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 01/04/2019

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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring 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).	F 580		1/31/19

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

Electronically Signed | 01/25/2019

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F 580	Continued From page 1 §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 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician interviews the facility failed to notify the Physician of changes in the resident's condition for 1 of 1 residents reviewed for changes in condition (Resident #4). The findings included: Resident #4 was admitted to the facility 04/04/18 with diagnoses including Alzheimer's disease, seizure disorder, hematuria (blood in the urine), obstructive uropathy (a condition where the flow of urine is blocked), benign prostatic hypertrophy (a condition where the prostate is enlarged, pushes against the bladder and urethra, and blocks the flow of urine), and hypertension (high blood pressure). Review of Resident #4's care plan for being at risk for pain related in part to benign prostatic hypertrophy with obstructive uropathy last updated 09/28/18 revealed he was to be assessed for pain and have relief from intensity within 1 hour after intervention. Review of the quarterly Minimum Data Set (MDS) dated 10/02/18 revealed Resident #4 was	F 580	Interventions for the affected Residents(s): Resident #4 discharged from the facility 12/25/2018. Root Cause: Nurses failed to notify the physician that the resident was showing signs of pain and had blood tinged urine. The nurses failed to understand the importance of documenting notification of change in residents condition reported to the physician and responsible party of the resident. Identification and Interventions for residents identified as having the potential to be affected: All residents residing at the facility have the potential to be affected by the deficient practice. On or by (please 1/31/2019 a audit was done on 100 Percent of charts for the previous two weeks to identify changes in conditions that the MD and or RP (responsible party) was not notified. Those identified as not having	

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F 580	Continued From page 2	F 580		

severely impaired for cognition. The MDS also revealed Resident #4 required extensive assistance with toileting and was always incontinent of bowel and bladder.

Review of Nurse #9's note dated 11/21/18 stated Resident #4 continued to complain of pain with urination and was straightening his legs and yelling when he had to urinate.

A telephone interview with Nurse #9 on 01/04/19 at 12:33 PM revealed she wrote the note dated 11/21/18. Nurse #9 stated she did not perform any intervention for Resident #4 other than encourage fluids because he had recently had a negative urinalysis and the doctor was aware that he was having urinary symptoms.

A telephone interview with the Physician on 01/04/19 at 2:57 PM revealed he would have expected to have been notified of Resident #4's complaints of pain.

Review of Nurse #3's note dated 11/27/18 stated she was called to Resident #4's room by a nurse aide (NA) because the NA stated Resident #4 had blood tinged urine in his incontinence brief. Nurse #3's note stated Resident #4's last urinalysis was negative for infection and he had been on antibiotics for a period of time ordered by the Physician. Nurse #3's note stated she would pass the information on to the oncoming shift and would continue to monitor Resident #4 for signs and symptoms of a urinary tract infection.

Nurse #3 was not available for interview after multiple attempts to contact her.

A telephone interview with the Physician on

documentation to support notification, were notified on or by 1/31/2019.

All nurses were provided with education on the requirements to notify the physician of any change in a resident's condition and the need for proper documentation of the notification and subsequent orders to ensure all pertinent information is available to the physician.
Education was completed by the DON and/or her Designee on or by 1/25/2019.

Systemic Change:

Education will be provided at time of orientation to all nurses regarding notification and documentation of change in condition.
As of 1/25/2019 and moving forward the Physician will be notified of changes in a residents condition and any new orders will be processed timely. A random audit of 6 residents weekly x 4 weeks, then 6 monthly x 2 months will be conducted by the DON/Designee.

Monitoring of the change to sustain system compliance ongoing:

Monthly for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee (QAPI). The QAPI will review the audit information and will make recommendations as to the need for further monitoring.

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F 580	Continued From page 3 01/04/19 at 2:57 PM revealed he would have expected to have been notified of Resident #4 having blood tinged urine. An interview with the Director of Nursing on 01/04/19 at 3:45 PM revealed she expected nurses to notify the Physician of any change in a resident's condition. An interview with the Administrator on 01/04/19 at 4:00 PM revealed he expected nurses to notify the Physician of any changes in a resident's condition.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Sets (MDS) for 2 of 7 sampled residents. Resident #2's MDS did not accurately reflect a skin condition and Resident #3's MDS did not accurately reflect hospice services. The findings included: 1. Resident #2 was admitted to the facility from the hospital on 09/27/18. His admission diagnoses included congestive heart failure, atrial fibrillation, cellulitis of the left lower extremity, and muscle weakness. Resident #2 was discharged to the facility on amoxicillin-clavulantate (an oral antibiotic) for the lower extremity cellulitis.	F 641	Interventions for the affected resident(s): Resident #2 was discharged from the facility on 10/27/2018. Root cause for Resident #2: The Minimum Data Set (MDS) nurse reviewed a wound consult from the Quality Surgical Management wound Nurse Practitioner dated for 10/8/2018 that was outside the Assessment Reference Date (ARD) date of 10/4/2018. The MDS nurse(s) were provided with education to only use information and supporting documentation during the 7 day look back period to support coding of skin integrity. Modification was completed and submitted to Centers for Medicare &	1/31/19

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F 641	Continued From page 4	F 641		

Review of the hospital records revealed no other skin integrity issues.

There were no admission notes or any documentation which noted Resident #2's skin was observed the day of admission.

Resident #2 was seen by the physician on 09/28/18. The physician noted this as a admission note and noted trace pedal edema. The progress note included orders for skin prep twice a day to both heels, and zinc oxide and cover with optifoam to the right forearm at the elbow to be completed daily and a needed. There was no further description of the heels or elbow.

Resident #2's physician (MD) was interviewed on 01/04/19 at 12:56 PM. MD stated that she should have written a more thorough note and described the wounds for which she ordered treatment. She stated that there was most likely something on Resident #2's heels since she ordered skin prep. She stated she could not recall specifically but stated she would have written the skin prep was "for prevention" if there was nothing on his heels. She could not recall if they were boggy, blistered or a deep tissue injury. She wanted the skin prep to be used to toughen the heels, which she stated most likely would have opened anyway even with the skin prep. MD further stated she would have expected the orders to be processed and started immediately. She could not recall who she handed the orders to on 09/28/18.

Review of the facility Resident Data Set, (the admission nursing assessment), Resident #2 was admitted on 09/27/18 at 6:15 PM. Different sections of this assessment were completed by

Medicaid Services (CMS) by 1/25/2019./

The education was done by the Clinical Process Analyst on 1/23/2019.

Resident #3 Was discharged from the facility on 10/30/2018.

Root cause for Resident #3 MDS nurse missed checking box for coding Hospice on residents discharge assessment due to an oversight while checking oneself. A modification of the assessment was completed and submitted to Centers for Medicare & Medicaid Services (CMS) on 1/9/2019.

Interventions for residents identified as having the potential to be affected:

All residents who received had wounds would be at risk for the same deficient practice. All residents receiving respite hospice services would be at risk for the same deficient practice. Audit was completed in both of these areas on 1/23/2019 by the Clinical Process Analyst. No other residents were identified. On January 23th education was completed by the Clinical Process Analyst on accuracy of assessments including the staging of wounds and use of hospice services. Education provided included both Minimum Data Set (MDS) nurses, the Director of Nursing (DON) and Staff development

Systemic Change:

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F 641	Continued From page 5 different nurses and on different dates ranging from 09/27/18 through 10/02/18. The skin assessment section was dated 09/30/18 by Nurse #2 who noted on the right elbow was an open area described as 2 centimeters (cm) by 1.5 cm and on the left heel was an open area described as 3.5 cm by 2 cm. The skin was noted warm and dry, with bruising and a skin tear. Pressure ulcer/sore was not checked and open lesions was not checked. The section of foot problems and care was signed by Nurse #2 and dated 09/30/18. There was no check by the resident having one or more foot problems, and cellulitis was not checked. There was a check by "open lesions other than ulcers, rashes, cuts, (e.g. cancer lesions)." Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for September 2018 revealed no treatments were administered to Resident #2's feet or elbow until 10/01/18. The first nursing progress note regarding Resident #2's skin was dated 10/01/18 at 8:18 AM, marked as a late entry but did not specify what day or time the late entry reflected. The note stated "Was advised that this is a new pt (patient) & that his skin issues need to be addressed--pt had +3 edema to BLE (bilateral lower extremity) with lt (left) leg worse than rt (right)--Pth (patient) has an area to Lt medial heel that is broken & draining a moderate amount of foul smelling tan fluid this area measures 4 cm x 4 cm in diameter & 0.5 cm in depth--when cleaning wound bed a large amount of yellow slough is noted, but there is also bright red blood during the cleaning process--pt tolerated assessment & dressing change well & has no c/o	F 641	As of January 25, 2019 and moving forward, the nurses have been educated on skin assessments related to all new admissions and readmission skin evaluations completed on the day of admission. The skin evaluation will also be reviewed in the daily clinical meeting to ensure it is completed timely. This information will also be included in the new hire orientation of newly hired nurses, A Random audit of 2 admissions (if available) will be reviewed weekly x4, then 5 monthly x 2 months by the DON for compliance. As of January 25, 2019 and moving forward, assessments for residents receiving Hospice services completed by the second MDS nurse will be reviewed by the lead MDS nurse to ensure Hospice services are coded accurately. Prior to submission to Centers for Medicare & Medicaid Services (CMS). A Random audit of 3 of residents receiving Hospice, will be reviewed by the DON/Designee monthly x 3 months. Monitoring the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit results to the QAPI Committee. T. Results will be tracked and trended and submitted to the QAPI Committee. Based on the information received the QAPI Committee will determine the need for ongoing	

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F 641	Continued From page 6	F 641		

(complaints) at this time." This note was signed by Nurse #3.

Resident #2 was seen by the Nurse Practitioner on 10/01/18 and noted left lower extremity had +3 edema. No additional notes were documented about his feet and no orders were noted for skin treatment.

Interview via phone with Nurse #2 on 01/03/19 at 3:20 PM revealed she vaguely recalled Resident #2 and did not think she worked on 09/27/18 or 09/28/18 (confirmed via the working schedules). She stated that she worked weekends and when she came to work she tried to make sure all new admission assessments were completed. Nurse #2 stated that the admitting nurse was to complete the skin assessments and she would be a second set of eyes on the wounds. She further stated she could not recall details but that if there was a wound, as per the skin assessment, she would have initiated a treatment and dressed the elbow and foot on 09/30/18.

The admission Minimum Data Set (MDS dated 10/04/18 noted Resident #2 was coded as having intact cognition, required extensive to total assistance with most activities of daily living skills and having one stage 3 pressure ulcer upon admission.

A nurse practitioner note dated 10/05/18 noted this was an acute visit and there was left heel drainage and this was a stage 2 wound. She wrote new treatment orders for calcium alginate.

The Pressure Ulcer/Injury Care Area Assessment (CAA) dated 10/10/18 listed under diagnoses cellulitis left lower extremity. She noted "Resident

auditing.

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F 641	Continued From page 7	F 641		

acquired a stage 3 pressure ulcer to left heel during hospitalization. Also has a skin tear to right elbow and treated by wound MD." Per the CAA, under resident and or family representative, Resident #2 got the pressure ulcer in the hospital.

An interview with the MDS nurse who completed the MDS and CAA was conducted on 01/03/19 at 9:23 AM. MDS nurse stated that she did not observe the wound herself but must have gotten the information about the pressure sore from somewhere. Upon follow up interview with the MDS nurse on 01/04/19 at 10:28 AM, the MDS nurse could not produce any documentation supporting the coding of a stage 3 pressure ulcer for Resident #2 being present upon admission. She further stated that perhaps the resident himself told her he got a pressure sore in the hospital but that she could not identify any documentation of a pressure ulcer upon admission.

Interview with the Director of Nursing on 01/04/19 at 10:44 AM revealed she could not locate any documentation that Resident #2 had a stage 3 pressure ulcer present on admission.

Interview with the administrator on 01/04/19 at 4:01 PM revealed he expected that the MDS information be accurate and explainable by documentation.

2. Resident #3 was admitted to the facility on 10/25/18 with diagnoses including Alzheimer's disease and heart disease.

A discharge Minimum Data Set (MDS) dated 10/30/18 indicated Resident #3 was not coded under Section O-Special Treatments and Programs as receiving hospice care.

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F 641	Continued From page 8 A review of Resident #3's medical record revealed daily communication notes from Hospice and Palliative Care dated 10/25/18-10/30/18. The MDS nurse for Resident #3 was interviewed 01/03/19 at 2:27 PM regarding the accuracy of Resident #3's discharge MDS. The MDS did not reflect hospice care for Resident #3. The MDS nurse stated the MDS should have been coded to reflect Resident #3 was receiving hospice care and it was an oversight that hospice was not coded. The MDS nurse stated the discharge MDS would require a correction to reflect Resident #3 was receiving hospice care. On 01/04/18 at 3:54 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the discharge MDS would have been coded accurately to reflect Resident #3 was receiving hospice care. The DON also stated she expected a correction to the discharge MDS to reflect Resident #3 was receiving hospice care. On 01/04/18 at 4:01 PM an interview was conducted with the Administrator. The Administrator stated it was his expectation that the MDS be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		1/31/19

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F 658	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interview, the facility failed to transcribe and process treatment orders for 2 days for 1 of 4 residents sampled with skin integrity issues (Resident #2). The findings included: Resident #2 was admitted to the facility from the hospital on 09/27/18. His admission diagnoses included congestive heart failure, atrial fibrillation, cellulitis of the left lower extremity, and muscle weakness. Per the hospital discharge orders, Resident #2 was discharged to the facility on amoxicillin-clavulantate (an oral antibiotic) for the lower extremity cellulitis. Resident #2 was seen by the physician on 09/28/18. The physician noted this as an admission note and noted trace pedal edema. The progress note included orders for skin prep twice a day to both heels, and zinc oxide and cover with optifoam to the right forearm at the elbow to be completed daily and a needed. This note was not initialed by any nurse indicating the orders were processed. Review of the facility Resident Data Set, (the admission nursing assessment), Resident #2 was admitted on 09/27/18 at 6:15 PM. Different sections of this assessment were completed by different nurses and on different dates ranging from 09/27/18 through 10/02/18. The skin assessment section was dated 09/30/18 by Nurse #2 who noted on the right elbow was an open area described as 2 centimeters (cm) by 1.5 cm and on the left heel was an open area described	F 658	Interventions for those affected Resident #2 was discharged from the facility on 10/27/2018. . Root Cause: The Physician wrote physician orders in the body of a progress note and the order was not processed for two days. MD unable to recall who she handed the orders to on 9/28/2018. The Physician□s normal practice was to give her progress notes to the unit manager to review after completing his/her rounds. The unit manager would review the progress notes and transcribe orders noted in the progress notes over to orders in PCC/telephone orders. On this particular day the Physician did not give her progress notes to the unit manager. She did not recall who she gave the progress notes to. The facility could not confirm what nurse received the progress notes and or if they knew to review the progress notes in efforts to transcribe order into PCC. Interventions for residents identified as having the potential to be affected: All residents rounded on by the physician have a potential to be affected by the alleged deficient practice. Physician/extenders were educated by 1/31/2019 , going forward from this date Physicians are to write orders on a telephone order and all progress notes will be given to the unit managers, SDC and	

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F 658	Continued From page 10 as 3.5 cm by 2 cm. The section of foot problems and care was signed by Nurse #2 and dated 09/30/18. Review of the computerized physician orders for September 2018 and October 2018 revealed orders dated: *09/30/18 skin prep to bilateral heels twice a day to start 10/01/18. *09/30/18 cleanse right forearm at elbow with wound cleanser, apply zinc oxide and cover with optifoam every day to start 10/01/18. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for September 2018 and October 2018 revealed the left heel wound, right elbow and the skin prep to both heels were not treated until 10/01/18. Interview via phone with Nurse #2 on 01/03/19 at 3:20 PM revealed she vaguely recalled Resident #2 and stated that she worked weekends and when she came to work she tried to make sure all new admission assessments were completed which included the skin assessment for Resident #2. She further stated she could not recall details of Resident #2's elbow and feet but that if there was a wound she would have initiated a treatment and dressed the elbow and foot on 09/30/18. During an interview on 01/04/19 at 10:44 AM, the Director of Nursing (DON) stated it was typical that the physician would have evaluated the resident the day after admission. The physician then writes a note and hands the note with any orders documented on the note to a nurse who would then process the orders. If a new area is noted by a nurse, that nurse was supposed to	F 658	or DON to review for physician orders that need to be transcribed to PCC orders or telephone orders. Systemic Change: As of 1/31/2019 and moving forward the Physicians have been educated on the acceptable forms to write physician orders. A random audit of 4 residents receiving physician visits weekly x 4 weeks, then 6 monthly x 2 months will be conducted by the DON/Designee. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee (QAPI). The QAPI committee will determine the need for further auditing and or monitoring.	

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 01/04/2019

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 658	Continued From page 11	F 658		

notify the physician and obtain orders and immediately start the treatments. She further stated that depending on the time of day the orders will not populate to the MAR until the following day.

Resident #2's physician (MD) was interviewed on 01/04/19 at 12:56 PM. MD stated that she should have written a more thorough note and described the wounds for which she ordered treatment. She stated that there was most likely something on Resident #2's heels since she ordered skin prep. She stated she could not recall specifically but stated she would have written the skin prep was "for prevention" if there was nothing on his heels. She could not recall if they were boggy, blistered or a deep tissue injury. She wanted the skin prep to be used to toughen the heels, which she stated most likely would have opened anyway even with the skin prep. MD further stated she would have expected the orders to be processed and started immediately. She could not recall who she handed the orders to on 09/28/18.

Nurse #4, day shift nurse who worked on 09/28/18, was interviewed on 01/04/19 at 3:05 PM. Nurse #4 stated she recalled the MD coming the morning of 09/28/18 and seeing Resident #2. Nurse #4 did not round with the MD and sometimes the MD made rounds by herself. Nurse #4 stated anyone can process orders and that the MD can hand her notes with the orders to any nurse. She further stated that if she had been given the note, she would have initialed and dated next to the orders that she processed them. Together, reviewing the MD note reflected no one initialed as processing the orders for the heels or the elbow.

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	345159	A. BUILDING _____ B. WING _____	C 01/04/2019

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F 658	Continued From page 12 Interview with Nurse #5, the unit manager, on 01/04/19 at 3:35 PM revealed the MD can give any nurse her notes to be processed. Nurse #5 stated she did not round with the MD on 09/28/18. Nurse #5 stated the admitting nurse should complete the initial assessment. She stated that she looked back at the time clock report and Nurse #6 was the nurse on duty at the time Resident #2 was admitted. Interview with the administrator on 01/04/19 at 4:01 PM revealed he expected that physician orders were processed the same day they are written and carried out immedately.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to assess a newly admitted resident for skin integrity issues and follow up with physician ordered treatments for two days for 1 of 4 residents sampled for skin issues. (Resident #2). The findings included: Resident #2 was admitted to the facility from the	F 684	Resident #2 was discharged from the facility on 10/27/18. Root Cause: The Physician wrote physician orders in the body of a progress note and the order was not processed for two days. MD unable to recall who she handed the orders to on 9/28/2018. The Physician□s normal practice was to give her progress notes to the unit manager to review after completing	1/31/19

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	345159	A. BUILDING _____ B. WING _____	C 01/04/2019

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F 684	Continued From page 13 hospital on 09/27/18. His admission diagnoses included congestive heart failure, atrial fibrillation, cellulitis of the left lower extremity, and muscle weakness. Per the hospital discharge orders, Resident #2 was discharged to the facility on amoxicillin-clavulantate (an oral antibiotic) for the lower extremity cellulitis. Review of the hospital records revealed no other skin integrity issues or orders for skin treatments. There were no admission notes or any documentation which noted Resident #2's skin was observed the day of admission. Resident #2 was seen by the physician on 09/28/18. The physician noted this as a admission note and noted trace pedal edema. The progress note included orders for skin prep twice a day to both heels, and zinc oxide and cover with optifoam to the right forearm at the elbow to be completed daily and a needed. There was no further description of the heels or elbow. These orders were not signed off by any nurse indicating they had been processed. Review of the facility Resident Data Set, (the admission nursing assessment) revealed Resident #2 was admitted on 09/27/18 at 6:15 PM. Different sections of this assessment were completed by different nurses and on different dates ranging from 09/27/18 through 10/02/18. The skin assessment section was dated 09/30/18 by Nurse #2 who noted on the right elbow was an open area described as 2 centimeters (cm) by 1.5 cm and on the left heel was an open area described as 3.5 cm by 2 cm. The skin was noted warm and dry, with bruising and a skin tear. Pressure ulcer/sore was not checked and open	F 684	his/her rounds. The unit manager would review the progress notes and transcribe orders noted in the progress notes over to orders in PCC/telephone orders. On this particular day the Physician did not give her progress notes to the unit manager. She did not recall who she gave the progress notes to. The facility could not confirm what nurse received the progress notes and or if they knew to review the progress notes in efforts to transcribe order into PCC. Interventions for residents identified as having the potential to be affected: A 100 Percent audit of the physician progress notes written in the last 2 weeks (1/7/2019 to 1/24/2019) was completed by 1/31/2019 to identify any other residents affected by the alleged deficient practice . The audit was completed by 1/31/2019 by the DON and/or Designee. Physician, RP and Medical Record will be notified of any discrepancies. Education was completed by the DON/Designee on or by 1/31/2019. Systemic Change: The physicians were educated on the correct forms to use when writing telephone orders. As of 1/31/2019 and moving forward the Physicians will write out all orders on a physicians telephone order to then be process into the medical record. A random audit of 4 residents receiving physician visits weekly x 4	

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	345159	A. BUILDING _____ B. WING _____	C 01/04/2019

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F 684	Continued From page 14 lesions was not checked. The section of foot problems and care was signed by Nurse #2 and dated 09/30/18 with no check by the resident having one or more foot problems, and cellulitis was not checked. There was a check by "open lesions other than ulcers, rashes, cuts, (e.g. cancer lesions)" under the foot problem section. Review of the computerized physician orders for September 2018 and October 2018 revealed orders dated: *09/30/18 to cleanse open area to left heel with normal saline, apply calcium alginate and cover with foam dressing. Change daily and as needed to start 10/01/18. *09/30/18 skin prep to bilateral heels twice a day to start 10/01/18. *09/30/18 cleanse right forearm at elbow with wound cleanser, apply zinc oxide and cover with optifoam every day to start 10/01/18. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for September 2018 and October 2018 revealed the left heel wound, right elbow and the skin prep to both heels were not treated until 10/01/18. The first nursing progress note regarding Resident #2's skin was dated 10/01/18 at 8:18 AM, marked as a late entry but did not specify what day or time the late entry reflected. The note stated "Was advised that this is a new pt (patient) & that his skin issues need to be addressed--pt had +3 edema to BLE (bilateral lower extremity) with lt (left) leg worse than rt (right)--Pth (patient) has an area to Lt medial heel that is broken & draining a moderate amount of foul smelling tan fluid this area measures 4 cm x	F 684	weeks, then 6 monthly x 2 months will be conducted by the DON/Designee. Monitoring of the change to sustain system compliance ongoing: Monthly monitoring for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee (QAPI). QAPI will review the audits to make recommendations to ensure compliance is ongoing and determine the need for further ongoing auditing.	

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F 684	Continued From page 15	F 684		

4 cm in diameter & 0.5 cm in depth--when cleaning wound bed a large amount of yellow slough is noted, but there is also bright red blood during the cleaning process--pt tolerated assessment & dressing change well & has no c/o (complaints) at this time." This note was signed by Nurse #3.

Resident #2 was seen by the Nurse Practitioner on 10/01/18 and noted left lower extremity had +3 edema (swelling). No additional notes were documented about his feet and no orders were noted for skin treatment.

Interview with Nurse #1 on 01/03/19 at 2:54 PM revealed that if a resident was admitted with treatment orders those orders were processed. If the resident had a skin issue and no treatment orders, the nurse was to call the physician and initiate orders and treat depending on the type of wound. Nurse #1 stated she was the supervisor for Resident #2 in September 2018. She further stated she would have started the assessment on admission but always left the wound and feet sections to the hall nurse which she assumed was Nurse #2 as she completed the skin section on the resident data sheet.

Interview via phone with Nurse #2 on 01/03/19 at 3:20 PM revealed she vaguely recalled Resident #2 and did not think she worked on 09/27/18 or 09/28/18 (confirmed via the working schedules). She stated that she worked weekends and when she came to work she tried to make sure all new admission assessments were completed. Nurse #2 stated that the admitting nurse was to complete the skin assessments and she would be a second set of eyes on the wounds. She further stated she could not recall details but that if there

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F 684	Continued From page 16	F 684		

was a wound she would have initiated a treatment and dressed the elbow and foot on 09/30/18.

A phone interview with Nurse #3, who was scheduled as the treatment nurse on 09/27/18 and 09/28/18, was conducted on 01/04/19 at 3:58 PM. Nurse #3 could not recall details but thought Resident #2 came with skin integrity issues on his foot. She stated she was helping out with treatments during the end of September and thinks the first time she saw the wound on his foot, it had a dressing already in place.

During an interview on 01/04/19 at 10:44 AM, the Director of Nursing (DON) stated the skin evaluation should be completed the day of admission. In addition to being documented on the facility Resident Data Set, there should have also been a nursing progress note about any wounds. DON stated it was typical that the physician would have evaluated the resident the day after admission. The physician then writes a note and hands the note with any orders documented on the note to a nurse who would then process the orders. If a new area is noted by a nurse, that nurse was supposed to notify the physician and obtain orders and immediately start the treatments. She further stated that depending on the time of day the orders will not populate to the MAR until the following day.

Resident #2's physician (MD) was interviewed on 01/04/19 at 12:56 PM. The MD stated that she should have written a more thorough note on 09/28/18 and described the wounds for which she ordered treatment. She stated that there was most likely something on Resident #2's heels since she ordered skin prep. She stated she could not recall specifically but stated she would

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F 684	Continued From page 17	F 684		

have written the skin prep was "for prevention" if there was nothing on his heels. She could not recall if they were boggy, blistered or a deep tissue injury. She wanted the skin prep to be used to toughen the heels, which she stated most likely would have opened anyway even with the skin prep. The MD further stated she would have expected the orders to be processed and started immediately. She could not recall who she handed the orders to on 09/28/18. She further stated she suspected the wound was going to open despite treatment.

Nurse #4, day shift nurse who worked on 09/28/18, was interviewed on 01/04/19 at 3:05 PM. Nurse #4 stated she recalled the MD coming the morning of 09/28/18 and seeing Resident #2. Nurse #4 did not round with the MD and sometimes the MD rounds by herself. Nurse #4 stated anyone can process orders and that the MD can hand her notes with the orders to any nurse. She further stated that if she had been given the note, she would have initialed and dated next to the orders that she processed them but she did not recall being handed the physician progress notes and orders.

Interview with Nurse #5, the unit manager, on 01/04/19 at 3:35 PM revealed the MD can give any nurse her notes to be processed. Nurse #5 stated she did not round with the MD on 09/28/18. Nurse #5 stated the admitting nurse should complete the initial assessment including the skin assessment. She stated that she looked back at the time clock report and Nurse #6 was the nurse on duty at the time Resident #2 was admitted.

A phone interview with Nurse #6 on 01/04/19 at 3:57 PM revealed that she was working the day

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F 684	Continued From page 18 Resident #2 was admitted. She stated that it was her understanding that Nurse #1 was completing the entire Resident initial assessment as that was her first day on that hall and there were 2 other admissions which she did not know how to do that Nurse #1 was doing. Nurse #6 recalled that Nurse #1 said she would do the assessment. Nurse #6 did not know Nurse #1 was leaving the skin assessment for Nurse #6 to complete. Interview with the administrator on 01/04/19 at 4:01 PM revealed he expected that the initial assessment including skin evaluations should be completed the day of admission and orders processed the same day they are written.	F 684		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/31/19

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F 842	Continued From page 19 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 20 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records for 1 of 7 sampled residents whose records were reviewed. Resident #5's treatment records did not reflect the treatments provided to him 4 out of 14 days. The findings included: Resident #5 was admitted to the facility most recently on 12/09/18 from a hospital stay. His diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, cellulitis, mild renal failure and diabetes. His 5 day Minimum Data Set dated 12/16/18 coded him with severely impaired cognition, and having 2 venous ulcers with infection. Review of the medical record revealed his skin continued to breakdown despite seeing a wound physician. The following orders and documentation revealed blanks in the Treatment Administration Records (TARs): a. On 12/27/18, the physician ordered staff to clean area to left medial lateral foot with normal saline and pat dry, apply betadine soaked gauze and cover with foam dressing every day on day shift. This was discontinued on 01/03/19.	F 842	Interventions for those affected: Resident #2 was discharged from the facility on 10/27/2018: Root Cause: The nurses had blanks on the treatment record due them not reviewing documentation at the end of shift to ensure completion. Interventions for residents identified as having the potential to be affected: All residents have the potential to be affected by the deficient practice. Due to standards of practice in regards to documentation there is no corrections that can be made for treatments not documented as being complete. By 1/31/2019 , the nurses were educated on the importance of documenting treatments on the Treatment Administration Record (TAR). Education was completed by the DON/Designee on or by 1/31/2019. Systemic Change: As of 1/31/2019 and moving forward each oncoming nurse will audit the previous shift 's nurses' TAR at the beginning of their shift, to ensure completion of all treatments as ordered.	

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	345159	A. BUILDING _____ B. WING _____	C 01/04/2019

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F 842	Continued From page 21 Review of the TARs revealed no initials which would indicate the treatment was not administered as ordered on 12/28/18, 12/31/18 and 01/01/19. On 01/04/19 at 12:17 PM, an interview was conducted with Nurse #8 who worked the day shift on 12/21/18, 12/31/18 and 01/01/19. Nurse #8 stated that she recalled doing Resident #5's treatments but must have forgotten to sign the TAR. On 01/04/19 at 12:26 PM an interview was conducted with Nurse #7 who worked the day shift on 12/28/18. Nurse #7 stated that she worked a 12 hour day on 12/28/18, remembered doing his dressings but forgot to sign the TAR. b. On 12/24/18, the physician ordered staff to clean left lateral foot with normal saline, pat dry, apply skin prep to proximal area daily on day shift. This order was ongoing. Review of the TARs revealed no initials which would indicate the treatment was not administered as ordered on 12/28/18, 12/31/18, and 01/01/19. On 01/04/19 at 12:17 PM, an interview was conducted with Nurse #8 who worked the day shift on 12/21/18, 12/31/18 and 01/01/19. Nurse #8 stated that she recalled doing Resident #5's treatments but must have forgotten to sign the TAR. On 01/04/19 at 12:26 PM an interview was conducted with Nurse #7 who worked the day shift on 12/28/18. Nurse #7 stated that she worked a 12 hour day on 12/28/18, remembered doing his dressings but forgot to sign the TAR.	F 842	A random audit of 6 residents requiring treatments weekly x 4 weeks, then 6 monthly x 2 months will be conducted by the DON/Designee. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of 3 months, the DON will report audit results to the Quality Assurance and Performance Committee (QAPI). The QAPI committee will determine the on-going need for further auditing/monitoring,	

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	345159	A. BUILDING _____ B. WING _____	C 01/04/2019

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 842	Continued From page 22	F 842		

c. On 12/27/18, the physician ordered staff to clean left lateral heel with normal saline, pat dry, apply alginate and cover with foam dressing daily on day shift. This order was discontinued on 01/03/19.
Review of the TARs revealed no initials which would indicate the treatment was not administered on 12/28/18, 12/31/18, and 01/01/19.

On 01/04/19 at 12:17 PM, an interview was conducted with Nurse #8 who worked the day shift on 12/21/18, 12/31/18 and 01/01/19. Nurse #8 stated that she recalled doing Resident #5's treatments but must have forgotten to sign the TAR.

On 01/04/19 at 12:26 PM an interview was conducted with Nurse #7 who worked the day shift on 12/28/18. Nurse #7 stated that she worked a 12 hour day on 12/28/18, remembered doing his dressings but forgot to sign the TAR.

d. On 12/21/18 the physician ordered staff to clean right heel with normal saline, pat dry, apply betadine soaked gauze and wrap with kling daily on day shift. This order was discontinued on 01/03/19.
Review of the TARs revealed no initials which would indicate the treatment was not administered on 12/21/18, 12/28/18, 12/31/18 and 01/01/19.

On 01/04/19 at 12:17 PM, an interview was conducted with Nurse #8 who worked the day shift on 12/21/18, 12/31/18 and 01/01/19. Nurse #8 stated that she recalled doing Resident #5's treatments but must have forgotten to sign the

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 01/04/2019

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LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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F 842	Continued From page 23	F 842		

TAR.

On 01/04/19 at 12:26 PM an interview was conducted with Nurse #7 who worked the day shift on 12/28/18. Nurse #7 stated that she worked a 12 hour day on 12/28/18, remembered doing his dressings but forgot to sign the TAR.

e. On 12/14/18 the physician ordered staff to clean the right lateral foot (plantar area) with normal saline, pat dry, apply betadine soaked gauze and wrap with ling every day on day shift. This order was discontinued on 01/03/19. Review of the TARs revealed no initials which would indicate the treatment was not administered on 12/21/18, 12/28/18, 12/31/18 and 01/01/19.

On 01/04/19 at 12:17 PM, an interview was conducted with Nurse #8 who worked the day shift on 12/21/18, 12/31/18 and 01/01/19. Nurse #8 stated that she recalled doing Resident #5's treatments but must have forgotten to sign the TAR.

On 01/04/19 at 12:26 PM an interview was conducted with Nurse #7 who worked the day shift on 12/28/18. Nurse #7 stated that she worked a 12 hour day on 12/28/18, remembered doing his dressings but forgot to sign the TAR.

Interview with the Director of Nursing on 01/04/19 at 1:19 PM revealed she expected staff to complete the TAR to indicate the treatments were administered as ordered.

Interview with the Administrator on 01/04/19 revealed he expected the TARS to be completed

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 01/04/2019

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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
F 842	Continued From page 24 and correctly reflected the care provided.	F 842		