| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345385 | A. BUILDING _____ B. WING _____ | C 05/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CARDINAL HEALTHCARE AND REHAB | 931 N ASPEN STREET LINCOLNTON, NC 28092 |

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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 05/05/2025 through 05/08/2025. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID: 5L7K11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced recertification and complaint investigation survey was conducted from 05/05/2025 through 05/08/2025. Event ID: 5L7K11. The following intakes were investigated NC00221690, NC221357, NC00224471, and NC00224074.<br><br>11 of 11 complaint allegations did not result in a deficiency. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- | F 641 | | 6/3/25 |

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

Electronically Signed | 05/21/2025

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| F 641 | Continued From page 1<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code a significant change Minimum Data Set (MDS) assessment in the area of special treatments, procedures, and programs for 1 of 3 residents reviewed for Dialysis treatments and Hospice care (Resident #13).<br><br>The findings included:<br><br>Resident #13 was readmitted to the facility on 02/18/25 with diagnoses which included cerebral vascular accident, and dementia.<br><br>Review of the significant change MDS assessment dated 02/24/25 for Resident #13 revealed she was moderately cognitively impaired. Under the section for Health Conditions/prognosis Resident #13 did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. Under the section for Special Treatments, Programs and Procedures Resident #13 was checked as being on Dialysis treatments while a resident and checked as being on Hospice care while a resident. | F 641 | On 5/10/25 resident #13 annual MDS assessment dated 2/24/25 was updated to accurately reflect the MDS section of Special Treatments, Program and Procedures to show resident #13 did not receive Hospice Services or Dialysis by the Minimum Data Set Nurse.<br><br>On 5/15/25 through 6/3/25 the MDS Nurse and/or Nursing Supervisor performed quality improvement monitoring of the last 30 days of MDS assessments for accurately coding active diagnoses. Any issues identified were addressed.<br><br>The Minimum Data Set Nurse was re-educated by the Regional Minimum Data Assessment Nurse on accurate coding of the MDS on 5/14/25. Newly hired MDS nurses will be educated upon hire.<br><br>On 5/26/25 the Director of Nursing and/or Designee to perform Quality Improvement Monitoring of the MDS's for accurate coding of active diagnosis three times per week for 12 weeks. | |

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| F 641 | Continued From page 2<br>An interview on 05/05/25 at 11:20 AM with Resident #13 revealed she was not on dialysis and had never had dialysis treatments. Resident #13 stated she was not on hospice care but was on palliative care for pain management. Resident #13 stated she had been on hospice care in the past but it was discontinued in 2022.<br><br>An interview on 05/08/25 at 12:14 PM with the MDS Coordinator at the facility revealed she had just started at the facility in April of 2025 and was not at the facility when the significant change MDS was completed. The MDS Coordinator stated the resident was under palliative care and should not have been coded as Hospice care. Additionally, the MDS Coordinator stated she did not see any reason Resident #13 would have been coded for Dialysis care and said it must have been a keying error. The MDS Coordinator further stated she would modify the assessment and resubmit.<br><br>An interview on 05/08/25 at 12:31 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident.<br><br>An interview on 05/08/25 at 12:40 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions. | F 641 | The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 5/21/25. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing/Infection Control Preventionist, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the | F 656 | | 6/3/25 |

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| F 656 | Continued From page 3 | F 656 | | |

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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| F 656 | Continued From page 4<br>care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop an individualized comprehensive care plan in the area of anticoagulant (blood thinner) medication use for 1 of 2 residents whose comprehensive care plans were reviewed (Resident #8).<br><br>The findings included:<br><br>Resident #8 was admitted to the facility on 04/09/2025 with diagnoses that included a left femur fracture with surgical repair and dementia.<br><br>A review of the active medication orders for Resident #8 revealed an order for Enoxaparin Sodium (an anticoagulant medication) 40 milligrams (mg.) subcutaneously (method of administering medication by injecting a drug into the fatty tissue layer beneath the skin) at bedtime for deep vein thrombosis (blood clot) prophylaxis. The medication had a start date of 04/09/2025.<br><br>Review of the admission Minimum Data Set (MDS) assessment for Resident #8 dated 04/16/2025 indicated Resident #8 was severely cognitively impaired and was receiving an anticoagulant.<br><br>A review of Resident #8's comprehensive care plan dated 04/29/2025 did not reveal any care plan focus area or interventions related to Resident #8 receiving an anticoagulant medication.<br><br>A review of Resident #8's Medication | F 656 | Comprehensive Care Plan was updated for Resident #8 on 5/8/25 to include anticoagulants.<br><br>On 5/9/25 through 6/3/25 the MDS Nurse and/or Designee performed quality improvement monitoring of current residents on anticoagulants. Any issues identified were addressed.<br><br>The Minimum Data Set Nurse was re-educated by the Regional Minimum Data Assessment Nurse on updating Comprehensive Care Plans to include interventions for anticoagulants on 5/14/25. Newly hired staff will be educated upon hire.<br><br>The Assistant Director of Nursing and/or Designee to perform Quality Improvement Monitoring of Comprehensive Care Plan interventions added three times per week for 12 weeks.<br><br>The Assistant Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 5/21/25. The Assistant Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Assistant Director of Nursing/Infection Control Preventionist, | |

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| F 656 | Continued From page 5<br>Administration Record from 4/09/2025 through 5/07/2025, revealed Resident #8 received Enoxaparin Sodium 40 mg subcutaneously every night at bedtime.<br><br>On 05/08/2025 at 12:25 PM an interview with the MDS Coordinator revealed Resident #8's care plan did not address anticoagulant medication. The MDS Coordinator explained the care plan should include the use of an anticoagulant medication.<br><br>An interview was conducted on 05/08/2025 at 12:30 PM with the Director of Nursing (DON). The DON indicated anticoagulant medications were considered high-risk medications. The DON stated the anticoagulant medication should be addressed in Resident #8's comprehensive care plan so all staff caring for her would be aware she was at risk for side effects like bleeding or bruising.<br><br>An interview was conducted with the Administrator on 05/08/2025 at 12:45 PM. The Administrator stated he expected all resident care plans to be reflective of their clinical condition including the use of anticoagulant medications. | F 656 | Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager and Minimum Data Set Nurse and an minimum of one direct care giver. The Assistant Director of Nursing will report findings to the Quality Assurance Performance Committee monthly for three months. | |
| 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. | F 880 | | 6/3/25 |

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| F 880 | Continued From page 6<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 §483.71 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:<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 | F 880 | | |

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| F 880 | Continued From page 7<br>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:<br>Based on observation, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when Nurse #1 did not doff her gloves, perform hand hygiene and don clean gloves prior to applying wound treatment and a clean dressing during wound care to Resident #2. The deficient practice occurred for 1 of 9 staff members observed for infection control practices (Nurse #1).<br><br>The findings included:<br><br>Review of the facility's policy entitled Handwashing/Hand Hygiene last updated August 2019 read in part:<br>Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.<br>7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap | F 880 | Resident #2 was identified as needing wound care. Wound Care Nurse and Assisted Director of Nursing/Infection Control Preventionist were immediately provided education on facility policy entitled Handwashing/Hand Hygiene by the Vice President of Cinical Services on 5/6/25.<br><br>An audit/competency for clincal staff was conducted by the Assisted Director of Nursing on 5/12/25, identifying Handwashing/Hand Hygiene for all clinical staff. Staff to follow Handwashing/Hand Hygiene policy.<br><br>On 5/12/25 the Director of Nursing and the Assistant Director of Nursing initiated staff education to the Registered Nurse's, Licensed Practical Nurse's and Certified | |

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| F 880 | Continued From page 8<br>(antimicrobial or non-antimicrobial) and water for the following situations:<br>b. Before and after direct contact with residents;<br>g. Before handling clean or soiled dressings, gauze pads, etc.;<br>j. After contact with blood or body fluids;<br>k. After handling used dressings, contaminated equipment, etc.;<br>m. After removing gloves;<br><br>An observation of Nurse #1 providing wound care on Resident #2's coccyx wound was made on 05/06/25 at 11:08 AM. Nurse #1 gathered her dressing supplies and placed them on wax paper on the overbed table. The old dressing was removed by Medication Aide #1 who was assigned to the resident. Nurse #1 doffed her gloves and washed her hands with soap and water and donned clean gloves and proceeded to clean the wound inside outward with normal saline-soaked gauze and patted the wound dry with dry gauze. After cleaning the wound and without doffing her gloves, sanitizing her hands, and donning clean gloves, Nurse #1 proceeded to pack the wound with normal saline-soaked gauze and applied bordered foam dressing with date and initials over the wound. Nurse #1 gathered her supplies and trash, doffed her gown and gloves, washed her hands with soap and water, and left the room.<br><br>An interview on 05/06/25 at 4:55 PM with Nurse #1 revealed she felt like she could have done a better job with the wound care on Resident #2. She stated she should have doffed her gloves, sanitized her hands, and donned clean gloves after cleansing the wound and prior to applying the treatment to Resident #2's wound. She stated she knew that you were supposed to doff, | F 880 | Nursing Assistant's pertaining to Handwashing/Hand Hygiene per policy.<br><br>The Director of Nursing or designee will conduct QI monitoring on F880 to ensure staff are following Hand Washing/Hand Hygiene policy when providing direct care 5x/week for 4 weeks, then 3x/week for 8 weeks, then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Assistant Director of Nursing/Infection Control Preventionist, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager and Minimum Data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. | |

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sanitize and don clean gloves after cleansing a wound and before applying the treatment because that was going from a dirty to clean procedure. Nurse #1 further stated it was an oversight on her part because she was nervous about being watched during wound care.

An interview on 05/07/25 at 9:16 AM with the Infection Preventionist (IP) revealed all the nurses had been in-serviced on handwashing and dressing changes and said anytime they were going from a dirty procedure to clean procedure they were supposed to doff their gloves, sanitize their hands and don clean gloves. The IP also revealed that anytime they doffed their gloves they were supposed to sanitize their hands before donning clean gloves.

An interview on 05/08/25 at 12:29 PM with the Director of Nursing (DON) revealed it was her expectation that Nurse #1 follow the facility's policy and procedure for Handwashing/Hand Hygiene during wound care.

An interview on 05/08/25 at 12:36 PM with the Administrator revealed he would have expected Nurse #1 to follow their Handwashing/Hand Hygiene policy and procedure while providing wound care.