PRINTED: 05/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345159	B. WING _		0	C <b>4/22/2016</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1410 EAST GASTON STREET  LINCOLNTON, NC 28092	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
F 224 SS=D	complaint investigation 483.13(c) PROHIBIT MISTREATMENT/NE The facility must deve	e cited as a result of the on Event ID #4BLQ11.  GLECT/MISAPPROPRIATN  elop and implement written	F 2	24		5/20/16
	policies and procedu mistreatment, neglec and misappropriation	t, and abuse of residents				
	by: Based on observation and staff interviews the provide oral care and required extensive as daily living causing the and unkempt for 1 of the findings included. Resident #19 was add 11/25/15 with diagnovascular accident (strespiratory disease.  Review of the quarted dated 02/19/16 code intact and capable of the MDS indicated Fextensive physical as	mitted to the facility on ses which included cerebral roke), hemiplegia, and rly Minimum Data Set (MDS) d Resident #19 as cognitively making her needs known. Resident #19 required resistance of 1 person with living (ADLs) which included		The statements included are not admission and do not constitute agreement with the alleged deficience herein. The plan of correction is completed in the compliance of sefederal regulations as outlined. To in compliance with all federal and regulations, the center has taken take the actions set forth in the federal plan of correction. The following correction constitutes the center allegation of compliance. All allegation of compliance. All allegation of compliance been or we completed by dates indicated.  Interventions for affected resident Resident #19 was assisted with a dentures were removed and clear placed back in her mouth on Apr 2016.	state and To remain d state or will bellowing plan of s ged will be a shower, aned and	
ABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/13/2016

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

**Electronically Signed** 

program participation.

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 _			0	4/22/2016
NAME OF P	ROVIDER OR SUPPLIER	L	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/22/2010
				14	10 EAST GASTON STREET		
LINCOLN.	TON REHABILITATION	I CENTER			NCOLNTON, NC 28092		
(V4) ID	SLIMMADY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 224	Continued From page	age 1	F:	224			
		and bathing. Further review of Resident #19's preferences for			Interventions for residents identified as	S	
	showers and hygie	ne was very important with no riors or refusal of care.			having the potential to be affected:		
					A facility audit was performed on April	28,	
	Review of a care p	lan dated 02/25/16 revealed			2016 by the Director of Nursing (DON)		
		an ADL self-care deficit related			and Assistant Director of Nursing (AD	(NC	
		emiplegia with approaches for			to ensure that resident's requiring		
		assistance with ADLs to level			assistance with denture/oral hygiene		
		with mouth care/denture care			received assistance. Dentures were		
	daily and as neede	a (prn).			cleaned for those resident's identified indicated. Oral hygiene was provided		
	On 04/18/16 at 4:1	0 PM Resident #19 was			those residents identified as needing of		
		ked if staff helped her to clean			hygiene.	лаі	
		esident answered, "No, they do			nygione.		
		dentures out at night for them			Director of Nursing and Assistant Director	ctor	
		#19 explained that she was			of Nursing performed an audit on April		
	unable to remove h	ner dentures on her own due to			2016 of scheduled showers to ensure	all	
		hat she had not had her			residents were receiving and or offere		
		r oral care provided in a "long			showers at least twice weekly. Reside	nts	
		t recall when the last time a			identified as needing a shower or		
		ted her with oral care.			requesting a shower was assisted with	١a	
		ures were observed to be			shower.		
	1	color, with thick accumulation			Licensed Nurses and Certified Nursing	~	
		g the teeth and gum line. a blue colored denture cup on			Assistants across all shifts including fu	-	
		sink and a box of denture			time, part time and as needed staff wil		
		the sinks vanity in her room.			educated by May 18, 2016 on ensurin		
	boaking packets of	The onne variety in her room.			oral hygiene is provided with morning		
	On 04/19/16 at 10:	43 AM Resident #19 was			bedtime care and as needed. Denture		
	observed in her roo	om disheveled. Resident #19's			are removed and soaked at bedtime,		
	hair was unclean, u	uncombed, greasy looking, and			cleaned and placed back in mouth price	or to	
	matted to her head	with her scalp visible.			breakfast. This education will be provi	ded	
	On 04/20/16 at 9:3	0 AM Resident #19 was			Coordinator(SDC).		
		ed and reported that she had			•		
	received her morni	ng care but that no one had			By May 18th, 2016, the facility SDC w	ill	<b> </b>
		out during the night to soak			provide education to Licensed Nurses	and	<b> </b>
	them. Her teeth we	ere observed and were visibly			Certified Nurses Assistants across all		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345159	B. WING _				C <b>22/2016</b>	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	22/2010	
					410 EAST GASTON STREET			
LINCOLN	ON REHABILITATION (	CENTER			INCOLNTON, NC 28092			
				_				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 224	Continued From pag	e 2	F 2	224				
	dirty with thick accur	nulation of food matter along			shifts including full time, part time and	as		
		ne and her hair was observed			needed staff. This education will focus			
	to be greasy looking.				ensuring showers are given as schedu	led		
					and upon request from a resident.			
	On 04/21/16 at 11:45	5 AM Resident #19 was						
	observed to be self-p	propelling in the hall and			Systemic Change:			
	disheveled. Residen	t #19's hair was greasy						
	•	er head on the left side with			Director of Nursing (DON), Staff			
	-	shoes were not fastened			Development Coordinator (SDC), Unit			
		flopping and her shoes			Manager (UM) or Designee will randor	-		
		n on her feet. Resident #19			audit ten (10) residents twice weekly fo			
		assisted her with removing			12 weeks, then ten (10) residents wee	kly		
		and that she was supposed			for 12 weeks, then twice monthly for 6			
	to have a shower.				months across all shifts. Audit will inclu			
	On 04/21/16 at 2:50	PM Resident #19 was			ensuring that dentures are removed at			
		er wheelchair in her room.			bedtime, placed in a denture cup with cleanser to soak and showers are			
	_	vas greasy looking, matted to			completed as scheduled.			
		entures were visibly dirty with			completed as softedured.			
		f food matter along the teeth			Newly hired Licensed Nurses and			
	and gum line.	3			Certified Nurses Assistants will be			
	3.				educated by the facility SDC on ensuri	ng		
	On 04/22/16 at 9:20	AM a follow-up interview was			oral hygiene and/or denture care is			
		dent #19. She stated she had			provided with morning and bedtime cal	re		
	not received a show	er all week and her shower			as as needed. Newly hired Licensed			
	_	ay and Wednesday. She			Nurses and Certified Nursing Assistant			
	reported she had a s	hower on Saturday 04/16/16			will be educated by the SDC on ensuri	ng		
		a shower since then.			residents receive showers as schedule	ed:		
	Resident #19 indicat				and upon request of the resident.			
	•	6 by the nurse aide (NA) #2						
		the shower later that day			Monitoring of the change to sustain			
		ke her. Resident #19			system compliance ongoing:			
	•	ursday NA #2 was supposed			Manthly for a minimum of twelve	h		
	_	but had not. Resident #19			Monthly for a minimum of twelve month			
		Friday and I still do not have			the DON, SDC, or UM will present resu	JIIS		
		has helped me with soaking The resident was observed			of the oral hygiene, denture care and shower audits to the Quality Assurance	,		
	•	ng hair, disheveled, unclean,			and Performance Improvement	7		
	and her dentures we				Committee. The Quality Assurance and	d		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345159	B. WING _				C <b>22/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	22/2010
					410 EAST GASTON STREET		
LINCOLN.	TON REHABILITATION C	ENTER			INCOLNTON, NC 28092		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES			PROVIDER'S PLAN OF CORRECTION		2.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 224	F 224 Continued From page 3		F 2	224			
	and reported Resider a shower on Wednes was unaware if the reobserved and stated and matted to her healike she has had a sh she was not responsi #19 and was unaware shower or her denture.  On 04/22/16 at 10:05 interviewed and state Resident #19 to have Wednesday. Nurse #Resident #19 had not Wednesday or during stated she was unaw not being assisted widentures. She indicate	d she would have expected			Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoin and determine the need for further auditing beyond the 12 months.		
	was conducted with N responsible for the cat Wednesday 04/20/16 from 7:00 AM until 3:1 had not given Reside Wednesday or Thurse behind and had forgot shower. NA #2 also sthe resident's denture On 04/22/16 at 12:50 was conducted with N was responsible for the wednesday of the resident's denture of the resident of the reside	PM, a telephone interview NA #2. NA #2 stated she was are of Resident #19 on and Thursday 04/21/16 00 PM. NA #2 confirmed she nt #19 a shower on day and that she had gotten atten to give the resident a tated she had not soaked as or provided oral care.  PM, a telephone interview NA #3. She confirmed she are care of Resident #19 100 AM. NA #3 stated she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245450	B. WING				C
NAME OF PR	ROVIDER OR SUPPLIER	345159	B. WING_	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	22/2016
LINCOLN	TON REHABILITATION C	ENTER			110 EAST GASTON STREET INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 224 F 241 SS=D	Continued From page 4 had not assisted the resident with soaking her dentures or provided oral care. NA #3 further stated she was unaware Resident #19 required assistance with her dentures.  On 04/22/16 at 1:30 PM, an interview was conducted with the Director of Nursing (DON). She stated it was her expectation that ADL care be provided to a resident as required or needed. She further stated she would have expected a resident to have a shower on their scheduled shower days and any other day should it be requested. The DON stated she would have expected the nursing staff to have assisted the resident with soaking her dentures and assist a resident with oral care as needed.  483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY		F 224				5/20/16
	manner and in an emenhances each reside full recognition of his.  This REQUIREMENT by: Based on observation and staff interviews the residents dignity duriticalling clothing protect possibility of causing children for 3 of 3 resignification (Resident #1, #76, and The findings included)	is not met as evidenced  ns, record review, resident, ne facility failed to provide ng dining observations by ctors "bibs" with the the residents to feel like idents sampled for dignity nd #85).			The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state at federal regulations as outlined. To remain compliance with all federal and state regulations, the center has taken or will take the actions set forth in the followin plan of correction. The following plan of correction constitutes the center's	nd ain g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345159	B. WING				С
			D. WING _			<u> </u>	04/22/2016
NAME OF PI	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 PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 241	Continued From p	page 5	F 2	241			
	03/06/13 with diad	gnoses which included			allegation of compliance. All alleged		
		egia, seizures, and depression.			deficiencies cited have been or will be		
		arterly Minimum Data Set (MDS)			completed by dates indicated.		
		oded Resident #1 with severe			,		
	cognitive impairm	ent and was totally dependent			Interventions for affected residents:		
	on staff for her ac	tivities of living (ADLs) which					
		ility, transfers, dressing,			The Staff Development Coordinator		
		hygiene, and bathing. Resident			(SDC) provided education to NA #1 on		
		extensive assistance of 1 person			April 10, 2016 related to providing care		
	physical assist wi	th eating.			residents in a manner that maintains o		
	0 044040 146	10 DM   1   11   11   1			enhances each resident's dignity. The		
		2:19 PM during the dining			education placed emphasis on proper		
		all 400 nurse aide (NA) #1 was k on the resident's door and			terminology such as clothing protectors rather than bibs.	3	
		e in and bring you a bib?" NA #1			Tauter triair bibs.		
		drape the clothing protector over			Interventions for residents identified as		
		thes and fastened it around her			having the potential to be affected:	•	
	neck.				manning and personal to the amount		
					Education will be provided to Licensed		
	On 04/21/16 at 12	2:15 PM during the dining			Nurses (LN) and Certified Nursing		
	observation on ha	all 400 NA #1 was observed to			Assistants (CNA's) (across all shifts		
		nt #1's door and stated "here let			including full time, part time and as		
		b." NA #1 was again observed			needed staff) by May 18, 2016. The		
		ing protector over the resident's			education will be provided by the facilit	:у	
	clothes and faster	ned it around her neck.			SDC. Education will include ensuring		
	0 - 04/04/40 -+ 0-	40 DM NA #4 into views d			resident's are provided care in a mann	er	
		42 PM NA #1 was interviewed.			that maintains or enhances each		
		her normal routine to go around poms, washed their hands, and			resident's dignity. Staff will be instructed to use the		
		She further stated she had			terminology, clothing protectors rather		
	_	clothing protectors "bibs" and			than bibs.		
		ot have been calling them that.					
		her explanation for calling the			Systemic Change:		
	clothing protector				- <b>-</b>		
					Director of Nursing (DON), Staff		
		49 PM Nurse #1 was			Development Coordinator (SDC), Unit		
		stated she would not have			Manager (UM), or Designee will rando		
	expected the cloth	ning protectors to be called bibs.			observe different meal service times in	l	
					resident rooms and/or the dining area		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345159	B. WING _				C <b>22/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	22/2010
					410 EAST GASTON STREET		
LINCOLN.	TON REHABILITATION C	ENTER			INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 241	Continued From page	e 6	F 2	241			
	On 04/22/16 at 1:30 I (DON) was interviewd have expected the cla "bibs."	PM the Director of Nursing ed. She stated she would not othing protectors to be called			three times weekly for four weeks, ther twice weekly for four weeks, then week for four weeks to ensure staff maintain resident's dignity by using the terminolo clothing protectors rather than bibs.	dy	
	05/22/14 with diagnor Parkinson's disease, heart failure. Review Data Set (MDS) date #76 as cognitively int his needs known. Fur indicated Resident #7 assistance of staff for dependent on staff for toileting, personal hydindependent for eatin On 04/18/16 at 12:19 observation on hall 4 observed to knock or asked "can I come in	osteoarthritis, tremors, and of the quarterly Minimum d 03/02/16 coded Resident act and capable of making rther review of the MDS 76 required extensive transfers, and was totally or bed mobility, dressing, giene, and bathing, and was			Newly hired Licensed Nurses and certi Nursing Assistants will be educated by facility SDC on ensuring resident's rece care in a manner that maintains or enhances their dignity. The education vinclude using the terminology clothing protectors rather than bibs.  Monitoring of the change to sustain compliance ongoing:  Monthly for a minimum of three months the DON, SDC, or UM will report result the dignity audits to the Quality Assural and Improvement Committee. The Quality review the audits to make	the eive will S., cs of nce ality	
	Resident #76's clother neck.  On 04/21/16 at 12:15 observation on hall 4 knock on Resident #7 me put on your bib." to drape the clothing clothes and fastened  On 04/21/16 at 2:30 I interviewed. He state time." The resident st protector "most of the sometimes at dinner.	is and fastened it around his is PM during the dining 00 NA #1 was observed to 76's door and stated "here let NA #1 was again observed protector over the resident's			recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the the months.	ie	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345159	B. WING_			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1410 EAST GASTON STREET  LINCOLNTON, NC 28092		04/22/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	supposed to be called #76 indicated he wo called clothing prote  On 04/21/16 at 2:42 She stated it was he to the resident's root give them a "bib." SI always called the clothat she should not INA #1 had no furthe clothing protectors "On 04/21/16 at 2:49 interviewed. She state expected the clothin On 04/22/16 at 1:30 (DON) was interview have expected the clothins."  3) Resident #85 was 11/10/15 with diagnod dementia, depressive weakness. Review of Set (MDS) dated 02 with mild to moderat required extensive to bed mobility, transfe bathing. Further review Resident #85 was in On 04/18/16 at 12:1 observation on hall 4 observed to knock of asked "can I come in the called the composition of the composition of the called the composition of the called the ca	know what they were ed other than bibs." Resident uld have preferred them to be ctors instead of bibs.  PM NA #1 was interviewed. From normal routine to go around ms, washed their hands, and the further stated she had othing protectors "bibs" and have been calling them that. It is rexplanation for calling the bibs."  PM Nurse #1 was teed she would not have g protectors to be called bibs.  PM the Director of Nursing wed. She stated she would not admits admitted to the facility on	F 2	41			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345159	B. WING _			C 04/22/2016
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092		J-112210
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	neck.  On 04/21/16 at 12:15 observation on hall 4 knock on Resident ## me put on your bib." to drape the clothing clothes and fastened  On 04/21/16 at 2:15 interviewed. She statiates (NAs) call the cisince she had reside further stated it made and that she preferre protectors and not bill.  On 04/21/16 at 2:42 She stated it was her to the resident's roon give them a "bib." She always called the clothat she should not hNA #1 had no further clothing protectors "but on 04/21/16 at 2:49 interviewed. She state expected the clothing.  On 04/22/16 at 1:30 in (DON) was interviewed. She state clothing on 04/22/16 at 1:30 in (DON) was interviewed.	es and fastened it around her  5 PM during the dining 00 NA #1 was observed to 85's door and stated "here let NA #1 was again observed protector over the resident's it around her neck.  PM Resident #85 was ed she had heard the nurse clothing protectors "bibs" d at the facility. Resident #85 e her feel like she was a child d them to be called clothing bs.  PM NA #1 was interviewed. In normal routine to go around his, washed their hands, and e further stated she had thing protectors "bibs" and ave been calling them that. explanation for calling the sibs."	F 2	41		
F 246 SS=D	"bibs." 483.15(e)(1) REASO OF NEEDS/PREFER	NABLE ACCOMMODATION RENCES	F 2	46		5/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345159	B. WING		C <b>04/22/2016</b>		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/22/2010		
				1410 EAST GASTON STREET			
LINCOLN	TON REHABILITATION (	CENTER		LINCOLNTON, NC 28092			
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION		
F 246	Continued From pag	e 9	F 24	6			
	A resident has the rice services in the facility accommodations of	ght to reside and receive y with reasonable individual needs and when the health or safety of					
	by: Based on observation interviews the facility resident's ability to uplace a call light with the possibility of cause unable to get the hele of 1 resident sample needs (Resident #13). The findings included Resident #133 was a 03/30/15 with diagnolower leg fracture, dedifficulty in walking, a Review of the annual dated 02/02/16 code cognitive impairment usually understood, The MDS revealed Fassistance of 1 persecating, toileting, persecutive in the same control of the same contro	REQUIREMENT is not met as evidenced ed on observations, record review, and staff views the facility failed to evaluate a lent's ability to use a call light and failed to e a call light within reach of the resident with possibility of causing the resident to feel to get the help or assistance needed for 1 resident sampled for accommodation of its (Resident #133).		The statements included are not a admission and do not constitute agreement with the alleged deficient herein. The plan of correction is completed in the compliance of statederal regulations as outlined. To in compliance with all federal and stregulations, the center has taken of take the actions set forth in the folloplan of correction. The following placorrection constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will completed by dates indicated.  Interventions for affected residents  On 04/22/2016, Resident #133's car was changed from a button style to pancake style (flat) call light. Call liplaced within reach and Resident # demonstrated the ability to press the light. Resident #133 care plan was updated to reflect use of a pancake (flat) call light in lieu of a button style (flat) call light in	te and remain state r will cowing an of d be : all light o a ght was #133 ne call e style		
	#133 had severely in			(flat) call light in lieu of a button sty light.  Interventions for residents identified	le call		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345159	B. WING				C
NAME OF D		345159	B. WING _	OTD	FET ADDRESS SITV STATE 7/D SODE	04/	22/2016
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLNI	ON REHABILITATION O	ENTER		141	0 EAST GASTON STREET		
				LIN	COLNTON, 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	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 246	Continued From page 10		F 2	46			
F 246	approaches for staff of activities of daily livin within reach.  On 04/21/16 at 9:55 observed sitting in a the foot of the bed with wheelchair against the floor and the resist to be stretched across approximately 2 incher #133 was asked if she Resident #133 was of and stated, "What car On 04/22/16 at 9:25 observed again sitting the foot of the bed ar was observed to be strength the head of the bed. She could reach her of "What call light? What just want to lay down On 04/22/16 at 10:00 conducted with nurse confirmed that Resid reach her call light ar	AM Resident #133 was high back wheelchair beside th the right front wheel of the regray colored fall mat on dent's call light was observed as the head of the bed es below the pillow. Resident re could reach her call light. Abserved to uncover her head ill light?"  AM Resident #133 was g in the wheelchair beside ad the resident's call light estretched across the pillow at Resident #133 was asked if call light and she stated, at are you talking about? I	F 2		having the potential to be affected:  A facility audit of the current resident population was performed on 04/28/20 by the facility Director of Nursing (DON and Assistant Director of Nursing (ADO to assess residents ability to utilize the call light. Upon audit completion, call lights were changed to the pancake strogral residents identified as being unate to use the push button style call light. These residents performed a return demonstration to ensure they were abuse the pancake style call light. Identified as the pancake style call light. Identified as the pancake style call light. Newly admitted residents will be educated upadmission on the button style call bell. return demonstration will be required to validate ability to use as applicable.  All resident rooms were audited on 04/28/2016 to ensure call lights were within reach of the resident.  Licensed Nurses (LN) and Certified Nursing Assistants (CNA) across all strongled including full-time, part-time and as needed) will be provided education by	N) DN) ne yle le to fied flect on A D	
	asked should the res would the staff know. #133 was checked or could yell out for assi	ident need assistance how  NA #1 indicated Resident  n frequently and that she istance or help.			05/18/2016 by the facility Staff Development Coordinator (SDC). Education will include completing maintenance request forms to change light styles for any resident identified a	call s	
	conducted with Nurse Resident #133 was u	is AM an interview was er #1. Nurse #1 confirmed inable to use her call light rrse #1 stated should the rrassistance she was			unable to use push button style call lig Education will also include completing therapy referrals for residents noted w functional decline resulting in a decrea in their ability to use the call light as we	ith a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUIDDUED	343139	B. WING		TREET ARRESCO CITY STATE ZIR CORE	04/	22/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON STREET		
LINCOLN	ON REHABILITATION C	ENTER			INCOLNTON, NC 28092		
0/0.15	CUMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 246	Continued From page	e 11	F:	246			
	had never thought ab	. Nurse #1 further stated she out the resident being			as monitoring to assure call lights are within reach of residents.		
	order for her to be eva	l light and would put in an aluated for a pancake type			Systemic Change:		
	conducted with the Restated Resident #133 case load from 09/28, further stated he was capability for the use  On 04/22/16 at 1:30 F conducted with the Di She stated she expect the reach of the resid it was everyone's res	PM an interview was irrector of Nursing (DON). Steed all call lights to be within ent. The DON further stated ponsibility to ensure call ch and that the residents			Director of Nursing, Assistant Director of Nursing, Unit Manager (UM) or Designa will audit ten (10) residents three times weekly for 4 weeks, then ten (10) residents twice weekly for 4 weeks, the ten (10) residents weekly for 4 weeks to ensure call lights are within reach and residents have the ability to press the clights with corrections made as indicated. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the SDC during their orientation period. Education will include completing maintenance request forms change call light styles for any resident identified as unable to use push button style call light. Education will also includes	ee n o all ed. e to	
					completing therapy referrals for resider noted with a functional decline resulting a decrease in their ability to use the cal light as well as monitoring to assure ca lights are within reach of residents.  Monitoring of the change to sustain system compliance ongoing:  Monthly for a minimum of three months the Director of Nursing, Assistant Director of Nursing and/or Unit Manager will present results of the call light audits to the Quality Assurance and Improvement	g in 	
					the Quality Assurance and Improvemer Committee. The Quality Assurance and Improvement Committee will review the	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345159	B. WING			C 04/22/2016	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1410 EAST GASTON STREET  LINCOLNTON, NC 28092	'		
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F 246	Continued From page	e 12	F 24	audits to make recommendation ensure compliance is sustained and determine the need for furth auditing beyond the three month	ongoing; her		
F 248 SS=E	of activities designed the comprehensive a		F 24			5/20/16	
	by: Based on observation interviews the facility activity program for a resident with the post resident to feel unact for 1 of 3 resident's sinceds (Resident #13). The findings included Resident #133 was a 03/30/15 with diagnot dementia, degenerati walking, and muscle Review of the annual dated 02/02/16 coded cognitive impairment usually understood, a The MDS revealed Resistance of 1 personal resident was the first programment as the programment of the manual dated of the manual da	sibility of causing the septed and socially isolated ampled for meeting activity 3).  :  dmitted to the facility on ses which included ye disc disease, difficulty in		The statements included are not admission and do not constitute agreement with the alleged definere in. The plan of correction is completed in the compliance of federal regulations as outlined. in compliance with all federal ar regulations set fourth in the following plan of correction following plan of correction conscenter's allegation of compliance alleged deficiencies cited have will be completed by the dates in the interventions for affected reside. An additional activities assessment completed by the Activities Diremand May 18th, 2016 on Resident #1 assist with completing a compression of the resident informating athered from the resident is failed.	ciencies s state and To remain nd state on. The stitutes the e. All been or ndicated. ent: nent will be ctor by 33. To ehensive on will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		Ι,	C
		345159	B. WING				22/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION (	PENTED		14	410 EAST GASTON STREET		
LINCOLN	ION REHABILITATION C	ZENIER		L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 248	Continued From pag	e 13	F:	248			
	Further review of the	MDS indicated Resident			order to establish an activities plan of c	are	
	#133 had severely in	33 had severely impaired vision.			designed to appeal to Resident #133		
					interests and to enhance the resident□	s	
		n, originally dated 09/15/15,			highest practicable level of physical,		
	and updated on 02/0				mental and psychosocial well-being.		
		em that Resident #133 had			Resident #133 activities plan of care wi	II	
		facility long term, and			be updated by the facility Activities		
		airment, problems with was not able to make her			Director to reflect activities that meet the resident s interests by May 18th, 2016	_	
	needs known. She w			Tesiderit   S linterests by May Totil, 2010	'·		
	1	or decision making. Goals			Interventions for residents with potentia	al to	
	1 -	33 would participate in social			be affected:		
	interaction with 1 on						
	week and would part	icipate in self-directed			Facility residents will be assisted by		
	activities daily which	included that she enjoyed			Facility Staff to out of room activities		
		ds. The approaches included			and/or offered 1 to 1 activities by the		
	I -	ssistance to and from all out			Activities Director as per the resident		
	1	mes per week and promote			activity assessment/plan of care.		
		eraction among staff and			O- M 404b 0040 4b - f	_	
	peers.				On May 13th, 2016, the facility Activitie		
	The most recent activ	vity note in the medical			Director was educated by the Regional Clinical Director on the expectation of		
		/18/16 which indicated			providing activities that appeal to the		
		some confusion, shows little			residents interests and to enhance the		
	1	ents, and enjoys in room."			resident⊡s highest practicable level of		
	g g p	,,.,.,			physical, mental and psychosocial		
	Review of the activity	attendance sheets revealed			well-being. Education focused on ensu	ring	
	·	ruary 2016 Resident #133			activities are offered as per the residen	- 1	
		one (1:1) in room activities			activity assessment/plan of care.		
		cise on 02/01/16, reality					
	I .	16, wiped the resident's			T. 0. #B		
	I .	on 02/05/16, and other 1:1 in			The Staff Development Coordinator or		
	I .	the particular activities were			Director of Nursing will provide education		
		07/16, 02/08/16, 02/14/16, 02/22/16, 02/26/16, and			to facility staff (across all shifts includin full-time, part-time and as needed staff		
		ies director was unable to			This education will be completed by Ma		
		dance sheets for the dates of			18th, 2016 and emphasize the importal	- 1	
	02/27/16 or 02/28/16				of the facility activities program and the		
					facility staff responsibility in assisting		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345159	B. WING				C 4/22/2016	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 04	4/22/2016	
TVAIVIL OF T	TOVIDER OR OUT FEEL							
LINCOLN	TON REHABILITATION O	ENTER			AST GASTON STREET			
				LINC	DLNTON, NC 28092			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 248	Continued From pag	e 14	F 2	48				
	March 2016 revealed provided 8 in room a the resident was prov cream on the following	ance sheets for the month of I Resident #133 was ctivities. The record indicated vided conversation and/or ice ng days: 03/08/16, 03/09/16, 03/19/16, 03/20/16, 03/21/16,		th ac	sidents to group activity programs of eir choice and/or as outlined in their ctivities plan of care. stematic Change:			
	and 03/30/16.			Ef	fective May 20th, 2016, announcen			
	for Resident #133 rev 1:1 in room activities 2016 (dated from 04/ The activity provided	activity attendance sheets vealed she was provided two during the month of April /01/16 through 04/22/16). was that Resident #133's on 04/01/16 and again on		sy to fa th	Il be made over the facility intercomestem 30 minutes and 15 minutes protection the start of any group activity to all cility staff to begin assisting residence scheduled activity.  The facility Administrator and Activitie	rior ert ts to		
	Resident #133 was of follows: On 04/21/16 at 9 sitting in her wheelch foot of the bed. The t			Di at w op ac	rector will review the activities tendance record weekly for twelve (eeks for group activities to ensure otimal resident attendance to group ctivities.	12)		
	room, in the wheelch the foot of her bed. On 04/21/16 at 2 sitting in her wheelch	10:35 AM she was in her air which was positioned at 2:20 PM she was in her room, nair which was positioned at and the television was playing.		Di to pr M	ne facility Administrator and Activitie rector will review (10) residents mo ensure 1 to 1 in-room activities are ovided as per care plan.  Onitoring of the change to sustain	nthly		
	room, sitting in her w her bed with a throw	10:15 AM she was in her heelchair, at the left side of over her head, and the a news type channel.		Th	stem compliance ongoing:  ne Administrator and Activity Director port the completed activities	or will		
	On 04/22/16 at 1:25 conducted with the A stated she collected resident's interest fro resident was cognitive described Resident #			pa Q Im m As Im	articipation and 1 to 1 audit results to uality Assurance and Performance approvement Committee monthly for inimum of three months. The Quality assurance and Performance approvement Committee will review the udits to make recommendations to asure compliance is sustained ongo	a y ne		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345159	B. WING			С	
NAME OF D	DOVIDED OD SUDDI IED	343133	B. WING _	ethert andress city state 710 /	CODE	04/22/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE		
LINCOLNT	ON REHABILITATION C	ENTER		1410 EAST GASTON STREET			
				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 ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 248	Continued From page	e 15	F 2	48			
	Show" until "one day indicated Resident #1 of putting lotion of her starting a prayer mee 04/27/16 and was hop participate in that acti room activities include men, playing scrabble females' hands, and rindicated the group achurch services, mus exercising for which a resident's attended the further indicated she on activities per mont included crafts, string AD stated there have members and the volfacility and assist wer	-		and determine the need for auditing beyond the three			
F 253 SS=E	was unaware that 27 that attended the facil He further stated the residents' to the activ 483.15(h)(2) HOUSE MAINTENANCE SER	dministrator. He stated he out of 100 residents' was all lity's biggest activity events. staff needed to assist more ity events.  KEEPING & EVICES  ide housekeeping and a necessary to maintain a	F 2	253		5/20/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI IDENTIFICATION NUMBER: A. BUILDING			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 50.25		<del></del>	(		
		345159	B. WING			04/	22/2016	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C		TREET ADDRESS, CITY, STATE, ZIP CODE			
LINCOLN'	TON REHABILITATION C	ENTER			410 EAST GASTON STREET			
				L	INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 253	Continued From page This REQUIREMENT by: Based on observatio facility failed to keep i equipment and the wa 4 halls (Halls 300 and The findings included  During a facility tour of 9:30 AM with the Main following environmen  a) In Room 309, ard was observed approximate between the unit and peeling of paint and of bottom of the unit, and wood, and crumbling on the left side. b) In Room 313 Bed railing around the mico observed to be separ and uneven. c) In Room 401 Bed in the plaster on the woof the bed which had repainted. d) In the bathroom I 409 the portable raise observed with numero metal frame.	e 16 In and staff interviews the in good repair resident alls in resident rooms on 2 of it 400).  It is not met as evidenced and staff interviews the in good repair resident rooms on 2 of it 400).  It is no 04/22/16 from 8:55 AM to intende Director (MD) the ital concerns were observed:  It is no 04/22/16 from 8:55 AM to intende Director (MD) the ital concerns were observed:  It is no 04/22/16 from 8:55 AM to intended to like the wood from 8:55 AM to intended to like the intended to like the intended in the intended in the lead black staining, rotten plaster underneath the unit intended A, the white colored chair intended in the wall was attended to the wall was attended with gashes in the paint intended in the lead board been chalked and intended intended intended in the lead board between Rooms 407 and intended intende		253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies here in. The plan of correction is completed in the compliance of state as federal regulations as outlined. To remain compliance with all federal and state regulations set forth in the following plan of correction constitutes center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicate Interventions for affected resident:  In room 309 the Maintenance Director replaced the rotten wood around the heating/cooling unit and replastered an painted underneath the unit on the left side on May 10, 2016.  In Room 313 Bed A, Room 401 Bed A 408 Bed B the chair rail will be remove and walls will be completely painted by Maintenance Director / Designee by Ma 20th, 2016.  In Room 407 and Room 409 the portal raised toilet seat frame in the bathroom	nd ain the d. d the and d the ay		
	in the plaster on the v of the bed which had repainted. f) In Room 412 Bed	d B, the tall deep back chair was observed to have			was replaced on May 10, 2016 with a r toilet seat frame.  In room 412 B the tall deep back cushio of the wheelchair was replaced on Apri 29, 2016 with a new cushion.	on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345159	B. WING			04/3	; 22/2016	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0.00		STREET ADDRESS, CITY, STATE,	ZIP CODE	04/2	22/2010	
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LINCOLN.	TON REHABILITATION	CENTER		LINCOLNTON, NC 28092				
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F 253	facility tour the MD of that each room obseneeded to be repair facility was in the prooms. He indicated remodeled approxing corporate office and and make changes continue with the otter stated he was unawe the remodeling of the begin. He further stand the hallway wal and/or repainted. He the 100 and 200 has remodeled with new curtains, furniture, a reiterated that he was resident rooms wou.	ge 17  AM and during part of the was interviewed. He stated erved was not homelike and ed. The MD further stated the ocess of remodeling resident I Room 115 had been nately 2 months ago for the interior decorator to observe or give the approval to her resident rooms. The MD hare of a schedule as to when he resident rooms would ated the offices, the dayroom, als had been either remodeled e also indicated the rooms on als had been repainted and a light fixtures, bedspreads, and sink vanities. The MD has unaware of when the light fixtures of when the light f	F 2		ents with potential be performed by tor by May 20, 20 ing units to ensure wood, crakes, ing of paint or bland resident's or all of the rooms months.  I be performed by tor by May 20, 20 or railing is not in the paint / not even behind leds or in the ll of the rooms or is.  I be performed by tor / Designee by tor / Designee by	y 016 re ack s y 016		
	approximately 80,00 remodeling or repair expected the other repainted and/or rer so. The Administrate			toilet seat frame have i metal frame for all the for three months.  A facility wide audit will the Maintenance Direc May 20, 2016 to ensur back cushions of the w peeling, torn or has tat the rooms once weekly  On May 9th, 2016, The re-educated the Mainte	no rust areas on rooms once weel by tor / Designee by the that all tall deep wheelchair are not tered vinyl for all of the for three months.	kly y p t s.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE COMP	SURVEY LETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1410 EAST GASTON STREET  LINCOLNTON, NC 28092			22/2016
(X4) ID PREFIX TAG	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	÷ 18	F 2	253	ensuring a home like environment.  Systematic Change:  By May 20th, 2016, Staff Members (across all shifts including full-time, part-time and as needed staff) will be educated by the Staff Development Coordinator and/or Designee on completing maintenance request forms replace or repair around heating/cooling units, repair or replace chair railing in the middle of the wall or behind the head board of the beds, replace raised toilet seats that have rust areas on the metal frame or repair/replace back cushions that are peeling, torn and tattered vinyl.  As follow-up, the facility Administrator of conduct facility audits (tours) with the Maintenance Director monthly for 3 months to ensure the facility exhibits a homelike environment.  Monitoring of the change to sustain system compliance ongoing:  The Administrator and Maintenance Director will report audit results monthly the Quality Assurance and Performance Improvement Committee for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits to mal recommendations to ensure compliance is sustained ongoing and determine the need for further auditing beyond the thr months.	g ne I that vill y in e ke e	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345159	B. WING		C <b>04/22/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	0.10.100	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	04/22/2016
TO UNIC OF T	TO VIDER OR GOTT EIER			1410 EAST GASTON STREET	
LINCOLN	TON REHABILITATION C	ENTER			
				LINCOLNTON, NC 28092	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 282	Continued From page	e 19	F 2	82	
F 282		/ICES BY QUALIFIED	F 2		5/20/16
SS=D	PERSONS/PER CAF		1 2	02	3/20/10
		d or arranged by the facility			
		n resident's written plan of			
	care.				
	This REQUIREMENT	is not met as evidenced			
	_	ons, record review, resident,		The statements included are no	ot an
		ne facility failed to follow the		admission and do not constitute	<b>;</b>
		g showers and oral care for		agreement with the alleged defi	ciencies
		oled for activities of daily		herein. The plan of correction is	
	living (Resident #19).			completed in the compliance of federal regulations as outlined.	
	The findings included	l:		in compliance with all federal ar regulations, the center has take	
	Resident #19 was ad	mitted to the facility on		take the actions set forth in the	following
	11/25/15 with diagnos	ses which included cerebral		plan of correction. The following	plan of
	,	roke), hemiplegia, and		correction constitutes the center	
	respiratory disease.			allegation of compliance. All alle	eged
				deficiencies cited have been or	will be
		rly Minimum Data Set (MDS) d Resident #19 as cognitively		completed by dates indicated.	
	The MDS indicated F	·		Interventions for affected reside	nt:
	extensive physical as	sistance of 1 person with		Resident #19 was assisted with	a shower,
	_	living (ADLs) which included		dentures were removed and cle	aned and
	bed mobility, transfer			placed back in her mouth on Ap	ril 22,
		d bathing. Further review of		2016.	
		esident #19's preferences for			
		were very important with no		Interventions for residents ident	
	documented behavio	rs or refusal of care.		having the potential to be affect	ed:
		n dated 02/25/16 revealed		A facility audit was performed o	
		ADL self-care deficit related		2016 by the Director of Nursing	
	ιο weakness and hen	niplegia with approaches for		and Assistant Director of Nursin	g (ADUN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7. 50.25	_		، ا	С	
		345159	B. WING				22/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
				1	410 EAST GASTON STREET			
LINCOLN	TON REHABILITATION C	ENTER		L	INCOLNTON, NC 28092			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 282	Continued From page	e 20	F	282				
	staff to provide the as	sistance with ADLs to level			to ensure that resident's requiring			
	•	th mouth care/denture care			assistance with denture/oral hygiene			
	daily and as needed	(prn).			received assistance. Dentures were			
					cleaned for those resident's identified a	is		
	On 04/18/16 at 4:10 F	PM Resident #19 was			indicated. Oral hygiene was provided for	or		
	interviewed and aske	d if staff helped her to clean			those residents identified as needing o	ral		
		dent answered, "No, they do			hygiene. DON & ADON performed an			
		entures out at night for them			audit on April 28, 2016 of scheduled			
		9 explained that she was			showers to ensure all residents were			
		dentures on her own due to			receiving and or offered showers at lea	st		
	her paralysis and that				twice weekly. Residents identified as			
		ral care provided in a "long ecall when the last time a			needing a shower or requesting a show was assisted with a shower.	ver		
	staff member assisted				was assisted with a shower.			
		es were observed to be			Licensed Nurses (LN) and Certified			
		lor, with thick accumulation			Nursing Assistants (CNA's) across all			
		he teeth and gum line.			shifts including full time, part time and	as		
	_	lue colored denture cup on			needed staff will be educated by May			
		nk and a box of denture			2016. Education will be provided by the			
		ne sink vanity in her room.			Staff Development Coordinator (SDC)			
	01	•			ensuring oral hygiene is provided with			
	On 04/19/16 at 10:43	AM Resident #19 was			morning and bedtime care. Dentures a	re		
	observed in her room	disheveled. Resident #19's			removed and soaked at bedtime, clear	ed		
	hair was unclean, unc	combed, greasy looking, and			and placed back in mouth prior to			
	matted to her head w	ith her scalp visible.			breakfast.			
	On 04/20/16 at 9:30 A	AM Resident #19 was			LN's & CNA"s across all shifts including	g		
	observed lying in bed	and reported that she had			full time, part time and as needed staff	-		
	received her morning	care but that no one had			be educated by May 18, 2016, on			
	taken her dentures or	ut during the night to soak			ensuring that showers are given as	ſ		
		observed and were visibly			scheduled and upon request from a	ſ		
	-	ulation of food matter along			resident. This education will be provide	:d		
	_	e and her hair was observed			by the facility SDC. The education will	ſ		
	to be greasy looking.				include assuring that assistance with	ſ		
					activities of daily living is provided as	ſ		
		AM Resident #19 was			outlined in the resident care plan.	ſ		
		ropelling in the hall and			Outtonia Observa	ſ		
		#19's hair was greasy r head on the left side with			Systemic Change:	ſ		
	Hookina. mattea to ne	Head on the left Side with	1		I .		1	

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	1/22/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				141	IO EAST GASTON STREET			
LINCOLN	TON REHABILITATIO	N CENTER		LIN	NCOLNTON, NC 28092			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	'	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 282	Continued From p	age 21	F 2	282				
		ner shoes were not fastened			Director of Nursing (DON), Staff			
		s flopping and her shoes			Development Coordinator (SDC), Unit			
		own on her feet. Resident #19			Manager (UM) or Designee will rando	•		
		ad assisted her with removing			audit ten (10) residents twice weekly f			
		ak and that she was supposed			12 weeks, then ten (10) residents wee			
	to have a shower.				for 12 weeks, then twice monthly for 6			
					months across all shifts to ensure oral			
		50 PM Resident #19 was			hygiene and showers are provided. A			
		n her wheelchair in her room.			will include ensuring that showers are			
		ir was greasy looking, matted to			received as scheduled and as request			
		dentures were visibly dirty with			dentures are removed at bedtime, pla			
	thick accumulation of food matter along the teeth in a denture cup with cleanser to soa		•					
	and gum line.				assistance is provided by staff for those residents identified and care planned and care pl			
	On 04/22/16 at 9:3	20 AM a follow-up interview was			requiring assistance.	35		
		esident #19. She stated she had			requiring addictance.			
		ower all week and her shower			Newly hired Licensed Nurses and			
		urday and Wednesday. She			Certified Nurses Assistants will be			
		a shower on Saturday 04/16/16			educated By the facility SDC on ensur	ing		
		ed a shower since then.			oral hygiene and/or denture care is	J		
	Resident #19 indid	cated she was told on			provided with morning and bedtime ca	ıre.		
	Wednesday 04/20	/16 by nurse aide (NA) #2 that			Newly hired Licensed Nurses and			
	she would take he	r to the shower later that day			Certified Nursing Assistants will be			
	and NA #2 had no	t taken her. Resident #19			educated by the facility SDC to ensure	<del>)</del>		
	stated on Thursda	y NA #2 was supposed to give			residents receive showers as schedule	ed		
	her a shower and	had not. Resident #19 stated			and upon request of the resident.			
		lay and I still do not have a			Education will include ensuring assista	ance		
		e has helped me with soaking			with activities of daily living is provided			
		r." The resident was observed			residents identified and care planned	as		
		oking hair, disheveled, unclean,			requiring assistance.			
	and her dentures	were visibly dirty.						
	0.04/00/15 1:5	00.444.444			Monitoring of the change to sustain			
		:00 AM, NA #1 was interviewed			system compliance ongoing:			
	•	dent #19 was supposed to have			Monthly for a minimum of 40	tho		
		nesday 04/20/16 and that she			Monthly for a minimum of 12 months,			
		e resident had a shower. NA #1			DON, SDC, or UM will present results	OT		
		ed "her hair is greasy looking			the audits ensuring residents receive			
		head and she does not look			assistance with activities of daily living	•		
	i iike she nas nad a	shower." NA #1 further stated			indicated, oral hygiene, denture care,	ariu	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
			A. BOILDII	NG		С	
		345159	B. WING _			/22/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		72272010	
				1410 EAST GASTON STREET			
LINCOLN.	TON REHABILITATION	I CENTER		LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C  (EACH CORRECTIVE AG  CROSS-REFERENCED TO  DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 282	#19 and was unaw shower or her dent on 04/22/16 at 10: interviewed and star Resident #19 to ha Wednesday. Nurse Resident #19 had Wednesday or dur stated she was unanot being assisted dentures. She indict the residents to be oral care.  On 04/22/16 at 12: was conducted wit responsible for the Wednesday 04/20/	nsible for the care of Resident are of why she had not had a ures cleaned during the week.  05 AM, Nurse #1 was ated she would have expected we had a shower on at #1 stated she was unaware not received a shower on ing the week. Nurse #1 further aware that Resident #19 was with oral care or soaking of her cated it was her expectation for assisted with showers and  45 PM, a telephone interview in NA #2. NA #2 stated she was care of Resident #19 on 16 and Thursday 04/21/16	F2	showers to the Quality As Performance Improvement The Quality Assurance an Committee will review the recommendations to ensitis sustained ongoing; and need for further auditing to months.	nt Committee.  Ind Improvement  audits to make  ure compliance  d determine the		
	had not given Resi Wednesday or Thu behind and had for shower. NA #2 also the resident's dent On 04/22/16 at 12: was conducted wit was responsible fo from 11:00 PM unt had not assisted th dentures or provide stated she was una assistance with he On 04/22/16 at 1:3 conducted with the	3:00 PM. NA #2 confirmed she dent #19 a shower on arsday and that she had gotten gotten to give the resident a constated she had not soaked cures or provided oral care.  50 PM, a telephone interview in NA #3. She confirmed she in the care of Resident #19 if 7:00 AM. NA #3 stated she is resident with soaking her red oral care. NA #3 further aware Resident #19 required in dentures.  0 PM, an interview was Director of Nursing (DON).					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		I	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345159	B. WING		C <b>04/22/2016</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1410 EAST GASTON STREET  LINCOLNTON, NC 28092	1 04/22/2010
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 282 F 312 SS=D	She indicated she excare plan for each reswould have expected assisted Resident #1 and assisted the residence ded.  483.25(a)(3) ADL CADEPENDENT RESIDENT RE	dent as required or needed. pected the NAs to follow the sident. The DON stated she the nursing staff to have 9 with soaking her dentures dents with oral care as RE PROVIDED FOR	F 28		5/20/16
	by: Based on observation and staff interviews the oral care and shower extensive assistance causing the resident of 1 of 3 residents salliving (Resident #19).  The findings included Resident #19 was ad 11/25/15 with diagnost vascular accident (str respiratory disease.  Review of the quarter dated 02/19/16 coded	mitted to the facility on ses which included cerebral toke), hemiplegia, and sly Minimum Data Set (MDS) d Resident #19 as cognitively making her needs known.		The statements included are not an admission and do not constitute agreement with the alleged deficience herein. The plan of correction is completed in the compliance of state federal regulations as outlined. To re in compliance with all federal and state regulations, the center has taken or take the actions set forth in the follow plan of correction. The following plar correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated.  Interventions for affected residents:  Resident #19 was assisted with a she dentures were removed, cleaned and	e and emain ate will ving n of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(	c
		345159	B. WING _			04/	22/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLNI	ON REHABILITATION C	ENTED		14	410 EAST GASTON STREET		
LINCOLN	ON REHABILITATION C	ENTER		L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page		F:	312			
	assist with her activiti	with 1 person physical es of daily living (ADLs)			back in resident's mouth on April 22, 2016.		
	toileting, personal hygreview of the MDS incorpreferences for shown	nobility, transfers, dressing, giene, and bathing. Further dicated Resident #19's ers and hygiene was very			Interventions for residents identified as having the potential to be affected:		
	refusal of care.	umented behaviors or			A facility audit was performed on April 2 2016 by the Director of Nursing (DON) and the Assistant Director of Nursing	22,	
	Resident #19 had an to weakness and hem staff to provide the as	n dated 02/25/16 revealed ADL self-care deficit related hiplegia with approaches for esistance with ADLs to level th mouth care/denture care (prn).	(ADON) to id requiring as Daily Living. updated to ridentified as		(ADON) to identify those residents requiring assistance with the Activities Daily Living. The resident care card we updated to reveal those resident's identified as needing assistance with Activities of Daily Living.		
	her teeth and the resi not help me get my de to soak." Resident #1 unable to remove her her paralysis and that dentures soaked or o time" and could not re staff member assisted	d if staff helped her to clean dent answered, "No, they do entures out at night for them 9 explained that she was dentures on her own due to a she had not had her ral care provided in a "long ecall when the last time a			Licensed Nurses and Certified Nursing Assistants across all shifts including ful time, part time and as needed staff will educated by May 18, 2016. Education be provided by the Staff Development Coordinator. Education will include providing resident's with assistance wit activities of daily living (ADL's) including denture care, showers and oral hygiend as needed.	l be will h g	
	visibly dirty, dull in co of food matter along t Resident #19 had a b setting on the shelf at denture soaking pack vanity in her room. On 04/19/16 at 10:43 observed in her room	lor, with thick accumulation he teeth and gum line. lue colored denture cup bove the sink and a box of ets setting on the sinks  AM Resident #19 was disheveled. Resident #19's combed, greasy looking, and			Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager (UM),will randomly audit ten (residents twice weekly for 12 weeks, then (10) residents weekly for 12 weeks then twice monthly for 6 months across shifts to ensure residents are assisted with denture care, oral hygiene and showers as scheduled and indicated.	ien	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345159	B. WING _			1	22/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	22/2010
				14	110 EAST GASTON STREET		
LINCOLN	TON REHABILITATION C	ENTER		LI	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	e 25	F3	312			
F 312	On 04/20/16 at 9:30 A observed lying in bed received her morning taken her dentures or soaked them. Her ted visibly dirty with thick along the teeth and g observed to be greas.  On 04/21/16 at 11:45 observed to be self-p disheveled. Resident looking, matted to he her scalp visible, her with the Velcro tabs ff flopping up and down reported no one had her dentures to soak to have a shower.  On 04/21/16 at 2:50 flobserved setting in her Resident #19's hair wher head, and her dethick accumulation of and gum line.  On 04/22/16 at 9:20 A conducted with Resident #19 indicated wednesday 04/20/16 she would take her to but the NA did not take to the served with the NA did not take the conducted with take her to but the NA did not take the server was a server we had a side would take her to but the NA did not take the top to the server was a server we had a side would take her to but the NA did not take the top to the server was a server	AM Resident #19 was and reported that she had care but that no one had at during the night to have with were observed and were accumulation of food matter um line and her hair was y looking.  AM Resident #19 was ropelling in the hall and #19's hair was greasy rhead on the left side with shoes were not fastened opping and her shoes on her feet. Resident #19 was ser wheelchair in her room. Was greasy looking, matted to intures were visibly dirty with food matter along the teeth was lent #19. She stated she had reall week and her shower any and Wednesday. She hower on Saturday 04/16/16 as shower since then. Sed she was told on by the nurse aide (NA) #2 of the shower later that day see her. Resident #19	F3	312	Newly hired Licensed Nurses and Certified Nursing Assistants will be educated by the Staff Development Coordinator on ensuring resident's recrassistance with activities of daily living including denture care, oral hygiene ar showers as indicated.  Monitoring of the change to sustain system compliance ongoing:  Monthly for a minimum of 12 months, to DON, ADON or UM will report results of the denture care, oral hygiene and should be addited to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoin and determine the need for further auditing beyond the three months.	he of wer .ce e	
	she would take her to but the NA did not tak explained that on Thu	the shower later that day					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY IPLETED	
		345159	B. WING _		0.	C 4/22/2016	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092		#/ <b>ZZ</b> / <b>Z</b> 0 10	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	a shower and no one my dentures either." to have greasy lookin and her dentures we On 04/22/16 at 10:00 and reported Reside a shower on Wednes was unaware if the robserved and stated and matted to her he like she has had a she was not respons #19 and was unawar shower or her dentur On 04/22/16 at 10:05 interviewed and state Resident #19 to have Wednesday. Nurse #Resident #19 had no Wednesday or during stated she was unawar not being assisted w	Friday and I still do not have has helped me with soaking. The resident was observeding hair, disheveled, unclean, re visibly dirty.  O AM, NA #1 was interviewed int #19 was supposed to have saday 04/20/16 and that she esident had a shower. NA #1 "her hair is greasy looking and and she does not look hower." NA #1 further stated ible for the care of Resident re of why she had not had a res cleaned during the week.  S AM, Nurse #1 was ed she would have expected	F 3	,			
	oral care.  On 04/22/16 at 12:45 was conducted with responsible for the care wednesday 04/20/16 from 7:00 AM until 3: had not given Reside Wednesday or Thurs behind and had forge shower. NA #2 also see	5 PM, a telephone interview NA #2. NA #2 stated she was are of Resident #19 on 6 and Thursday 04/21/16 00 PM. NA #2 confirmed she ent #19 a shower on iday and that she had gotten often to give the resident a stated she had not soaked es or provided oral care.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345159	B. WING _				22/2016
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIF 1410 EAST GASTON STREET LINCOLNTON, NC 28092	CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
F 312	was conducted with N was responsible for the from 11:00 PM until 7 had not assisted the redentures or provided stated she was unawassistance with her deconducted with the D She stated it was her be provided to a resident to have a she shower days and any requested. The DON	PM, a telephone interview IA #3. She confirmed she he care of Resident #19 :00 AM. NA #3 stated she resident with soaking her oral care. NA #3 further hare Resident #19 required hentures.  PM, an interview was irrector of Nursing (DON). expectation that ADL care hent as required or needed. he would have expected a hower on their scheduled other day should it be stated she would have	F3	312			
F 412 SS=D	resident with soaking resident with oral care 483.55(b) ROUTINE/SERVICES IN NFS  The nursing facility man outside resource, §483.75(h) of this par covered under the Stadental services to me resident; must, if necessident; must, if necessident; must, if necessident; must promptly refer redamaged dentures to	ust provide or obtain from in accordance with t, routine (to the extent ate plan); and emergency et the needs of each essary, assist the resident in ; and by arranging for from the dentist's office; and esidents with lost or	F 4	112			5/20/16

OLIVILIV	O I OI WILDIO II LE C	MEDIO (ID CEITTICE)				CIVID IVE	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	0
		345159	B. WING				22/2016
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	ON REHABILITATION C	ENTER		14	410 EAST GASTON STREET		
LINGOLIN	TON REHABILITATION O	ENTER		L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 412	Continued From page		F	412			
		ns, medical record review,			The statements included are not an		
		amily interviews the facility			admission and do not constitute		
		ne dental services for 1 of 2			agreement with the alleged deficiencie	S	
	residents (Resident # The findings included	•			herein. The plan of correction is completed in the compliance of state a	nd	
		ginally admitted to the facility			federal regulations as outlined. To rem		
		s recently discharged to the			in compliance with all federal and state		
		ed on 03/24/16. The most			regulations, the center has taken or wil		
	recent annual Minimu	ım Data Set (MDS) dated			take the actions set forth in the followir		
	04/06/16 revealed the	e resident had diagnoses			plan of correction. The following plan o	f	
	which included non-A	· · · · · · · · · · · · ·			correction constitutes the facility's		
	diabetes, heart disea				allegation of compliance. All alleged		
		others. The MDS also			deficiencies cited have been or will be		
	revealed Resident #6	nobility and transfers, and			completed by dates indicated.		
	total assistance with	dressing, eating, personal bathing. The MDS further			Interventions for affected residents:		
	indicated Resident #6	_			Resident #62 received a Comprehensi	ve	
	fragments. The MDS'	s reviewed for the past year			Oral Examination by Long Term Care		
	indicated the payor so	ource for Resident #62 was			Professional Dental Services on May 2	.,	
	Medicaid unless she				2016 with no current restorative dental		
	hospitalization and hatime.	ad been Medicare for a brief			needs and/or recommendations.		
		(D. :1. 4.800			Interventions for residents identified as		
	During an observation				having the potential to be affected.		
	have 3 teeth in her bo	I the resident was noted to			A facility audit of the current resident		
	appeared to be a full				population was performed 04/21/2016	_	
	appeared to be a fair	apper plate.			05/06/2016 by the facility Social Service		
	On 04/21/16 at 9:40 A	AM the Social Services			Director (SSD) and a representative from		
		nterviewed. The SSD stated			Long Term Care Professional Dental		
	there was a hygienist	at the facility once a month			Services to ensure dental services has		
		nere every other month			been offered at least annually. Resider		
		ist. The SSD further stated			identified as being affected were offere		
		or resident sign a consent			dental services and those accepting wi	II	
	form to see the dentis				be assessed by Long Term Dental		
	residents are usually	seen twice a year.			Associates on May 20, 2016.		
	A review of the medic	cal record for Resident #62			Re-education was provided with the		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED	
		345159	B. WING			C <b>04/22/2016</b>	
	ROVIDER OR SUPPLIER TON REHABILITATION	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		HOULD BE	(X5) COMPLETION DATE
F 412	Continued From page	ge 29	F 4	12			
F 412	revealed no docume referrals or routine paince the resident's 07/11/14.  During an observatiou/21/16 at 10:55 A have 3 teeth in her appeared to be a further for Resident #62 to facility but was unsured on 04/21/16 at 12:4 Director was intervied Resident #62 had not found where she had dentist.  On 04/22/16 at 12:5 interviewed. The SSD furthis had slipped throfollowed up on.  On 04/22/16 at 12:5 interviewed. The DO that each resident is	entation of dental consults or periodic dental examinations original admit date of  on of Resident #62 on M the resident was noted to bottom jaw and what II upper plate.  Enview with a Family Member 62 on 04/21/16 at 12:38 PM, membered signing a consent be seen by a dentist in the cure if she had actually seen  15 PM the Medical Records ewed. She verbalized that o documentation that could be ad ever been seen by a	F4	facility Social Services Director of 05/13/2016 by the facility Director Nursing on the expectation of er dental services are offered year needed.  Systemic Change:  The facility will ensure dental services Director will connew admission information to Locare Professional Dental Service enrollment into the dental prograresident and/or responsible part dental servcies, declination lette sent to the facility from Long Ter Professional Dental Associates. Term Care Professional Dental Associ	or of insuring illy and as  ervices are facility inmunicate ong Term ices for iam. If a ity decline irrs will be irm Care i. Long i. Long i. Long Associates iffer dental  dit it i		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
		345159	B. WING _			C <b>04/22/2016</b>
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1410 EAST GASTON STREET LINCOLNTON, NC 28092	I )E	34.ZZZ310
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA	
F 412	Continued From page	<del>2</del> 30	F 4	need for further auditing beyon twelve months.	and the	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS		F 5.	. 20		5/20/16
	assurance committee nursing services; a ph	in a quality assessment and consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of ified quality deficiencies.				
		rds of such committee h disclosure is related to the pmmittee with the				
		y the committee to identify ficiencies will not be used as				
	This REQUIREMENT	is not met as evidenced				

OLIVILIN	O I OI ( WEDIO/ WE W	T OF THE SERVICES				T	0.0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 55.25	_			С
		345159	B. WING			1	/22/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER			410 EAST GASTON STREET		
				L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page by: Based on observation and staff interviews, the Assessment and Assimaintain implemented these interventions the place in June of 2015 which were originally recertification and condeficiencies in the arresident's written plant daily living were recitive recertification and concontinued failure of the surveys of record shot facility's inability to surveys and contained to follow the care showers and oral car sampled for activities #19).  On the recertification facility was cited a deto follow the care plant a pull/tab alarm. On the	e 31  ons, record reviews, resident, the facility's Quality urance Committee failed to d procedures and monitor nat the committee put into 5. This was for 2 deficiencies cited in May of 2015 on a implaint survey. The leas of failure to follow a in of care and activities of ed on the current implaint survey. The ne facility during two federal lowed a pattern of the lustain an effective Quality  orred to:  ollow a resident's written on observations, record staff interviews the facility re plan for providing e to 1 of 3 residents of daily living (Resident  survey in May of 2015, the efficiency at F 282 for failure in intervention for the use of he current survey the facility a resident's care plan for		520		s nd ain e the red.	
		Daily Living: Based on review, resident, and staff			LN's & CNA"s across all shifts including full time, part time and as needed staff		

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON IDENTIFICATION NUMBER: A. BUILDING COMPLET		OF DEFICIENCIES F CORRECTION				
NAME OF PROVIDER OR SUPPLIER  LINCOLNTON REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					B. WING	345159		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	22/2010		410 EAST GASTON STREET	141		ENTER		
E E20 Continued From your 20	(X5) COMPLETION DATE	-	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		(EACH DEFICIENC)	PRÉFIX
interviews the facility failed to provide oral care and showers for a resident who required extensive assistance with activities of daily living causing the resident to feel unclean and unkempt for 1 of 3 residents sampled for activities of daily living (Resident #19).  On the recertification survey in May of 2015, the facility was cited a deficiency F 312 for failure to wash resident's hands before every meal who required assistance with activities of daily living. On the current survey the facility lailed to provide oral care and showers to a resident.  During an interview on 04/22/16 at 2:20 PM the Administrator stated the Quality Assessment and Assurance Committee had monthly meetings and it was his plan to correct the issues presented in this survey and develop systems to keep the issues from reoccurring.  F 520  be educated by May 18, 2016, on ensuring that showers are given as scheduled and upon request from a resident. This education will be provided by the facility SDC. The education will include assuring that assistance with Activities of Daily Living is provided as outlined in the resident care plan.  Re-education will be provided as outlined in the resident care plan.  Re-education was provided to the facility Quality Assessment and Assurance Committee (DA & A Committee) by the Regional Clinical Director. Education included importance of maintaining an effective QA & A Committee Ox & A Committee Ox & A Committee Ox & A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement actions by correcting and sustaining compliance and evaluating the effectiveness of quality management activities.  Systematic Change:  Random audits will be completed by the Director of Nursing / Designee to validate that oral hygiene is provided uning morning and bedtime care and scheduled showers are offered at least twice weekly and upon request from any resident.  Audits will be performed randomly on ten (10) residents twice Week		n ns e lity e ete ed dy en ss, are	ensuring that showers are given as scheduled and upon request from a resident. This education will be provided by the facility SDC. The education will include assuring that assistance with Activities of Daily Living is provided as outlined in the resident care plan.  Re-education was provided to the facility Quality Assessment and Assurance Committee (QA & A Committee) by the Regional Clinical Director. Education included importance of maintaining an effective QA & A Committee. Education emphasized ensuring the QA & A Committee oversees and identifies all efforts that improve the quality of care in the facility by monitoring performance measures, directing improvement action by correcting and sustaining compliance and evaluating the effectiveness of qualmanagement activities.  Systematic Change:  Random audits will be completed by the Director of Nursing / Designee to validate that oral hygiene is provided during morning and bedtime care and schedules showers are offered at least twice week and upon request from any resident. Audits will be performed randomly on terms of the providents twice weekly for 12 weeks, then twice monthly for 6 months across all shifts to ensure residents are assisted with Activities of Daily Living cares.	520	F	failed to provide oral care sident who required with activities of daily living to feel unclean and unkempt ampled for activities of daily survey in May of 2015, the efficiency F 312 for failure to is before every meal who with activities of daily living, by the facility failed to provide is to a resident.  In 04/22/16 at 2:20 PM the end he was unaware there are past action plans were not improve the systems. The the Quality Assessment and the had monthly meetings and frect the issues presented in lop systems to keep the	interviews the facility and showers for a resextensive assistance causing the resident t for 1 of 3 residents saliving (Resident #19).  On the recertification facility was cited a dewash resident's hands required assistance won the current survey oral care and showers.  During an interview of Administrator indicate was a problem and the followed through to im Administrator stated the Assurance Committee it was his plan to correthis survey and developed.	F 520

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345159	B. WING _			l	C
		345159	B. WING _			04/	22/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN.	TON REHABILITATION C	ENTED		14	110 EAST GASTON STREET		
LINCOLIN	TON KENABILHATION C	LNILK		LI	INCOLNTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	33	F 5	520	denture care, oral hygiene and shower as scheduled and indicated.  Monitoring of the change to sustain system compliance ongoing:  Monthly for a minimum of 12 months, the Director of Nursing / Designee will repose audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement committee will review the audits to make recommendations to ensure compliance is sustained ongoin and determine the need for further auditing beyond the twelve months.	ne ort ind ce	