PRINTED: 05/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345159	B. WING _			04/	11/2019
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLNI	TON REHABILITATION C	ENTER		1	410 EAST GASTON STREET		
LINCOLIN	TON KENABILHATION C	LINIER		L	LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	through 4/11/2019. TI	ey was conducted 4/8/2019 ne facility was in compliance s of CFR 483.73, Emergency t ID# 1JLK11.					
F 000	INITIAL COMMENTS		F	000			
F 641		cited as a result of the on. Event ID# 1JLK11. pents	F 6	341			5/8/19
SS=E	CFR(s): 483.20(g)						
	resident's status. This REQUIREMENT	of Assessments. It accurately reflect the is not met as evidenced					
	facility failed to accura	iews and record review, the ate code the Minimum Data prognosis of life for 4 of 4 no received hospice care 167 and #68).			The following residents significant change Minimum Data Set (MDS) was updated by the Resident Care Specialis RN (RCS RN) on 4/10/2019 to reflect the resident(s) had prognosis of life		
	The findings included				expectancy of less than 6 months to reflect the need for hospice care.		
	1. Resident #5 was r 07/13/18 under hospi	eadmitted to the facility on ce care.			Resident #5 significant change MDS dated 07/26/2018 Resident #37 significant change MDS		
	Minimum Data Set (Morevealed the MDS incomplete care. The More More More More More More More Mor	5's significant change fDS) dated 07/26/18 flicated Resident #5 received fDS indicated Resident #5 findicated Resident #5 findicated Resident #5 findicated Resident #5			dated 08/21/2018 Resident #67 significant change MDS dated 03/07/2019 Resident #68 significant change MDS dated 02/28/2019		
I AROBATORY	Review of Resident # 10/12/18 revealed Re care. The MDS indic	5's quarterly MDS dated esident #5 received hospice ated Resident #5 did not			Root cause analysis reflected that the RCS RN could not locate the hospice certification in the charts and did not follow up with hospice to obtain the		(X6) DATE

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.

Electronically Signed

05/03/2019

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ILIMDED:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345159	B. WING_				С	
NAME OF B	DOLUBER OF OURDLUES	345159	D. WING _			<u> </u>	04/11/2019	
NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
LINCOLN	TON REHABILITATIO	N CENTER			110 EAST GASTON STREET			
				LI	NCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 641	Continued From p	page 1	F 6	541				
	-	of life expectancy of less than 6			certification that the residents' prognos	eie		
	months.	of the expectancy of less than o			of life expectancy was 6 months or les			
	monano.				when receiving hospice services. On	Ū		
	Review of Reside	nt #5's quarterly MDS dated			4/12/2019 both of the RCS RNs were			
		Resident #5 received hospice			provided with education on the need for	or		
		ndicated Resident #5 did not			accuracy of assessment with residents			
	have a prognosis	of life expectancy of less than 6			receiving hospice services and how to			
	months.				certify that the resident(s) had a progn	osis		
					of life expectancy of less that 6 months	3.		
		nt #5's quarterly MDS dated						
		Resident #5 received hospice			The education was done by the Direct	or of		
		ndicated Resident #5 did not			Nursing (DON) by 4/19/2019.			
		of life expectancy of less than 6			All wasidants who wassive because some			
	months.				All residents who receive hospice serv would be at risk for the same deficient			
	Interview with the	MDS Coordinator on 04/10/19			practice. On 4/10/2019 an audit was			
		aled Resident #5 received			completed by the RCS RN of all reside	nts		
		ch indicated a prognosis of life			receiving Hospice services and update			
		s than 6 months. The MDS			the MDS sent for all discrepancies on			
		ined the physician's hospice			4/10/2019. On 4/12/2019 education w	as		
	certification which	documented a life expectancy			completed by the DON on accuracy of			
	of six months or le	ess was not available for review.			assessment and certifying that residen	ıts		
	The MDS Coordin	nator reported the MDS should			receiving hospice services had a			
		#5's prognosis of less than 6			prognosis of life expectancy of less that			
	months.				months. Education was provided to be			
		D: ((N) : (DON)			of the RCS RNS and the Social Worke	r.		
		Director of Nursing (DON) on			Customia Changa			
		AM revealed the MDS should eflect Resident #5's prognosis			Systemic Change: As of 4/12/2019 and moving forward, t	ho		
	of life.	ellect itesidelit #03 progriosis			RCS RNs have been educated on	i i C		
	or mo.				process to certify the need for hospice			
	2. Resident #37 v	was readmitted to the facility on			services and the need for accurate			
	08/21/18 under ho				assessments. The significant change	for		
		•			resident starting to receive hospice			
	Review of Reside	nt #37's significant change			services will be reviewed for accuracy	by		
		et (MDS) dated 09/03/18			the other RCS RN.			
		indicated Resident #37						
		care. The MDS indicated			A random audit of 2 significant change			
	Resident #37 did	not have a prognosis of life			for hospice services (if available) will b	е		

Facility ID: 923312

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ISTRUCTION	(X3)) DATE SURVEY COMPLETED
		345159	B. WING _				C 04/11/2019
	ROVIDER OR SUPPLIER	CENTER		1410 E	ET ADDRESS, CITY, STATE, ZIP CODE EAST GASTON STREET DLNTON, NC 28092		04/11/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	11/19/18 revealed R care. The MDS indi have a prognosis of months. Review of Resident 02/05/19 revealed R care. The MDS indi have a prognosis of months. Interview with the M at 11:32 AM reveale hospice care which expectancy of less t Coordinator explains certification which do f six months or less The MDS Coordinatindicate Resident #3 months. Interview with the Di 04/10/19 at 11:33 Al be accurate and refl of life. 3. Resident #67 wa 02/22/19 under hospice care. The MDS in hospice care. The MDS in hospice care. The MDS in hospice care.	#37's quarterly MDS dated esident #37 received hospice cated Resident #37 did not life expectancy of less than 6 #37's quarterly MDS dated resident #37 received hospice cated Resident #37 received hospice cated Resident #37 did not life expectancy of less than 6 DS Coordinator on 04/10/19 d Resident #37 received indicated a prognosis of life than 6 months. The MDS and the physician's hospice occumented a life expectancy is was not available for review. For reported the MDS should it?'s prognosis of less than 6 rector of Nursing (DON) on M revealed the MDS should ect Resident #37's prognosis	F 6	ree m M cc Fc Dr th tra Q in	viewed weekly x 4, then 5 monthly onths by the DON for compliance. onitoring the change to sustain systempliance ongoing: or a minimum of 3 months, the ON/Designee will report audit result e QAPI Committee. Results will be acked and trended and submitted to API Committee. Base on the formation received the QAPI Committed determine the need for ongoing additing.	tem	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		MPLETED
		345159	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092	(04/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 3	F 6	41		
	at 11:32 AM revealed hospice care which is expectancy of less the Coordinator explained certification which do of six months or less. The MDS Coordinator indicate Resident #6 months. Interview with the Disport of life. Interview with the Disport of life. A review of the hospicated Resident #6 on 02/28/19. A review of the hospicated Resident #6 on 02/28/19. A review of the hospicated 02/28/19 which the physician on 03/0 had a life expectancy. The significant changes assessment dated 03/468 had a diagnosis coded under Section a condition or chronical life expectancy of life in the physician of the life of life expectancy of life expectancy of life expectancy of life in the lospic of life expectancy of l	DS Coordinator on 04/10/19 d Resident #67 received indicated a prognosis of life inan 6 months. The MDS det the physician's hospice becumented a life expectancy was not available for review. For reported the MDS should rector of Nursing (DON) on Morevealed the MDS should dect Resident #5's prognosis admitted to the facility on dice physician's verbal orders so was admitted to hospice dice certification narrative note in was electronically signed by 01/19 indicated Resident #68 of less than 6 months. ge Minimum Data Set (MDS) 3/08/19 indicated Resident of cancer and had not been of J1400 Prognosis as having de disease that could result in ess than 6 months. 4 AM an interview was				
	conducted with the M	ADS Coordinator who stated for coding Resident #68's				

C 04/11/2019
04/11/2013
RECTION (X5) SHOULD BE COMPLETION APPROPRIATE DATE

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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0.0.00			TREET ADDRESS, CITY, STATE, ZIP CODE	04/	11/2019
PRECEDED BY FULL			,		(X5) COMPLETION DATE
S assessment dated Resident #68 had months.					
Care Plans st develop and person-centered onsistent with the 33.10(c)(2) and neasurable meet a resident's and psychosocial e comprehensive sive care plan must of furnished to attain nest practicable social well-being as 3.25 or §483.40; and cherwise be required 483.40 but are not as exercise of rights right to refuse b) or specialized sing facility will R disagrees with the cust indicate its dical record. sident and the	F	656			5/8/19
		A. BUILDI 345159 B. WING OF DEFICIENCIES E PRECEDED BY FULL FIFYING INFORMATION) Faubmit a modification S assessment dated Resident #68 had months. Thensive Care Plan Care Plans st develop and person-centered consistent with the 83.10(c)(2) and measurable meet a resident's and psychosocial e comprehensive sive care plan must of furnished to attain hest practicable social well-being as 3.25 or §483.40; and therwise be required 483.40 but are not s exercise of rights right to refuse S). or specialized rsing facility will R disagrees with the ust indicate its dical record. sident and the dmission and	A BUILDING 345159 B. WING PREFIX TAG F 641 Submit a modification S assessment dated Resident #68 had months. Tensive Care Plan Care Plans st develop and person-centered consistent with the 83.10(c)(2) and measurable meet a resident's and psychosocial e comprehensive sive care plan must furnished to attain hest practicable social well-being as 3.25 or §483.40; and therwise be required 483.40 but are not s exercise of rights right to refuse S). or specialized rsing facility will R disagrees with the ust indicate its dical record. sident and the dmission and	A BUILDING 345159 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 D. PROVIDER'S PLAN OF CORRECTION E PRECEDED BY PULL IFYING INFORMATION) F 641 Submit a modification S assessment dated Resident #68 had months. lensive Care Plan F 656 Care Plans st develop and person-centered consistent with the 83.10(c)(2) and measurable meet a resident's and psychosocial e comprehensive sive care plan must of furnished to attain hest practicable social well-being as 3.25 or \$483.40; and therwise be required 483.40 but are not a exercise of rights right to refuse b). or specialized right refuse c). or specialized right refuse c). or specialized right refuse d). or specialized right and the dmission and	A BUILDING 345159 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 OF DEFICIENCIES E PRECEDED BY FULL IFFING INFORMATION) F 641 Submit a modification S assessment dated Resident #68 had months. ensive Care Plan Care Plans st develop and person-centered consistent with the 83.10(c)(2) and measurable meet a resident's and psychosocial e comprehensive sive care plan must e furnished to attain hest practicable social well-being as 3.25 or \$483.40; and therwise be required 483.40 but are not s exercise of rights right to refuse)), or specialized sing facility will R R r disagrees with the ust indicate its dicial record, sident and the dmission and

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345159	B. WING			C 4/11/2019	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092	<u> </u>	4/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	whether the resident community was asselected contact agencial entities, for this purportion (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on staff intention facility failed to develoare for a right resting recommended by Odworn daily for up to 60 (Resident #4) review. Findings included: Resident #4 admitted with most recent read Resident #4 had diag muscle weakness and hand. Review of the Quarte (MDS) dated 1/7/201 severely cognitively in required total assistate living (ADL). Reside impairment to upper side. Review of Resident #1/9/2019 revealed not resting hand splinting facility in the community of	silities must document is desire to return to the seed and any referrals to is and/or other appropriate ose. In the comprehensive care in accordance with the in paragraph (c) of this in paragraph (c) of this is not met as evidenced views, and record review, the op an individualized plan of g hand splinting device cupational Therapy to be hours for 1 of 3 residents ed for range of motion. If to the facility on 9/12/2017 dmission being 9/29/2017, gnoses which included d contracture of the right erly Minimum Data Set 9 revealed Resident #4 was mpaired. Resident #4 nce with activities of daily int #4 was coded as having and lower extremities on one	F 65	The root cause analysis reveled SDC was, responsible for comple Care plan for resident #4 and she adding the use of the right resting splinting devise to his 15 page ca The splint was being applied to R #4 as ordered but the use was no planned. The SDC and both of the RNs were provided with education documentation and creation of the individualized care plan. This edwas done on April 12, 2019 by the Interventions for the affected resing hand splinting device the deficient practice was found on A 2019. Interventions for resident identifies having the potential to be affected Current resident(s) with splints, cowere audited 100% by the RCS F the SDC one instance was found immediately corrected. Audited was completed by 4/26/2019.	eting the emissed by hand are plan. Resident of care ne RCS on on e ucation e DON. dent: as right day the pril 9, ad as d: are plans RNS and and		

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AND DIAN OF CORRECTION INTERCATION NUMBERS			(X3) DATE SURVEY COMPLETED	
345159	B. WING			C 4/11/2019
		STREET ADDRESS CITY STATE ZIP CODE	1 04	4/11/2019
CENTER		LINCOLNTON, NC 28092		
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
off (place on/ take off) resting hand splint for up to 6 d. Impleted on 4/9/2019 at 3:21 coordinator. The MDS she was aware Resident #4 ce. The MDS Coordinator is resting hand splint should ed into a plan of care for ing by the Staff Development The MDS Coordinator stated as to why the resting hand ind not care planned for Impleted on 4/9/2019 at 3:57 The SDC stated she was had a right resting hand ie SDC explained that the colint should have been an of care for Resident #4. Intertain as to why the right intertain as to why the right intertain as to reflect Resident #4's colinting device. Impleted on 4/10/2019 at 9:50 Intertain of Nursing (DON). The		As of 4/12/2019 and moving forw Care plans will be updated accuratimely upon receipt of splint order therapy and checked for accuracy RCS RN with in 3 working days. Systemic Change: Education was completed by the updating the individualized care preflect the use of any splinting de Education was completed to both RNs and the SDC on 4/12/2019 b DON. A random audit of 2 orders for sp devices (if available) will be revieweekly x 4, then 5 monthly x 2 me the DON for compliance. Monitoring the change to sustain compliance ongoing: For a minimum of 3 months, the DON/Designee will report audit re the QAPI Committee. Results wi tracked and trended and submitte QAPI Committee. Base on the information received the QAPI Co	DON on lans to vise. RCS by the inting wed onths by system	DATE
SDC and doubled checked nent to capture all resident by and regulation. nd Revision 2)(i)-(iii)	F 6	auditing.	S	5/8/19
The State of the State of Stat	` '	CENTER STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) Ge 7 off (place on/ take off) resting hand splint for up to 6 d. completed on 4/9/2019 at 3:21 coordinator. The MDS she was aware Resident #4 ce. The MDS Coordinator is resting hand splint should ded into a plan of care for ing by the Staff Development The MDS Coordinator stated as to why the resting hand and not care planned for completed on 4/9/2019 at 3:57 The SDC stated she was had a right resting hand are SDC explained that the polint should have been an of care for Resident #4. certain as to why the right was omitted from the plan of ted she was going to develop is time to reflect Resident #4's polinting device. completed on 4/10/2019 at 9:50 or of Nursing (DON). The deceted splinting devices to be a SDC and doubled checked ment to capture all resident cy and regulation. The RUSCOORDINATE AND THE STATE AND TH	TOENTIFICATION NUMBER: 345159 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 DPROVIDERS PLAN OF CORRECT LINCOLNTON, NC 28092 PREFEIX TAG FREETX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPP DEFICIENCY) Ge 7 Off (place on/ take off) resting hand splint for up to 6 d. Impleted on 4/9/2019 at 3:21 coordinator: The MDS she was aware Resident #4 ce. The MDS Coordinator or resting hand splint should ad into a plan of care for mg by the Staff Development The MDS Coordinator stated as to why the resting hand and not care planned for The SDC stated she was shad a right resting hand are SDC explained that the Dint should have been an of care for Resident #4. ertain as to why the right was omitted from the plan of ted she was going to develop s time to reflect Resident #4's pointing device. In PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPP DEFICIENCY) As of 4/12/2019 and moving forw Care plans will be updated accurate timely upon receipt of splint order therapy and checked for accuracy RCS RN with in 3 working days. Systemic Change: Education was completed by the I updating the individualized care pereflect the use of any splinting devices (if available) will be review weekly x 4, then 5 monthly x 2 months are the DON for compliance. Monitoring the change to sustain sompliance ongoing: For a minimum of 3 months, the DON/Designee will report audit rethe QAPI Committee. Base on the information received the QAPI Committee. B	A SUILDING 345159 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 DEPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREETIX TAG FROM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM As of 4/12/2019 and moving forward: Care plans will be updated accurately and timely upon receipt of splint orders from therapy and checked for accuracy by the RCS RN with in 3 working days. Systemic Change: Education was completed by the DON on updating the individualized care plans to reflect the use of any splinting devise. Education was completed to both RCS RNs and the SDC on 4/12/2019 by the DON. A random audit of 2 orders for splinting devise. Education was completed to both RCS RNs and the SDC on 4/12/2019 by the DON. A random audit of 2 orders for splinting devices (if available) will be reviewed weekly x 4, then 5 monthly x 2 months by the DON for compliance. 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. Results will be tracked and trended and submitted to the QAPI Committee. Will determine the need for ongoing auditing. For an indirection of the QAPI Committee will determine the need for ongoing auditing.

Facility ID: 923312

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY MPLETED
		345159	B. WING _		0	C 4/11/2019
	ROVIDER OR SUPPLIER	I CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1410 EAST GASTON STREET LINCOLNTON, NC 28092	•	47172010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 657	be- (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending p (B) A registered nuresident. (C) A nurse aide wiresident. (D) A member of for (E) To the extent position the resident and the An explanation murmedical record if the and their resident in not practicable for resident's care plan (F) Other appropriate disciplines as deteror as requested by (iii) Reviewed and interesidents. This REQUIREMED by: Based on observation record review the fiplan regarding splin sore prevention bowith contractures (III) The findings included.	mprehensive care plan must n 7 days after completion of assessment. interdisciplinary team, that limited to- physician. rse with responsibility for the th responsibility for the od and nutrition services staff. racticable, the participation of re resident's representative(s). Is be included in a resident's re participation of the resident representative is determined the development of the resident resident's needs the resident. revised by the interdisciplinary ressment, including both the diquarterly review NT is not met as evidenced resident application and pressure of for 1 of 3 sampled residents Resident #5). red: readmitted to the facility on roses which included traumatic	F	The root cause analysis reveresident scare plan was not imely and accurately to reflethis orders after returning to the center upon his return from a stay at the hospital. RCS Remanagers were educated on importance of ensuring that care updated timely and accureflect any new orders. This was done on April 12, 2019 by	of updated ect changes to the care an extended N and Unit of the care plans irately to s education	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			7 50 5			С
		345159	B. WING _		04	/11/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
I INGOLNI	TON DELLA DIL ITATIO	N OFNITED		1410 EAST GASTON STREET		
LINCOLN	TON REHABILITATIO	NCENTER		LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From p	page 9	F 6	57		
	Review of Reside	nt #5's significant change		Interventions for the affected	d resident:	
		t (MDS) dated 07/26/18		Therapy screening and eval		
		ssment of severely impaired		performed and new orders for		
		DS indicated functional		splint was obtained. The cor		
	impairment on one	e side of Resident #5's upper		Care plan was updated to in	clude the use	
	and lower extremi	ties with no pressure sores.		of the hand splinting device		
				4/11/2019. Additionally the	•	
		an's orders dated 01/22/19		updated to reflect the use of	•	
		olication of a brand specific boot		boot as an off loading device	e as of	
		eft foot used to prevent pressure		4/13/2019		
	sores.			Interventions for resident ide	antified as	
	Review of Reside	nt #5's quarterly MDS dated		having the potential to be aff		
		I an assessment of severely		Current resident(s) with splir		
		n. The MDS indicated functional		were audited 100% by the R		
		e side of Resident #5's upper		the SDC one instance was f		
		ties with no pressure sores.		immediately corrected. Aud completed by 4/26/2019.	it was	
		nt #5's care plan dated 04/03/19				
		tions related to functional range		As of 4/12/2019 and moving		
		ent included application of a		Care plans will be updated a		
		left hand. The care plan did		timely upon receipt of splint		
	application on the	ervention regarding boot left foot.		therapy and checked for acc RCS RN with in 3 working d		
		4/08/19 at 9:49 AM and at 2:52				
		dent #5 seated in a wheel chair		Systemic Change:		
		left foot. Resident #5's left				
	nand contracture	did not have a splint.		Education was completed by		
	Observation on O	1/00/10 at 10:42 AM and at 1:22		updating the individualized of		
		4/09/19 at 10:42 AM and at 1:22 dent #5 seated in a wheel chair		reflect the use of any splintir Education was completed to	•	
		left foot. Resident #5's left		RNs and the SDC on 4/12/2		
		did not have a splint.		DON.	0.0 by tile	
		rse Aide (NA) #1 on 04/10/19		A random audit of 2 orders f		
	revealed Resident	t #5 did not use a hand splint.		devices (if available) will be weekly x 4, then 5 monthly x		

Facility ID: 923312

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345159	B. WING		04/		
NAME OF PE	ROVIDER OR SUPPLIER	040100		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	11/2019	
				1410 EAST GASTON STREET			
LINCOLN	ON REHABILITATION C	ENTER		LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 657	Continued From page	e 10	F 65	57			
		ff Development Nurse (who		the DON for compliance.			
	9:52 AM revealed Re	lications) on 04/10/19 at sident #5 no longer used a assive range of motion.		Monitoring the change to sustain s compliance ongoing:	system		
	Interview with the MD	S Coordinator on 04/10/19		For a minimum of 3 months, the			
		Resident #5's care plan did		DON/Designee will report audit res			
		terventions for range of sore prevention. The MDS		the QAPI Committee. Results will tracked and trended and submitted			
		the care plan required		QAPI Committee. Base on the	a to trie		
	revision related to boo	ot application and splint		information received the QAPI Cor	mmittee		
		S Coordinator explained she		will determine the need for ongoin	g		
	was not aware of the application and nonus			auditing.			
		ector of Nursing (DON) on revealed Resident #5's					
	needed. The DON re	ccurate and revised as ported Resident #5's care					
	plan should contain the hand splint.	ne boot application and omit					