On 2/1/2024, an audit was completed by

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| F 550 | Continued From page 2<br><br>Resident #6 had a plan of care in place regarding impaired communication related to the use of glasses initiated on 5/30/2023. Interventions were inclusive of providing extensive assistance of 1staff person transfer with gait belt.<br><br>An interview was completed with Resident #6 on 1/30/23 at 3:08 PM. Resident #6 stated approximately one month ago a Nurse Aide (NA) on 3rd shift was pushing her, pulling on her, and rushing her when transferring her from the wheelchair back to her bed. Resident #6 verbalized that made her feel "unsafe" during that transfer. Resident #6 was able to identify NA #2 as the aide who was rough with her during care.<br><br>A follow up interview was performed on 1/31/24 at 11:00 AM with Resident #6. She verbalized she did not allow NA #2 to assist with transferring her after the prior incident due to feeling "unsafe" and afraid of being hurt. She stated she allowed NA #2 to assist her with providing incontinent care in the bed at night because she can assist with rolling while in bed.<br><br>An additional interview and observation was conducted on 1/31/24 at 3:01 PM with Resident #6. Resident #6 explained the incident with NA #2 was a dignity issue for her. She voiced NA #2 made her feel "this tall" holding up her thumb and index fingers spaced approximately one inch apart.<br><br>A telephone interview was conducted with NA #2 on 1/31/24 at 10:30 AM. She stated she never had a problem with Resident #6 not allowing her to assist with care. NA #2 verbalized Resident #6 allowed her to provide incontinent care and did | F 550 | the Social Service Manager of all residents who have the potential to be affected in the center who require assistance with transferring with a BIMs of 13 or higher to ensure they felt safe and were treated with dignity during transfers with staff. The residents indicated they felt safe and treated with dignity during transfer. By 3/5/2024, cognitively impaired residents were evaluated by Director of Nursing/designee observing facial and body expression and/or behavior during transfers. There were no residents identified as appearing to be uncomfortable or distressed during the transfers.<br>On 2/1/2024, a visual audit was completed by the unit manager, staff development coordinator, assistant director of nurses and social services manager on current residents who have the potential to be affect and who require assistance during meals to ensure staff are assisting residents by being positioned at eye level. Any staff found to stand while assisting the residents with meals were immediately re-educated.<br>3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br>By 2/26/2024, the Director of Nursing provided education to certified nursing aides and licensed nursing staff on ensuring residents feel safe during transfers, treated with dignity, and assisting residents during meals by being positioned at the level of the resident. Should any resident report feeling unsafe | |

F 550

Continued From page 3

not complain of her being rough with care. NA #2 stated Resident #6 sometimes did not stand well, and she must try to pick her up and put her into bed. She described picking her up as using a gait belt to assist her up and lifting her into the bed. She verbalized Resident #6 had not complained of pain or discomfort or asked her to stop during transfers. NA #2 stated she had last worked with Resident #6 last weekend on Sunday (1/28/24) and assisted her with incontinent care. NA #2 was not aware of any other concerns related to Resident #6.

A telephone interview on 1/31/24 at 9:08 AM was conducted with Nurse #1. She worked night shift every weekend and was routinely assigned to Resident #6. Nurse #1 verbalized Resident #6 did not like NA #2 to assist her to bed at night on the weekends. Nurse #1 stated Resident #6 requested for her to put her to bed on the weekends instead of NA #2. She verbalized she did not ask Resident #6 why she did not want NA #2 to put her to bed. Nurse #1 stated NA #2 still worked with Resident #6. The nurse verbalized Resident #6 allowed NA #2 to perform incontinent care during the night but asked Nurse #1 to assist her to bed and to help pull her up in the bed during the night.

An interview was conducted on 1/31/24 at 4:38 PM with the Medical Director (MD). He stated staff had not reported any behavior issues, concerns, refusal of care, or any manipulative behaviors for Resident #6. The MD verbalized staff have not reached out to him to report any concerns of dignity.

An interview with the Director of Nursing (DON) was conducted on 2/1/24 at 10:24 AM. The DON

F 550

and/or not treated with dignity or show any signs of distress during the transfer the staff will immediately stop the transfer and report the residents concern or verbal/visual cues of distress to their direct supervisor. Staff found to be assisting residents with meals not at eye level will be immediately re-educated.
On 2/29/2024, audits will be initiated on all residents that require assistance with transfers and ensure residents feel safe and are treated with dignity. The audit will be performed 5 times weekly for 4 weeks, then 4 times weekly for 4 weeks, and then 3 times weekly for 4 weeks.
On 2/29/2024, audits will be initiated to ensure that staff members are positioned at eye level while assisting residents during meals. The audit will be performed 5 times weekly for 4 weeks, then 4 times weekly for 4 weeks, and then 3 times weekly for 4 weeks.
New clinical staff will be educated on ensuring residents feel safe during transfers, treated with dignity and assisting residents during meals by being positioned at eye level of the resident upon hire prior to their first worked shift.
4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
On 2/29/2024, audits will be initiated on all residents that require assistance with transfers and ensure residents feel safe and are treated with dignity. The audit will be performed 5 times weekly for 4 weeks, then 4 times weekly for 4 weeks, and then 3 times weekly for 4 weeks.
On 2/29/2024, audits will be initiated to

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| F 550 | Continued From page 4<br>was interviewed regarding the grievance dated 12/12/23 for Resident #6. She was not aware of the grievance prior to 1/30/24 and she revealed the facility was currently following their reporting process and investigating the grievance further. She explained staff should explain to residents what they were going to do. She verbalized some residents have pain and staff should try to be as gentle as possible when providing activity of daily living (ADL) care and transfers. The DON stated staff should look at the resident's care guide for how a resident transferred. She voiced that all residents should be treated with dignity and respect. She stated residents have the right to refuse care and the residents wishes and rights should be honored and respected. The DON verbalized residents should always be handled in a safe, dignified, respectful manner. She stated if a resident did not want to be cared for by a particular staff member, the staff member should not continue to go into the resident's room and care for them and their wishes should be honored. She voiced that residents should feel comfortable and safe.<br><br>An interview was conducted on 1/30/24 at 4:45 PM with the Regional Director of Clinical Services. She stated the facility had spoken to Resident #6 about the grievance she reported on 12/12/23 today. She verbalized the facility was reporting the incident to the police, was interviewing staff, and had suspended the NA associated with the grievance, and was investigating Resident #6 report of staff being rough during care. The Regional Clinical Director was not aware of the grievance prior to 1/30/24.<br><br>An interview was performed with the Vice President of Operations and the Regional | F 550 | ensure that staff members are positioned at eye level while assisting residents during meals. The audit will be performed 5 times weekly for 4 weeks, then 4 times weekly for 4 weeks, and then 3 times weekly for 4 weeks.<br>The results of these audits will be submitted to the Quality Assurance Activity/Quality Assurance and Performance Improvement (QAA/QAPI) Committee by the Director of Nursing monthly times 3 months.<br><br>The alleged compliance date is 3/14/2024. | |

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|---|---|---|---|---|
| F 550 | Continued From page 5 | F 550 | | |

Director of Clinical services together on 2/1/24 at 12:26 PM. They stated residents should be treated with respect and dignity. They voiced the facility should have ensured the resident was cared for the way she wanted to be cared for. The Regional Clinical Director discussed speaking with Resident #6 and stated Resident #6 told her "She was not happy." They stated staff received training in dignity and respect during general orientation, annually, and as needed when issues arise.

2. Resident #3 was admitted to the facility on 7/30/20 with multiple diagnoses that included Alzheimer's Disease with late onset, dementia, dysphagia, generalized muscle weakness.

Resident #3's care plan dated 12/13/23 revealed Resident #3 should maintain her current level of function by having one staff member assist Resident #3 while eating.

A quarterly Minimum Data Set (MDS) assessment dated 12/8/23 revealed Resident #3 was severely cognitively impaired and required substantial/maximum assistance with feeding.

A continuous observation conducted on 1/30/24 from 1:01 pm to 1:13 pm revealed Resident #3's bed was observed in a low position with NA #8 towering over her while feeding. NA#8 was not engaged in any conversation with Resident #3. There was no chair observed in Resident #3's room.

An interview with NA #8 was conducted on 1/30/24 at 1:25 pm. NA #8 verbalized she received education about feeding during orientation. She learned how to deliver a tray and

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|---|---|---|---|---|

F 550 Continued From page 6 F 550

how to feed the resident, which included sitting while feeding the resident.

An interview with NA #9 was conducted on 1/30/24 at 1:29 pm. NA #9 verbalized that she witnessed NA #8 standing while assisting residents with the lunch meal. NA #9 explained that they were provided frequent education on assisting residents with meals.

An interview with the Assistant Director of Nursing (ADON) was conducted on 2/1/24 at 9:23 am. The ADON stated that NAs and Nurses received education about feeding during day two of orientation by the Staff Development Coordinator (SDC). She verbalized the correct way to feed a resident, which included sitting at eye level with the resident. The ADON reported if she witnessed a staff member standing while feeding a resident, she would redirect the staff member and get them a chair.

An interview with the SDC was conducted on 2/1/24 at 9:39 am. She stated that NAs and Nurses received education about feeding during clinical orientation. She reported staff are instructed to sit eye to eye level with the resident and to only feed one resident at a time, even in the dining room. The SCD stated staff received yearly education and completed feeding competencies in March of 2023. She reported that if she witnessed a staff member standing while feeding, she would get them a chair and have them sit down.

An interview with the Director of Nursing (DON) was conducted on 2/1/24 at 9:56 am. The DON stated NAs and Nurses were educated about feeding during general orientation, yearly, and on

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| F 550 | Continued From page 7<br>an as needed basis. She verbalized the correct steps for feeding a resident, which included having staff sit while feeding. The DON verbalized if she witnessed a staff member feeding a resident while standing, she would ask the resident if they were comfortable with the staff member standing and if not, she would get the staff member a chair. She stated if the staff member was standing while feeding, the bed would need to be raised to eye level. The DON reported that standing while feeding could be intimidating to some residents.<br><br>An interview with the Regional Clinical Director was conducted on 2/1/24 at 10:24 am. She stated NAs and Nurses received education on feeding during competency skill checks, yearly education, clinical orientation, and on an as needed basis. The Regional Clinical Director verbalized the correct steps for feeding a resident, including that staff should be seated while feeding residents. She stated if she witnessed a staff member feeding a resident while standing, she would knock on the door, quietly remind the staff member, and ask them to take a seat. The Regional Clinical Director stated it would be intimidating if residents were fed with a staff member standing over them. | F 550 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring | F 580 | | 3/14/24 |

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| F 580 | Continued From page 8 | F 580 | | |

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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|---|---|---|---|---|
| F 580 | Continued From page 9<br>room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review staff, and Physician interviews the facility failed to notify the Physician of a resident's wound upon admission and failed to notify the Physician when the resident's wound had started to deteriorate for 1 of 1 resident reviewed for notification (Resident #1).<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 11-24-23 with multiple diagnoses that included malignant neoplasm of the vulvar, vulvar lesions.<br><br>Review of the facility's admission documentation by Nurse #4 dated 11-24-23 revealed an initial skin assessment that documented Resident #1's external vaginal area was red and irritated, her outer labia skin was hard/crusty, and there was a darkened area on Resident #1's left labia area. The skin assessment also showed Resident #1's bottom was red.<br><br>Review of the Physician orders dated 11-24-23 revealed an order for Resident #1 to have weekly skin assessments but there were no orders for wound care to Resident #1's vulvar lesions.<br><br>The Wound Care (WC) Nurse was interviewed on 1-31-24 9:08am. The WC Nurse revealed Resident #1's vulvar lesions were deteriorating throughout the resident's admission but stated she had not informed the Physician of the deterioration. She explained she had informed Resident #1 of the deterioration and had educated her on the importance of returning to | F 580 | 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>Resident #1 was discharged from the facility on 12/30/23. On 1/31/2024 the wound care nurse was removed from the schedule by the Director of Nursing.<br><br>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br><br>On 2/1/2024, current residents with wounds were reviewed to ensure physician and resident or responsible party notification was made if the wound had started to deteriorate.<br>By 2/20/2024, residents admitted with wounds in the past 30 days were reviewed to ensure physician or specialty physician and resident or responsible party notification was complete by the Director of Nursing.<br><br>3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br>By 2/20/2024, the Director of Nursing provided education to all licensed nursing staff on notification to the physician or specialty physician and resident or responsible party on residents with wounds upon admission and any noted | |

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|---|---|---|---|---|

F 580

Continued From page 10

Oncology to have her lesions treated.

An interview with the Physician occurred on 1-30-24 at 2:00pm, with a follow up telephone interview on 2-13-24 at 11:04am. The Physician discussed first learning about Resident #1's vulvar lesions on 11-28-23 when he performed his admission assessment. He stated at that time Resident #1's vulvar lesion was extensive in the shape of a "V" pattern extending downwards towards her anus. The Physician described the lesion as having necrotic tissue, green colored drainage, and an odor. While reviewing the initial skin assessment written on 11-24-23, the Physician said he had found Resident #1's vulvar lesion "much worse" than how it was described in the initial skin assessment. He stated he would have expected the admitting nurse to inform him of Resident #1's vulvar lesions at the time of Resident #1's admission so he could have provided orders. The Physician also discussed not being informed of Resident #1's vulvar lesions deteriorating but explained Resident #1 was in a weakened state and due to her extensive comorbidities and cancer, the deterioration was unavoidable.

An interview was conducted with the Regional Nursing Consultant on 2-1-14 at 12:25 pm. The Regional Nursing Consultant stated the admitting nurse should review the hospital discharge orders and if there were not wound care orders present then she should inform the Physician of the resident's wound. She discussed wound care orders not being obtained upon Resident #1's admission and stated the admitting nurse should have contacted the Physician for wound care orders.

F 580

deterioration. New clinical staff will be educated upon hire notification to the physician or specialty physician and resident or responsible party on residents with wounds upon admission and any noted deterioration prior to their first worked shift.
On 3/5/2024, an audit will be initiated on all residents admitted with wounds to ensure physician or specialty physician and resident or responsible party notification is complete upon admission and with any deterioration. An audit will be completed on current residents with wounds that are deteriorating to ensure the physician, specialty physician and resident or responsible party is notified. Audits will be performed five (5) times weekly on Monday, Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then four (4) times weekly on Monday, Tuesday, Wednesday and Friday for four (4) weeks, and then three (3) times weekly on Monday, Wednesday and Friday for four (4) weeks.
4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
On 3/5/2024, an audit will be initiated on all residents admitted with wounds to ensure physician or specialty physician and resident or responsible party notification is complete upon admission and with any deterioration. An audit will be completed on current residents with wounds that are deteriorating to ensure the physician, specialty physician and resident or responsible party is notified. Audits will be performed five (5) times

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET<br>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 |
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| F 580 | Continued From page 11<br>A telephone interview occurred with Nurse #4 on 2-14-24 at 1:08pm. Nurse #4 confirmed she admitted Resident #1 and had completed the skin assessment on 11-24-23. Nurse #4 discussed remembering Resident #1's vulvar wound on admission. She said she could not remember if there were wound care orders from the hospital and stated she had not contacted the facility Physician for wound care orders. Nurse #4 explained when Resident #1 had been admitted to the facility she was not familiar with the procedure to obtain orders, how to document the wound and the need to measure the wound. | F 580 | weekly on Monday, Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then four (4) times weekly on Monday, Tuesday, Wednesday and Friday for four (4) weeks, and then three (3) times weekly on Monday, Wednesday and Friday for four (4) weeks.<br>The results of these audits will be submitted to the Quality Assurance Activity/Quality Assurance and Performance Improvement (QAA/QAPI) Committee by the Director of Nursing monthly. The QAA/QAPI Committee will reevaluate the need for further monitoring or until substantial compliance is achieved.<br>Date of completion 3/14/2024. | |
| F 585<br>SS=D | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information | F 585 | | 3/14/24 |

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|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

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|---|---|---|---|---|
| F 585 | Continued From page 12<br>on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; | F 585 | | |

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|---|---|---|---|---|
| F 585 | Continued From page 13<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews the facility failed to communicate, investigate and resolve a grievance for 1 of 1 resident (Resident #6) reviewed for grievances. | F 585 | 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; | |

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F 585

Continued From page 14

The findings included:

Resident #6 was admitted to the facility on 1/27/23.

The annual Minimum Data Set (MDS) dated 12/27/23 indicated Resident #6 was cognitively intact.

An interview with Resident #6 conducted on 1/30/23 at 3:08 PM revealed she had completed a grievance form approximately one month ago reporting a NA being rough when providing care for her. She verbalized NA #1 on 2nd shift filled out the grievance form for her.

The facility's grievance log was reviewed from November 2023 through January 2024 and did not reveal Resident #6 name on the grievance log.

An interview was performed on 1/30/23 at 4:35 PM with Resident #6. She verbalized she thought the grievance form was given to the Social Worker (SW) after the NA had filled out the grievance form with her. She stated she did not hear from the SW, and nothing ever happened after she filled out the grievance form.

A telephone interview was conducted on 1/31/24 at 9:07 AM with NA #1 and revealed she remembered filling out the grievance form for Resident #6. She stated Resident #6 was upset and told her no one would help her when she wanted to go to bed. She said Resident #6 told her it was after 1:00 AM when someone came to help her to bed and the NA was rough and pulled on her. NA #1 stated Resident #6 did not have

F 585

On 1/30/2024, grievance investigation was initiated with associated state reporting guidelines for resident #6 by the Director of Nursing (DON). On 1/31/2023, staff #2 was removed permanently from schedule. On 2/1/2024, the grievance resolution was signed and a copy of the grievance was given to the resident.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
On 2/1/2024, current residents were reviewed by the Social Services Manager of grievances from the past twelve (12) months to ensure grievances were properly investigated in accordance with the center□s grievance process. Grievances that did not follow the center□s grievance resolution process were completed, with resolution given to the resident or responsible party, and signatures obtained as warranted.

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
On 1/31/2024, the Regional Clinical Director provided education to the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Infection Preventionist, Rehabilitation Director, Social Service Manager, Activities Director, Minimum Data Set coordinator, Staff Development Coordinator, Unit managers, Business Office Manager, Admission coordinator and Maintenance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

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|---|---|---|---|---|

F 585

Continued From page 15

any bruises or marks. She explained she notified the nurse, who told her to complete a grievance for Resident #6 and to put the grievance in the SW's box. NA #1 stated Resident #6 did not have any behaviors, did not refuse care, or have any manipulative behaviors if she didn't get her way. She verbalized she had not witnessed Resident #6 have any behaviors with other staff.

An interview and observation was conducted on 1/30/24 at 4:57 PM with the SW. The SW stated he was not aware of a grievance form for Resident #6 from approximately a month ago. He stated when staff filled out a grievance form during non-business hours, they slide the paper grievance form under his door, he then added the grievance to the grievance log, and distributed the grievance to the department manager associated with the grievance for follow up. The SW stated the interdisciplinary team would talk about grievances in the morning meeting. He specified the department managers returned the grievance form to him once the follow up was completed and he filed the grievance form in the grievance book. An observation of the facility's grievance book with the SW revealed a grievance form dated 12/12/23 filed by Resident #6 for an NA being rough with her during care. The SW stated he was unable to recall if the grievance for Resident #6 was discussed in the morning meeting.

Review of Resident #6's Grievance form dated 12/12/23 was completed on 1/30/24 at 5:15 PM and revealed the back section of the grievance form titled "Conclusion of Grievance" was filled out by the Assistant Director of Nursing (ADON) and signed by the Nursing Home Administrator (NHA) but was incomplete in the following areas:

F 585

Director on the grievance process to include discussing grievance in daily morning meeting, reviewing the conclusion of the grievance, relaying the findings of the grievance to the resident and/or resident□s representative, and providing a signed copy to the resident and/or resident□s representative.
By 2/20/2024, the Director of Nursing and staff development coordinator re-educated all staff (Nursing staff, therapy staff, dietary staff, housekeeping staff, maintenance staff, business office staff, admissions office staff, receptionist staff, social service staff) on the center□s grievance process.
On 3/4/2024, an audit will be initiated on grievances within the center to ensure an investigation was initiated, has appropriate documentation, and completed. This audit will be performed five (5) times weekly on Monday, Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then four (4) times weekly on Tuesday, Wednesday, Thursday and Friday for four (4) weeks, and then three (3) times weekly on Monday, Wednesday and Friday for four (4) weeks.
New staff will be educated upon hire on the grievance process prior to their first worked shift.
4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
On 3/4/2024, an audit will be initiated on grievances within the center to ensure an investigation was initiated, has appropriate documentation, and

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| F 585 | Continued From page 16<br>- summary statement of the grievance,<br>- summary of the pertinent findings/ conclusions regarding residents' concerns<br>- corrective actions taken or to be taken by the facility because of the grievance.<br>- steps taken to investigate the grievance.<br>- date the written decision was issued.<br>- identification of the method used to provide notification to the resident.<br>- delivery method of conclusion<br>- was grievance conclusion accepted or declined?<br>- resident/ responsible party offered conclusion; date notification offered.<br><br>An interview was completed on 1/31/24 at 3:10 PM with the Assistant Director of Nursing (ADON) and revealed the ADON had spoken with NA #1 on 12/13/23 and asked her "can you tell me what happened last night". She stated she did not ask NA #1 specifically about the grievance or the information included in the grievance. The ADON verbalized she did not speak to any other residents, nurses, NAs, or other staff to further investigate Resident #6 grievance complaint. The ADON verbalized she did not ask Resident #6 if she remembered completing a grievance, what she had put in the grievance, or specifics about the grievance she had filed. She stated she did not use the words rough or push when she asked Resident #6 questions. The ADON verbalized the grievance process had been discussed in orientation, but no other specific training had been provided. She explained the Administrator was the grievance official, and the SW assisted with grievances. She verbalized grievances that were brought to the morning meeting by the SW and were given to the respective department for follow up. | F 585 | completed. This audit will be performed five (5) times weekly on Monday, Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then four (4) times weekly on Tuesday, Wednesday, Thursday and Friday for four (4) weeks, and then three (3) times weekly on Monday, Wednesday and Friday for four (4) weeks.<br>The results of these audits will be submitted to the Quality Assurance Activity/Quality Assurance and Performance Improvement (QAA/QAPI) Committee by the Director of Nursing monthly. The QAA/QAPI Committee will determine the need for further monitoring or until substantial compliance is achieved.<br>5. The alleged compliance date is 3/14/2024. | |

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|---|---|---|---|---|
| F 585 | Continued From page 17 | F 585 | | |

A follow up interview was conducted on 2/1/24 at 8:45 AM with the Regional Clinical Director and revealed she did not know NA #2 was the NA who Resident #6 had reported as being rough during care through the grievance she filed on 12/12/23. She stated the facility was investigating the grievance allegation regarding Resident #6. She stated the facility suspended NA #1 originally because her name was on grievance and the facility thought it was against her. She verbalized she did not realize the grievance was about NA #2. She stated the facility suspended NA #2 at the end of the day yesterday pending investigation.

A follow up interview was conducted with the SW on 2/1/24 at 9:26 AM and he explained the Grievance process. The SW stated grievance boxes were located outside the SW's office and outside the dayroom door. He verbalized anyone could fill out a grievance form. The SW stated when he received a grievance, he looked at the grievance and then logged it on the grievance log. The SW explained he would give the grievance to the associated department to be addressed and for follow up. He stated he reviewed open grievances and the ones that have been resolved with department managers in the morning meeting but did not review specifics. He verbalized he only reviewed the resolution of the closed grievances if a manager asked what the resolution was. He explained once a grievance was resolved the department returned the grievance form to him to file in the grievance book. The SW stated he followed up with the resident or RP (Resident Representative) once the grievance was resolved and provided a copy if requested. The SW was asked to explain the "Conclusion of Grievance" section located on the back of the grievance form. The SW reviewed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 585 | Continued From page 18 | F 585 | | |

Resident #6 grievance form and stated the back portion of the form titled "Conclusion of Grievance" should have been completed. The SW stated the person who completed the grievance investigation and follow up should complete the back section of the form titled "Conclusion of Grievance". The SW was unable to specify why the "Conclusion of Grievance" section for Resident #6 grievance was not completed.

An interview was conducted on 2/1/24 with the Director of Nursing (DON). The DON was interviewed regarding the grievance dated 12/12/23 for Resident #6. She was not aware of the grievance prior to 1/30/24 and she revealed the facility was currently following their reporting process and investigating the grievance further. She explained staff should explain to residents what they were going to do. She stated all staff were educated on the grievance process and any staff member could write up a grievance. She stated the grievance official in the building was the Administrator and the SW maintained the grievance log and resolved grievances. the DON verbalized if the SW received the grievance during building hours, he would give the grievance to the DON if the issue was nursing related. She explained if grievances were received during non-business hours the SW would bring them to the morning meeting. She verbalized grievances were distributed to the associated department to complete and then they were returned to the SW to be filed in the grievance book. The DON reviewed the back page of Resident #6 grievance form titled "Conclusion of Grievance". The DON stated she completed all boxes when she completed a "Conclusion of Grievance" section. She

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ________ B. WING ________ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LINCOLNTON REHABILITATION CENTER** | **1410 EAST GASTON STREET LINCOLNTON, NC 28092** |

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|---|---|---|---|---|
| F 585 | Continued From page 19<br>verbalized she expected other staff to complete all boxes on the grievance form as well, for any grievance in any department. She verbalized she could not say if any follow up had been completed with Resident #6 grievance because the "Conclusion of Grievance" section had not been entirely completed.<br><br>An interview was conducted on 2/1/24 at 12:26 PM with the Vice President of Operations and the Regional Clinical Director. They were asked to explain the grievance process and stated anytime a person had a concern they should fill out the grievance form. They verbalized if the issue in the grievance required reporting it should be brought to the DON and Administrator. They stated the SW should receive the grievance, decipher the issue, understand the problem, and then follow through with completing the grievance. They stated after the grievance had resolved the facility should provide the resolution of the grievance to the person or family. They stated the SW should have read the grievance for Resident #6 and reported the grievance to the DON or Administrator. The Vice President of Operations stated failure with Resident #6 grievance was because the facility did not follow the grievance process. He stated the NA should have given the grievance to the nurse and the nurse should have taken the grievance to the DON or Administrator. He stated the facility's grievance process was broken. | F 585 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, | F 600 | | 3/14/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|

F 600

Continued From page 20

neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on record review and staff, Physician, and family interviews the facility neglected to obtain wound care orders on admission, complete and document thorough weekly skin and wound assessments that included measurements and descriptions, the occurrence of a new sacral wound and notify the Physician of the resident's refusal to attend oncology appointments and deterioration of the wounds. Additionally, the facility neglected to involve the family with discharge planning to determine if they were able to provide wound care when the resident was discharged home. This occurred for 1 of 1 resident (Resident #1) reviewed for neglect.

The findings included:

The hospital discharge summary dated 11-24-23 revealed Resident #1 would be discharged to the facility but had no documentation regarding Resident #1's vulvar cancer lesions or wound care orders.

Resident #1 was admitted to the facility on 11-24-23 with multiple diagnoses that included

F 600

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident #1 was discharged from the facility on 12/30/23. On 1/31/2024, the wound care nurse was removed from the schedule by the Director of Nursing.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Any resident that is discharged from the center has the potential to be affected by this deficient practice. On 2/1/2024, current residents with wounds were reviewed to ensure physician orders were in place, including measurements and descriptions and resident or responsible party notification was made.

The center evaluated residents that were discharged in the past 30 days by the

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|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

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|---|---|---|---|---|

F 600 Continued From page 21

vulvar lesions, malignant neoplasm of the vulvar, severe protein-calorie malnutrition.

Nurse #4's admission note dated 11-24-23 did not have any documentation that she had contacted the Physician or hospital for wound care orders to Resident #1's vulvar lesions. There was also no documentation that the facility Physician was made aware of Resident #1's vulvar lesions.

Review of the facility's admission documentation by Nurse #4 dated 11-24-23 revealed an initial skin assessment that documented Resident #1's external vaginal area was red and irritated, her outer labia skin was hard/crusty, and there was a darkened area on Resident #'1's left labia area. The skin assessment also showed Resident #1's bottom was red. There were no wound measurements documented.

A review of the Physician orders dated 11-24-23 revealed an order for weekly skin assessments but there were no orders documented for wound care to Resident #1's vulvar lesions.

A telephone interview occurred with Nurse #4 on 2-14-24 at 1:08 pm. Nurse #4 confirmed she had admitted Resident #1 and had completed the skin assessment on 11-24-23. She explained she had never seen a vulva wound like Resident #1's before and did not know how to describe the wound on the skin assessment. She also said she was unaware she was supposed to measure the wound. Nurse #4 discussed remembering Resident #1's vulvar wound did not have any drainage at the time of admission. She said she could not remember if there were wound care orders from the hospital and stated she had not contacted the facility Physician for wound care

F 600

Director of Nursing on 2/20/2024 to ensure the resident and/or responsible party were discharged with education and instructions on wound care treatment and received the DME they were scheduled to receive.

On 2/20/2024, residents scheduled to be discharged were reviewed by the interdisciplinary team (director of nursing, unit managers, rehabilitation director, social services director) to ensure the resident and/or responsible party have received education on wound care treatment and the responsible party can complete the wound care and medical equipment is scheduled for delivery after discharge.

By 2/20/2024, current residents admitted with wounds in the past 30 days were reviewed by the Director of Nursing/designee to ensure they have physician or specialty physician orders in place, including measurements and descriptions and resident or responsible party notification was complete.

On 2/20/2024, the specialty wound care physician assessed residents with wounds and ensured the wounds had measurements and descriptions in the documentation. There was no resident identified to have deterioration in the wound condition.

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345159 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED C 02/15/2024 |
|---|---|---|---|

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|---|---|---|---|---|

F 600 Continued From page 22

orders. Nurse #4 explained when Resident #1 had been admitted to the facility she was not familiar with the procedure to obtain orders, how to document the wound and the need to measure the wound. She also explained the wound care nurse was responsible for reviewing new admissions for any wound care needs.

Resident #1's care plan dated 11-25-23 revealed the resident was at risk for skin impairment due to limited mobility, weakness, and stage 4 vulvar cancer. Resident #1's goals were to minimize the risk of complications for skin impairments. The interventions included encouraging good nutrition and hydration, keeping skin clean and dry, monitoring for signs and symptoms of infection, turn, and repositioning with care rounds. Resident #1's discharge plan was to return home. The goal for Resident #1 was to verbalize/communicate required assistance post-discharge and the services required to meet her needs before discharge. The interventions included establishing a pre-discharge plan with the resident's family/caregiver and evaluate progress. Revise the plan as needed.

The Physicians admission documentation dated 11-28-23 revealed Resident #1 had multiple comorbidities that included vulvar lesions with some necrotic (dead tissue) and green drainage. The Physician documented his plan to start betadine wet to dry dressings to Resident #1's vulvar lesions.

A Physician order dated 11-28-23 read for Resident #1 to have a betadine wet to dry dressing applied to the right vulvar lesion daily.

Review of Resident #1's Treatment Administration

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recur;

By 2/20/2024, the Director of Nursing/designee provided education to all licensed nursing staff on notification to the physician or specialty physician and resident or responsible party on residents with wounds upon admission and any noted deterioration and to ensure the physician is aware of the residents wishes to not pursue further treatment.

By 2/20/2024, the Director of Nursing/designee re-educated the licensed nurses and wound care nurse on ensuring residents have wound treatment orders, weekly skin integrity documentation on any wounds and ensure the measurements with descriptions are in the medical record.

By 2/20/2024, the Director of Nursing/designee provided education to the licensed nurses to provide education to the discharge process with emphasis on wound care treatment and equipment needs provided to alert and oriented residents and/or resident responsible party upon discharge ensuring the residents caregivers can provide the necessary care and services for the resident.

Newly hired clinical staff will be educated upon hire to notify the physician or specialty physician and resident or responsible party on residents with wounds upon admission and note deterioration prior to their first worked

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|---|---|---|---|
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|---|---|---|---|---|

F 600

Continued From page 23

Record (TAR) from November 2023 through December 2023 revealed Resident #1 had received all wound care treatments as ordered for the vulvar lesions.

The admission Minimum Data Set (MDS) dated 11-30-23 revealed Resident #1 was cognitively intact, did not have any refusal of care, and was documented as having open cancer lesions. The MDS also documented Resident #1 as needing extensive assistance with all activities of daily living care. The MDS further revealed Resident #1 was planning to discharge back into the community and was involved in the discharge process.

The subsequent skin assessments dated 11-30-23, 12-5-23, and 12-12-23 did not contain any description of Resident #1's vulvar cancer lesions and only 12-5-23 contained measurements. There were no skin assessments completed the week of 12-19-23.

Resident #1's vulvar lesion measurement on 12-5-23 was 15.4 centimeters long and 4.9 centimeters wide. This was the only documented measurement in Resident #1's medical record.

A review of the facility's Physician orders revealed an order written on 12-21-23 for wound care to the sacral area that read, clean with normal saline, apply calcium alginate (absorbs wound fluid) to wound bed then cover with a foam dressing daily.

Resident #1's medical record did not contain documentation as to when the sacral wound was first observed or a description of the wound or size of the wound.

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shift.

Newly hired clinical staff will be educated on the discharge process with emphasis on instructions to residents and/or responsible party on wound care and medical equipment needed and to ensure the caregiver can provide the necessary care for the resident.

The clinical services team, director of nursing, unit managers, care plan coordinator and social services director, will review the new admissions daily at the clinical morning meeting to ensure new admissions have orders for wound care treatment and medical equipment scheduled at home.

4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

Starting 3/4/2024 an audit will be initiated by the Director of Nursing/designee on all residents admitted with wounds to ensure physician or specialty wound physician and resident or responsible party notification is complete upon admission and ensure orders are obtained.

On 3/4/2024 an audit will be initiated on current residents with wounds to ensure the physician, specialty wound physician and resident or responsible party is notified, treatment orders are in place, has weekly wound assessment with documentation to include description and measurements.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 600 | Continued From page 24 | F 600 | | |

Review of Resident #1's Treatment Administration Record (TAR) from November 2023 through December 2023 revealed Resident #1 had received all wound care treatments as ordered for the sacral wound.

The skin assessment completed by Nurse #5 on 12-26-23 described the external vaginal area as red/irritated, outer labia skin was hard/crusty, and a darkened area on the left labia. The skin assessment documented Resident #1's sacrum was "red" and there was a "treatment in place" but there were no measurements documented for the vulva lesions or the sacrum wound.

A review of the "interdisciplinary discharge summary" completed by social work, therapy, and nursing dated 12-28-23 revealed Resident #1 was planning to be discharged home on 12-30-23. The discharge summary documented that a referral was made to home health to include physical/occupational therapy and nursing services for medication review but did not include a list of Resident #1's medication or instructions for her wound care.

The home health referral dated 12-28-23 revealed an order for Resident #1 to discharge home on 12-30-23 with a home health evaluation for physical/occupational therapy and nursing services. The home health referral did not include an order for evaluation/treatment for Resident #1's wounds to her vulvar and sacral areas.

Resident #1's medical record revealed a discharge note dated 12-30-23 written by Nurse #2. The discharge note described Nurse #2 performing wound care to Resident #1's vulvar

On 3/4/2024 an audit will be initiated by the Director of Nursing/designee on discharged residents with wounds to ensure the resident and/or responsible party is provided discharge instructions and education for wound care/equipment needs, and the caregiver can provide the necessary care for the residents.

Audits will be performed five (5) times a week for four (4) weeks, then four (4) times weekly for four (4) weeks, and then three (3) times weekly for four (4) weeks. The results of these audits will be submitted to the Quality Assurance Activity/Quality Assurance and Performance Improvement (QAA/QAPI) Committee by the Director of Nursing monthly. The QAA/QAPI Committee will reevaluate the need for further monitoring or until substantial compliance is achieved.

5) Date of completion 3/14/2024.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 600 | Continued From page 25 area as well as her sacrum prior to discharge but did not include any documentation as to the description of the wounds or measurements. The discharge note continued to document that discharge instructions were provided to Resident #1 that included her medications and prescriptions but not instructions on the wound care. Nurse #2 documented that Resident #1 had told her there was a family member who was a nurse and was able to manage her medications and perform the needed wound care.<br><br>The Wound Care (WC) Nurse was interviewed on 1-31-24 9:08 am. The WC Nurse explained Resident #1's Oncologist was monitoring the resident's vulvar lesions but stated she was aware Resident #1 was refusing to attend the appointments, so the facility was monitoring and treating the vulvar lesions. She confirmed she was completing both the wound dressing and wound treatments for Resident #1. The WC Nurse discussed completing weekly wound care assessments on residents with skin impairments and stated she would measure the wounds at that time. The WC nurse confirmed she completed the weekly wound assessments on Resident #1 but had not completed measurements as required. She explained she had not completed a skin assessment on Resident #1 the week of 12-19-23 but had been informed of the sacral wound by a nurse aide (could not remember who) "I think on 12-22-23." She confirmed she had not documented a description of the sacral wound and had not measured it because "I forgot." The WC Nurse said she had not measured or provided specific details about Resident #1's vulvar wound or sacral wound because she was expecting the resident to return to the Oncologist. The WC Nurse revealed Resident #1's vulvar | F 600 | | |

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|---|---|---|---|---|
| F 600 | Continued From page 26 | F 600 | | |

lesions were deteriorating throughout the resident's admission but stated she had not informed the Physician of the deterioration or that Resident #1 was refusing to attend her oncology appointments. She explained she had informed Resident #1of the deterioration and had educated her on the importance of returning to Oncology to have her lesions treated.

An interview with the Physician occurred on 1-30-24 at 2:00 pm, with a follow up telephone interview on 2-13-24 at 11:04am. The Physician discussed first learning about Resident #1's vulvar lesions on 11-28-23 when he performed his admission assessment. He stated at that time Resident #1's vulvar lesion was extensive in the shape of a "V" pattern extending downwards towards her anus. The Physician described the lesion as having necrotic tissue, green colored drainage, and an odor. While reviewing the initial skin assessment written on 11-24-23, the Physician said he had found Resident #1's vulvar lesion "much worse" than how it was described in the initial skin assessment. He stated he thought Resident #1's vulvar lesions were being managed by Oncology and was unaware the resident had been refusing to attend her appointments. The Physician discussed not seeing any documentation of Resident #1's sacral wounds but remembered being informed of the sacral wound and providing orders to treat the wound. He also discussed not being informed of Resident #1's vulvar lesions deteriorating but explained Resident #1 was in a weakened state and due to her extensive comorbidities and cancer, the deterioration was unavoidable. The Physician stated he would have wanted to see more details documented on the skin assessments of how the wounds appeared, if there was any drainage/what

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|---|---|---|---|
| | 345159 | A. BUILDING ____ B. WING ____ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 27<br>type/color of drainage, and measurements.<br><br>An interview was conducted with the Social Worker on 1-30-24 at 3:00 pm. He stated Resident #1 initiated her discharge from the facility and planned to go and stay with a family member. The Social Worker stated he made a referral to a home health agency which included an order for physical/occupational therapy and nursing services to review her medications. He indicated he was not aware of her wound care needs and wound care was not included in the order sent to the home health agency. He stated he received confirmation from the home health agency that they received the order and start of care was scheduled for 1-6-24. The Social Worker stated he also placed an order for the needed medical equipment which included a wheelchair and hospital bed. He stated he was not aware that the needed equipment was not available. He stated he was informed by Resident #1 that she was communicating her discharge needs to the family, so he did not schedule a meeting with them prior to discharge. The Social Worker indicated the family was not present on the day of discharge and Resident #1 was transported to the family home by a wheelchair transport company.<br><br>A telephone interview occurred with Nurse #2 on 1-31-24 at 11:16 am. Nurse #2 confirmed she had discharged Resident #1 on 12-30-23 to home. She stated she could not remember if Resident #1's family was present for the discharge or who she provided the discharge instructions to. Nurse #2 said she had reviewed the wound care treatment with Resident #1 and stated Resident #1 had told her the family knew how to perform her wound care. She explained | F 600 | | |

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|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 600 | Continued From page 28 | F 600 | | |

she had provided "some" wound care supplies to Resident #1 but stated she could not remember if she had provided written wound care instructions. Nurse #2 confirmed she had provided wound care to Resident #1 prior to discharge. She stated she had not documented a description of Resident #1's vulvar lesions or sacral wound and she had not obtained any measurements. Nurse #2 discussed remembering that Resident #1's sacral wound was open and draining. She also remembered Resident #1's vulvar wound had a green drainage with necrotic tissue.

A telephone interview was conducted with Resident #1's family on 1/31/24 at 10:00 am. They stated the facility did not contact them to review Resident #1's discharge instructions or wound care needs prior to her being discharged. They indicated when Resident #1 arrived home on 12/30/23 they were concerned they would not be able to meet her needs. They stated Resident #1 required extensive assistance with mobility and transfers, but the medical equipment company did not have a hospital bed available. The family reported since the hospital bed was not available, they allowed Resident #1 to remain in a recliner chair until her transfer back to the hospital. The family stated they observed Resident #1's vulvar wound to have an odor and green drainage and took her to the hospital for evaluation on 1/2/24.

A follow-up telephone interview was conducted with Resident #1's family on 2-13-24 at 9:55 am. The family stated Resident #1 was totally immobile and was not able to do anything. They provided incontinent care to Resident #1 in the recliner chair. The family explained they were not doing any type of wound care and had no

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 29 | F 600 | | |

intention of touching the wounds. The family stated they did not receive any wound care instructions from the facility or Resident #1 upon her arrival home. The family communicated that Resident #1 had a folder with a face sheet, list of medications, list of diagnoses, and an interdisciplinary discharge summary.

An interview was conducted with the Director of Nursing (DON) on 2-1-24 at 10:25 am. She revealed she was aware Resident #1 was planning to discharge home with family. She stated the Social Worker was responsible for coordinating resident discharges and involving the family in the discharge planning process. The DON indicated Resident #1 was not able to manage her wound care independently and her discharge instructions should have been reviewed with the family.

An interview was conducted with the Regional Nursing Consultant on 2-1-14 at 12:25 pm. She stated resident discharges were an interdisciplinary care team process lead by the Social Worker. She stated the discharge planning was ongoing throughout a resident's stay at the facility. She indicated Resident #1 was cognitively intact however the Social Worker should have asked her permission to involve her family in the discharge planning process. The Regional Nurse Consultant further indicated that Resident #1's care needs including her wound care instructions should have been discussed with the family prior to her discharge from the facility. The Regional Nursing Consultant also stated she had become aware of the issue regarding skin assessments and measuring of resident wounds not being completed on 1-2-24. She explained during Resident #1's stay in the

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|---|---|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 30<br>facility, the facility had staffing issues which caused a lack in management oversite. The Regional Nursing Consultant said there should have been more thorough skin assessments completed, weekly skin assessments to include measurements and the Physician should have been made aware of Resident #1's wound condition. | F 600 | | |
| F 624 SS=D | Preparation for Safe/Orderly Transfer/Dschrg<br>CFR(s): 483.15(c)(7)<br><br>§483.15(c)(7) Orientation for transfer or discharge.<br>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, family member, home health agency, physician and staff interviews, the facility failed to meet the resident's care needs upon discharge by not communicating the physician ordered wound care treatments and ensuring the needed medical equipment was delivered for 1 of 1 resident (Resident #1) reviewed for a safe and orderly discharge.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 11/24/23 and discharged to the family home via wheelchair transport on 12/30/23. Her admitting diagnosis included malignant neoplasm of the vulva. | F 624 | 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>Resident #1 discharged on 12/30/2023.<br>On 1/31/2024, the Director of Nursing provided one on one re-education to nurse #2, who discharged the resident, on providing information to the resident and/or responsible to ensure the resident has a safe and orderly discharge to include wound care.<br>On 1/31/2024, the Social Services Manager was re-educated by regional clinical director on the discharge process and ensuring medical equipment is ordered prior to discharge and delivery of | 3/14/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| F 624 | Continued From page 31<br>Review of the admission Minimum Data Set (MDS) dated 11/30/23 revealed Resident #1 was cognitively intact. She required extensive assistance from staff with toileting, hygiene, bathing, dressing and transfers. The MDS further revealed Resident #1 was planning to discharge back to the community and was involved in the discharge process.<br><br>Review of Resident #1's care plan dated 12/13/23 indicated Resident #1's goal was to discharge home with family.<br><br>Review of the interdisciplinary discharge summary dated 12/28/23 revealed Resident #1 was planning to discharge home with family on 12/30/23 and a referral was made to a home health agency for physical/occupational therapy and nursing to provide a medication review. The discharge summary did not include Resident #1's list of medications or wound care instructions for her vulva and sacral wounds.<br><br>The physician order dated 11/30/23 regarding wound treatment to Resident #1's vulva area stated clean the open vulva lesion area daily with normal saline, apply betadine and allow to air dry.<br><br>The physician order dated 12/22/23 regarding wound treatment to Resident #1's sacrum area stated clean the area with normal saline daily, apply calcium alginate (water absorbing wound dressing) to the wound bed and cover with foam gauze.<br><br>Review of the home health agency referral dated 12/28/23 revealed an order for Resident #1 to discharge home on 12/30/23 with a home health evaluation for physical/occupational therapy and | F 624 | medical equipment is scheduled with the resident and/or resident□s responsible party to ensure the resident has a safe and orderly discharge.<br><br>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br>On 2/13/2024, an initial audit on all residents was completed by the Director of Nurses of residents discharged since 1/1/2024 on resident that were discharged with wounds and needed medical equipment to ensure the discharge process was followed with education needed to have a safe and orderly discharge was provided to the resident and/or responsible party.<br>The audit revealed the discharged residents received the appropriate education to the resident and/or responsible party was completed and documented in the medical record.<br><br>3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>On 1/31/2024, the Social Services Manager was re-educated by regional clinical director on the discharge management process and ensuring medical equipment is ordered prior to discharge and delivery of medical equipment is scheduled with the resident and/or resident□s responsible party to ensure the resident has a safe and orderly discharge. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 624 | Continued From page 32<br>nursing services. The home health referral did not include an order for nursing to evaluate and treat Resident # 1's vulva and sacral wounds.<br><br>A telephone interview was conducted with the home health agency on 2/13/24 at 9:18 am. They confirmed they received the referral for Resident #1 on 12/28/23 for physical/occupational therapy and nursing services. The home health agency verbalized that start of care would have been initiated on 1/6/24 and Resident #1 would have been assessed by the admission nurse who would have completed a full body assessment and addressed the wound care needs at that time.<br><br>The nurse's note (Nurse #2) dated 12/30/23 indicated Resident #1 was being discharged home with family and a referral was made to a home health agency. The discharge packet of information was reviewed with Resident #1 including her list of medications and wound care instructions.<br><br>An interview was conducted with the Physician on 1/30/24 at 2:00pm. The Physician stated Resident #1 was in a weak and vulnerable state and the lesion to her vulva was significant which caused further breakdown to her sacrum area. He stated due to her poor health and nutrition further skin breakdown was unavoidable. The Medical Director indicated it was possible for Resident #1's vulva wound to have worsened during the 3 days she was home after discharge from the facility.<br><br>A telephone interview was conducted with Nurse #2 on 1/31/24 at 11:16 am. She stated she did not recall if Resident #1's family was present on | F 624 | By 2/20/2024, the Director of Nursing provided education to current licensed nursing staff on the discharge management process that includes education and documentation specific to wound care to the resident and/or resident□s representative prior to discharge to ensure a safe and orderly discharge. New licensed nursing staff will be educated upon hire prior to their first worked shift.<br>The interdisciplinary team (social services director, director of nursing, unit managers, and rehabilitation director) will review the discharges 3 days prior to discharge to ensure the discharge management process is followed and all educational needs to include wound care, medical equipment needs are reviewed with the resident and/or responsible party.<br>4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;<br>On 3/4/2024, audits will be initiated on center discharges to ensure the discharge process is completed to include resident and/or responsible party educated on wound care after discharge and given discharge instructions including medical equipment needs, to ensure a safe and orderly discharge. Audits will be conducted five (5) times a week on Monday, Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then four (4) times a week on Tuesday, Wednesday, Thursday and Friday for four (4) weeks, then three (3) times a week on Monday, Wednesday and Friday for four (4) weeks. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 624 | Continued From page 33<br>the day of discharge or if discharge instructions or wound care needs were reviewed with the family. Nurse #2 stated she reviewed the list of medications and wound care instructions for the vulva and sacral wounds with Resident #1. She also gave Resident #1 the needed wound care supplies. Nurse #2 did not recall giving Resident #1 a printed list of medications or wound care instructions.<br><br>An interview was conducted with the Social Worker on 1/30/24 at 3:00 pm. He stated Resident #1 initiated her discharge from the facility and planned to go and stay with a family member. The Social Worker stated he made a referral to a home health agency which included an order for physical/occupational therapy and nursing services to review her medications. He indicated he was not aware of her wound care needs and wound care was not included in the order sent to the home health agency. He stated he received confirmation from the home health agency that they received the order and start of care was scheduled for 1/6/24. The Social Worker stated he also placed an order for the needed medical equipment which included a wheelchair and hospital bed. He stated he was not aware that the needed equipment was not available. He stated he was informed by Resident #1 that she was communicating her discharge needs to the family, so he did not schedule a meeting with them prior to discharge. The Social Worker indicated the family was not present on the day of discharge and Resident #1 was transported to the family home by a wheelchair transport company.<br><br>A telephone interview was conducted with Resident #1's family on 1/31/24 at 10:00 am. | F 624 | The results of these audits will be submitted to the Quality Assurance Activity/Quality Assurance and Performance Improvement (QAA/QAPI) Committee by the Director of Nursing monthly. The QAA/QAPI Committee will reevaluate the need for further monitoring or until substantial compliance is achieved.<br>5) Date of compliance 3/14/2024 | |

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|---|---|---|---|---|

F 624

Continued From page 34

They stated the facility did not contact them to review Resident #1's discharge instructions or wound care needs prior to her being discharged. They indicated when Resident #1 arrived home on 12/30/23 they were concerned they would not be able to meet her needs. They stated Resident #1 required extensive assistance with mobility and transfers, but the medical equipment company did not have a hospital bed available. The family reported since the hospital bed was not available, they allowed Resident #1 to remain in a recliner chair until her transfer back to the hospital. The family stated they observed Resident #1's vulva wound to have an odor and green drainage and took her to the hospital for evaluation on 1/2/24.

An interview was conducted with the Director of Nursing (DON) on 2/1/24 at 10:25 am. She revealed she was aware that Resident #1 was planning to discharge home with family. She stated the Social Worker was responsible for coordinating resident discharges and involving the family in the discharge planning process. The DON indicated Resident #1 was not able to manage her wound care independently and her discharge instructions should have been reviewed with the family.

An interview was conducted with the Regional Nursing Consultant on 2/1/24 at 12:25 pm. She stated resident discharges were an interdisciplinary care team process lead by the Social Worker. She stated the discharge planning was ongoing throughout a resident's stay at the facility. She indicated Resident #1 was cognitively intact however the Social Worker should have asked her permission to involve her family in the discharge planning process. The

F 624

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| | 345159 | A. BUILDING ______<br>B. WING ______ | C<br>02/15/2024 |

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|---|---|---|---|---|
| F 624 | Continued From page 35 | F 624 | | |

Regional Nurse Consultant further indicated that Resident #1's care needs including her wound care instructions should have been discussed with the family prior to her discharge from the facility.

Review of Resident #1's hospital discharge summary dated 1/10/24 revealed she was admitted on 1/02/24 for multiple illnesses including chronic progression of her vulva cancer and sacral wound. The vulva area contained "leathery" eschar (dead tissue) over the wound. Resident #1's hospital record further revealed she was evaluated by general surgery and given the extent of the eschar tissue; simple debridement was not appropriate. There were no specific hospital interventions for Resident #1's wounds documented. The recommendation was for a referral to a specialized care hospital where she could receive multidisciplinary surgery. The specialized care hospital was not accepting new patients, determined the procedure was non-emergent and Resident #1 was discharged home with family.

A follow-up telephone interview was conducted with Resident #1's family on 2/13/24 at 9:55 am. The family stated Resident #1 arrived home via wheelchair transport company. A male family member along with the wheelchair transport driver lifted Resident #1 in the wheelchair up the stairs (3 stairs) into the home. The family did not consider this a struggle for them or the wheelchair transport driver. Resident #1 remained in the wheelchair throughout the whole process and the family did not recall Resident #1 having any signs or symptoms of distress. The family did recall Resident #1 was excited to be home. The family stated Resident #1 was totally

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F 624 Continued From page 36 F 624

immobile and was not able to do anything. They provided incontinent care to Resident #1 in the recliner chair. The family explained they were not doing any type of wound care and had no intention of touching the wounds. The family stated they did not receive any wound care instructions from the facility or Resident #1 upon her arrival home. The family communicated that Resident #1 had a folder with a face sheet, list of medications, list of diagnoses, and an interdisciplinary discharge summary. The family did not reach out to the home health agency due to Resident #1 being discharged on a Saturday as well as it being a holiday weekend. The family stated they took the holiday weekend into account and knew that home health would start the following week. The family transported Resident #1 to the hospital for evaluation of her vulva wound on 1/2/24. A male family member placed Resident #1 in a private vehicle and when they arrived at the hospital a security guard took Resident #1 into the emergency department.

A follow-up telephone interview was conducted with the Physician on 2/14/24 at 9:52am. The Physician stated he was informed Resident #1 had a family member that was aware of the wound care needs and was comfortable performing the ordered treatments when Resident #1 was discharged home. He indicated the ordered wound care treatments were not going to improve Resident #1's vulva and sacral wounds and due to her having multiple comorbidities deterioration of the wounds were unavoidable.

F 684 SS=D Quality of Care F 684
CFR(s): 483.25

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|---|---|---|---|---|
| F 684 | Continued From page 37<br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, and Physician interviews, the facility failed to assess skin impairments for 1 of 2 residents (Resident #1) reviewed for pressure ulcers.<br><br>The findings included:<br><br>The hospital discharge summary dated 11-24-2023 revealed Resident #1 would be discharged to the facility but had no documentation regarding Resident #1's vulva cancer lesions or wound care orders.<br><br>Resident #1 was admitted to the facility on 11-24-2023 with multiple diagnoses that included malignant neoplasm of vulva, cancer lesions vulva area, severe protein-calorie malnutrition.<br><br>Review of the facility's admission documentation by Nurse #4 dated 11-24-2023 revealed an initial skin assessment that documented Resident #1's external vaginal area was red and irritated, her outer labia skin was hard/crusty, and there was a darkened area on Resident #'1's left labia area. The skin assessment also showed Resident #1's bottom was red. There were no wound measurements documented. | F 684 | Past noncompliance: no plan of correction required. | |

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|---|---|---|---|---|
| F 684 | Continued From page 38<br>Resident #1's care plan dated 11-25-2023 revealed the resident was at risk for skin impairment due to limited mobility, weakness, and stage 4 vulvar cancer. Resident #1's goals were to minimize the risk of complications for skin impairments. The interventions included encouraging good nutrition and hydration, keeping skin clean and dry, monitoring for signs and symptoms of infection, turn, and repositioning with care rounds.<br><br>The Physicians admission documentation dated 11-28-2023 revealed Resident #1 had multiple comorbidities that included vulva lesions with some necrotic (dead tissue) and green drainage. The Physician documented his plan to start betadine wet to dry dressings to Resident #1's vulva lesions.<br><br>A Physician order dated 11-28-2023 read for Resident #1 to have a betadine wet to dry dressing applied to the right vulvar lesion daily.<br><br>The admission Minimum Data Set (MDS) dated 11-30-2023 revealed Resident #1 was cognitively intact, did not have any refusal of care, and was documented as having open cancer lesions.<br><br>The subsequent skin assessments dated 11-30-2023, 12-5-2023, and 12-12-2023 did not contain any description of Resident #1's vulva cancer lesions and only 12-5-2023 contained measurements. There were no further skin assessments completed until 12-26-2023 which described the external vaginal area as red/irritated, outer labia skin was hard/crusty, and a darkened area on the left labia. There were no measurements documented for 12-26-2023. | F 684 | | |

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| F 684 | Continued From page 39<br>Resident #1's vulva lesion measurement on 12-5-2023 was 15.4 centimeters long and 4.9 centimeters wide. This was the only documented measurement in Resident #1's medical record.<br><br>A nurse's note dated 12-30-23 written by Nurse #2 revealed Resident #1 was discharged home. The nurse documented she had performed wound care prior to Resident #1 leaving the facility, however there was no documentation of what Resident #1's vulva lesions looked like or measurements.<br><br>The Wound Care (WC) Nurse was interviewed on 1-31-2024 9:08am. The WC nurse explained Resident #1's Oncologist was monitoring the resident's vulva lesions but stated Resident #1 was refusing to attend the appointments, so the facility was monitoring and treating the vulva lesions. The WC nurse discussed completing weekly wound care assessments on residents with skin impairments and stated she would measure the wounds at that time. She said she had not measured or provided specific details about Resident #1's vulva wound or sacral wound because she was expecting the resident to return to the Oncologist. The WC nurse revealed Resident #1's vulva lesions were deteriorating throughout the resident's admission but stated she had not informed the Physician. She explained she had informed Resident #1of the deterioration and had educated her on the importance of returning to Oncology to have her lesions treated.<br><br>During a telephone interview with Nurse #2 on 1-31-2024 at 11:16am, Nurse #2 confirmed she had cared for and discharged Resident #1 on 12-30-2023. She stated she performed wound | F 684 | | |

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|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

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|---|---|---|---|---|
| F 684 | Continued From page 40 | F 684 | | |

care to Resident #1's vulva area and sacral region. Nurse #2 said she was unaware she had to document what the wounds looked like upon discharge or their measurements. She stated the vulva lesion on 12-30-23 had a green discharge and was necrotic.

The Regional Clinical Director was interviewed on 2-1-2024 at 10:24am. The Regional Clinical Director discussed receiving a phone call on 1-2-2024 from Resident #1's family voicing concerns related to the resident's wound care during her admission in the facility. She stated when she began to investigate the concern, she realized assessments had not been completed as ordered/with specific information about the wounds including measurements. The Regional Clinical Director explained she started a Performance Improvement Plan (PIP) on 1-4-2024 related to skin management that included proper assessment/documentation of wounds and performing weekly measurements. The PIP also included education on skin management and audits. She also explained during the time Resident #1 was a resident, there had been some staffing issues and oversite of staff duties was lax. The Regional Clinical Director stated there should have been more thorough skin assessments and measurements completed on Resident #1.

During a telephone interview with the Physician on 2-13-2024 at 11:04am, the Physician stated the first time he was made aware of Resident #1's vulva lesions was when he completed the admission examination on 11-28-2024. Upon being made aware of Nurse #4's initial skin assessment, the Physician stated when he saw Resident #1 on 11-28-2023 her vulva lesions

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|---|---|---|---|---|
| F 684 | | F 684 | | |

Continued From page 41
were "much more severe." He explained the vulva lesion was in a "V" shape extending downwards containing necrotic tissue and a green drainage and odor. The Physician discussed wanting to see on a skin assessment specific information on how the area looked, if there was drainage, odor, any signs or symptoms of infection, and measurements. He stated he was not aware Resident #1 was not receiving weekly skin assessments or that the assessments were not specific. The Physician also said he was not aware that measurements were not being performed weekly. He discussed the difficulty of measuring a cancerous growth but stated he still would have wanted to see measurements. The Physician revealed that he thought Resident #1 was going to the Oncologist for her wound care and was not aware she had been refusing to go to her appointments. He also said he was not made aware of Resident #1's lesions deteriorating but stated due to the resident's multiple comorbidities and cancer, deterioration of the lesions was unavoidable.

The facility provided the following corrective action plan with a completion date of 01/05/24.

1. Resident #1 discharged home with home health on 12/30/2023. The center performed a discharge follow up call on 1/2/24 conducted by Social Services Assistant to Resident #1. During the call, the Social Services Assistant was notified by the resident's family member that Resident #1 was in the hospital.

In a conversation with the family member, concern was noted with cancerous lesion. The family member alleged that a dressing was left in place during the resident's stay. Based upon

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| F 684 | Continued From page 42<br>record review, resident's current treatment was lidocaine external cream 4%, topically, apply every shift to vulvar lesion. In conjunction to apply betadine external solution 10% to the labia/pubis topically every day shift. Additional review of the resident's record revealed missing skin check and measurement of the wound.<br><br>Based upon findings, the center failed to follow skin management protocol. ADHOC QAPI was held on 1/2/2024, to include the Medical Director.<br><br>2. The center conducted a skin audit of all current residents. Audit was conducted by center nurse leadership on 1/3/2024-1/4/2024 with new additional skin integrity findings.<br><br>3. Licensed nurses were in-serviced to check residents' skin on the days they are due and document. They are to notify the physician and responsible party of any skin issues and document response from the physicians and responsible party. They are to follow the skin preventative protocol. Education completed by Staff Development Coordinator/designee by 1/3/2024.<br><br>Certified Nursing Assistants were in-serviced regarding the skin care program. They are to notify the nurse of any skin changes. Education completed by Staff Development Coordinator/designee by 1-3-2024.<br><br>Wound Nurse/Unit Manager will maintain a log of any identified skin issues specifying the origin (pressure, stasis, surgical, etc.) and making sure there are treatments, care plans, preventive measures, MD, and resident representative (RP) notification. Education completed by Staff | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LINCOLNTON REHABILITATION CENTER** | **1410 EAST GASTON STREET** **LINCOLNTON, NC 28092** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 43 | F 684 | | |

Development Coordinator/designee by 1-3-2024.

Residents with pressure ulcers/injuries will be reviewed in a weekly focus meeting. Focus meeting is collaborative meeting with the interdisciplinary team that focuses on specific clinical systems. The interdisciplinary team includes nursing, dietary, therapy, and administrative staff. In respect to wounds, the following areas are reviewed: nutrition, preventative measures, treatments, support surfaces and progress.

Effective 1-5-2024, newly hired staff will be educated during department orientation by the Staff Development Coordinator.

Effective 1-5-2024, Director of Nursing/Unit Managers will audit weekly for skin checks to validate completion.

4. Effective 1-5-2023, data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

Validation of the facility's POC was conducted on 2-1-2024 through record review, staff interviews, and observation of wound care. The licensed nurses interviewed were able to recall the education on skin management and discussed how to document wounds, completing weekly wound assessments which would include measuring resident wounds. The resident records

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 684 | Continued From page 44 reviewed showed recent weekly skin audits that included a description of the resident wounds and measurements. The skin management education was reviewed and contained staff signature sign in sheets. The completion date of 01/05/24 was validated. | F 684 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. | F 867 | | 3/14/24 |

| (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 867 | Continued From page 45<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health | F 867 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ____ B. WING ____ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LINCOLNTON REHABILITATION CENTER** | **1410 EAST GASTON STREET LINCOLNTON, NC 28092** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 46 | F 867 | | |

outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

F 867

Continued From page 47
resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 3-11-21 and 11-10-22. This was for a deficiency in Infection Control (F880). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

The findings included:

This tag was cross referenced to:

F880: Based on record review, observation, and staff interviews the facility failed to implement their infection control policy when the wound care nurse did not perform hand hygiene or don a new pair of gloves after cleaning a wound that was draining and before applying a clean dressing. This occurred for 1 of 3 resident (Resident #9) for pressure ulcer treatment.

During the recertification and complaint investigation conducted on 3-11-21, the facility was cited for facility staff not wearing personal protective equipment (masks, gowns, and gloves) when caring for residents on enhanced droplet precautions.

During a recertification and complaint investigation conducted on 11-10-22, the facility

F 867

1) The center□s Quality Assurance and Assessment (QAA)/Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint investigation survey of 2/15/2024. This included recited deficiencies in the areas of F880 Infection Prevention and Control:

On 1/31/2024, Resident #9 was reassessed, and the wound dressing change was completed by the Assistant Director of Nursing. The center□s Director of Nursing removed the Wound Care nurse from performing further wound treatments and provided immediate education on hand hygiene on dressing change 1/31/2024 prior to termination.

" Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

2) On 2/20/2024, a full center visual assessment was completed by the Wound Care Physician of residents with wounds to ensure no wounds were deteriorating. No residents were identified as being affected. Residents with wounds are being followed by the centers wound specialty physician.

" Address what measures will be put

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 48<br>was cited for staff not performing hand hygiene after removing a dirty dressing and before cleansing the wound.<br><br>The Regional Vice President of Operations was interviewed on 2-1-24 at 12:57 pm. The Regional Vice President of Operations explained he was aware of the past infection control citations but stated he did not know why the processes put in place through Quality Assurance had not been followed. He discussed the wound care nurse had not followed the process for hand hygiene and said he thought it maybe due to a comprehension issue with the wound care nurse. | F 867 | into place or systemic changes made to ensure that the deficient practice will not recur.<br><br>3) On 2/23/2024, the Vice President of Operations conducted education with the Quality Assurance and Assessment (QAA/QAPI) Quality Assurance Performance Improvement (QAPI) Committee on F880 with emphasis on ensuring sustained compliance when deficient practice has been identified and corrected. The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br>The center contacted the Quality Improvement Organization (QIO) for assistance with enhancing our QAA/QAPI process and with their input initiated a center self-assessment with follow-up call with the QIO for assessment and designing next steps in the process.<br>Director of Nursing, Infection Preventionist or Staff Development Coordinator will conduct competency checklists with return demonstration on appropriate hand hygiene during wound dressing changes and general hand hygiene will occur 3 times a week on Monday, Wednesday and Fridays for four (4) weeks and then 2 times a week on Tuesday and Thursday for 4 weeks then weekly on Wednesday for 4 weeks. Thereafter, plans for a quarterly infection control skills fair on 5/7/2024, 8/6/2024 and 11/5/2024 will be held to include wound care and hand | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 867 | Continued From page 49 | F 867 | hygiene. The results of the hand hygiene and wound dressing competencies will be calculated monthly Director of Nursing or Infection Preventionist and presented to the Quality Assurance Assessment/Quality Assurance and Performance Improvement (QAA/QAPI) committee with of a goal of 98%.<br><br>" Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;<br><br>4) Director of Nursing, Infection Preventionist or Staff Development Coordinator will conduct competency checklists with return demonstration on appropriate hand hygiene during wound dressing changes and general hand hygiene will occur 3 times a week on Monday, Wednesday and Fridays for four (4) weeks and then 2 times a week on Tuesday and Thursday for 4 weeks then weekly on Wednesday for 4 weeks. Thereafter, plans for a quarterly infection control skills fair on 5/7/2024, 8/6/2024 and 11/5/2024 will be held to include wound care and hand hygiene. The results of the hand hygiene and wound dressing competencies will be calculated monthly Director of Nursing or Infection Preventionist and presented to the Quality Assurance Assessment/Quality Assurance and Performance Improvement (QAA/QAPI) committee with of a goal of 98%. Performance improvement plans will be initiated should the center not meet its compliance goal by the Director of Nursing monthly. Quality Assurance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 867 | Continued From page 50 | F 867 | Assessment/Quality Assurance and Performance Improvement (QAA/QAPI) Committee will present the findings to the Vice President of Operations and Regional Clinical Director to determine if substantial compliance has been achieved.<br>The alleged compliance date is 3/14/2024. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: | F 880 | | 3/14/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LINCOLNTON REHABILITATION CENTER** | **1410 EAST GASTON STREET LINCOLNTON, NC 28092** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 51<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by: | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345159 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED C 02/15/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

F 880

Continued From page 52

Based on record review, observation, and staff interviews the facility failed to implement their infection control policy when the wound care nurse did not perform hand hygiene or don a new pair of gloves after cleaning a wound that was draining and before applying a clean dressing. This occurred for 1 of 3 resident (Resident #9) for pressure ulcer treatment.

The findings included:

The facility's infection control policy titled "Hand Washing/Hygiene" dated 6-5-19 revealed hand hygiene should be performed after contact with a resident's mucous membranes, body fluids or secretions.

Review of the facility's "Skin Management Guide" dated October 2020 revealed a section titled "Clean Dressing Change." The guide documented that after cleaning a wound as ordered the nurse would remove her gloves, perform hand hygiene, and don a new pair of gloves then apply the clean dressing.
Resident # was admitted to the facility on 6-20-22 with multiple diagnoses that included stage 4 pressure ulcer to lower back.

The quarterly Minimum Data Set (MDS) dated 1-18-24 revealed Resident #9 was moderately cognitively impaired.

An observation of wound care with Resident #9 occurred on 1-31-24 at 8:45am with the wound care nurse. Resident #9 wound was open with moderate drainage. The wound was observed not to have any odor or signs/symptoms of infection. The wound care nurse was observed to wash her hands, don a pair of gloves, and proceed to clean

F 880

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
On 1/31/2024, Resident #9 was re-assessed, and the wound dressing change was completed by the Assistant Director of Nursing. The center□s Director of Nursing removed the Wound Care nurse from performing further wound treatments and provided immediate education on 1/31/2024 to perform handwashing/hand hygiene prior to removing a dressing, after removing a dressing, and prior to placing the new dressing on the resident prior to termination.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 2/20/2024, a full center visual assessment was completed by the Wound Care Physician of residents with wounds to ensure no wounds were deteriorating. No residents were identified as being affected. Residents with wounds are being followed by the centers wound specialty physician.

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
By 2/20/2024, licensed nursing staff were re-educated on the handwashing/hygiene policy by the Director of Nursing, staff development coordinator), and center□s infection control preventionist. By

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLNTON REHABILITATION CENTER | 1410 EAST GASTON STREET LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

F 880 Continued From page 53

Resident #9's pressure ulcer. She then proceeded, without performing hand hygiene or changing her gloves, to open a foam dressing package and apply a clean dressing to Resident #9's pressure ulcer. After completing the wound care, the wound care nurse then doffed her dirty gloves and performed hand hygiene.

The wound care nurse was interviewed on 1-31-24 at 9:08am. The wound care nurse explained when performing wound care, she would perform hand hygiene and don new gloves after removing the old dressing, touching any dressing packages, and cleaning the wound. She further explained hand hygiene and donning new gloves were required prior to applying a clean dressing. The wound care nurse discussed her steps during her wound care with Resident #9. While discussing her steps with Resident # 9 wound care, the wound care nurse stated she had not performed hand hygiene or donned new gloves after cleaning Resident #9 wound and before applying a new dressing. The wound care nurse stated she was unaware she needed to perform hand hygiene and don new gloves after cleaning a wound and before applying a new dressing. She said she had received education on wound care management that included how to perform dressing changes in January 2024.

During an interview with the Director of Nursing (DON) on 1-31-24 at 10:47am, the DON explained the procedure for providing wound care. She discussed the nurse should ask the resident about pain, gather supplies, perform hand hygiene, don gloves, remove old dressing, perform hand hygiene, don new gloves, clean the wound, perform hand hygiene, don new gloves, and apply clean dressing to the wound. The DON

F 880

2/20/2024, the licensed nursing staff were re-educated by the Director of Nursing, Staff Development Coordinator, and Infection Preventionist on the wound competency checklist that includes performing hand hygiene and donning a new pair of gloves after cleaning a wound and before applying a clean dressing. Newly hired employees will be educated on the center□s infection control policy related to hand hygiene. All newly hired licensed nurses will complete the wound competency checklist prior to their first worked shift.

4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Beginning on 2/26/2024, audits will be conducted by the Director of Nursing, Infection Preventionist or Staff Development Coordinator on hand hygiene and wound dressing changes to include hand hygiene, donning and doffing a gloves after removing a dressing and before applying a new dressing to the wound to ensure compliance with the center□s infection control policy. This audit will include 5 observations daily and to be performed five (5) times weekly on Monday, Tuesday, Wednesday, Thursday, and Friday for four (4) weeks, then four (4) times weekly on Tuesday, Wednesday, Thursday, and Friday for four (4) weeks, and then three (3) times weekly on Monday, Wednesday and Friday for four (4) weeks. An audit on wound dressing changes to include hand hygiene and donning a new pair of gloves

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING ____ B. WING ____ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (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 |
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F 880

Continued From page 54

confirmed the wound care nurse should have performed hand hygiene and donned a new pair of gloves after cleaning Resident #9 pressure ulcer and before applying a clean dressing. She also confirmed the wound care nurse had received education on wound care management that included how to perform a dressing change. The DON said she did not know why the wound care nurse would not have followed the hand hygiene procedures.

An interview with the Assistant Director of Nursing (ADON) occurred on 2-1-24 at 9:23am. The ADON explained during wound care, the nurse would perform hand hygiene and don a pair of gloves prior to cleaning a resident's pressure ulcer and then perform hand hygiene and don a new pair of gloves before applying a clean dressing. She stated she did not know why the wound care nurse had not followed the procedure for changing a wound dressing on Resident #9 and said the wound care nurse had received education on wound care management that included how to perform dressing changes.

The Regional Clinical Director was interviewed on 2-1-24 at 10:24am. The Regional Clinical Director discussed having a performance improvement project with education on skin management that was started on 1-4-24 which included a clean dressing change competency evaluation. She stated she did not know why the wound care nurse would not follow the clean dressing change procedure when performing the pressure ulcer wound care on Resident #9 but said the wound care nurse could have been nervous. The Regional Clinical Director confirmed the wound care nurse had completed the education and competency on performing clean dressing

F 880

after cleaning a wound and before applying a clean dressing will be conducted. This audit will include 2 observations daily and to be performed five (5) times weekly for four (4) weeks, then four (4) times weekly for four (4) weeks, and then three (3) times weekly for four (4) weeks.
The results of these audits will be submitted to the Quality Activity Assurance/Quality Assurance and Performance Improvement Committee (QAA/QAPI) by the Director of Nursing monthly. The QAA/QAPI Committee will reevaluate the need for further monitoring or until substantial compliance is achieved.
5) The alleged compliance date is 3/14/2024.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 345159 | A. BUILDING ______ B. WING ______ | C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
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| F 880 | Continued From page 55<br>changes. | F 880 | | |