	-						M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			COMF	E SURVEY PLETED
		345385	B. WING _				C / 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	20/2020
CARDINA	L HEALTHCARE AND RE	EHAB					
	N OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345385 B. WING SF PROVIDER OR SUPPLER STREET ADDRESS, CTY, STATE, ZIP CODE INAL HEALTHCARE AND REHAB STREET ADDRESS, CTY, STATE, ZIP CODE D SUMMARY STATEMENT OF DEFICIENCIES BY NASPEN STREET INCOLNTON, NC 28092 D PROVIDERS PLAN OF CORRECTION SHOULD (CROSS-REFERENCE) D SUMMARY STATEMENT OF DEFICIENCIES D IX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION SHOULD (CROSS-REFERENCE) 00 Initial Comments E 000 An unannounced COVID-19 Focused Survey and complaint investigation was conducted on 07/27/2020. An extended survey was conducted on 07/27/2020. The survey team returned to the facility on 08/19/20 through 08/20/20 to conduct an unannounced complaint investigation survey and COVID-19 Focused Infection Control Survey. Therefore, the exit date was changed to 08/20/20. The facility was found in compliant envestigation were conducted OVID-19 Focused Infection Control Survey and complaint investigation were conducted OVID-19 Focused Infection Control Survey and complaint investigation survey and COVID-19 Focused Infection Control Survey was conducted on 07/27/2020. The survey. 00 INITIAL COMMENTS F 000 An unannounced COVID-19 Focused Infection Control Survey and COVID-19 Focused Infection Control Survey. F 000 An unannounced COVID-19 Focused Infectio			1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
F 000	complaint investigation 07/20/2020 through 0 survey was conducted team returned to the 3 08/20/20 to conduct a investigation survey a Infection Control Survey was changed to 08/20 in compliance with 42 E-0024 (b)(6), Subpar Term Facilities. Even INITIAL COMMENTS An unannounced CC Control Survey and c conducted 07/20/202 extended survey was The survey team retu 08/19/20 through 08/20 unannounced compla COVID-19 Focused I Therefore, the exit da 08/20/2020. Eighteen complaint allegations cited. Immediate Jeopardy CFR 483.12 at tag F6	on was conducted on 7/27/2020. An extended d on 07/27/20. The survey facility on 08/19/20 through an unannounced complaint and COVID-19 Focused vey. Therefore, the exit date 0/20. The facility was found 2 CFR 483.73 related to rt-B-Requirements for Long it ID# NYKK11. VID-19 Focused Infection omplaint investigation were 0 through 07/22/20. An conducted on 07/27/2020. rned to the facility on 20/2020 to conduct an int investigation survey and nfection Control Survey. te was changed to n (18) of the twenty-four (24) were substantiated and was identified at:	FC	000			
	The facility was notific additional immediate	ed on 08/13/2020 of jeopardy identified after					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
Electroni	cally Signed						09/10/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED C
		345385	B. WING				/20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET		
					LINCOLNTON, NC 28092		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page management quality r	eview.	F	000	0		
	-	was identified at: 80 at a scope and severity					
	(K) Immediate Jeopardy I	began on 06/22/20 and was					
	removed on 07/27/20	20.					
	The tag F600 constitu Care.	Ited Substandard Quality of					
_	An extended survey v 07/27/2020.						
F 580 SS=D	Notify of Changes (Inj CFR(s): 483.10(g)(14	jury/Decline/Room, etc.))(i)-(iv)(15)	F	58(0		9/14/20
	consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue	ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ving the resident which as the potential for requiring ; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial eatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the					

Event ID: NYKK11

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345385	B. WING			08/	_ 20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB			31 N ASPEN STREET		
				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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	 (ii) When making notii (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must at resident and the reside when there is- (A) A change in room as specified in §483.11 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a composite dis §483.5) must disclose its physical configurate locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revisistaff interviews, the far resident's responsible of a resident's intimate resident (Resident #2 3 residents reviewed The findings included 	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and resident obsite distinct part. A facility stinct part (as defined in e in its admission agreement ion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced ews, responsible party and acility failed to notify the e party regarding the details e relationship with another 6 and Resident #27) for 1 of for notification.	F	580	F580 On 8/21/2020 a phone meeting by the Executive Director was held with Resident #26 Responsible Party To provide an update of the current events. No other concerns voiced at that time. On 8/28/2020		

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/24/2020 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345385	B. WING		08	C / 20/2020
NAME OF P	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CO		
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	ЕНАВ		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	a 3	F 58			
1 000	11/3/19 with diagnosi	s which included heart	F 30	Resident #27 was discharge	d.	
	and asthma. Review of Resident # Data Set (MDS) date severely cognitively in required limited assis for most activities of of Resident #27 was ad 11/15/19 with diagnos hypertension, anxiety Review of Resident # Data Set (MDS) date alert and oriented rec one staff member for Review of a progress AM revealed the Assi had talked with Resider regarding her and Rec	mitted to the facility on sis which included anemia, v, depression and asthma. 27's quarterly Minimum d 7/1/20 revealed he was quiring limited assistance of most ADL. a note dated 6/19/20 at 6:37 istant Director of Nursing lent #26's family member		On 8/21/2020 the Director of and/or designee Completed a QA (quality ass monitoring of resident charts about notif Responsible Party related to change in co- include a inappropriate relati between residents from 7/28 through 8/21/2020 with no ac findings. On 9/08/2020 through 9/11/2 Director of Nursing and/or de provided education to license about notification to the responsible party related condition to include a inappro- relationship between residen in condition and pertinent inf- be documented in the nursin	surance) fication to the ondition to ionship k/2020 dditional 2020 the esignee ed nurses I to change in opriate tts.Changes iormation will	
	family member stated Review of a progress Resident #26 and Re every 15-minute mon occurring where Resi aggressive towards s On 8/20/20 at 5:30 P conducted with NA #4 around 3:00 AM she in Resident #26's bed to do rounds and said was inappropriate, ar	d she was ok with that. a note dated 8/6/20 revealed esident #27 were placed on itoring due to an incident ident #27 became staff over Resident #26.		The Director of Nursing and/ to complete Quality Improved monitoring for notification to responsible pa changes in condition. Monitoring to be completed of three times a week for four w then one time a week for three The Director of Nursing intro- plan of correction to the Quality Assurance Performan Improvement Committee on	ment arty related to on 5 residents veeks, ee months. iduced the nce	

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		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		PLETED
						С
		345385	B. WING	······	08	/20/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CARDINA	L HEALTHCARE AND RE	ЕНАВ		931 N ASPEN STREET		
0/11/2010/1				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 ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	e 4	F 58	80		
		noking. NA #9 told Nurse #8		The Director of Nursing i	s responsible for	
		and by the time, they came		implementing this plan.		
		sident #27 had left Resident		Findings will be reviewed		
		ned to his room. NA #9		committee monthly and (•	
		not do anything or say		monitoring (audit) update		
		#27 because he was already n she got to Resident #26's		needed based on finding The Quality Assurance P		
		she told the ADON what had		Improvement Committee		
	happened and had w			of but not limited to the E		
				Director, Director of Nurs	sing,	
	On 8/19/20 at 10:18 A	AM an interview was		Assistant Director of Nur	sing, Unit	
		e #5. She stated Resident		Manager, Social Service	s Manger,	
	#26 and Resident #2	•		Business		
	-	e felt was inappropriate due		Office Manager, Activitie		
		g cognitively impaired. She on was on 8/6/20 when the		Human Resources, Phar Medical Director, CNA, D		
		olding hands in the hallway.		Maintenance Director, CNA, L	netary manager,	
		was on 8/16/20 when		Housekeeping Superviso	or, Admissions.	
		served in Resident #27's		Medical Records, and M		
	room. Resident #27 v	vas undressed from the		The Quality Assurance P		
	waist down with no sh	heet lying in bed. Nurse #5		Improvement Committee	meets	
		out of the room and notified		monthly and quarterly at	a minimum.	
		g, Administrator and family				
	-	he extent of what happened.		AOC Data: 0/14/2020		
		ed Nurse #5 worked 7:00 AM		AOC Date: 9/14/2020		
		ing they needed to do				
	something immediate					
	On 8/19/20 at 11:22 A					
		ssistant Director of Nursing				
	· ,	she had called the residents				
		lationship began in June.				
		ed the daughter was ok with friendship with Resident #27				
		nother taken advantage of.				
	She stated because t					
		n holding hands, they didn't				
	see anything wrong w					1

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_		C 20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINAI	L HEALTHCARE AND RE	НАВ		931 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	8/12/20 to speak with statement because sh situation between Res that had occurred the ADON stated NA #9 h #26's room to find Res the two residents were stated Resident #27 h #26 while lying in the #9 to get out. She the of time and when she Resident #27 coming wheelchair from the re she did not contact Re receiving the stateme On 8/19/20 at 3:30 PM conducted with the Di During the interview h aware of the relations and Resident #27 a cor reported the residents hallway together and # 5 had told him she h kissing Resident #26 staff weren't happy the in each other. He state during a morning inter (IDT) discussing whet right to have a relation Administrator had cor daughter who stated i seek affection however didn't know the extent DON stated it was rep recall the date that the	d she had come in early on NA#9 and receive a he had been notified of a sident #26 and Resident #27 day prior on 8/11/20. The had walked into Resident sident #27 in her bed and e under the sheets. She had his arm around Resident bed. Resident #27 told NA n left the room for a period came back, she saw out into the hall in his bom. The interview revealed esident #26's daughter after nt from NA #9. M an interview was rector of Nursing (DON). the stated he was made hip between Resident #26 ouple of weeks ago. Staff is had been sitting in the were holding hands. Nurse ad seen Resident #27 in the hallway. He stated the e residents were interested ed the topic had come up rdisciplinary team meeting ther the resident #26's t was ok for the resident to er he didn't talk to her, so he t of the conversation. The borted to him but could not e residents were in the bed	F 580				
	together from the ADC	DN. He stated the ADON #9 had walked in and found					

Facility ID: 923059

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SIATE MENIOR OF DERICIENCIES AND PLAN OF CORRECTION (M) IDENTIFICATION NUMBER: (M) OUTFIE CONSTRUCTION A BUILDING (M) OUTFIE SUPPLY (C) OB/20/2020 IMME OF PROVIDER OR SUPPLIER 345385 STREET ADDRESS, CITY, STATE_ZIP CODE CARDINAL HEALTHCARE AND REHAB STREET ADDRESS, CITY, STATE_ZIP CODE IMME OF PROVIDER OR SUPPLIER SIMMARY STATEMENT OF DEFICIENCIES IN NOAPEN STREET LINCOLATION (N) C 20092 STREET ADDRESS, CITY, STATE_ZIP CODE CARDINAL HEALTHCARE AND REHAB SIMMARY STATEMENT OF DEFICIENCIES IN NOAPEN STREET LINCOLATION, N, C 20092 STREET ADDRESS, CITY, STATE_ZIP CODE MORE OF PROVIDERS OF DEFICIENCY MAST BE PRECEDED BY TULL TAG MEDIA TO CORRECTION (EACH OPPRECED ACTION ON NOAMINON) If No F 580 Continued From page 6 F 580 F 580 C ON 8/19/20 at 4:24 PM an interview was conducted with the Administrator had told her. F 580 On 8/19/20 at 4:24 PM an interview was conducted with the Administrator. He stated both residents desired a relationship however Resident #26 was unable to consent. The residents and buspected both residents and buspected both and sand hang out although encouraged not to by staff. He stated her ADD(N who had neceived a statement from NA #9. He stated NA #9 had observed the resident in bed toget in add with Resident #25 by the ADD(N who had neceived as the envert conducted with Resident #26 by the ADD(N who had neceived as the was conducted with Resident #26 by the ADD(N who had neceived as the member. She stated Nuras 65 had contacted Resident H25 may in a statel Nuras		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 MAPPROVED). 0938-0391
J45385 ILVING	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARDINAL HEALTHCARE AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE MUID TAG SUMMARY STATEMENT OF DEFICIENCIES DID RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S TAU OF CORRECTION (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CORRECTION (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CORRECTION (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CORRECTION (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CORRECTION (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CITY, STATE, ZIP CODE SIN NASPEN STREET LINCOLATORY ON SHOLD DE (EACH DEPICENCY MUST BE PROCEEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CITY, STATE, ZIP CODE SIN NASPEN STREET LINCOLATORY ON SHOLD DE (EACH DEPICATION ON IS CORRECTION RECOLLATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S CITY, STATE, ZIP CODE SIN NASPEN STREET LINCOLATORY OR LSC IDENTIFYING INFORMATION) ON SIN RECOLLATORY OR LSC IDENTIFYING INFORMATION (EACH DEPICATION OR LSC IDENTIFYING INFORMATION) F 580 F 580 Continued From page 6 Resident #20's non the Administrator had told her. F 580 F 580 OR 8/19/20 at 424 PM an interview was conducted a formal investigation into the incident nor had nursing stated on. He sident #20's Samily member. F 580 No 8/19/20 at 4247 PM an interview was conducted with Resident #20's family member. She stated Nurse #5 had contacted her se			345385	B. WING		_		
CARDINAL HEALTHCARE AND REHAB LINCOLNTON, NC 2892 (M) D PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH EDFLOXY MUST BERECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) ID PREFIX TAG PROVINCES PLAN OF CORRECTOR (EACH EDFLOXY MUST BERECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) ID PREFIX TAG PROVINCES PLAN OF CORRECTOR (EACH EDFLOXY MUST BERECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) ID PREFIX TAG PROVINCES PLAN OF CORRECTOR (EACH EDFLOXY MUST BERECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) ID PROVINCES PLAN OF CORRECTOR (EACH EDFLOXY OR LSC DENTFYING INFORMATION) ID PROVINCES PLAN OF CORRECTOR (EACH EDFLOX OF CORRECTOR (EAC	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
Pričej TAG REALATORY OR LSCI DENTIFYING INFORMATION) PRĚTIX TAG CEACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMETTION DEFICENCY) F 580 Continued From page 6 Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the daughter, but he dich't know what the Administrator. He stated both residents desired a relationship however Resident #26 was unable to consent. The residents desired a relationship however Resident #26 was unable to consent. The residents desired a relationship however Resident #26 was unable to consent. The residents desired a relationship however Resident #26 was unable to consent. The residents desired a relationship however Resident #26 was unable to consent. The resident #26 was unable to bold hands and ut atthough encouraged not to by staff. He stated he was notified date unknown, that Resident #26 by the ADON who had received a statement from NA #9. He stated NA #9 had observed the residents in bed together and suspected something may have happened. The interview revealed he never conducted with Resident #26 because he didn't feel like they needed to. He stated he had contacted Resident #26 stanily member. She stated Nurse #5 had contacted her several times regarding the relationship, belvee the two residents and to tel her Resident #26	CARDINAI	L HEALTHCARE AND RE	НАВ			2		
Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the daughter, but he didn't know what the Administrator had told her. On 8/19/20 at 4:24 PM an interview was conducted with the Administrator. He stated both residents desired a relationship however Resident #26 was unable to consent. The residents liked to hold hands and hang out although encouraged not to by staff. He stated he was notified date unknown, that Resident #27 attempted to get in bed with Resident #27 tatempted to get in bed with Resident #26 by the ADDN who had received a statement from NA #9. He stated NA #9 had observed the residents in bed together and suspected something may have happened. The interview revealed he never conducted a formal investigation into the incident nor had nursing staff complete a physical assessment of Resident #26 bccause he didn't feel like they needed to. He stated he had contacted Resident #26 bccause he didn't feel like they needed to. He stated he had contacted Resident #26 bringing member and she was ok with the relationship, so he decided the allegation did not need to be investigated further.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		COMPLETION
male resident's room when he was found naked from the waist down. She stated she then called the Administrator because he had not contacted her, wanting more details regarding the incident however he just stated the two residents had	F 580	Resident #27 in Resid sheets. NA #9 left the returned, she saw Re #26's room. He stated about the incident and but he didn't know wh her. On 8/19/20 at 4:24 PM conducted with the Ad residents desired a re Resident #26 was una residents liked to hold although encouraged was notified date unk attempted to get in be ADON who had receiv #9. He stated NA #9 H in bed together and si have happened. The conducted a formal in nor had nursing staff assessment of Reside feel like they needed contacted Resident #2 was ok with the related allegation did not nee On 8/19/20 at 4:47 PM conducted with Resid She stated Nurse #5 H times regarding the re residents and to tell h male resident's room from the waist down. the Administrator beca her, wanting more defined and the stated Nurse #5 H	dent #26's bed under the room and when she sident #27 leaving Resident d the Administrator knew d had notified the daughter, hat the Administrator had told M an interview was dministrator. He stated both elationship however able to consent. The d hands and hang out not to by staff. He stated he nown, that Resident #27 ed with Resident #26 by the ved a statement from NA had observed the residents uspected something may interview revealed he never vestigation into the incident complete a physical ent #26 because he didn't to. He stated he had 26's family member and she ponship, so he decided the d to be investigated further. M an interview was ent #26's family member. had contacted her several elationship between the two er Resident #26 was in a when he was found naked She stated she then called ause he had not contacted tails regarding the incident	F 580				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345385	B. WING _			08/20/2020
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP 931 N ASPEN 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 O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 585 SS=E	gotten too "risqué". S further details nor was resident was found in interview revealed shi comfortable with them stated she needed to the thought of the two her. She stated when Administrator, she tol- with the residents hav hands but nothing fur Administrator should extent of the relations residents. The intervie weren't detailed enou was going on and she facility due to COVID- Grievances CFR(s): 483.10(j)(1)-(§483.10(j) Grievances state and without fer reprisal and without fer reprisal. Such grievan respect to care and tr furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The resi facility must make pro- resolve grievances th accordance with this p	 She stated he didn't go into a she aware the male Resident #26's bed. The e was absolutely not in being in bed together. She keep her mother safe and oresidents together disgust she talked to the d him she was comfortable ving a friendship and holding ther. She stated the have notified her of the hip between the two ew revealed she felt staff gh with her discussing what e was unable to visit the 19. S. S.<td>F 5</td><td></td><td></td><td>9/10/20</td>	F 5			9/10/20

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_		C 20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	_	
CARDINA	L HEALTHCARE AND RE	HAB		931 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	to the resident. §483.10(j)(4) The faci grievance policy to en of all grievances rega contained in this para provider must give a c to the resident. The g include: (i) Notifying resident in postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance offici- can be filed, that is, h address (mailing and number; a reasonable completing the review to obtain a written dec grievance; and the co independent entities w be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Griev	lity must establish a isure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must individually or through locations throughout the ile grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone e expected time frame for of the grievance; the right cision regarding his or her intact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system; ance Official who is	F 58		DEFICIENCY)		
	receiving and tracking conclusions; leading a by the facility; maintai information associate example, the identity grievances submitted written grievance dec	of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as					

If continuation sheet Page 9 of 109

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/24/20 MAPPROVE <u>D. 0938-03</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	Сом	E SURVEY PLETED C
		345385	B. WING				/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	- HEALTHCARE AND R	EHAB			1 N ASPEN STREET		
					NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 585	Continued From page	o 0		585			
1 000				505			
		king immediate action to tial violations of any resident					
	right while the allege	-					
	investigated;	- ····g					
		483.12(c)(1), immediately					
		violations involving neglect,					
		ries of unknown source,					
		ion of resident property, by rvices on behalf of the					
		nistrator of the provider; and					
	as required by State						
		written grievance decisions					
		grievance was received, a					
	-	of the resident's grievance,					
	-	vestigate the grievance, a nent findings or conclusions					
	· ·	nt's concerns(s), a statement					
		evance was confirmed or not					
	5	ctive action taken or to be					
	taken by the facility a	as a result of the grievance,					
		ten decision was issued;					
		te corrective action in					
		te law if the alleged violation is is confirmed by the facility					
		having jurisdiction, such as					
	-	ency, Quality Improvement					
		I law enforcement agency					
		or any of these residents'					
	rights within its area						
		ence demonstrating the					
		es for a period of no less than ance of the grievance					
	decision.	and of the grievance					
		T is not met as evidenced					
	by:						
	Based on record rev	iews, resident, family and			F585		
		acility failed to make prompt					
		ident grievances and provide nvestigation summary with			On 9/2/2020 the Executive Director s with Resident #9 about showers in	spoke	

Facility ID: 923059

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COMPI	
		345385	B. WING		(
NAME OF P	ROVIDER OR SUPPLIER	545505		STREET ADDRESS, CITY, STATE, Z		20/2020
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	EHAB		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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETIO DATE
F 585	Continued From page	- 10	F 58			
1 000		on filing the grievance for 3	F 30		iovancos All	
		ts reviewed (Resident #'s 9,		reference to previous gr concerns have been ad		
	1, and 12).			Resident #9 is satisfied		
	, /·			concerns noted. On 7/4		
	Findings included:			#12 was discharged hol Resident #1 expired.	me. On 7/16/2020	
	Review of the facilitie	s "Complaint/Grievance				
	Policy and Procedure			On 9/2/2020 the Execut	tive Director /	
	revealed the following	g:		designee completed a C		
				Improvement Monitor of	•	
		t each resident's right to		between the dates of 6/		
	-	ulting in a follow-up and		to ensure that all were o	-	
	its progress toward re	ing the resident apprised of		resolutions and that the was provided a copy of		
	lis progress toward re			was provided a copy of was satisfied with resolu		
	"Process: The grieva	ance follow-up should be		On 9/02/2019 the Socia		
		nable time frame; this		was educated by the Ex		
	should not exceed 14			on the Grievance Policy On 9/10/2020 education	and Procedure.	
	1. Resident #9 was a	dmitted to the facility on		the Executive Director to		
		noses which included		Interdisciplinary Team M	lembers, including	
	Parkinson's disease,	and heart failure.		the Director of Nursing,		
				of Nursing, Minimum Da		
		⁴ 9's annual Minimum Data		Social Services Manage		
	set (MDS) dated 02/0 cognitively intact and	07/2020 revealed he was		Business Office Manage		
		h bathing. The MDS also		Resources, Business D Coordinator, Maintenan		
		tremity was impaired on one		Dietary Manager, House		
	side.			Supervisor, Activities, C		
				Medical Records Manag		
		e form filed on 05/04/2020		Manager on the grieval		
		on behalf of Resident #9		the responsibility of the		
		plaint/Grievance" section of		to ensure a complete ar		
		t claimed he had not had a		investigation has been of		
		said he was told it was due		written copy of resolutio		
	-	In the "Documentation of of the form it was blank. In		concerned party if reque		
	-	ion of the form it was blank.		The Executive Director	-	
		ed to the Administrator and		Officer will track, monito	-	

Facility ID: 923059

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		MEDICAID SERVICES			CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
							С
		345385	B. WING			08	S/20/2020
NAME OF P	ROVIDER OR SUPPLIER		- 1 - T	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				93	1 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	ЕНАВ		LI	NCOLNTON, NC 28092		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 585	Continued From page	e 11	F 58	85			
	Director of Nursing a	s responsible for the			investigation and written resolution		
	investigation.				provided to the concerned party utilizin	ıg	
					Quality Monitoring Tool 1x/week for thr	ee	
		#9's admission Minimum			months then monthly x three months.		
	. ,	d 06/03/2020 revealed he			Grievance Officer will discuss grievance		
	assistance of one sta	t and required extensive aff with bathing.			daily Monday-Friday in morning meetir for compliance.	ıg	
	Review of Resident #	49's care plan dated			The Executive Director introduced the		
		he had a care plan for being			plan of correction to the Quality Assura	ance	
		elf-care/mobility due to			Performance Improvement Committee		
		reased range of motion of			9/10/2020.		
					The results of the Quality Monitoring		
		2/2020 at 9:00 AM with			Tools will be reported to the QAPI		
	Resident #9 revealed				committee monthly by the Executive		
		ack of Nurse Aides (NAs)			Director. The Quality Assurance		
	and stated it was still	y shift there were only 2 NAs			Performance Improvement Committee evaluate effectiveness of the observati		
		g, and he could not get his			tools and make changes if necessary t		
		ed. Resident #9 stated he			maintain compliance with investigation		
		shower per week but stated			and timely delivery of written resolution		
		with no shower. He stated			grievances to concerned parties. The		
	-	ers before when the staff			Quality Assurance Performance		
	-	late in the evening and			Improvement Committee consists of bu	ut	
		nem early morning or			not limited to the Executive Director,		
		he evening. Resident #9			Director of Nursing, Work Force Manag	•	
	-	oken with him about his			Unit Manager, Social Services Manger	,	
		ne had not received anything			Business Office Manager, Activities Director, Human Resources, Pharmac	iet	
	in writing to address	nio grievanceo.			Medical Director, CNA, Dietary Manag		
	An interview on 07/22	2/2020 at 2:20 PM with the			Maintenance Director, Housekeeping	ы, ,	
		ager (SSM) revealed she			Supervisor, Admissions, Medical Reco	ords,	
		grievance form back for			and MDS Nurse. The Quality Assurance		
		investigation and resolution.			Performance Improvement Committee		
	-	ormal process was for the			meets monthly and quarterly at a		
	grievance section to				minimum.		
		to her to record. The SSM					
	stated she made cop	ies of the form and then			Date of Alleged Compliance is 9/14/20	20	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345385	B. WING				/20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	gave them to the Adm the appropriate depar explain once the inves- the resolution is docu up letter to the resider whomever filed the gr letter with the copy of the SSM, grievances morning meeting as w down meeting. She s asked if there were no response had been yo were still outstanding been resolved. The S that were not returned investigation and reso received follow up lett An interview on 07/22 Director of Nursing (D there was a "72-hour grievances." He state process and stated he some of the forms he the residents. The D0 more team approach stated he had not folk handling grievances a not recall the specifica grievances filed. An interview conducte with the Administrator discussed during their stated their process w	hinistrator for distribution to treat head. She went on to stigation is completed and mented she crafts a follow int or family member or ievance and she files the the grievance. According to were discussed in the vell as the afternoon stand stated the Administrator ew concerns and her es or no and stated there complaints that had not SSM stated the grievances d to her with the olution completed had not ters to the grievance. 2/2020 at 3:40 PM with the OON) revealed he was aware window for handling ed he had issues with the e didn't recall receiving had been asked about for ON stated he would like a to handling grievances and owed their process in assigned to him and had not He stated they had a orning and they needed to as a team. The DON could	F	58	5		

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING			_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 2809	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	The Administrator exp SSM gave the form to to the appropriate dep once completed, the S resident and/or family with the grievance att According to the Adm were discussed in the in the afternoon stand Administrator recalled unresolved grievance with all the extra work grievances had "fell th been followed up on a had not followed up on have done and stated changes it had been of but stated they could The Administrator stat grievances should be and resolution given to member by letter. Th recall the specifics of and stated he had not should have done. 2. Resident #1 was at 04/08/2020. Her diag cerebrovascular accid communication deficit among others. Review of Resident # Data Set (MDS) dated was severely cognitive extensive assistance daily living (ADL) inclu	by in the grievance book. Iained once logged, the the Administrator to assign partment head. He stated SSM follows up with the member via written letter ached to the letter. inistrator, the grievances morning call meeting and down meeting. The the SSM had mentioned is in the meetings and stated with COVID-19 some of the brough the cracks" and not as needed. He stated he in grievances as he should with all the COVID-19 difficult to prioritize duties do better with their process. ted he was aware completed within 72 hours to the resident or family e Administrator could not Resident #9's grievances followed up on it like he dmitted to the facility on noses included lent (CVA), cognitive	F	585				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED C	
		345385	B. WING				20/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CARDINA	L HEALTHCARE AND RE	ЕНАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 585	Resident #1 had impa extremities. Review of Resident # 04/17/2020 revealed having an ADL care p her impaired balance Review of a grievance by the Social Service conversation with a fa #1 revealed in the "Co of the form, the family resident was being le dressed. In addition, she wanted the reside minimum of Tuesday, Sunday. In the "Doct section of the form it " "Resolution" section of form was assigned to Director of Nursing as investigation. An interview on 07/22 Social Services Mana had not received the Resident #1 with the She explained the no grievance to be given stated she made copi gave them to the Adm the appropriate depar explain once the inve	airment of both lower "I's care plan dated she had a care plan for performance deficit related to and history of CVA. e form filed on 06/15/2020 s Manager after a amily member of Resident omplaint/Grievance" section v member stated the ft in the bed and not being the family member stated ent up and dressed a , Thursday, Saturday and umentation of Investigation" was blank. In the of the form it was blank. The the Administrator and s responsible for the 2/2020 at 2:20 PM with the ager (SSM) revealed she grievance form back for investigation and resolution. rmal process was for the	F	58			
	whomever filed the g	nt or family member or rievance and she files the the grievance. According to					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345385	B. WING				_ 20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	the SSM, grievances morning meeting as w down meeting. She s asked if there were ne response had been yw were still outstanding been resolved. The S that were not returned investigation and reso received follow up lett An interview on 07/22 Director of Nursing (D there was a "72-hour grievances." He state process and stated he some of the forms he the residents. The DC more team approach stated he had not follo handling grievances a DON, he remembered started his follow up of resolved. An interview conducted with the Administrator discussed during their stated their process w complete a grievance the form is given to th grievance book. The once logged, the SSM Administrator to assig department head. He	are discussed in the vell as the afternoon stand stated the Administrator ew concerns and her es or no and stated there complaints that had not SSM stated the grievances d to her with the olution completed had not ters to the grievance. 2/2020 at 3:40 PM with the OON) revealed he was aware window for handling ed he had issues with the e didn't recall receiving had been asked about for ON stated he would like a to handling grievances and owed their process in assigned to him and had not He stated they had a orning and they needed to as a team. According to the d the grievance and had on it but stated it was not ed on 07/22/2020 at 4:34 PM revealed grievances are r morning call meeting. He vas that anyone could form and once completed e SSM to log in the Administrator explained A gave the form to the	F	585			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345385	B. WING				C /20/2020
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	member via written le attached to the letter. Administrator, the grie the morning call meet stand down meeting. the SSM had mention the meetings and stat with COVID-19 some through the cracks" a as needed. He stated grievances as he sho with all the COVID-19 difficult to prioritize du better with their proce stated he was aware completed within 72 h the resident or family stated he did not reca behalf of Resident #1 it like he should have 3. Resident #12 was 06/19/2020 and disch Her diagnoses include presence of left artific weakness. Review of a grievance of Resident #12 revea "Complaint/Grievance resident stated she ha with ADL. In addition had washed herself o wash her hair in the s assistance from staff "Documentation of In- form it was blank. In	tter with the grievance According to the evances are discussed in ting and in the afternoon The Administrator recalled ned unresolved grievances in ted with all the extra work of the grievances had "fell nd not been followed up on d he had not followed up on uld have done and stated 0 changes it had been ties but stated they could do ess. The Administrator grievances should be nours and resolution given to member by letter. He all the grievance filed on and had not followed up on done. admitted to the facility on farged home on 07/04/2020. ed fracture of the left femur, ial hip joint, falls and muscle e form filed on 06/25/2020 s Manager (SSM) on behalf aled in the e" section of the form, the ad not had any assistance , the grievance stated she ff at the sink and had to ink because she had no	F	585			

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CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				FORM	0: 09/24/2020 APPROVED 0: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMP	
		345385	B. WING		_		20/2020
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINAI	L HEALTHCARE AND RE	HAB		31 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	responsible for the inv Review of Resident # Data Set (MDS) dated was cognitively intact assistance of one stat An interview on 07/22 Social Services Mana had not received the g Resident #12 with the resolution. She expla was for the grievance the grievance to be gi SSM stated she made then gave them to the distribution to the app She went on to explai completed and the re- crafts a follow up letter member or whomever files the letter with the According to the SSM in the morning meeting. Administrator asked if and her response had there were still outsta not been resolved. The grievances that were investigation and reso	Director of Nursing as vestigation. 12's admission Minimum 106/26/2020 revealed she and required limited ff with bathing. 2/2020 at 2:20 PM with the ger (SSM) revealed she grievance form back for investigation and ined the normal process section to be filled out and ven to her to record. The ecopies of the form and e Administrator for ropriate department head. n once the investigation is solution is documented she er to the resident or family r filed the grievance and she e copy of the grievance. I, grievances are discussed g as well as the afternoon She stated the i there were new concerns d been yes or no and stated nding complaints that had he SSM stated the not returned to her with the puttion completed had not ers to the grievance.	F 585				
	there was a "72-hour grievances." He state	ON) revealed he was aware window for handling ed he had issues with the e didn't recall receiving					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/24/2020 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345385	B. WING				C / 20/2020
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB			31 N ASPEN STREET 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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 585	the residents. The DO more team approach stated he had not follo handling grievances a completed the forms. morning call every mo discuss the process a DON, he did not recal about Resident #12. An interview conducte with the Administrator discussed during their stated their process w complete a grievance the form is given to the grievance book. The once logged, the SSM Administrator to assig department head. He SSM follows up with the member via written le attached to the letter. Administrator, the grie the morning call meet stand down meeting. the SSM had mention the meetings and state with COVID-19 some through the cracks" a as needed. He stated grievances as he sho with all the COVID-19 difficult to prioritize du better with their proces	had been asked about for ON stated he would like a to handling grievances and owed their process in assigned to him and had not He stated they had a orning and they needed to as a team. According to the I receiving a grievance ed on 07/22/2020 at 4:34 PM revealed grievances are morning call meeting. He vas that anyone could form and once completed e SSM to log in the Administrator explained 4 gave the form to the n to the appropriate e stated once completed, the he resident and/or family tter with the grievance According to the evances are discussed in ing and in the afternoon The Administrator recalled ued unresolved grievances in ed with all the extra work of the grievances had "fell nd not been followed up on uld have done and stated o changes it had been ties but stated they could do ass. The Administrator grievances should be nours and resolution given to	F 5	85			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(V2) D4	NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	MPLETED
						С
		345385	B. WING		0	08/20/2020
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
	L HEALTHCARE AND RE	EHAB		931 N ASPEN STREET LINCOLNTON, NC 28092		
04015				PROVIDER'S PLAN OF COF	PRECTION	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 585	Continued From page	e 19	F 58	35		
		inistrator, he could not recall				
	any specifics about R	esident #12's grievance and				
		owed up on it like he should				
F 600	have done. Free from Abuse and	Noglaat	F 60			9/14/20
F 000 SS=J	CFR(s): 483.12(a)(1)	-	FOU			9/14/20
00 0						
		m Abuse, Neglect, and				
	Exploitation	right to be free from abuse,				
		ition of resident property,				
		efined in this subpart. This				
	includes but is not lim					
		involuntary seclusion and ical restraint not required to				
	treat the resident's me					
	§483.12(a) The facilit	y must-				
	§483.12(a)(1) Not use	e verbal, mental, sexual, or				
	physical abuse, corpo					
	involuntary seclusion; This REQUIREMENT	; is not met as evidenced				
	by:					
		iew, staff interviews, family		F600- Free from Abuse and N	leglect	
		medical services (EMS) mactitioner interview the		1. The corrective action for t	he alleged	
		rovide nursing and medical		deficient practice was accomp	•	
		who was unresponsive.		1) Resident #2 no longer res	ides in	
		sident reviewed for neglect		facility, expired at hospital. On		
	(Resident #2). The re Emergency Room (El	sident was sent to the		DHHS in facility for Complaint 7/21/20 during visit a surveyor		
	experienced cardiopu	-		Regional Director of Clinical S		
	occasions. Resident #	#2 passed away at the		Administrator aware of an alle	gation of	
	-	ailed to protect a resident's		abuse/neglect for Resident #2		
		om sexual abuse for 1 of 3		Administrator submitted a 24 h	•	
	#26). Resident #27 w	viewed for abuse (Resident		for allegation of abuse and sus Nurse #1. Law enforcement w		

Facility ID: 923059

If continuation sheet Page 20 of 109

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			ATE SURVEY
			A. BUILDING	<u> </u>		
		345385	B. WING			С
		545565		STREET ADDRESS, CITY, STATE, ZIP CODE		08/20/2020
NAME OF P	ROVIDER OR SUPPLIER				1	
CARDINA	L HEALTHCARE AND R	ЕНАВ		931 N ASPEN 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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 20	F 60	00		
		with Resident #26 who was		notified. Nurse #1 is no longe	employed	
		d female resident on 8/11/20.		at facility.	employed	
		#26 was observed sitting in		2) Resident #27 was placed	on one on	
		her hand on Resident #27's		one on 8/19/2020. On 8/19/20		
	genitals.			assessment was completed or	n Resident	
				#26. No new issues. The Alleg	ation of	
	Immediate jeopardy I	began on 06/06/20 when		Resident to Resident Abuse w		
	Nurse #1 assessed F	•		to the State of North Carolina		
		led to provide nursing and		of Health and Human Services		
		the resident. Immediate		with a 5 Day Investigative Rep	ort	
		ed on 07/27/20 when the		submitted on 8/26/2020.		
		a credible allegation of				
		removal. The facility		2. Residents with the potent		
		liance at a lower scope and		affected by alleged deficient p Current residents have the po		
	severity level of G (ad immediate jeopardy)			affected by this alleged deficie		
		due to example #2.			ni practice.	
	Findings included:			1) On 7/22/20 the facility So	cial Worker	
				conducted resident interviews		
	1. Resident # 2 was a	admitted to the facility on		interviewable residents (BIMS		
	06/05/20 with a diagr	nosis including hemiplegia,		than 8) to ensure free from ab	-	
	hemiparesis following	g a cerebral infarction		neglect. Any negative findings	were	
	affecting the left non-	-dominant side, muscle		addressed immediately accord	ling to the	
	weakness and transi	ent ischemic attack.		facility abuse and neglect polic	-	
				reported to the appropriate ag		
		sessment dated 06/06/20,		On 7/24/20, the Regional Dire		
		be alert and oriented.		Clinical Services completed a		
		ode status of full code on		current residents Code Status		
		cility. Resident #2 required		accurate to include: Physician		
	-	n assistance with most		MOST/DNR form, and order e electronic medical record. Any		
	activities of daily livin			identified were addressed.	135065	
	Review of pursing po	te dated 06/06/20 at 9:35		On 7/22/20, current resident s	kin	
	-	1 had written a late entry on		assessments completed by Re		
		occurred earlier in the day.		Nurse, no new issues noted.	9.010104	
		dent #2 was alert and		On 7/24/20, resident assessm	ents were	
		and two Nurse Aides (NA)		completed by a Registered Nu		
		dent up to her Geri-chair		ensure the following was in pla		
		ft to assist her with the lunch		change in conditions identified		

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,)	COMP	
						2
		345385	B. WING		08/2	20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	THAB		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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 21	F 60	n		
		e room with Resident #2's	1 00	changes in condition noted.		
		hecked on the resident		" Family/Responsible Party	Notification	
		Nurse #1. At that point		" Physician Notification		
		ed to be unresponsive to		" Physician order for treatme	ent (if	
		sable to sternum rub with		indicated)	···	
		g and squeezing of her eyes		" Appropriate documentation	n	
		xygen saturation level was		(SBAR/progress note if indicate		
		nd oxygen was applied at 3		" Interventions to prevent fur		
	liters. The note revea	led Resident #2 stopped		changes and /or worsening of		
	breathing, no pulse w	/as found, and		" Appropriate Care Plan and	Nursing	
	cardiopulmonary resu			Assistant Kardex		
	-	and Nurse #2. Nurse #3				
	· ·	and chest compressions		2) Resident skin assessment		
		emergency medical services		completed from 8/19/2020 throu	•	
	· ,	ok over. EMS intubated		8/26/2020 for BIMS < 8 with no	new	
	Resident #2 started in			issues.	atad from	
	transported Resident			Resident questions were comp 8/19/2020 through 8/26/2020 fc		
	On 07/21/20 at 2:30 F			8 with no new issues.		
		1. NA #1 stated on 6/6/20		On 7/22/2020 the Degional Dire	ator of	
		t #2's family outside of the		On 7/23/2020 the Regional Dire		
	-	rived to work and told them ye out for her during the day.		Clinical services educated the I Nurse Managers (Director of N		
		M on 06/06/20 she was		Assistant Director of Nursing) re	•	
		Il and heard a banging on		Abuse, neglect, Notification of		
	-	v. When she entered the		condition, how to identify and R	•	
		d spit up onto her shirt and		manage a change in condition		
		d her family was outside of		status / code blue to include red		
		get the staffs attention. NA		and response. Additionally, on		
		#2 up and assisted her to		the Director of Nursing and Ass		
	the bed with help from			Director of Nursing educated lic		
		ke and communicating. NA		nurses and certified nursing as		
		rse #1 the resident was		regarding Abuse, neglect, Noti		
		pit up. Nurse #1 told her to		change in condition, how to ide	-	
		d give her some ginger ale		Respond / manage a change in		
		refused the drink. At lunch		and code status / code blue to i	nclude	
		k into the room to assist		recognition and response.		
		lunch meal. She stated the				
	resident was alert and	d able to eat, NA #2 came		On 9/8/20-9/11/20 education wa	ac providad	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · · ·	IPLETED
						С
		345385	B. WING		08	3/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	ЕНАВ		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 22	F 60	00		
1 000			FOU		doursing	
		n helping the resident and She stated about 15-20		to all licensed nurses, certified assistants, therapy staff, house	•	
		1:00 PM she heard a loud		staff, dietary staff, Director of		
		Resident #2's room. When		Housekeeping Manager, Bus		
	-	lent's room Resident #2 was		Manager, Human Resources		
	in her Geri chair with	her mouth wide open		Medical Records Director, So		
		She stated she conducted a		Director and Admissions Dire		
	sternum rub and calle	ed the residents name with		Interim Executive Director, Di	rector of	
	no response from the	e resident. She stated she		Clinical Services and Assistar	nt Director of	
	left the resident's roo	m to get Nurse #1 from 200		Clinical Services related to the	e reporting of	
		entered the resident's room,		alleged violations involving m		
		esident was unresponsive.		neglect, or abuse, including ir	-	
		came to Resident #2's room		unknown, source and misapp		
		rub and wiped the residents		resident property that is repor	-	
		Nurse #1 asked NA#1 to		staff as defined per regulation		
		#2 went back out of the ms Nurse #1 asked for and		well as per the State of North Reporting guidelines	Carolinas	
		1 to obtain vital signs. As		Reporting guidennes		
		gather her vital sign machine				
		r a needle and told her to				
		IA #1 stated Resident #2's				
	vital signs were blood	d pressure 125/100, pulse				
		n 84% on room air. NA #1		The Regional Director of Clini	cal	
		the needle from her and		Services/Designee will condu		
		e top, bottom and side of		Improvement (QI) monitoring	of concerns	
		ound 6-8 times in an attempt		reported to facility staff as we		
	- ·	NA #1 stated she had seen		ensure staff understand the d	~ .	
	red substance comin			of abuse/neglect, who to repo		
		which Nurse #1 had placed		neglect to as well as the time		
	the needle and Resid			reporting abuse / neglect. Qu	•	
		o movement. Nurse #1		Monitoring will also ensure the	•	
		et oxygen tubing and Nurse 2 liters on the resident. NA		reported any allegations of at		
		#1 told her , "this is normal		to the state agency in the 2 he timeframe as outlined by the		
		stroke I will have to go read		for four weeks 1x / week then		
		tated Nurse #1 believed		ensure concerns that are app		
		have feeling in her body		reportable event as outlined in		
		nced a stroke. NA#1 stated		the State of North Carolinas r		

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D PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345385	B. WING		C 08/20/2020
IAME OF PI	ROVIDER OR SUPPLIER	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•
CARDINA	L HEALTHCARE AND R	ЕНАВ		931 N ASPEN STREET 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 600	Continued From pag	e 23	F 600		
	the resident complain stated Nurse #1 left to the nurse's station are Resident #2. NA #1 so resident after her oxy stated at 2:00 PM sh vital signs and found wouldn't read, and R unresponsive. She so resident's room to fin Resident #2. NA #1 so the breakroom. NA # "Of course her oxyge mouth breather". NA outside for a smoke to hall to assess Reside Nurse #1 returned sh place Resident #2 in in and out urinary can the residents color has in the bed and she so yelled for another nu room and Nurse #2 re to Nurse #1, "Is she as she thought the reside full code. Nurse #1 to the supervisor Nurse compressions on the neither Nurse #1 or N	stated she never left the /gen level had dropped. She e checked Resident #2's her oxygen saturation level esident #2 was still tated she then left the id Nurse #1 to assess stated she found Nurse #1 in f1 stated Nurse #1 told her, en level is dropping she's a #1 stated Nurse #1 went break before returning to the ent #2. She stated when he instructed the NAs to the bed so she could do an theterization. NA #1 stated ad changed a pale gray while topped breathing. Nurse #1 rse to come to the resident's responded. Nurse #2 stated a full code". Nurse #1 stated to the nurse's station to ck stating the resident was a hen stated to NA #1 to go get #3 to start chest resident. NA #1 stated Nurse #2 started chest y the time Nurse #3 got to the		officials in accordance with federal a state law within 2 hours for an alleg of abuse. Quality Improvement (QI) monitorin also include how to identify and res manage a change in condition/statu include but not limited to code statu code blue to include recognition and response. QAPI: The Executive Director will report of results of the quality monitoring (au and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality mor (audit) updated as indicated. The re- of the quality monitoring will be brow the Quality Assurance Performance Improvement meeting by the Execut Director for review of abuse/neglect monthly. Quality Improvement monitoring. Date of compliance: 9/14/2020	ation g will pond / us to s/ d d n the dit) nitoring esults ught to e titive t

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	S FOR MEDICARE &		0.00		OMB NO. 0938-0		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILDIN	G			
		0.45005			C		
		345385	B. WING		08/20/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	P CODE		
	L HEALTHCARE AND R	EHAB		931 N ASPEN STREET			
UANDINA				LINCOLNTON, NC 28092			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI			
PREFIX TAG	(LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE DATE		
F 600	Continued From pag	e 24	F 60	00			
		#2 still unresponsive at 2:00					
		P2 still unresponsive at 2:00 Nurse #1 who was in the					
		her the resident's oxygen					
		d not read because she was					
		r mouth. NA #1 stated she					
	• •	se's station and could not find					
		at that point she felt					
		alled Resident #2's family to					
		or the resident to not					
		ked them to come to the					
	-	urse #1 and Nurse #2 were					
	-	g smoking when she called					
		to come to the facility. She					
		he had just called 911 when					
		was wrong with the resident					
	instead of waiting on	-					
	On 7/21/20 at 7:30 P	M an interview was					
		NA #2 stated she was					
	•	#2's hall on 06/06/20. She					
	-	rning of 06/06/20 Resident					
		ented. She stated NA #1					
		ne 300 hall however kept					
		he resident to help her. She					
		ound 1:00 PM she was					
	picking up the trays a						
		g when NA #1 came and got					
		nt #2 was unresponsive. NA					
		nd NA #1 went and told					
		it was fine and that was					
		#2. She stated Nurse #1 had					
		and entered Resident #2's					
		dent unresponsive. She					
		1 entered the room she saw					
		and use a tool or needle to					
	SUCK THE DOTTOM OF R	esident #2's feet to attempt					
	4 4 h	La la al del cara del 1997					
		l, she did not see a red om the areas in which Nurse					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED	
		245205				С	
		345385	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODI		3/20/2020	
NAME OF F	ROVIDER OR SUPPLIER		931 N ASPEN STREET		=		
CARDINA	L HEALTHCARE AND RE	ЕНАВ		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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 600	She stated Nurse #1 returned to the nurse and NA #1 told Nurse something was wrong PM to 2:30 PM howe the room to assess th resident's daughter w stating something was because she wouldn' stated she ran to get whether the resident Nurse #2 had to chec said the resident's da stated Nurse #1 nor N compressions. They a supervisor Nurse #3 Nurse #3 arrived, she compressions before stated they had told N something was wrong did not come down th resident. She stated a entire time and never prior to when the resi Nurse #1 couldn't even happened to EMS wh On 07/21/20 at 10:23 conducted with Nurse responsible for Resid interview revealed Re around 11:00 AM she instructed NA #1 to g to drink in which the r after lunch she did no	then left the room and 's station. NA #2 stated she, # 11 two times that g with Resident #2 from 1:00 ver Nurse #1 never came to he resident. She stated the vas then at the window s wrong with her mother, t respond at 2:30 PM. She Nurse #1 who didn't know was a DNR or full code and ck the resident's chart. She ughter called 911. She Nurse #2 started chest asked NA #1 to go get the to start compressions, when a completed 5 minutes of the EMS arrived. NA #2 Nurse #1 for 2 hours g with Resident #2, but she he hall to assess the she was on the hall the 's aw Nurse #1 in the room dent was coding. She stated en tell the story of what had hen they arrived. AM an interview was e #1. She stated she was ent #2 on 06/06/20. The esident #2 had stated to her e was nauseated, and she et the resident a ginger ale resident refused. She stated of recall the NAs coming to dents vital signs had been	F 6				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING			_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 2809	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	had obtained vital sig Resident #2's oxygen she asked the NAs to she applied oxygen b residents oxygen satu Resident #2's oxygen her objective was to g out of the facility. She the residents blood pr she was unable to ob ran out of the room to status of the resident Nurse #2 verified cod when the two got bac in the room checking began compressions. using the ambu bag w being called by the re at her window. She st exact times of when th however it was only a time the resident was was taken by the two never used a needle o or poke the resident's unresponsive. On 07/22/20 at 10:34 conducted with Nurse recall the NAs coming Resident #2's oxygen had placed suppleme at 2 liters. She stated Physician after placin supplemental oxygen saturation level nor di	recall a specific time, she ns herself and noticed saturation level was low; move her to the bed and ut could not recall what the iration level was. She stated level dropped quickly, and get the resident stable and stated she then checked ressure and pulse in which tain. Nurse #1 stated she get Nurse #2 to verify code and get the crash cart. e status as full code and k to the room Nurse #3 was Resident #2's pulse and Nurse #1 stated she was when EMS arrived after sident's daughter who was ated she could not recall he incident occurred matter of minutes from the unresponsive until action nurses. She stated she for any other object to stick feet when she found her AM a second interview was e #1. She stated she did to her after lunch stating level was low because she ntal oxygen on the resident she did not notify the g Resident #2 on due to a low oxygen d she notify the residents in condition. The interview	F	600				

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CENTER STATEMENT (AND PLAN OF NAME OF P CARDINA (X4) ID	S FOR MEDICARE & DE DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER L HEALTHCARE AND RE	TEMENT OF DEFICIENCIES	A. BUILDING		 ATE, ZIP CODE	FORM OMB NC (X3) DATE COMP (08/	2: 09/24/2020 1 APPROVED 2: 0938-0391 SURVEY LETED 2: 0/2020
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERE	NCED TO THE APPROPRIA DEFICIENCY)		DATE
F 600	not have a chance to On 7/21/20 at 6:00 Pt conducted with Nurse Nurse #1 came down working to get her bee resident who was unr looked up the residen which was full code. N Resident #2 was unre glazed over. NA #1, N #3 were in the room. ' supervisor Nurse #3 fr roughly 5 minutes prio stated she had heard residents oxygen leve but could not recall a had the NAs lay the ro She stated she had n room prior to when th had not seen Nurse # with a needle. On 07/21/20 at 5:31 F conducted with Nurse gotten back to the nur residents who smoke Smoking time was at revealed she saw NA room so she walked of was going on. She stat the room, she saw Nu pressure and pulse of asked if she would try stated she tried to find saw Resident #2 was find a pulse. She state	declined so quickly she did call either of them. M an interview was #2. She stated on 06/06/20 the 100 hall where she was cause Nurse #1 had a esponsive. She stated she t's code status for Nurse #1 When she entered the room esponsive with her eyes IA #2, Nurse #1, and Nurse The interview revealed the had initiated compressions for to EMS arriving. She NA #1 tell Nurse #1 the el was low earlier in the day specific time and Nurse #1 esident down in the bed. ot gone into Resident #2's e resident was coding and a sticking the resident's foot	F 600				

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDIN	BUILDING		
		345385	B. WING	WING		C
		545565				8/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CARDINA	L HEALTHCARE AND R	EHAB		931 N ASPEN STREET LINCOLNTON, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From pag	e 28	F 6	00		
1 000			Г U	00		
		nterview revealed neither 2 started compressions or				
	used the ambu bag.	•				
		s of compressions until EMS				
		ited she believed Nurse #1				
	had not started chest	t compressions because she				
	was waiting on a sec	•				
	On 07/22/20 at 10:00) AM an interview was				
		dent #2's family member.				
		20 at 8:00 AM she had				
	called the facility and	spoke with Nurse #1				
	-	ent #2 had faired through the				
	night. She stated Nu	rse #1 told her she did not				
	know and that she w	ould text the third shift nurse				
		ted the third shift nurse had				
		sident had done well but				
		nuous positive airway				
		ch during the night. She				
	•	ted Resident #2 around 9:30 at morning through the				
		t #2 was alert and talking.				
	Around 11:12 AM she					
		g and saying, "help me". The				
		ing, coughing and yelling to				
		began beating on the				
		y in order to gain staff's				
		ered the room and cleaned				
		g her face. The family				
		e #1 entered the room				
		asked Resident #2 if she				
	÷ .	er Geri chair for lunch, she				
		cility at 12:00 PM before ound 2:20 PM she received				
		other family member stating				
		m and had asked if Resident				
		up, when the family member				
		ected the family to come to				
		he stated at 2:28 PM she				

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	-	D HUMAN SERVICES				FORM): 09/24/2020 MAPPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE COMP	LETED
		345385	B. WING			08/2	C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
			9	31 N ASPEN STREET			
CARDINA	L HEALTHCARE AND RE	HAB	L	INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 600	arrived at the facility t bed with supplementa and no staff members she picked up her phy #1 run into Resident # and stated to her to c stated Nurse #1 enter to pull the blinds down Resident #2 however to stop. The interview any nurses performing room. She stated onc pulled the blinds down into the room and Res hospital shortly after. #2 had experienced a lunch and the family w nor had the Nurse cal Review of the 911 con 6/6/20 revealed one p 2:34 PM requesting a location. The 911 con the one call was place member. On 07/24/20 at 1:00 F conducted with EMS when he arrived at the PM he observed an u outside of the facility w Resident #2's family r revealed when enter observed 2 staff mem compressions and no ventilate the resident.	o find Resident #2 lying in al oxygen on, unresponsive is in the room. She stated one to dial 911 then saw NA #2's room, open the window all 911 at 2:34 PM. She red the room and attempted in to block her view of the family member told her revealed she did not see g CPR or a crash cart in the e EMS arrived Nurse #1 in so she could no longer see sident #2 was taken to the She stated she felt Resident in change of condition after vasn't notified by Nurse #1 led 911 in a critical situation. mmunications call log dated ohone call was placed at ssistance at the facilities inmunications log confirmed ed by the residents family PM an interview was responder #1. He stated e facility on 6/6/20 at 2:40 pset woman standing which he later learned was nember. The interview ing Resident #2's room he	F 600				

Facility ID: 923059

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	MENT OF HEALTH AN						FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING			_		C 20/2020
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	K	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #2 was not the resident. He state their title) told him Resident is in-service on CPR and the state their title) told him Resident is in-service on CPR and the state their title) told him Resident is in-service on CPR and the state position with oxygen as stated if a resident as upine position with oxygen as stated if a resident is in-service on CPR and the state is a state of the st	breathing so they intubated ad a staff member (unsure of sident #2 was found at 2:15 and in bed in a supine applied. EMS responder #1 in respiratory distress the have been done was place tion. cords revealed Resident #2 ergency Department (ED) on She was intubated by EMS he ED. Resident #2 Ilmonary arrest on 4 a ED and was pronounced 0 PM on 06/06/20 in the	F	500				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		345385	B. WING				C 6/20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	conducted with the Duif a resident had previous upplemental oxygen placed due to a change oxygen saturation lew notify a physician alor a resident who dischathrs prior when they we stated any change of a red flag to call the Fibeen the best practice. On 7/23/20 at 3:35 Pf conducted with the Nuinterview revealed shaccepting care of resifer the staff to care for change of condition in use of supplemental of nurse on duty to notify identifying the need for resident. She also state needle to poke an unit was unacceptable. The Administrator was Jeopardy on 07/23/20 1:19 PM the facility proceedible allegation of removal. F600- Free from Abust Identify those recipier are likely to suffer, a sa result of the noncomparison	M a second interview was ON. The interview revealed iously not had an order for and oxygen had to be ge of condition and low el the nurse would need to ng with the family especially arged from the hospital 24 ere in a critical state. He condition would have been Physician which would have e. M an interview was urse Practitioner. The e had concerns of the facility dents who were too acute r. She stated regarding a n a resident requiring the boxygen she would want the y her immediately after or oxygen and assess the ited the practice of using a responsive patients' foot s notified of the Immediate 0 at 5:30 PM. On 07/26/20 at rovided the following Immediate Jeopardy se and Neglect	F	600			

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	S FOR MEDICARE &					938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUILDIN	/G		
		245295	B. WING		C	
		345385	B. WING _		08/20/2	2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CARDINA	L HEALTHCARE AND R	ЕНАВ		931 N ASPEN STREET		
				LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE CO HE APPROPRIATE	(X5) DMPLETIO DATE
F 600	Continued From pag	e 32	F 6	500		
1 000			FO			
		cility. Nurse Aide (NA) #1 am for her scheduled shift				
and was approached by Resident #2's						
	member before entering the facility for her scheduled shift. Resident#2's family member					
		-				
asked NA#1 to help un-cover Resident's #2 since she is unable to do so herself. NA#1						
		n shortly after clocking into esident #2 with un-covering				
		ng she was comfortable.				
		he was comfortable but not				
		AM Resident #2's family				
	-	he window a few minutes				
	-	e room. Nurse #1 arrived in				
		2's family member stated				
		owing up. Nurse #1 stated				
		vas elevated in the bed and				
		in of her throwing up.				
		IA#1 and NA#2 to assist				
	Resident#2 into a Ge					
		ident#2 a ginger ale to help if				
		Resident#2 declined the				
		11:45 AM Resident #2's				
		e facility. At 12:30 PM NA#1				
	-	ident#2. NA#1 held a				
	-	sident#2 the entire duration				
		t #2 stated she was not very				
		her salad. NA#1 stated,				
		just slow, she told me she				
		chewed slowly". No complaint				
	-	er lunch around 1:00 PM				
	NA#2 picked up lunc	h trays and was completing				
		when NA #1 came and got				
		dent #2 was unresponsive.				
		2 reported to the Nurse #1				
		Nurse #1's response was "it				
		mal". Nurse #1 did not go to				
		-				
	Resident #2 s room	. Around 10-15 minutes later				

Facility ID: 923059

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STATURATION CONTRECTOR (M) PROVIDENSING PREPRICA (DOWNERSING PREPRICATION NUMBER (DOWNERSI		-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 APPROVED 0. 0938-0391
J45385 9. WHO OB/20/2020 NMME OF PROVIDER OF SUPPLER STREET ADDRESS, CITY, STATE, ZP COCE 311 ASPEN STREET UNCOLATOR, NO. 2802 STREET ADDRESS, CITY, STATE, ZP COCE 311 ASPEN STREET UNCOLATOR, NO. 2802 STREET ADDRESS, CITY, STATE, ZP COCE STREET ADDRESS, CITY, STATE, ZP COCE STREET ADDRESS, STATE, STAT	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /				(3) DATE COMP	SURVEY LETED
BIT ASPENT STREET LINCOLNTON, NC 2802 CARDINAL HEALTHCARE AND REHAB CARDINAL HEALTHCARE AND REHAB SUMMARY STATEMENT OF DEFICIENCIES PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES INCOLNTON, NC 28022 F 600 Continued From page 33 was sitting up in geri-chair with eyes closed and mount open. NAT altermpted to get a response by rubbing a cool washoldh on her face. Resident #2 did not respons. NA #1 attempted to get a response by rubbing a cool washoldh on her face. Resident #2 did not respons. NA #1 attempted to get a response by rubbing a cool washoldh on her face. Resident #2 did not respons. NA #1 attempted to get a response notified Resident #2 assisted to bed. Nurse #1 went to Resident #2 assisted to bed. Nurse #1 went to Resident #2 assisted to bed. Nurse #1 left the room while Resident #2 wasturation level wouldn't read and was still unresponsive. NA #1 went to Resident #2 assisted to bed. Nurse #1 attempted to get status to diffed Resident #2 wasturation level wouldn't read and was still unresponsive. NA #1 went to Resident #2 wasturation level wouldn't read and was still unresponsive. NA #1 wased Nurse #1 to come assess Resident #2 to check Resident #2 wasturation level was a Full Code. Nurse #1 who was to lead for Nurse #2 to check Resident #2 start to determine code status. Nurse #3 wasturation level was a Full Code. Nurse #1 to get the for the press Nurse #3 who was the get her com Nurse #1 who was the get her com Nurse #1 who was the get her com Nurse #1 who was the get her com so Nurse #1 wasted wasted was wase Aldes (NA #1 and NA #2) going in Resident #2 was a Full Code. Nurse #3 anted compressions until ENS arrived. Also, during the 2.00 PM to 2:30 PM time Resident #2. Nurse #3 that code hat #2 was a Full Code. Nurse #3 that down the 2 waste (NA #1 and NA #2) going in			345385	B. WING					
CARDINAL HEALTHCARE AND REHAB LINCOLNTON, NC 28092 (M) ID PREERX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST BE RECERCIP OF YELL ACCURRENT AND TO CONTROL AND THE RECERCIP OF YELL ACCURRENT AND TO CONTROL AND THE RECERCIP OF YELL ACCURRENT AND THE ACTION APPROPRIATE SECOND ENTROL AND THE RECERCIP OF YELL ACCURRENT AND THE ACTION APPROPRIATE SECOND ENTROL AND THE RECERCIP OF YELL ACCURRENT AND THE ACTION APPROPRIATE SECOND APPROPRIATE TAC PROVIDERS ALANCE CORRECTION (EACH CORRECTIVE ACTION APPROPRIATE DEFICIENCY) 245 (CREASEFERENT ACTION APPROPRIATE DEFICIENCY) F 600 Continued From page 33 was sitting up in geri-chair with eyes closed and mouth open. NA#1 called Resident #2's name several times and conducted a stemum rub with no response. NA #1 attempted to get a response by rubbing a cool washold on other tace. Resident #2 did not respond. Around 1:10pm Nurse#1 was notified Resident#2's room. Vital signs obtained; O2 saturation 84% at Room Air: Oxygen applied and Resident #2's assisted to bed. Nurse #1 left the room while Resident#2's with word fir tread and was still uncersponsive. NX #1 asked Nurse #1 to come assess Resident #2. Between 2:00 PM to 2:30 PM Nurse #1 came to Resident #2's room. Nice #1 alked to M#1 and NA #2 to assist the resident #2's and to determine code status. Nurse #1 asked NA #1 to get the Nurse #2 to check Resident #2 went to nurse \$1 asked NA#1 adv A21 going into Resident #2 was a Full Code. Nurse #3 asked NA #1 to get the Nurse #1 asked AN A#1 to get the Nurse #3 stated down the hall to see what was going on. When Nurse #3 entered the room Nurse #1 was king to get a blood pressure and pulse on Resident #2. Nurse #3 third to obtain pulse but immediately saw Resident #2 was a full Code. Nurse #3 asked on the saw Nurse Aides (NA#1 and NA #2) going into Resident #2 was a full Code. Nurse #3 asked on the saw not breathing and could not find	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DATE Display Display <thdisplay< th=""> <thdisplay< th=""> <thdisp< td=""><td></td><td></td><td>HAR</td><td></td><td>9</td><td>31 N ASPEN STREET</td><td></td><td></td><td></td></thdisp<></thdisplay<></thdisplay<>			HAR		9	31 N ASPEN STREET			
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Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	bed. Resident #2's fa to find resident unres family member called EMS arrived and took Pulse obtained, but re unresponsive. Reside Resident #2 left facilit transferred to Atrium expired at the hospital investigation Nurse # Physician/Nurse Prace Party of change in co notify anyone to inclu Responsible Party that unresponsive. The Nut timely to resident hav On 7/20/20 DHHS in On 7/21/20 during vis Director of Clinical Se aware of an allegation Resident #2. The Ad 24-hour report for alle suspended Nurse#1. notified. Specify the action the process or system fai adverse outcome fror when the action will b Current residents hav affected by this allege 7/22/20 the facility So resident interviews of (BIMS greater than 8) and neglect. Any neg addressed immediate	mily knocked on the window ponsive. Resident #2's 911 at 2:34 PM. At 2:38 PM a over chest compressions. esident was still ent #2 was intubated. y with EMS and was Health Lincoln. Resident #2 I on 6/6/20. Based on the 1 failed to notify stitioner and Responsible ndition. Nurse #1 did not de the Physician and at Resident #2 was urse#1 also failed to respond ing an acute episode. facility for Complaint Survey. it a surveyor made Regional ervices and Administrator n of abuse/neglect for ministrator submitted a egation of abuse/neglect and Law enforcement was also e entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete. re the potential to be ed deficient practice. On ocial Worker conducted all interviewable residents o to ensure free from abuse	F	600			

Facility ID: 923059

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C / 20/2020
NAME OF PROVID	DER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARDINAL HE	ALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
app On Ser Coo Phy entuided On con not On con folk con not	vices completed a de Status to ensure visician's Order, MC ered into electronio ntified were addres 7/22/20, current re- npleted by Registe ed. 7/24/20, current re- npleted by a Regis bowing was in place iditions identified, r ed. Family/Respo Physician Not Physician Not Physician orde Appropriate do BAR/progress note Interventions to Appropriate C sistant Kardex 7/23/20, the Regio vices educated the Nursing and Assista arding Abuse and ange of Condition, spond/Manage a c de Status/Code Blu ponse to include th	enal Director of Clinical review of current residents e accurate to include: DST/DNR form, and order c medical record. Any issues ased. esident skin assessments red Nurse, no new issues esident assessments were tered Nurse to ensure the for any change in no new changes in condition insible Party Notification ification er for treatment (if indicated) ocumentation if indicated) to prevent further changes are Plan and Nursing onal Director of Clinical e Nurse Managers (Director ant Director of Nursing) Neglect, Notification of a How to Identify and hange in condition and ue to include recognition and	F	600			

Facility ID: 923059

If continuation sheet Page 36 of 109
	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345385	B. WING				C / 20/2020
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	and Resident Repress when the resident has For acute change in o do not leave resident appropriate actions by Reassess resident ca MD orders that may in out to hospital. Nurses and Certified on change in resident change. In the event of an em called and the attendi Resident Representa possible. The nurse to complet Patient/Resident. Doo medical record. Document resident/pa 24 Hour Report CNAs must notify lice in condition. If nurse of action CNA is to repo nurse/house superviss immediately. Upon discovering, or unresponsive resident One nurse to stay wit another staff member room to verify Code S	entative as soon as possible s a change in condition. condition stay with resident, unattended. Take y following physician orders. all physician back and follow include to transfer resident Nursing Assistants to report ts ' condition during shift ergency situation, 911 to be ing physician and the tive to be notified as soon as e an evaluation of the cument evaluation in the atient change in condition on ensed nurse with any change does not respond or take rt concern to another for and/or call DON being made aware of, an	F	600			

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C / 20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	 CPR training May inc. Verbal stimulu Gentle shakin resident Sternal rub to WILL NOT inc. Poking the fee Using any obj part Using any oth reasonably be expect body Only nurses will perference on Call 911 Open door of o Bring chart to o Bring chart to o Bring crash cate Education was initiated (Director of Nursing and Nursing) on 7/23/20 at will return to work unt mandatory education notification of change will be provided to all new hire orientation, ostaff, this education with license and Neglect, Notificat Condition, How to Ide a change in condition recognition and respondence of the second second	lude: us to rouse resident g of shoulders to rouse rouse resident dude: et with a needle ect to poke or prod any body er stimuli that may red to cause damage to the orm CPR, other staff may: facility for responders Nurse for review art to Code Blue ed by the Nurse Managers nd Assistant Director of and will be on-going, no staff il they have completed the on abuse and neglect and in condition. This education new employees as part of contract staff and agency vill be provided prior to i currently working will be and neglect immediately. e Managers then initiated ed nurses regarding Abuse	F	600			

Facility ID: 923059

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345385	B. WING				20/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	and Resident Representations of the second o	A the Attending Physician entative when the resident ition. condition stay with resident, unattended. Take y following physician orders. Ill physician back and follow noclude to transfer resident report on change in during shift change. ergency situation, 911 to be ng physician and the tive to be notified as soon as e an evaluation of the cument evaluation in the atient change in condition on nsed nurse with any change does not respond or take rt concern to another or and/or call DON being made aware of, an	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
	345385					C 08/20/2020	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	CARDINAL HEALTHCARE AND REHAB			9	931 N ASPEN STREET		
				l	LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 600	Continued From page Initial approach to a fr CPR training May incl Verbal stimulu Gentle shakin resident Sternal rub to WILL NOT include: Poking the fee Using any obj part Using any oth reasonably be expect body Only nurses will perfor o Call 911 o Open door of o Bring chart to o Bring crash ca On 7/23/20, the Nurse education with Certifie regarding Abuse and Change of Condition, Respond/Manage a c Code Status to includ to include the followin ·Abuse and Neglect p include education time change in condition.	e 39 Ill code resident to follow lude: Is to rouse resident g of shoulders to rouse rouse resident et with a needle ect to poke or prod any body er stimuli that may ed to cause damage to the rm CPR, other staff may: facility for responders Nurse for review art to Code Blue e Managers then initiated ed Nursing Assistants Neglect, Notification of a How to Identify and hange in condition and e recognition and response g: policy reviewed with staff to ely response to resident's report on change in during shift change		600	DEFICIENCY)		
	change in condition. I	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	ЕНАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	nurse/house supervis immediately. On 7/24/20, Certified educated notification observation to include ·CNAs to report on ch during shift change. ·CNAs must notify lice change in condition. I take action CNA is to nurse/house supervis immediately. Upon discovering, or unresponsive residen ·One nurse to stay wi another staff member room to verify Code S ·Initial approach to a f CPR training May incl Verbal stimulu Gentle shakin resident Sternal rub to WILL NOT include: Poking the fee Using any obj part Using any oth reasonably be expect body	Nursing Assistants were of a change of condition e the following: hange in residents' condition ensed nurse with any f nurse does not respond or report concern to another for and/or call DON being made aware of, an it: th resident at all times and to bring chart to resident's Status (2 Nurses) at bedside. full code resident to follow	F	600			

Event ID: NYKK11

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	 Bring chart to Bring crash ca The center Executive of immediate jeopardy On 07/28/20 at 8:45 A immediate jeopardy refollowing. Review of in revealed staff from all been in-serviced on 0 regarding Abuse and Change of Condition, Respond/Manage a c Code Status/Code Bill 07/28/20 multiple interstaff in different depart interviews validated s the previous week reg Notification of a Chan Identify and Respond condition and Code S facility's date of imme 07/27/20 was validated Resident #26 was a 11/3/19 with diagnosis and Alzheimer's disea Review of Resident # Data Set (MDS) date of most activities of context of the context of cont	facility for responders Nurse for review art to Code Blue Director alleges abatement y on 07/27/20. At the facility's plan for emoval was validated by the n-service training records I shift and disciplines had 17/23/20 and 07/24/20 Neglect, Notification of a How to Identify and hange in condition and ue. Beginning at 9:00 AM on rviews were conducted with rtments/shifts. These taff had undergone training garding Abuse and Neglect, uge of Condition, How to /Manage a change in status/Code Blue. The diate jeopardy removal of ed. admitted to the facility on s which included dementia ase. 26's quarterly Minimum d 7/16/20 revealed she was npaired. Resident #26 tance of one staff member	F	600			

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345385	B. WING				/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	had talked with Resid regarding her and Re relationship and affect resident's family ment that. Review of a progress PM revealed Resident Resident #27's room him. The note revealed following Resident #22 Review of a progress PM revealed Resident another room to hold Resident #27. Review of a progress PM revealed Resident Resident #27's room day. The note stated naked in his bed and room and was sitting resident's hand. Resident #27 was add 11/15/19 with diagnos hypertension, anxiety Review of Resident # Data Set (MDS) dated alert and oriented req one staff member for Review of a progress Nurse #5 at 6:42 PM	stant Director of Nursing ent #26's family member sident #27 having a tionate touching. The aber stated she was ok with note dated 8/6/20 at 6:37 t #26 had been going into stating she was in love with ed Resident #26 was 7 around the building. note dated 8/9/20 at 6:55 t #26 continued to go in hands and attempted to kiss note dated 8/16/20 at 6:44 t #26 had been going into numerous times during the Resident #26 was lying Resident #27 went into his by the bed holding the mitted to the facility on sis which included anemia, , depression and asthma. 27's quarterly Minimum d 7/1/20 revealed he was uiring limited assistance of most ADL. note dated 8/6/20 written by revealed Resident #27 was	F	600			
	trying to remove Resi	revealed Resident #27 was dent #26 from her room for grabbed the wheelchair					

Facility ID: 923059

If continuation sheet Page 43 of 109

DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & N						FORM): 09/24/2020 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	345385	B. WING _					C 20/2020	
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE	E, ZIP CODE			
			931	N ASPEN STREET				
CARDINAL HEALTHCARE AND RE	нав		LIN	COLNTON, NC 28092				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
chair by a Nurse Resid Nurse #5 and almost h #27 was agitated statil with him and do whate note revealed Resider had gone all of the wa the day. Resident #27 15-minute monitoring. removed from the situa #5 to the nurse's statio On 8/19/20 at 10:18 A conducted with Nurse #26 and Resident #27 relationship in June 20 occasion she saw was were observed holding second occasion was NA #10 walked by Res noticed Resident #26 her wheelchair. She th from the room. She stat she had seen Resider room and Resident #26 waist down with no sh pulled Resident #26 of the Director of Nursing members. The intervie worked 7:00 AM to 7:0 texted the DON and th needed to do somethin interview revealed the #27 from the 100 hall 8/17/20. Nurse #5 stat about the relationship removed Resident #26	When asked to let go of the dent #27 swung his arm at hit Resident #26. Resident ng Resident #26 could stay ever they wanted to. The ht #26 and Resident #27 by to the front door earlier in was placed on every Resident #26 was ation and taken with Nurse on. M an interview was #5. She stated Resident had developed a 020. She stated the first on 8/6/20 when the two g hands in the hallway. The on 8/16/20 when she and sident #27's room and was in the room sitting in hen removed Resident #26 ated earlier that morning ht #26 in Resident #27's ?7 was undressed from the eet lying in bed. Nurse #5 ut of the room and notified g, Administrator and family ew revealed Nurse #5 00 PM. She stated she he Administrator stating they ng immediately. The facility moved Resident to the 200 hall on Monday ted she was concerned because when she 6 from Resident #27's room a nurse's station she stated,	F 6	500					

Facility ID: 923059

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	-	D HUMAN SERVICES //EDICAID SERVICES				FORM): 09/24/2020 APPROVED 0. 0938-0391
STATEMENT OF DEF AND PLAN OF CORF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345385	B. WING		_	(08/2) 20/2020
NAME OF PROVID	ER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
_			9	31 N ASPEN STREET			
CARDINAL HEA	ALTHCARE AND RE	HAB	1	INCOLNTON, NC 2809	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	ntinued From page opening.	44	F 600				
with #26 boy Res hers resi beir reve cou inte resi see stat she resi afte 200 On con arou in R to d was She nurs whe bac #26	h Nurse Aide (NA) is and Resident #27 friend and girlfrien- sident #26 was una self. She stated sta idents however the ng removed from o ealed Resident #26 Idn't go into Resider riview revealed she idents in the hallwa in Resident #27 at ted she always sep is saw them. The inf idents were on ever is saw them. The inf idents were on ever is 8/6/20 but Resider hall until Monday 8/20/20 at 5:30 PM ducted with NA #9 und 3:00 AM she h Resident #26's bed to rounds and said is inappropriate, and is noom the room to gu is room and return is room and return is room and return is down when it hing to Resident # is noom when it hing to Resident # is noom when it hing to Resident # is noom when it in his room when it in his room when it is noom when it is noom when in it is noom when in it is noom when in the information is noom when it is noom when it is noom when it is noom when it is noom when it is noom when it is noom when it is noom whe	ay holding hands and had Resident #26's door. She parated the residents when rerview revealed both ery 15-minute monitoring ent #27 wasn't moved to the 8/17/20.					

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/24/2020 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345385						C 20/2020	
NAME OF PROVIDER OR SUPPLIER			•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CARDINA	ARDINAL HEALTHCARE AND REHAB				31 N ASPEN STREET INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	only in-service trainin from her agency com On 8/19/20 at 11:04 A conducted with Nurse she worked night shif interview revealed sh holding hands with Re and had received rep between the two durin had heard on 8/16/20 Resident #27's room with her hand on his I had moved Resident to get him away from night he came back to leave. She stated Res were sitting on the 10 a close eye on them. had started every 15- of the residents 2 were had both of the reside stated no one had tol- residents separated. #26 was very confuse times to get her up ar The interview reveale #9 coming to her to sa #26 and Resident #27. In the interview she c with NA #9 on 8/11/20 was too confused to h On 8/19/20 at 11:22 A conducted with the As (ADON). She stated sa	r. The interview revealed the g she had on abuse was pany. M an interview was #8. She stated on 8/11/20 t from 7 PM to 7 AM. The e had seen Resident #26 esident #27 in the hallway orts that things had gone on ng the day. She stated she that Resident #26 was in when he was undressed eg. She stated the facility #27 to 200 hall on 8/17/20 Resident #26 however that to the 100 hall and wouldn't sident #26 and Resident #27 0-hall talking while she kept The interview revealed they minute monitoring on both exs prior and on 8/17/20 she ents monitoring sheets. She d her to keep the two Nurse #8 stated Resident ed, one night asking staff 13 of then put her back in bed. d she did not remember NA ay she had seen Resident 7 in bed together on 8/11/20. onfirmed she had worked 0. She stated Resident #26 have a relationship.	F	500				

Facility ID: 923059

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345385	B. WING _				C 08/20/2020	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE	•	
				93	31 N ASPEN STREET			
CARDINA	INAL HEALTHCARE AND REHAB			LI	INCOLNTON, NC 28092	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	č	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	mother taken advanta the family member wa holding hands, they d with the relationship of had come in early on and receive a statemen notified of a situation Resident #27 that had 8/11/20. The ADON s Resident #26's room bed and the two resid She stated Resident # Resident #26 while ly told NA #9 to get out. period of time and wh Resident #27 coming wheelchair from the re- calling for Resident # She stated NA #9 des "spooning" in the bed obtained the statemen Administrators door o somehow gotten lost. on every 15-minute m another hall. She stat severely demented an #27 holding her hand check. The ADON stat saw Resident #27 kis cheek and Resident # him, but he still had ke interview revealed Re- get Resident #26 to c stated she had spoke member who said to l	the resident having a ent #27 but did not want her age of. She stated because as comfortable with them idn't see anything wrong continuing. She stated she 8/12/20 to speak with NA#9 ent because she had been between Resident #26 and d occurred the day prior on tated NA #9 had walked into to find Resident #27 in her ents were under the sheets. #27 had his arm around ing in the bed. Resident #27 She then left the room for a en she came back, she saw out into the hall in his pom. Resident #27 was then 26 to come into his room. Scribed the residents as . The ADON stated she nt and placed it under the n 8/12/20 however it had Resident #27 was placed nonitoring and moved to ed Resident #26 was nd she had seen Resident and kissing her on the ted on one occasion she s Resident #26 on the #26 turned to get away from issed part of her mouth. The isident #27 would attempt to oome into his room. She n with Resident #26's family	F	00				
	Continued From page member was ok with friendship with Reside mother taken advanta the family member wa holding hands, they d with the relationship of had come in early on and receive a statemen notified of a situation Resident #27 that had 8/11/20. The ADON s Resident #26's room bed and the two resid She stated Resident # Resident #26 while ly told NA #9 to get out. period of time and wh Resident #27 coming wheelchair from the re calling for Resident # She stated NA #9 deg "spooning" in the bed obtained the statemen Administrators door o somehow gotten lost. on every 15-minute m another hall. She stat severely demented an #27 holding her hand check. The ADON sta saw Resident #27 kis cheek and Resident # him, but he still had ke interview revealed Re- get Resident #26 to c stated she had spoke member who said to l	e 46 the resident having a ent #27 but did not want her age of. She stated because as comfortable with them idn't see anything wrong continuing. She stated she 8/12/20 to speak with NA#9 ent because she had been between Resident #26 and d occurred the day prior on tated NA #9 had walked into to find Resident #27 in her ents were under the sheets. #27 had his arm around ing in the bed. Resident #27 She then left the room for a en she came back, she saw out into the hall in his form. Resident #27 was then 26 to come into his room. Cribed the residents as . The ADON stated she ht and placed it under the n 8/12/20 however it had Resident #27 was placed ionitoring and moved to ed Resident #26 was hd she had seen Resident and kissing her on the ted on one occasion she s Resident #26 on the 26 turned to get away from issed part of her mouth. The isident #27 would attempt to ome into his room. She n with Resident #26's family et her know if the 1. The interview revealed		00				

Facility ID: 923059

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		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
ND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	G			
					C		
		345385	B. WING		0	8/20/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
				931 N ASPEN STREET			
CARDINA	L HEALTHCARE AND R	ЕНАВ		LINCOLNTON, NC 28092			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION	
F 600	Continued From pag	e 47	F 6	00			
			1 0				
		ng the statement from NA istrator and ADON had					
		orning meeting along with					
		w to get the residents away					
	from each other to ke						
		view revealed the ADON did					
		at #26 after receiving the					
		he had left it up to the DON					
	and Administrator to						
	On 8/19/20 at 1:46 P	M an interview was					
	conducted with the S	ocial Worker (SW). She					
		the ADON came to her and					
		6 could have a relationship					
		he stated she told the ADON					
	no, because Resider	nt #26 had a low BIMS score.					
	She stated the next of	day a nurse told her they're					
		omething because Resident					
	#27 had been caugh	t kissing Resident #26. She					
	could not recall the d	ate but also recalled					
	Resident #27 was se	en in the bed telling					
	Resident #26 to com	e over into his room and					
		d her hand under the cover					
		She stated she couldn't					
		er that but she had sent an					
		20 to the Administrator,					
		mission Coordinator saying					
		d to be moved. The interview					
		eceived a response back					
		SW did not follow up after					
		sent with no response. On d Nurse #5 told her Resident					
		7 were going into each					
		DON told her the family of					
		ay with the two residents					
		nd that the friendship was					
		ated Administration never					
		mail, so she decided to send					
		man, so she decided to sella					

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 09/24/2020 APPROVED 0: 0938-0391
STATEMENT OF D AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345385	B. WING		_) ()80	20/2020
NAME OF PROV	/IDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINAL H	EALTHCARE AND RE	НАВ		931 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
le la th Ti w st fo to ei is to R th be re ki R to R S be fo b O co R re re R w re w th R ro	est Tuesday on 8/11/2 the morning meeting r he MDS Nurse states hat had happened of tated the MDS Nurse ound in Resident #26 old everyone in the m mail in June saying t sue. She stated the 200 hall on 8/17/20 eview of an email da the Administrator reve eing inappropriate with evealed Resident #27 ssing Resident #26. esident #27 should the ocontinue to monitor eview of an email da W had notified the O etween Resident #26 or guidance regarding ecause he was refus on 8/19/20 at 2:02 PM onducted with MDS N esident #26 was cog equired a lot of staff r evealed she had seen esident #27 holding eeks ago and they h elationship in morning eek before. She stat the relationship was g esident #26 had war oom and there was in	hing going on. She stated 20 something came up in regarding the two residents. d they needed to discuss ver the weekend. She e said Resident #27 was i's bed. The SW stated she neeting that she had sent an he relationship was an facility moved Resident #27 ated 6/18/20 from the SW to raled Resident #27 was ith Resident #26. The email 7 was being touchy and The Social Worker asked if be moved or if staff needed the resident. ated 8/17/20 revealed the ombudsman of the incident 5 and Resident #27. Asking g moving Resident #27 sing to be moved. <i>M</i> an interview was Nurse #1. She stated gnitively impaired and redirection. The interview in Resident #26 and hands in the hallway 2-3	F 600				

Facility ID: 923059

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_		C 20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB		931 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	what was going on wi interview revealed the Resident #26 couldn't her room due to confu- consent to a relations On 8/19/20 at 2:56 Pf conducted with Resid not recall what day of believed it was Friday had a male friend but name. The interview r kissed her, but she st kisses from him beca She stated she didn't hands, nor if he had g didn't know if he had g loved her, and she low had asked him if he h Resident #26 however intercourse. Resident never been in bed tog asked him when they intercourse. He stated #26's room and she h interview further rever kissed, but he had ne intercourse. He stated on top of her, but he w rolled into his room ev she loved him. The in	nistrator investigate into th the relationship. The e biggest concern was even find her way back to usion and wasn't able to hip. M an interview was ent #26. Resident #26 could the week it was stating she or Sunday. She stated she couldn't remember his revealed her male friend had ated she didn't want any use she, "didn't need that". remember if they had held jotten into her bed. She entered her room or if she M an interview was ent #27. He stated Resident nd they loved each other. He ent #26's skin and stated he ved him. He stated the DON ad sexual intercourse with	F 600				

Facility ID: 923059

If continuation sheet Page 50 of 109

	S FOR MEDICARE &					D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · ·	E SURVEY PLETED
	CONTLOTION	IDENTIFICATION NOWDER.	A. BUILDING			
						С
		345385	B. WING		08	/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
	L HEALTHCARE AND R	EUAR		931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	ENAD		LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From pag	e 50	F 60	00		
1 000						
	exciled when he saw	/ her because he loved her.				
	On 8/19/20 at 3:30 PM an interview was					
		Director of Nursing (DON).				
During the interview he sta aware of the relationship b		2 , <i>j</i>				
		couple of weeks ago. Staff				
		ts had been sitting in the				
		l were holding hands. Nurse				
		had seen Resident #27				
	kissing Resident #26	in the hallway. He stated the				
		he residents were interested				
		ted the topic had come up				
	during a morning inte	erdisciplinary team meeting				
	(IDT) discussing whe	ether the residents had the				
	right to have a relation	onship. He stated the				
	Administrator had co	ntacted Resident #26's				
	family member who	stated it was ok for the				
	resident to seek affect	ction however he didn't talk				
	to her, so he didn't kr	now the extent of the				
	conversation. The DO	ON stated it was reported to				
	him but could not rec					
		e bed together from the				
		thought Resident #26 was in				
		however had realized this				
		ther way around. He stated				
		ned him NA #9 had walked in				
		#27 in Resident #26's bed				
		A #9 left the room and when				
		w Resident #27 leaving				
		. He stated the Administrator				
		ent and had notified the				
	•	ecided it was not abuse and a				
	-	t completed. The interview				
		assessment was completed				
				1		1
		was an investigation initiated				
	after the allegation w	vas an investigation initiated vas received. He stated he N had received a statement				

Facility ID: 923059

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		G) (CO	MPLETED
						С
		345385	B. WING		o	8/20/2020
NAME OF PF	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	HEALTHCARE AND R			931 N ASPEN STREET		
CARDINAI	- HEALTHCARE AND R	ERAD		LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	o 51				
1 000			F 60			
		8/16/20 in which he was e Administrator had talked				
		id they moved Resident #27				
		esult of it. The DON stated				
	Resident #26 was unable to consent to a relationship due to her BIMs score (which					
	relationship due to he	er BIMs score (which				
		verely impaired cognition).				
	On 8/19/20 at 4:24 PM an interview was					
		dministrator. He stated both				
	residents desired a re					
		able to consent. The				
	residents liked to hole	d hands and hang out				
		l not to by staff. He stated he				
		known, that Resident #27				
		ed with Resident #26 by the				
		ived a statement from NA				
		had observed the residents suspected something may				
	5	interview revealed he never				
		nvestigation into the incident				
		completed a physical				
		lent #26 because he didn't				
	feel like they needed					
		26's family member and she				
		ionship, so he decided the				
		ed to be investigated. He				
		tected Resident #26 by				
		minute monitoring which en they noticed the residents				
		together. The interview				
		placed Resident #27 on one				
	on one monitoring. H	•				
	-	e email from the Social				
		and was first notified of the				
	two residents forming	g a relationship on 8/6/20.				
	On 9/10/20 at 4.47 D	M an intonviou was				
	On 8/19/20 at 4:47 P conducted with Resid					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345385	B. WING		_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB		31 N ASPEN STREET INCOLNTON, NC 2809	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 SS=D	times regarding the re- residents and to tell h Resident #27's room of from the waist down. I the Administrator wan the incident however residents had gotten to didn't go into further of Resident #27 was four The interview reveale comfortable with them stated she needed to the thought of the two her. She stated when Administrator, she told with the residents hav hands but nothing furt Reporting of Alleged V CFR(s): 483.12(c)(1)(§483.12(c) In respons neglect, exploitation, of must: §483.12(c)(1) Ensure involving abuse, negled hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resi the administrator of th officials (including to the	had contacted her several elationship between the two er Resident #26 was in when he was found naked She stated she then called ting more details regarding he just stated the two too "risqué". She stated he letails nor was she aware and in Resident #26's bed. d she was absolutely not n being in bed together. She keep her mother safe and o residents together disgust she talked to the d him she was comfortable ring a friendship and holding ther. Violations 4) se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to	F 609				9/14/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345385 B. WING 08/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092 577 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
MAKE OF PROVIDER OR SUPPLIER 345385 № WIG 08/20/2020 NAME OF PROVIDER OR SUPPLIER STIMEET ADDRESS, CITY, SIME, ZIP CODE STIMEET ADDRESS, CITY, SIME, ZIP CODE STIMEAT ADDRESS, CITY, SIME, ZIP CODE Comments (AND IN COMPANY STATEMENT OF DEFICIENCES, RECOLUCING IN COMPANY STATEMENT ADDRESS, CITY, SIME, ZIP CODE STIMEAT ADDRESS, CITY, SIME, ZIP CODE Comments Comment	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, í			COMPLETED		
SINASPENSIVE INCOLATION, CONSTRUCTION CARDINAL HEALTHCARE AND REHAB PROVIDERS TATELENT OF DEFICIENCES PROVIDERS FLAV OF CORRECTION CONSTRUCT ACTION SHOULD BE (May 10) (EACH DEFICIENCY MUST DE PRECIDED DE Y FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PRECY TAG PROVIDERS FLAV OF CORRECTION (EACH DERORECTIVE ACTION SHOULD BE CROSS-REFERENCE/OF TO THE APPROPRIATE DEFICIENCY) CONSTRUCT ACTION (EACH DERORECTIVE ACTION SHOULD BE CROSS-REFERENCE/OF TO THE APPROPRIATE DEFICIENCY) CONSTRUCT ACTION (EACH DERORECTIVE ACTION NEI/OLD EXCIDENTIFYING INFORMATION) CONSTRUCT ACTION (EACH DERORECTIVE ACTION NEI/OLD EXCIDENTIFYING INFORMATION) PRECINATION (CONSTRUCT ACTION (EACH DERORECTIVE ACTION NEI/OLD EXCIDENTIFY) CONSTRUCT (EACH DERORECTIVE ACTION NEI/OLD EXCIDENTIFY) F6092 F6092 REFORMED (FALLING) F6092 REFORMED (FALLING) F6092 REFORMED (FALLING) F6092 REFORMED (FALLING)			345385	B. WING _				-	
CARDINAL HEALTHCARE AND REHAB LINCOLNTON, NC 28092 (%1)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST EAR PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH CORRECTVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENT DEFICIENCY) F 609 Continued From page 53 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. F 609 F 609 § 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: F609: Reporting of Alleged Violations: Abuse and Neglect The Mergeny of Alleged Violations: Abuse and Neglect Findings included: Findings included: Findings included: Resident #26 was admitted to the facility on 11/3/19 with diagnosis which included dementia, Alzheimer's disease. F609: Reporting of Alleged Violations: Abuse and Neglect Review of Resident #26's quarterly Minimum Data Set (MDS) dated 7/16/20 revealed she was severely cognitively impaired. Resident #26's required limited assistance of one staff member for most activities of daily living (ADL). F609: Reporting of Alleged Violations: Abuse and Neglect	NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CMUID PRETX TXG SUMMARY STATEMENT OF DEPICIENCIES (EQC) DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) D PRETX TXG PROVIDENS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETC (ACC STATE DEFICIENCY) F 609 Continued From page 53 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. F 609 F 609 F 609 § 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, louding to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: F609: Reporting of Alleged Violations: Abuse and Neglect F609: Reporting of Alleged Violations: Abuse and Neglect Findings included: Findings included: F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Vi			HAR	931 N ASPEN STREET		1 N ASPEN STREET			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFX TAG (EACH DERCIPUE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMMENTE DEFICIENCY F 609 Continued From page 53 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. F 609 F 609 F 609 F 609 F 609 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a sexual abuse allegation to the state agency within a two-hour time frame of the abuse allegation being made for one (Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to Resident #26 was admitted to the facility on 11/3/19 with diagnosis which included dementia, Alzheimer's disease. F007: The Executive Director of Nursing were relieved of their duties at the Facility by the Regional Director of Nursing were relieved of their duties at the Facility by the Regional Director of Nursing were relieved and updated accordingly by the Interdisciplinary Team. Review of Resident #26's quarterly Minimum Data Set (MDS) date 7/16/20 revealed she was severely cognitively impaired. Resident #26 required limited assistance of one staff member for most activities of daily iwing (ADL). Comment abusen reviewed and updated					LI	NCOLNTON, NC 28092			
for jurisdiction in long-term care facilities) in accordance with State law through established procedures. \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: F609: Reporting of Alleged Violations: Abuse and Neglect 8 ased on record review and staff interviews, the facility failed to report a sexual abuse allegation to the state agency within a two-hour time frame of the abuse allegation being made for one (Resident #26) of three abuse investigations reviewed. F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident to the facility on 11/3/19 with diagnosis which included dementia, Alzheimer's disease. The Allegation of Resident #26's quarterly Minimum Data Set (MDS) dated 7/16/20 revealed she was severely cognitively impaired. Resident #26's required limited assistance of one staff member for most activities of daily liming (ADL). F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident #26's quarterly Minimum Data Set (MDS) dated 7/16/20 revealed she was severely cognitively impaired. Resident #26's quarterly Minimum for most activities of daily liming (ADL). F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of Resident #26's quarterly Minimum for most activities of daily liming (ADL). F609: Reporting of Alleged Violations: Abuse and Neglect 1. The Allegation of the included assistance of one staff member	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
Review of Resident #26's care plan dated initiated on 5/3/20 and current through 8/22/20 revealed no focus area for sexual behaviors.2. Current interview-able residents have been interviewed by the ED/DON/Social Services and no residents have stated allegations of Abuse or Neglect. The (ED/DON/Social Services has interviewed true staff regarding any resident allegations of Abuse or Neglect and no	F 609	for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi facility failed to report the state agency with the abuse allegation b (Resident #26) of thre reviewed. Findings included: Resident #26 was add 11/3/19 with diagnosis Alzheimer's disease. Review of Resident # Data Set (MDS) dated severely cognitively in required limited assis for most activities of o Review of Resident # initiated on 5/3/20 and revealed no focus are Resident #27 was add	 term care facilities) in a law through established the results of all administrator or his or her ative and to other officials in a law, including to the State in 5 working days of the eged violation is verified a action must be taken. is not met as evidenced ew and staff interviews, the a sexual abuse allegation to in a two-hour time frame of being made for one eabuse investigations mitted to the facility on swhich included dementia, 26's quarterly Minimum d 7/16/20 revealed she was mpaired. Resident #26 tance of one staff member faily living (ADL). 26's care plan dated d current through 8/22/20 ta for sexual behaviors. 	F	609	 Abuse and Neglect The Allegation of Resident to Resident Abuse was reported to the St of North Carolina Department of Health and Human Services on 8-19-20 with a Day Investigative Report submitted on 8/26/2020. The Executive Director (ED and Director of Nursing (DON) were educated by the Regional Director of Clinical Services (RDCS) on 8-19-20. The Executive Director and Director of Nursing were relieved of their duties at Facility by the Regional Vice President Operations on 8-20-20. Resident #26 care plan has been reviewed and upda accordingly by the Interdisciplinary Tea Resident #27 no longer resides at the facility. Current interview-able residents h been interviewed by the ED/DON/Soci Services and no residents have stated allegations of Abuse or Neglect. The (ED/DON/Social Services has interview current staff regarding any resident 	ate n a 5) the of □s ited m. ave al		

Event ID: NYKK11

Facility ID: 923059

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	OF DEFICIENCIES	I de la constante de	1			
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345385	B. WING		C 08/20/2	020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		520
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	EHAB		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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COM TO THE APPROPRIATE	(X5) MPLETIO DATE
F 609	Continued From page	2 54	E 60			
F 609	Data Set (MDS) date alert and oriented req one staff member for Review of Resident # initiated on 5/3/20 and revealed no focus are On 8/20/20 at 5:30 Pl conducted with NA #S around 3:00 AM she in Resident #26's bec to do rounds and said was inappropriate, an She left the room to g nurse was outside sm when she found her a back to the room Res #26's room and return stated the Nurse did nay anything to Resident back in his room whe room. NA #9 stated sh happened and had w stated following the in training on abuse nor the ADON contact he only in-service trainin from her agency com On 8/19/20 at 11:04 A	27's quarterly Minimum d 7/1/20 revealed he was juiring limited assistance of most ADL. 27's care plan dated d current through 8/22/20 ea for sexual behaviors. M an interview was 0. She stated on 8/11/20 had witnessed Resident #27 d. NA #9 walked in the room d she told Resident #27 that id he told her to get out. to get Nurse #8, but the hoking. NA #9 told Nurse #8 and by the time, they came ident #27 had left Resident hed to his room. NA #9 hot do anything or say #27 because he was already n she got to Resident #26's she told the ADON what had ritten a statement. She hoident she received no did any other staff besides r. The interview revealed the g she had on abuse was pany.	F 60	19 further allegations receiv DON/Nurse Manager ha audits of current residen evidence of suspicious ir 3. The RDCS has educ Executive Director and th Nursing on 9/10/2020 re reporting of alleged viola mistreatment, neglect, or injuries of unknown, sou misappropriation of resic is reported to facility staf regulation F609 as well a North Carolina S Report On 9/8/20-9/11/20 educa to all licensed nurses, ce assistants, therapy staff, staff, dietary staff, Direct Housekeeping Manager, Manager, Human Resou Medical Records Directo Director and Admissions Interim Executive Directo Clinical Services related alleged violations involvi neglect, or abuse, includ unknown, source and mi resident property that is staff as defined per regu well as per the State of N Reporting guidelines	s conducted skin ts to ensure no njuries. cated the new he Director of lated to the tions involving r abuse, including rce and lent property that f as defined per as per the State of ting guidelines. ation was provided ertified nursing housekeeping tor of Rehab, Business Office irces Coordinator, ir, Social Services Director by or, Director of sistant Director of to the reporting of ng mistreatment, ing injuries of sappropriation of reported to facility lation F609 as	
	revealed she had see hands with Resident received reports that	to 7 AM. The interview en Resident #26 holding #27 in the hallway and had things had went on between y. She stated she had heard		 The Regional Direct Services/Designee will c Improvement (QI) monitor reported to facility staff a ensure staff understand 	onduct Quality pring of concerns s well as to	

Facility ID: 923059

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
			A. BUILDING	3		С
		345385	B. WING			08/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		08/20/2020
				931 N ASPEN STREET	OODL	
CARDINA	L HEALTHCARE AND RE	EHAB		LINCOLNTON, NC 28092		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 609	Continued From page	- 55	F 60	9		
		was undressed with her	1 00	as the timeframe for repor	ting abuse for	
		stated the facility had moved		four weeks 1x / week then	-	
	-	hall on 8/17/20 to get him		ensure concerns that are	-	
	away from Resident #26 however that night he came back to the 100 hall and wouldn't leave. She stated Resident #26 and Resident #27 were sitting on the 100-hall talking while she kept a close eye on them. The interview revealed they had started every 15-minute monitoring on both			reportable event as outline		
				the State of North Carolina		
				guidelines are reported to		
				officials in accordance with		
				state law within 2 hours fo	r an allegation	
				of abuse. Results of the Q	I monitoring will	
		eks prior and on 8/17/20 she		be presented to the facility	•	
		ents monitoring sheets. She		Assurance Performance I		
	stated no one had tol	•		Committee monthly for co		
		Nurse #8 stated Resident		substantial compliance an	d/or revision for	
	-	ed, one night asking staff 13		six months.		
		nd then put her back in bed.		The center Executive Dire		
		ed she did not remember NA		an ADHOC Quality Assura		
		ay she had seen Resident 7 in bed together on 8/11/20.		Performance Improvemen 09/10/20, Director of Nurs	-	
		tated she had worked with		Director of Nursing, Regio	•	
		e stated Resident #26 was		Clinical Services, Regiona		
	too confused to have			of Operations, Director of		
				Housekeeping Manager, S		
	On 8/19/20 at 11:22 /	AM an interview was		Director, Business Office I		
	conducted with the As	ssistant Director of Nursing		Human Resources Coordi	-	
	(ADON). She stated s	she had called the resident's		Records, Admissions Dire		
		the relationship began in		Manager, Activity Director		
		evealed the family member		Director for reporting of all	-	
		ent having a friendship with		5. Allegation of Complia	nce Date:	
		not want her mother taken		September 14, 2020		
	-	ated because the family				
		able with them holding				
		e anything wrong with the				
		g. She stated she had come				
	-	speak with NA#9 and because she had been				
		between Resident #26 and				
		d occurred the day prior on				
		stated NA #9 had walked into				

Facility ID: 923059

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345385	B. WING					C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	L HEALTHCARE AND RE			93	31 N ASPEN STREET			
CARDINA	L HEALINGARE AND RE	INAD		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	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 609	She stated Resident # Resident #1 while lyin told NA #9 to get out of the room for a period back, she saw Reside hall in his wheelchain #27 was then yelling f into his room. She sta residents as "spoonin stated she obtained th under the Administrate however it had some #27 was placed on ev and moved to another #26 was severely den Resident #27 holding	ents were under the sheets. #2 had his arm around g in the bed. Resident #27 of the room. She then left of time and when she came ent #27 coming out into the from the room. Resident for Resident #26 to come ated NA #9 described the g" in the bed. The ADON he statement and placed it	F	609				
	she saw Resident #27 cheek and Resident # him, but he still had ki interview revealed Re get Resident #26 to c stated she had spoke member who said to I relationship escalated she did not contact Re member after receivin #9. The DON, Admini discussed the allegati bed together in the m the Social Worker on away from each other happening. The interv not examine Resident	7 kiss Resident #26 on the #26 turned to get away from issed part of her mouth. The isident #27 would attempt to ome into his room. She n with Resident #26's family et her know if the 1. The interview revealed esident #26's family og the statement from NA strator and ADON had on of the residents being in orning meeting along with how to get the residents to keep anything else from view revealed the ADON did t #26 after receiving the ne had left it up to the DON nvestigate.						

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CENTER		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			FORM	0: 09/24/2020 1 APPROVED 0: 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345385	B. WING		_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB		031 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	During the interview h aware of the relations and Resident #27 a c DON stated it was rep recall the date that the together from the ADO Resident #26 was in H however had realized other way around. He informed him NA #9 h Resident #27 in Resid sheets. NA #9 left the returned, she saw Re #26's room. He stated about the incident and member however ded 24-hr. report was not revealed no physical for Resident #26 nor after the allegation wa never knew the ADON from NA #9. On 8/19/20 at 4:24 Pf conducted with the Ado residents desired a re Resident #26 was una residents liked to hold although encouraged was notified but did not that Resident #27 atte Resident #26 by the A statement from NA #9 observed the resident suspected something interview revealed he investigation into the	rector of Nursing (DON). the stated he was made hip between Resident #26 ouple of weeks ago. The borted to him but could not the residents were in the bed DN. He stated he thought Resident #27's room this morning it was the the stated the ADON had had walked in and found dent #26's bed under the room and when she sident #27 leaving Resident d the Administrator knew d had notified the family ided it was not abuse and a completed. The interview assessment was completed was an investigation initiated as received. He stated he N had received a statement M an interview was dministrator. He stated both lationship however able to consent. The I hands and hang out not to by staff. He stated he ot recall the date or by who empted to get in bed with ADON who had received a D. He stated NA #9 had	F 609				

Facility ID: 923059

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 09/24/2020 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMF	SURVEY LETED
		345385	B. WING			-		C 20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 28092	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 609 F 656 SS=D	#26 because he didn' stated he had contact member and she was he decided the allega reported and investiga protected Resident #2 15-minute monitoring when they noticed the time together and was revealed he had not p one-on-one monitorin Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that inc objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.24 (ii) Any services that a under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of	t feel like it was needed. He ed Resident #26's family ok with the relationship, so tion did not need to be ated. He stated the facility 26 by completing every which started on 8/6/20 e residents spending more s on going. The interview laced Resident #27 on g. omprehensive Care Plan ensive Care Plans sility must develop and ensive person-centered sident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive oprehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and vould otherwise be required 25 or §483.40 but are not esident's exercise of rights ing the right to refuse .10(c)(6). ervices or specialized the nursing facility will		609				9/10/20

Facility ID: 923059

If continuation sheet Page 59 of 109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF POVIDER OR SUPPLIER 345385 B. WING C C NAME OF POVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET DID P31 N ASPEN STREET C (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656 F 656		-					FORM	/ APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED A. BUILDING		()		(X2) MULT	TIPLE			
Image: Name of PROVIDER OR SUPPLIER 345385 B. WING OB/20/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET CARDINAL HEALTHCARE AND REHAB 931 N ASPEN STREET LINCOLNTON, NC 28092 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (K5) COMPLETIC DATE F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARDINAL HEALTHCARE AND REHAB 931 N ASPEN STREET LINCOLNTON, NC 28092 10 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETION DATE F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656			345385	B. WING				-
LINCOLNTON, NC 28092 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIN DATE F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656	NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
Kall Summary statement of deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETIC DATE F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656					93	31 N ASPEN STREET		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 656 Continued From page 59 findings of the PASARR, it must indicate its rationale in the resident's medical record. F 656	CARDINA	L REALINGARE AND RE	INAB		L	INCOLNTON, NC 28092		
findings of the PASARR, it must indicate its rationale in the resident's medical record.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	N SHOULD BE	
(iv)in consultation with the resident and the resident's greesentative(s)- (A) The resident's greaternoe 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. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop a comprehensive, individualized, and person- centered care plan in the area of behaviors for 2 of 3 sampled residents reviewed for sexual abuse (Resident #26 and Resident #27). The findings included: Resident #26 was admitted to the facility on 11/3/19 with diagnosis which included heart failure, dementia, Atzheimer's, respiratory failure and asthma. Review of Resident #26's quarterly Minimum Data Set (MDS) dated 7/16/20 revealed she was severely cognitively impaired. Resident #26's required limited assistance of one staff member for most activities of daily living (ADL). F656 Review of Resident #26's care plan dated On 9/2/2020-9/4/2020 the Minimal Data Set Nurse Review of Resident #26's care plan dated On 9/2/2020 the Regional Minimal Data Set Nurse	F 656	findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goad desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident's community was assess local contact agencies entities, for this purpoo (C) Discharge plans in plan, as appropriate, I requirements set forth section. This REQUIREMENT by: Based on record revit facility failed to develor individualized, and pet the area of behaviors reviewed for sexual a Resident #27). The findings included 1. Resident #26 was a 11/3/19 with diagnosis failure, dementia, Alzt and asthma. Review of Resident # Data Set (MDS) dated severely cognitively in required limited assiss for most activities of com-	RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and efference and potential for ilities must document is desire to return to the ssed and any referrals to is and/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced iews and staff interviews, the op a comprehensive, erson- centered care plan in for 2 of 3 sampled residents buse (Resident #26 and : admitted to the facility on s which included heart heimer's, respiratory failure 26's quarterly Minimum d 7/16/20 revealed she was mpaired. Resident #26 tance of one staff member daily living (ADL).	F	656	Resident #26 care plan was updated to reflect current behaviors and cognition 8/21/2020. Resident #27 care plan was updated to reflect current behaviors on 8/21/2020. On 9/2/2020-9/4/2020 the Minimal Data Set Nurse performed a Quality Improvement Monitoring of care plans for all residents to identify behaviors an cognition changes. No other issues were identified. On 9/2/2020 the Regional Minimal Data Set Nurse provided Education to the Minimal Data Set Nurse	on 5 a nd	

Facility ID: 923059

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345385	B. WING			8/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CARDINA	L HEALTHCARE AND RE	ЕНАВ		931 N ASPEN 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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 60	F 65	56		
		d current through 8/22/20	1 00	As needed to reflect change	nes in behaviors	
		ea for sexual behaviors.		and cognition changes.	yes in penaviors	
				On 9/08/2020 through 9/1	1/2020 the	
	Review of an email d	ated 6/18/20 from the Social		Director of Nursing and/or		
	Worker to the Admini	strator revealed Resident		provided re-education to li		
	#27 was being inappr	ropriate with Resident #26.		Certified nursing assistant		
	The email revealed R	Resident #27 was being		and therapy staff on the p		
	touchy and kissing Re	esident #26.		identifying and reporting c		
				behaviors and cognition to	the Director of	
		note dated 6/19/20 at 6:37		Nursing and/or designee.		
		istant Director of Nursing				
		dent #26's family member		The Minimal Data Set Nur		
	regarding her and Re	0		Perform Quality Improvem		
	relationship and affect	clionately louching.		of identifying and reporting behaviors and cognition.	g changes in	
	Review of a progress	note dated 8/6/20 at 6:37		Completed two times a we	ek for four	
		nt #26 had been going into		weeks,		
		stating she was in love with		then one time a week for e	eight weeks and	
	him. The note reveale	0		then	ight weeks, and	
		27 around the building.		one time monthly for three	months.	
	1 0	note dated 8/6/20 revealed		The Director of Nursing in	troduced the	
		sident #27 were placed on		plan of correction to the		
	•	nitoring due to an incident		Quality Assurance Perform		
	occurring where Resi			Improvement Committee of		
	aggressive towards s	staff over Resident #26.		The Director of Nursing wi		
	Review of a prograss	note dated 8/9/20 at 6:55		results of the quality monit the Quality Assurance Per	,	
		nt #26 continued to go in		Improvement committee.		
		hold hands and attempted		reviewed by QAPI commit		
	to kiss Resident #27.			Quality monitoring (audit)	•	
				changes are needed base	•	
	Review of a progress	note dated 8/16/20 at 6:44		The Quality Assurance Pe		
		nt #26 had been going into		Improvement Committee		
		numerous times during the		not limited to the Executiv		
		Resident #27 was lying		Director of Nursing, Work	-	
		Resident #26 went into his		Unit Manager, Social Serv	-	
		by the bed holding the		Business Office Manager,		
	resident's hand.			Director, Human Resource	es, Pharmacist,	

Facility ID: 923059

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SI	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	COMPLE	
					С	
		345385	B. WING		08/20)/2020
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
	L HEALTHCARE AND R			931 N ASPEN STREET		
CANDINA				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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page 61		F 65	56		
	On 8/20/20 at 5:30 P			Medical Director, CNA, Di Maintenance Director, Ho	usekeeping	
		9. She stated on 8/11/20 had witnessed Resident #27		Supervisor, Admissions, N		
		d . NA #9 walked in the room		and MDS Nurse. The Qua Performance Improvemer		
		d she told Resident #27 that		meets monthly and quarter		
		nd he told her to get out.		minimum.		
	She left the room to g	go get Nurse #8, but the				
		noking. NA #9 told Nurse #8				
		and by the time, they came				
		sident #27 had left Resident		AOC Date: 9/14/2020		
	#22's room and return	ned to his room.		AUC Date: 9/14/2020		
	On 8/20/20 at 10:24 /	AM an interview was				
	conducted with the S	ocial Worker. She stated				
	Resident #26 did not					
	U U	n. The interview revealed				
	-	se would initiate the care				
		e had overheard the MDS istrator and Director of				
	Nursing if she needed					
	U U	er to wait and it was never				
	done.					
	On 8/20/20 at 10:28 /	AM on interview was				
		IDS Nurse. She stated she				
		re plan with the Director of				
		trator when the two residents				
	initially started having					
		e was told they wanted to				
		rate nurse prior to initiating a				
		ey would get back with her.				
	-	ght it up again on Monday istrator however he told her				
		ated she didn't want to put a				
	care plan in place wit					
		ne interview revealed the				
		nd Administrator never got				
	back with hor rogardi	ng the approval of adding a	1	1		

Facility ID: 923059

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			0/00 P == ===			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	E SURVEY PLETED
			A. BUILDING	<u> </u>		
		245205	B. WING			С
		345385	B. WING			/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	L HEALTHCARE AND RI	EHAB		931 N ASPEN STREET		
				LINCOLNTON, NC 28092		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION
F 656	Continued From page	e 62	F 65	56		
	care plan for the resid					
	On 8/19/20 at 3:30 P	M an interview was				
	conducted with the Director of Nursing (DON).					
	During the interview I	he stated he was made				
	aware of the relations	ship between Resident #26				
	and Resident #27 a c	couple of weeks ago. Staff				
	reported the resident	s had been sitting in the				
	hallway together and	were holding hands. Nurse				
	#5 had told him she h	nad seen Resident #27				
	kissing Resident #26	in the hallway. He stated the				
	staff weren't happy th	ne residents were interested				
	in each other. He sta	ted the topic had come up				
		rdisciplinary team meeting				
		ther the residents had the				
		nship. The DON stated it				
	•	out could not recall the date				
		re in the bed together from				
		he thought Resident #26				
		s room however had realized				
	-	e other way around. He				
		l informed him NA #9 had				
		Resident #27 in Resident				
		sheets. NA #9 left the room				
		ed, she saw Resident #27				
	-	's room. He stated the				
		bout the incident and had				
	0	however decided it was not				
		eport was not completed.				
		ed no physical assessment esident #26 nor was an				
	•	after the allegation was				
	-	ne never knew the ADON				
		ment from NA #9. The				
		ere was another situation on				
		vas notified. He stated the				
		vas noumeu. He stateu lhe				1
	Administrator had to	kad with Pasidant #27 and				
		ked with Resident #27 and t #27 to the 200 hall as a				

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345385	B. WING				20/2020	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CARDINA	L HEALTHCARE AND RE	HAB		931 N ASPEN STREET LINCOLNTON, NC 28092				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 656	unable to consent to a BIMs score however a related to cognition of stated it was the MDS care plans for resident this hadn't been comp 2. Resident #27 was a 11/15/19 with diagnost hypertension, anxiety Review of Resident # Data Set (MDS) dated alert and oriented req one staff member for Review of Resident # initiated on 5/3/20 and revealed no focus are On 8/19/20 at 1:46 Pf conducted with the Se June 2020 the ADON Resident #26 could h Resident #27. She sta because Resident #2 She stated the next d going to have to do se #27 had been caught also said Resident #26 to and when she did, he cover rubbing his gen Review of a progress Nurse #26 at 6:42 PM trying to remove Resi supper. Resident #27	a relationship due to her she did not have a care plan r sexual behaviors. He S Nurse who initiated the tits, and he did not know why oleted. admitted to the facility on sis which included anemia, , depression and asthma. 27's quarterly Minimum d 7/1/20 revealed he was uiring limited assistance of most ADL. 27's care plan dated d current through 8/22/20 ea for behaviors. M an interview was ocial Worker. She stated In came to her and asked if ave a relationship with ated she told the ADON no, 6 had a low BIMS score. ay a nurse told her they're omething because Resident kissing Resident #26. She 7 was seen in the bed o come over into his room had her hand under the	F	656				

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CARDINA	L HEALTHCARE AND RE	HAB			31 N ASPEN STREET 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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 656	chair by a Nurse Resi Nurse #5 and almost #27 was agitated stat with him and do what note revealed Reside had went all of the wa the day. Resident #27 15-minute monitoring leave the facility. Res the situation and take nurse's station. On 8/20/20 at 5:30 Pl conducted with NA #9 around 3:00 AM she H in Resident #26's bed to do rounds and said was inappropriate, an She left the room to g nurse was outside sm Nurse when she foun came back to the root Resident #26's room On 8/20/20 at 10:24 A conducted with the So Resident #27 did not behaviors. The intervit MDS Nurse would initi stated she had overthe Administrator and Dim needed to add a care to wait and it was new On 8/20/20 at 10:28 A conducted with the M had discussed the care	dent #27 swung his arm at hit Resident #26. Resident ing Resident #26 could stay ever they wanted to. The nt #26 and Resident #27 by to the front door earlier in 7 was placed on every due to stating he wanted to ident #26 was removed from n with Nurse #5 to the M an interview was 0. She stated on 8/11/20 had witnessed Resident #27 . NA #9 walked in the room 1 she told Resident #27 that d he told her to get out. o get Nurse #8, but the toking. NA #9 told the d her and by the time, they m Resident #27 had left and returned to his room. M an interview was boial Worker. She stated have a care plan for ew revealed usually the tiate the care plans. She eard the MDS Nurse ask the ector of Nursing if she plan however, they told her er done. M an interview was DS Nurse. She stated she re plan with the Director of rator when the two residents	F	656			

Facility ID: 923059

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345385	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			93	31 N ASPEN STREET		
CARDINAL HEALTHCARE AND RE	нав		L	INCOLNTON, NC 28092		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
speak with the corpora care plan and that the She stated she brough 8/17/20 to the Adminis again to wait. She stat care plan in place with Administrator first. The Director of Nursing an back with her regardin care plan for the resid On 8/19/20 at 3:30 PM conducted with the Dir During the interview h aware of the relations and Resident #27 a cor reported the residents hallway together and w #5 had told him she ha kissing Resident #26 i staff weren't happy the in each other. He stated during a morning inter (IDT) discussing whet right to have a relation was reported to him b that the residents were the ADON. He stated was in Resident #27's this morning it was the stated the ADON had walked in and found F #26's bed under the si and when she returne leaving Resident #26's Administrator knew at notified the daughter f	e was told they wanted to ate nurse prior to initiating a y would get back with her. ht it up again on Monday strator however he told her ted she didn't want to put a nout running it by the e interview revealed the d Administrator never got ng the approval of adding a ent. <i>M</i> an interview was rector of Nursing (DON). e stated he was made hip between Resident #26 ouple of weeks ago. Staff is had been sitting in the were holding hands. Nurse ad seen Resident #27 in the hallway. He stated the e residents were interested ed the topic had come up rdisciplinary team meeting her the residents had the hship. The DON stated it ut could not recall the date e in the bed together from he thought Resident #26 a room however had realized e other way around. He informed him NA #27 had Resident #27 in Resident heets. NA #9 left the room d, she saw Resident #27	F	556			

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345385	B. WING				20/2020
NAME OF PRC	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	HEALTHCARE AND RE	HAR		9	31 N ASPEN STREET		
CANDINAL				L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658 SS=D (vas completed for Re nvestigation initiated eceived. He stated he nad received a statem neterview revealed the 8/16/20 in which he w Resident #26 had bee every 15-minute moni a care plan in place to stated it was the MDS care plans for residen his hadn't been comp Services Provided Me CFR(s): 483.21(b)(3) (6483.21(b)(3) Compre The services provided Me CFR(s): 483.21(b)(3)(6483.21(b)(3) Compre The services provided as outlined by the com nust- i) Meet professional s This REQUIREMENT by: Based on record revi- nurse practitioner inte unresponsive resident imes to check for resi esident reviewed (Re care in accordance to Findings included: Dn 07/21/20 at 2:30 F conducted with NA #1 around 1:00 PM she h rom Resident #2's roo Resident #2 was in he	d no physical assessment sident #26 nor was an after the allegation was e never knew the ADON bent from NA #9. The re was another situation on as notified. He stated en moved and placed on toring however did not have or effect his behaviors. He Nurse who initiated the ts, and he did not know why leted. The Professional Standards i) whensive Care Plans or arranged by the facility, hprehensive care plan, standards of quality. is not met as evidenced ew, staff interview, and rview a nurse poked an t with a needle over twenty ponsiveness for 1 of 1 sident #2) for providing professional standards.		656	F658 On 6/06/2020 resident #2 was discharg to Atrium Health Lincoln. On 7/25/2020 Nurse #1 was relieved of her duties. On 7/22/2020 Nurse #2 was relieved of her duties. On 7/22/2020 all residents skin assessments completed To evaluate for any new areas not addressed previously and/or any new Areas of concern. No areas of concern noted.	f	9/14/20

Event ID: NYKK11

Facility ID: 923059

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, í				IPLETED
		345385	B. WING			08	C B/20/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				93	31 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	ЕНАВ		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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 658	Continued From page	e 67	Í F	658			
			1	000			
		rub and called the residents			The Director of Nursing and/or design	00	
	#1 when she discove	se. She went to get Nurse			The Director of Nursing and/or design re-educated Licensed	ee	
		#1 conducted a sternum rub			Nurse and Certified Nursing Assistant		
	- ·	nts face with a cold cloth but			regarding the proper way to		
	-	se from the resident. Nurse			Arouse an unresponsive resident on		
		get Nurse #2, who came to			7/24/2020 through 7/25/2020.		
		ked by Nurse #1 to get			On 9/08/2020 through 9/11/2020		
		1 asked NA #1 to obtain vital			education was provided to Licensed		
		eeded to gather her vital			Nurses and Certified Nursing Assistar	nts	
	-	#2 handed her a needle and			regarding the proper way		
	•	Jurse #1. Nurse #1 took the			To arouse an unresponsive resident.		
		nd proceeded to stick the					
		of Resident #2's foot around			The Director of Nursing and/or design	ee	
		esponse. NA #1 stated she			will conduct		
	had seen blood comi	-			Quality improvement monitoring of		
		which Nurse #1 had placed			resident skin assessments		
	the needle and Resid	-			two times a week for four weeks,		
	unresponsive with no	movement.			then one time a week for eight weeks then	, and	
	On 7/21/20 at 7:30 Pl conducted with NA #:	M an interview was 2. NA #2 stated she was			one time monthly for three months.		
		#2's hall on 06/06/20. She			The Director of Nursing introduced the	2	
	-	b her and said Resident #2			plan of correction to the Quality Assur		
		he went with her to Resident			Performance Improvement Committee		
		Nurse #1 entered the room			9/10/2020. The Executive Director is		
		a sternum rub and use a tool			responsible for implementing this plan	1.	
		bottom of Resident #2's feet			The Quality Assurance Performance		
		to respond. She stated			Improvement Committee members		
		e room and returned to the			consist of but not limited to Executive		
	nurse's station.				Director, Director of Nursing, Staff		
					Development Coordinator, Unit Mana	ger,	
	On 07/21/20 at 10:23	AM an interview was			Social Services, Medical Director,		
		e #1. She stated she was			Maintenance Director, Housekeeping		
		lent #2 on 06/06/20. She			Services, Dietary Manager, and Minin	num	
		d Resident #2's vital signs			Data Set Nurse and a minimum of one		
	-	en saturation level was low;			direct care giver. Quality Improvemer		
		d NA #2 to move her to the			Quality monitoring schedule modified		
		oxygen but could not recall			based on findings.		

Facility ID: 923059

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	APPROVED 0. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	345385	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINAL HEALTHCARE AND REHA	AB	931 N ASPEN STREET LINCOLNTON, NC 28092				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
 stable and out of the fact used a needle or any off the resident's feet when unresponsive. On 7/21/20 at 6:00 PM a conducted with Nurse #2 gone into Resident #2's resident was coding and sticking the resident's for Nurse #1 a needle. On 07/22/20 at 10:00 AM conducted with Residen The interview revealed w taken to the ED and the questioning as to why the holes on the top and bot family member stated the feet were small, dark put a line across the top of t bottom and had not bee on 6/05/20 when Resident #2's feet. The #2 had 29 small purple for the family member family fam	gen saturation level was. 's oxygen level dropped 'e was to get the resident cility. She stated she never her object to stick or poke she found her an interview was 2. She stated she had not room prior to when the d had not seen Nurse #1 oot with a needle or given M an interview was it #2's family member. when Resident #2 was Physician was he resident had over 20 ttom of her feet. The he areas on Resident #2's imple filled holes directly in the resident's foot and in present the day before ent #2 was admitted into re provided by the r dated 06/06/20 of photos revealed Resident holes located in a straight ht foot and bottom of her an interview was ctor of Nursing (DON). He	F	658	AOC DATE: 9/14/2020		

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BOILDING	,	с
		345385	B. WING		08/20/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				931 N ASPEN STREET	
CARDINA	L HEALTHCARE AND RE	EHAB		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 658	Continued From page	- CO	F. 0.5	0	
F 030	Continued From page		F 65	8	
		was wrong. The DON stated			
	there were other ways to get a response from an unresponsive resident and that was not what the				
	facility wanted nurses				
	On 7/23/20 at 3:35 P				
		urse Practitioner. She stated			
	the practice of using				
E 077		s' foot was unacceptable	ГСТ	7	0/14/20
F 677 SS=E	CFR(s): 483.24(a)(2)	or Dependent Residents	F 67		9/14/20
	§483.24(a)(2) A resid	ent who is unable to carry			
		living receives the necessary			
	services to maintain g	good nutrition, grooming, and			
	personal and oral hyg				
		is not met as evidenced			
	by:				
		ns, record reviews, resident		F677	
		he facility failed to provide			
		e bed baths as scheduled to		On 0/2/2020 regident #0 shower has	haan
	maintain the persona	reviewed for 3 of 3		On 9/3/2020 resident #9 shower has scheduled	been
		sident # 9, #10 and #11).		For Monday and Friday on first shift	
				according to his preference.	
	Findings included:			On 9/3/2020 resident #10 shower ha	is
	_			been scheduled	
		dmitted to the facility on		For Monday, Wednesday and Friday	
	09/06/18 and readmit			1st shift according to her preference	
	Parkinson's disease a	and a history of falls.		On 9/9/2020 resident #11 discharged	d from
	Resident #0's annual	Minimum Data Set (MDS)		the facility	
		realed he was cognitively		On 9/3/2020 □- 9/9/2020 all	
		her revealed Resident #9		residents/responsible party	
		t on one staff with bathing.		were questioned regarding shower	
		C C		preference by the	
	A grievance filed on 0)5/04/2020 by Resident #9's		Activities Director. On 9/10/2020 a s	hower
		led the resident told the		schedule was	

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU	0938-039 JRVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLE	
					С	
		345385	B. WING			/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
CARDINA	L HEALTHCARE AND RE	НАВ		931 N ASPEN 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From page	e 70	F 67	77		
	family member he ha	d not received a shower in a to a shortage of staff.		Developed by the Director reflect the current Shower preferences.	or of Nursing to	
	(MDS) dated 06/03/20 cognitively intact. Th Resident #9 required assistance with bathin The shower schedule Resident #9 was sche during the second shi A second grievance fi Resident #9's family of resident told the famil had a shower in a we Resident #9 told the f because there were of (NAs) to do showers. Resident #9's nurse a from 05/04/2020 through had given Resident # week. Review of the the same time period had refused his show An observation and in with Resident #9 on 0	e MDS further revealed extensive two-person ng. for July 2020 revealed eduled to receive showers ift on Tuesday and Friday. iled on 07/20/2020 by member revealed the ly member again he had not ek. The grievance specified family member it was not enough nurse aides aide (NA) documentation ugh 07/22/20 revealed staff 9 at least one shower a nursing progress notes for did not reflect Resident #9		 The Director of Nursing a will re-educate Licensed Nursing Assistant regard showers and shower sch 9/8/2020 through 9/11/2020. The Director of Nursing a will conduct Quality improvement moresident showers two times a week for fout then one time a week for fout then one time monthly for three one time monthly for three 9/10/2020. The Director of Nursing i plan of correction to the Performance Improvement The Quality Assurance F Improvement Committee consist of but not limited Director, Director of Nursing Evelopment Coordinate Social Services, Medical 	Nurse/Certified ling nedules on and/or designee unitoring of r weeks, r eight weeks, and ee months. Introduced the Quality Assurance ent Committee on of nursing is nting this plan. Performance e members to Executive sing, Staff or, Unit Manager,	
	Resident #9 stated he showers per week as provided on Tuesday Resident #9 stated he shower time changed been changed. Resid	y, flaky skin on his face. had not received his two scheduled which were to be and Friday on second shift. had requested to have his to first shift, but it had not dent #9 further stated, staff vide his showers later in the		Maintenance Director, H Services, Dietary Manag Data Set Nurse and a m direct care giver. Quality Quality monitoring scheo based on findings.	ler, and Minimum inimum of one y Improvement	

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING			C 20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CARDINA	L HEALTHCARE AND RE	HAB		931 N ASPEN 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	at that time, so he refi were offered later in the was not receiving his not enough nurse aided provide care for the re- stated he had previous getting his scheduled said, "I am lucky if I guinterview revealed Re- when he was clean and two showers per week An interview conducted AM with NA # 3 reveal #9's hall 7:00 AM to 7 try to get everything do complete some of the stated she was assign and when she had to halls it was not posside showers as scheduled An interview was cond 4:00 PM with the Dire DON said they should according to the resid needed to do a full aud preferences of the resid they were fully staffed be a problem with ress The DON explained the team, but those positi He stated regardless be given as scheduled DON also stated they residents on a regular	hot used to having showers used his showers when they he evening. He specified he showers because there was es (NAs) in the building to esidents. Resident #9 isly complained about not showers twice a week and et one a week." The isident #9 felt much better nd stated he felt clean with k. ed on 07/22/2020 at 11:30 led she worked on Resident :00 PM. NA #3 stated they lone but just are not able to scheduled showers. NA #3 ned to care for Resident #9 care for residents on two oble to give residents their d. ducted on 07/22/2020 at ctor of Nursing (DON). The be providing showers ent's preference and they dit of showers to determine sidents. He stated once with NAs there should not idents getting their showers. ney used to have a shower ons had been eliminated. of staffing, showers should d whenever possible. The should check with the basis to ensure they were	F 677	AOC DATE: 9/14/2020		
	receiving their shower	r basis to ensure they were rs on a day and time of their g to the DON Resident #9				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C /20/2020
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	EHAB			931 N ASPEN STREET LINCOLNTON, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 677	should have received scheduled. An interview conducted with the Administrator were expected to wor preference and time t stated if a resident wa instead of second shi as a first shift shower staff were expected to as residents were at t skilled care. The Adr expected staff to tag- care was completed f showers should be pr according to their pre 2. Resident #11 was 07/08/2020 with diagr peripheral venous ins and syncope and coll Resident #11's admiss dated 07/08/2020 rev cognitively intact. Th revealed Resident #1	I showers twice a week as ed on 07/22/2020 at 4:34 PM r revealed staff members rk around the resident's they wanted a shower. He anted a first shift shower ft they should be scheduled \therefore The interview revealed the o give the best care possible the facility to be provided ministrator stated he team and make sure the for the residents and rovided for residents ference for days and time. admitted to the facility on noses which included sufficiency, atrial fibrillation, apse. ession Nursing assessment realed Resident #11 was e assessment further 1 was dependent on two and for toileting and was	F	677			
	assistance needed fo	narked for the type of or grooming, personal nd there was no goal marked					
	Resident #11 was sch	e for July 2020 revealed heduled to receive showers Saturday during the second					

Facility ID: 923059

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ERVICES SUPPLIER/CLIA FION NUMBER:				MB NO. 093	8-0391
	. ,	PLE CONSTRUCTION G		X3) DATE SURVE COMPLETED	
345385	B. WING		_	-	20
	· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		931 N ASPEN STREET LINCOLNTON, NC 2809	2		
EDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE	COMF	X5) PLETION ATE
	F 67	77			
led Resident ed bath and g. Review of same time had refused a conducted t 9:30 AM. e dry flaky skin was with Resident monitor on illowed to take d not get wet. could not give ild not get wet. could not get wet. could not get wet. he had not had on to the w revealed stated she ody. She ne time when ut of her brief cause "they Resident #11 een washed 08/20 and her 020 at 11:30 ed on Resident . NA #3 stated ust are not ers. NA #3					
	345385	ICIENCIES EDED BY FULL INFORMATION) F 6 n from iled Resident ed bath and g. Review of same time had refused a conducted t 9:30 AM. e dry flaky skin was with Resident : monitor on allowed to take d not get wet. could not give uld not get wet. ne had not had on to the w revealed I stated she nody. She ne time when jut of her brief cause "they " Resident #11 een washed 08/20 and her 020 at 11:30 ed on Resident . NA #3 stated just are not ers. NA #3	STREET ADDRESS, CITY, ST. 331 N ASPEN STREET LINCOLNTON, NC 2809 ICIENCIES EDED BY FULL INFORMATION) PREFIX TAG F 677 F	street ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET LINCOLNTON, NC 28092 ICIENCIES EDED BY FULL INFORMATION) PREFIX TAG INFORMATION) F 677 In from led Resident ed bath and g. Review of same time had refused a Conducted 19:30 AM. a dry flaky skin was with Resident monitor on IIIowed to take d not get wet. could not give IIId not get wet. he had not had on to the w revealed I stated she lody. She ne time when ut of her brief cause "they ' Resident #11 een washed 08/20 and her D20 at 11:30 ad on Resident . NA #3 stated just are not ers. NA #3	street ADDRESS, CITY, STATE, ZIP CODE 31 N ASPEN STREET LINCOLNTON, NC 28092 ICIENCIES EDD BY FULL INFORMATION) PREFIX TAG F 677 F

Facility ID: 923059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 09/24/2020 1 APPROVED 2: 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_	08/2	C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ		931 N ASPEN STREET LINCOLNTON, NC 2809	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	was not possible to gi as scheduled. She st to get the heart monit could not be showere know why the residen bed bath since her ad An interview was cond 4:00 PM with the Dire DON said they should according to the resid needed to do a full au preferences of the resid they were fully staffed be a problem with res The DON explained they residents on a regular receiving their shower preference. The DON should have been give scheduled. An interview conducted with the Administrator were expected to wor preference and time t staff were expected to as residents were at t skilled care. The Adm	for residents on two halls it ve residents their showers ated she had been told not or wet and the resident d but stated she did not t had not had a complete mission. ducted on 07/22/2020 at ctor of Nursing (DON). The d be providing showers ent's preference and they dit of showers to determine sidents. He stated once with NAs there should not idents getting their showers. hey used to have a shower ons had been eliminated. of staffing, showers should d whenever possible. The should check with the basis to ensure they were rs on a day and time of their A stated Resident #11 en a complete bed baths as ed on 07/22/2020 at 4:34 PM revealed staff members k around the resident's hey wanted a shower. He anted a first shift shower ft they should be scheduled . The interview revealed the o give the best care possible he facility to be provided hinistrator stated he team and make sure the	F 677				

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C / 20/2020
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 677	showers should be pr according to their pre According to the Adm not be going a week y and it was unaccepta been bathed complete 3. Resident #10 was a 07/25/18 and readmit diagnoses which inclu pulmonary disease (C accident (CVA), musc dementia. Resident #10's annua dated 07/17/2020 rev cognitively intact. The Resident #10 required assistance with bathin Resident #10 required assistance with bathin Resident #10's care p revealed she had a ca being at risk for ADL s decline related to her impaired balance. The shower schedule Resident #10 was sch on Wednesday and S shift. Resident #10's nursin documentation from C revealed Resident #1 three times per week three weeks she had per week.	ovided for residents ference for days and time. inistrator residents should without a shower or bed bath ble Resident #11 had not ely since admission. admitted to the facility on ted on 11/21/18 with uded chronic obstructive COPD), cerebrovascular cle weakness and vascular al Minimum Data Set (MDS) ealed Resident #10 was e MDS further revealed d extensive one-person ng. blan dated 07/09/2020 are plan for ADL due to self-care performance lung mass, hip pain and for July 2020 revealed neduled to receive showers faturday during the second	F	677			

Facility ID: 923059

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING			_		C 20/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 2809	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	she had dry flaky skin Resident #10 stated a showers. She stated wanted showers on M Friday and stated it ha she had a shower. R shower was on Mond when she asked about told they did not have showers. The intervie did not feel clean whe per week and stated a clean. Resident #10 admission she wanted but stated they had no of the time she was o According to Residen be short staffed most have time to provide to residents. An interview conducted AM with NA # 3 reveat #10's hall 7:00 AM to try to get everything of complete some of the was assigned to Resi she had to care for re not possible to give re scheduled. She stated overlooked Resident is previous Monday. An interview was con- 4:00 PM with the Dire DON said they should	W with Resident #10. as disheveled and dirty and o on her arms and legs. she was not getting enough she had told staff she londay, Wednesday and ad been over a week since esident #10 stated her last ay 07/13/2020 and stated ut getting a shower, she was enough staff to provide ew revealed Resident #10 en she only had one shower she felt better when she felt stated she had told staff on d three showers per week of provided three and most nly given one per week. t #10 the facility seemed to days and the staff did not the care needed by the ed on 07/22/2020 at 11:30 and she worked on Resident 7:00 PM. NA #3 stated they lone but just are not able to e showers. NA #3 stated when sidents on two halls it was esidents their showers as ad she must have	F	677				

Facility ID: 923059

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>	G	COMPLETED	
		345385	B. WING			C 3/20/2020
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		5/20/2020
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	EHAB		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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From pag	e 77	F 67	77		
1 011		udit of showers to determine	FU			
		sidents. He stated once				
	•	d with NAs there should not				
		sidents getting their showers.				
		they used to have a shower				
	· · ·	tions had been eliminated.				
	•	of staffing, showers should				
		ed whenever possible. The y should check with the				
		ar basis to ensure they were				
	-	ers on a day and time of their				
		N stated Resident #10				
	should have received week as requested.	d showers three times per				
		ted on 07/22/2020 at 4:34 PM				
		r revealed staff members rk around the resident's				
		they wanted a shower. He				
	-	anted a first shift shower				
		ift they should be scheduled				
		r. The interview revealed the				
		o give the best care possible				
		the facility to be provided				
	skilled care. The Ad	team and make sure the				
	care was completed					
	showers should be p					
	-	eference for days and time.				
F 725	Sufficient Nursing St	aff	F 72	25		9/14/20
SS=E	CFR(s): 483.35(a)(1))(2)				
	§483.35(a) Sufficient	t Staff.				
	,	e sufficient nursing staff with				
	-	petencies and skills sets to				
	provide nursing and	related services to assure				
	-	attain or maintain the highest				
	practicable physical,					

Facility ID: 923059

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	MENT OF HEALTH AN	ID HUMAN SERVICES			F	FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345385	B. WING _			C 08/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	!	
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	HAB		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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	well-being of each res resident assessments and considering the n diagnoses of the facil accordance with the f at §483.70(e). §483.35(a)(1) The fac by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on record revif accommodate schedu bed baths for 3 of 3 s (Resident #9, #10 and Findings included: This tag was cross re F 677 - Based on obs resident and staff inte provide resident show as scheduled to main 3 of 3 dependent resi	sident, as determined by a and individual plans of care number, acuity and ity's resident population in acility assessment required cility must provide services of each of the following a 24-hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not when waived under section, the facility must nurse to serve as a charge i duty. is not met as evidenced ews and staff interviews, the le sufficient nursing staff to uled showers and complete ampled dependent residents d #11).	F 7	 F-725 SUFFICIENT NURSING Residents #9, #10, and #17 no physical harm. Residents #8 were given a bath on (date) by its staff, and continue to receive a per their preferences. On 9/9/20 resident #11 was discharged hot Current residents have the to be affected by insufficient dire nursing staffing. On 8/20/2020, the Executive Di with the Director of Nursing and Resources to ensure recruiting open positions were in place alorements. 	1 suffered 9 and #10, nursing bath as 020 ome. e potential ect care rector met I Human efforts for	

Event ID: NYKK11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				93	31 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	HAB		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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page A review of the Daily s revealed:		F	725	approved incentives for new hires and referrals. Additionally, bonus structure implemented by the Executive Director staff who work additional shifts, as		
	300 hall and the top of 3:00 PM and from 3:0 2. 07/14/2020 - One M and the top of 200 ha 3. 07/15/2020 - One M and the top of 200 ha 4. 07/16/2020 - One M and the top of 200 ha 5. 07/17/2020 - One M and the 200 hall from 6. 07/18/2020 - One M	NA assigned to the 300 hall II from 7:00 AM to 7:00 PM NA assigned to the 300 hall II from 7:00 AM to 7:00 PM NA assigned to the 300 hall II from 7:00 AM to 7:00 PM NA assigned to the 300 hall 7:00 AM to 3:00 PM NA assigned to the 300 hall, s (VS) and pass ice to all			needed, on 8/20/20. Agency contracts place to meet staffing needs. The Executive Director, Director of Nursing and the Human Resources Person reviewed staffing levels on 8/20 to ensure adequate staffing levels base on residents needs and acuity. Staffin inadequacies identified were corrected immediately. On 8/20/20 the Executive Director and Director of Nursing reviewed the nursir staffing schedule was completed and it there was sufficient staff scheduled to	D/20 ed ng the ng	
	7. 07/19/2020 - One M and the top of 200 ha ice to all halls from 7: 8.07/20/2020 - One M top of 200 hall from 7 An interview on 07/21	NA assigned to the 300 hall II and to do all VS and pass 00 AM to 3:00 PM IA assigned to 300 hall and :00 AM to 7:00 PM /2020 at 10:20 AM with			care for the residents. Additionally, th staffing assignment sheets were review to ensure adequate staffing to the residents as per the schedule on 8/20/ and no issues were identified.	ved	
	on some days rather stated she had worke and stated she had no showers and bed batt stated on bad days th the showers done as recall if she had repor done to the Nurse or An interview on 07/21 #3 revealed there we with staffing. NA #3 in	evealed staffing was better than others. NA #4 further d on 07/17/20 and 07/21/20 ot been able to complete all ns as scheduled. NA #4 ey were not able to get all scheduled. NA #4 could not ted not getting showers DON. /2020 at 11:30 AM with NA re good days and bad days ndicated on the bad days get all the showers done as			 From 9/3/20- 9/9/20, the Activities Dire interviewed interview-able (BIMS of 8 a above) residents on bathing preference Bathing preferences were utilized by the Director of Nursing to establish a bathing schedule for current residents by 9/10/ The Interdisciplinary Team then update the residents □ plans of care and Kardexes accordingly by 9/11/20. Beginning on 9/8/20 - 9/11/20, the Director of Nursing/Assistant Director of Nursing/RN Nurse Manager educated 	and es. ng 20. ed	

Facility ID: 923059

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPLI	ETED
		345385	B. WING		C 08/2	0/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	EHAB		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	<u>> 80</u>	F 7	25		
F 725	scheduled. She state time allowed with ans assisting residents. N worked on 07/14/20, 07/18/20, 07/20/20, 0 had not been able to bed baths. She said showers not being do she tried to make the able to do so. A telephone interview with Nurse #2 reveale stated no one wanted were numerous call of trying to get help in th further revealed wher AM to 7:00 PM and th NAs they were not at showers and bed bat According to Nurse # the Director of Nursin bed baths were not of scheduled. A telephone interview with Nurse #1 revealed stated sometimes the AM did not show up a until relief was found. stated on bad days w help, showers were m as scheduled. Nurse	ed the nurses did help as swering call lights and IA #3 further stated she had 07/16/20, 07/17/20. 17/21/20 on the 300 hall and complete her showers or she had not reported the one to the nurse and stated showers up but was just not on 07/20/2020 at 5:00 PM ed staffing was "horrible" and to work. She stated there buts and they were always ne building. The interview in Nurse #2 had worked 7:00 here were only three or four	F7	 Nursing Staff on regulation F directly notify the ED, DCS, any call outs, so that facility aware of and can intervene staffing needs that could lear inadequate staffing to meet needs. The ED, DCS, ADC Scheduler will attempt to regmember who is calling out b facility staff to stay over or c work, using a current nursing roster/phone list and/or by n contracted agency of staffing staffing needs cannot be means, the ED, DCS, ADCS mandating for staff member working. Facility Nursing St educated on waiting for their arrive prior to leaving the fac of their shifts. Facility Nursing also educated on giving a sh resident report to the oncom relieving them of their job du shift to shift report should er status of the residents on the assignment to include any b of baths, or baths that were completed, so that they can up to completion. 4. The Director of Nursing Director of Nursing will cond monitoring of regulation F-72 sufficient direct care nursing 	or ADCS for leadership is with any d to residents' S or blace the staff y calling on ome into g staff otifying g needs. If et using these S may enforce (s) currently aff has been r relief to cility at the end ng Staff was nift to shift ning employee uties. This neompass the eir staff aths, refusals not be followed /Assistant fuct QI 25 to ensure staff to meet	
	given to the DON. An interview on 07/2	1/2020 at 10:00 AM with		the needs of residents and t residents are bathed per the preferences. QI monitoring	eir	
		ere were good days and bad		conducted five times a week		
	days with staffing. N	urse #6 stated on bad days		weeks, then three times a w	eek for four	

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	· · ·	MPLETED
			A. DOILDING			С
		345385	B. WING			8/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/20/2020
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	EHAB		LINCOLNTON, NC 28092		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION
F 725	Continued From page	e 81	F 72	5		
		done as scheduled. Nurse		weeks, once weekly for four v	veeks then	
	#6 could not recall having reported showers not			monthly for three months utili		
	being done to the DC	•		sample size of five random re	-	
	-			Director of Nursing/Assistant	Director of	
		1/2020 at 12:10 PM with		Nursing will report findings to	-	
		ere were "some days that		Assurance Performance Imp		
		e not" with staffing. Nurse #5		Committee monthly for 6 mor		
		ere were not enough NAs		substantial compliance is me	t.	
		and bed baths were not			D-1-044	
	-	Iled. According to Nurse #5		5. Allegation of Compliance	Date 9-14-	
	she had not reported showers not being done to the Director of Nursing (DON) because he knew			20.		
	there was not enough					
		nducted on 07/22/2020 at				
		ector of Nursing (DON).				
		N there were 4 vacant				
	•	d 2 vacant positions for				
		e working to interview and fill				
		said they had recently				
	acquired a contract w	vith another Agency that had				
	been responsive to the	neir needs when they called				
	for NAs to work. The	DON stated he was aware				
		numbers with 4 NAs and 2				
		eally, they needed 4-6 NAs				
	1 0	sidents and at least one				
		3 nurses. He stated once				
		d with NAs there should not				
		sidents getting their showers residents did not have that				
		e stated he recalled Resident				
		nowers as scheduled and				
		g on a plan for that resident.				
		was not aware of the other				
	two residents but sta	ted he would follow up with				
	staff. According to th	e DON if he had known the				
	-	about not getting a shower,				
		NAs in just specifically to				
	aive showers to the r	esidents. The daily staffing				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION	· · ·	E SURVEY
	CONNECTION	BENTIFICATION NOWBER.	A. BUILDIN	G		
						С
		345385	B. WING		0	8/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	L HEALTHCARE AND R	EHAR		931 N ASPEN STREET		
				LINCOLNTON, NC 28092		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETION DATE
F 725	Continued From page	e 82	F 7	25		
		20 through 7/20/20 were		20		
	reviewed during the i	8				
		probably not many days the				
		d or showered according to				
		given the number of staff				
		s particularly on the 300 hall				
		10 and #11 resided, The				
		ed he wanted staff to tell him				
	or their nurse when t					
	complete their assigr	-				
		ed on 07/22/2020 at 4:34 PM				
		r revealed he and the				
		epresentative were doing				
		Nurses and NAs. The				
	Administrator stated	•				
	-	sure the care was completed				
		showers should be provided ng to their preference for				
		rding to the Administrator, on				
	-	not short staffed but stated				
		ate call outs. He further				
		had a high acuity and some				
	of the staff were not u					
		in acuity. According to the				
		is week they had contracted				
		to provide NAs as needed at				
		all outs and stated they were				
		her agency to provide				
		he Administrator indicated he				
	was not aware of the	showers and bed baths not				
		scheduled and stated he				
	· ·	ts to receive their showers				
		dministrator also indicated				
		o a shower team but stated				
	-	hose positions due to				
	-	vork on the floor providing				
		cated he would follow up with				
	I the Director of Nursin	ng to evaluate their current				

Facility ID: 923059

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CENTER	<u>S FOR ME</u> DICARE &	MEDICAID SERVICES			OMB NO. 0938-03
ATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345385	B. WING		C 08/20/2020
NAME OF P	ROVIDER OR SUPPLIER	•	- -	STREET ADDRESS, CITY, STATE, ZIP CODE	•
CARDINA	L HEALTHCARE AND R	ЕНАВ		931 N ASPEN STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIC
F 725	13		F 72	5	
	-	see what adjustments could esidents received their s.			
F 760 SS=E	Residents are Free c CFR(s): 483.45(f)(2)	of Significant Med Errors	F 760		9/14/20
	medication errors. This REQUIREMEN by: Based on record rev practitioner (NP), and the facility failed to a antiseizure mediation Potassium Chloride a residents (Resident # administration.	nts are free of any significant 「 is not met as evidenced riew, staff interview, nurse d physician (MD) interviews dminister Keppra (an n), Sodium Chloride and		F 760E: Free of Significant Medication Errors: (1) What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice?	nd to
	08/28/2018 with diag hypokalemia, seizure disease, dementia, h depressive disorder, The Quarterly Minim 05/28/2020 revealed intact and had the ab understood and under	and history of falling. um Data Set (MDS) dated Resident #4 was cognitively		" On 7-20-20, Resident #4 had a C CMP and Keppra level drawn and Nur Practitioner was made aware of lab results. Resident #4 has a new order written on 7-24-20 for the nurse to che the resident □s mouth after administra of medication. Resident #4 was asses by a licensed nurse on 7/24/20 and w not experiencing a change in condition requiring transfer to a higher level of c as a result of not taking Keppra, Sodiu and Potassium medications as prescribed.	rse eck tion ssed as n care,
	antidepressants 7 ou period.	baired vision, and received It of 7 days in the look back Ian last updated 07/15/2020,		 (2) How you will identify other reside having potential to be affected by the same practice and what corrective act will be taken; A quality review/observation was 	tions

Facility ID: 923059

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		MEDICAID SERVICES				938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
					С	
		345385	B. WING		08/20/	2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
CARDINA	L HEALTHCARE AND R	ЕНАВ		931 N ASPEN STREET		
				LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE C TO THE APPROPRIATE IENCY)	(X5) OMPLETIO DATE
F 760	Continued From pag	e 84	F 76	50		
		mia due to being at risk for		completed to ensure cu	rrent facility	
		onatremia. The interventions		residents prescribed r		
		nd reporting labs for sodium		being administered by t		
		the provider. Resident #4		ordered.		
	had a care plan for m	nood due to being at risk for		" A quality review/ob	servation was	
	mood decline related	to her history of depression.		conducted for current fa	acility resident to	
	The interventions inc	luded administration of		ensure no medications		
		ed and monitoring and		bedside for self-adminis		
		e effects and effectiveness		assessment and a phys		
		resident had a care plan for		" Current residents v	5	
		ng a diagnosis of a seizure		Registered Nurse to en		
		ntions included giving		illness or harm with reg	-	
	effectiveness and sic	ed and monitoring for le effects		and appropriate care ar " A review of medica		
				Emergency Drug Kit (E		
	The medical record r	evealed no assessment for		completed by the Medic		
		medications and no order		ensure it contains the m		
	for self-administration	n for Resident #4.		prescribed medications residents.		
	Resident #4's nursing	g progress note dated				
		y Nurse #5, documented		" Issues or concerns	were addressed	
		esident #4's room while		as they were identified.		
		was making the bed. NA #6				
		d further search of the		(0)) / //		
		Ited in additional pills being		(3) What measures will		
		es in Resident #4's room.		or what systematic char		
		tal signs (VS) and notified er (NP) and Director of		to ensure that the pract	ice does not recur;	
	Nursing (DON). The			" Current facility Lice	ensed Nursing Staff	
	/	banel (CMP), complete blood		were re-educated from	J. J	
		ppra level for the following		9/13/2020 by the Direct		
		20. Resident #4's vital signs		Nursing/Assistant Direc		
	-	118/66, heart rate 76,		Manager on following fa		
		nd temperature 97.8.			s regulation with an	
	Resident #4's July 2	020 Medication		prevention to include th		
	Administration Recor			¿ Right Resident,	U	
		as of 07/19/2020 included:		¿ Right Medication/T	reatment,	

Facility ID: 923059

	OF DEFICIENCIES	MEDICAID SERVICES		וחו ר	CONSTRUCTION	(X3) DATE	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	, í			I Y Y	PLETED
			A. DOILDIN	<u> </u>			с
		345385	B. WING				20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	20/2020
				93	31 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	EHAB		L	INCOLNTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 760	Continued From page	o 95					
F 700			F 7	60			
		g (milligrams) two times a			¿ Right Route,		
	day for seizures	extended release tablet 20			¿ Right Time,	the	
	-	Q) two times a day for low			¿ Documentation is complete within Resident⊡s Medication Administration		
	potassium level				Record	•	
		let 1 gram give 3 tablets 4			o Additionally, Medication		
	times a day for low s				Administration Education was complet	ed	
					with current Licensed Nursing Staff		
	An interview conduct	ed on 07/21/2020 at 2:46 pm			regarding what to do when a resident		
	with NA #6 revealed	she was working on			refuses a medication to include notifyir	ng	
		07/19/2020. She stated she			the attending physician/physician exter	nder	
		to the bathroom and was			for additional orders, and then		
	•	found a pill cup filled with			documenting in the medical record.		
		ot of the bed. She stated she					
		e #5) who was taking care of ted she was in the resident's			o Last, Medication Administration	~~	
		e searched the room and			Observations were completed to ensure competency of current facility Licensed		
		in Resident #4's slippers and			Nurses and to ensure Residents		
		she did not know the total			physicians orders were followed		
		l in Resident #4's room, but a			appropriately.		
		vas over half full of pills.			Licensed Nurse will remain with reside	ent	
					to validate that the resident accepted of	or	
	A phone interview co	nducted on 07/20/2020 at			refused prescribed medication.		
		#5 revealed she was working					
		on 07/19/2020. NA #6 was					
	making up the reside				(4) How the corrective action(s) will be		
		with pills under her blankets.			monitored to ensure the practice will ne	ot	
		searched Resident #4's room			recur, i.e., what quality assurance		
	cup and others found	pills including the pills in the			program will be put in place;		
		wrappings of food items, in			The Director of Nursing/Assistant Director	ctor	
		er shoes. Nurse #5 stated			of Nursing will complete a quality revie		
		s as medications that were			Medication Administration Observation		
		ent #4. She stated she			at least 1 licensed nurse on each shift		
		sident #4's family, and the			(7am-7pm and 7pm-7am) for a total of	2	
		labs for CBC, CMP, and			nurses regarding the following:		
	Keppra level to be dr	-			" To ensure current facility residents	S 🗌	
	07/20/2020. She stat				Medication Administration per		
	preferred to sleep lat	e and didn't like to get up			physicians orders:		1

Facility ID: 923059

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	6) ´cc	OMPLETED
						С
		345385	B. WING	······		08/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE			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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	- 86	F 76	50		
		ions and sometimes refused	170			
	to take medications d			o Right Resident, o Right Medication/Treatme	nt	
		nings. Nurse #5 stated she		o Right Dose,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		edications or medication		o Right Route,		
		om and watched residents		o Right Time,		
	-	before leaving the room.		o Documentation is comple	te within the	
				Resident s Medication Admin		
	An interview conduct	ed on 07/21/2020 at 9:06 AM		Record		
		frequently found pills on the		Licensed Nurse will remain w	ith resident	
		lent rooms and on the		to validate that the resident ac	cepted or	
	dietary trays during h	er rounds twice a week. She		refused prescribed medication	•	
	stated she didn't rem	ember specifically if she had				
	seen pills or cups in F	Resident #4's room. She		" Also, if a resident refuses	а	
	stated when she foun	nd medications in a		medication, notification the att		
		took the medications to the		physician/physician extender f		
		he saw the pills that were		orders, and then documenting	in the	
		s room on 7/19/20 and the		medical record.		
		ately 240. She stated				
	Resident #4 was not					
		e not watching her take her				
		odium was low because of		These quality reviews will be o		
	this reason.			x weekly for 1 month, then 2 x		
	A phone interview co	nducted on $07/21/2020$ at		1 month, then 1 x weekly for 1 then 1 x monthly for 6 months		
	-	nducted on 07/21/2020 at #1 revealed she worked on				
		d was very familiar with the		The findings of these quality re	oviews will	
		she was aware of pills being		be reported to the Quality		
		s room on $07/19/2020$. She		Assurance/Performance Impro	ovement	
		vere found, she talked to		Committee monthly until comm		
		lained to her that she can		determines substantial compli		
		She explained she doesn't		been met and recommends m		
		ben her mouth after she		quarterly monitoring by the Re		
		ons to her but plans to ask		Director of Clinical Services w	-	
	Resident #4 to open I	-		completing their systems revie	W.	
		ons to her in the future. She				
	stated that she doesn	n't leave medications in		Date of compliance Septembe	er 14, 2020	
	Resident #4's room.	She stated she had not				
		on or in-servicing regarding				
	medication administra	ation after the pills were				

Facility ID: 923059

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB		931 N ASPEN STREET LINCOLNTON, NC 2809	12		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 760	Continued From page	87	F 760				
	found in Resident #4's		1700				
	An interview conducter with the DON revealer an assessment or an medications. He state over 200 pills were for on 7/19/2020. He state doing it, but I don't thi bedside and she may time." He stated that Keppra level had beer the provider on call. Review of Resident # CBC drawn on 07/20/ level was 130 milliequi which was below norr sodium level being 13 potassium level was 4 (mmol/L) which was we A phone interview corr 10:58 AM with the face revealed not taking m contribute to decreased levels and a subthera Resident #4. The MD notified of the medicar room or that she had medications recently. aware of Resident #4 An interview conducter	ed on 07/21/2020 at 4:24 PM d Resident #4 did not have order to self-administer d he was unsure of how und in Resident #4's room ed, "I don't know how she is nk they were left at the have collected them over lab results except for n resulted and reported to 4's lab results for CMP and 2020 revealed her sodium tivalents per liter (mEq/L) nal (normal range for 66-144 mEq/L) and her 4.2 millimoles per liter within normal range. nducted on 07/22/2020 at fility's Medical Director (MD) edications as ordered would ed sodium and potassium peutic Keppra level for stated he had not been tions found in Resident #4's refused to take her The MD stated he was not having any seizure activity.					
	was aware of greater Resident #4's room of	e Consultant revealed she than 200 pills being found in n 7/19/2020. She stated that for medications to be left in					
		nd it was expected for					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345385	B. WING				C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
					931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE	:HAB			LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 760	Continued From page nurses to ensure the by the resident at the An interview conducte AM with the NP revea of the lab results for F level was pending. Sh sodium level was low receiving her medicat and potassium. She s #4 to see if she would be crushed if possible want medications cru expected nurses to st them take medication administration. A phone interview cor 5:51 PM with the NP the results of the Kep results ordered on 07 The NP stated that th was sub-therapeutic v micrograms/milliliter (range is 12-46 mcg/m Keppra level was cau medication. The NP s watch Resident #4 tal	e 88 medications are swallowed time of administration. ed on 07/22/2020 at 10:04 aled she had reviewed some Resident #4 and Keppra he stated that Resident #4's because she was not ions including her sodium stated she talked to Resident I prefer for medications to e, but the resident did not shed. The NP stated she ay with residents and watch s at the time of nducted on 07/27/2020 at revealed she had reviewed pra level and other lab /20/2020 for Resident #4. e resident's Keppra level with a value of 3.7 mcg/ml) and therapeutic		760	DEFICIENCY)		
	medication or if Resid medications, it should The NP stated she ha Resident #4 had refus medications only a fe had not been notified Resident #4 had incu stated the falls Reside have been related to	lent #4 had refused I have been documented. Id been notified that					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345385	B. WING				C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 760 F 880 SS=K	hyponatremia (low so potassium), falls, and receiving her medicat stated that Resident # and if she had receive four times a day as of had to be on this rest so badly, because she thirsty." A phone interview cor 1:22 PM with the DOI the pills found in Resi 7/19/2020 but observe identify some of the p unable to identify most the markings on the p missing. The DON sta investigation of the im found in Resident #4% Infection Prevention & CFR(s): 483.80(a)(1)() §483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and tran diseases and infection p program. The facility must estal and control program (a minimum, the follow	dium), hypokalemia (low possible death due to not ions appropriately. She #4 was on a fluid restriction ed her sodium chloride tablet rdered, she would not have riction. The NP stated, "I feel e is always saying she is nducted on 08/07/2020 at N revealed he did not count dent #4's room on ed them and was able to ills as Keppra but was st of the medications due to oills were unreadable or ated he did not document an cident of the medications s room. & Control (2)(4)(e)(f) ntrol blish and maintain an nd control program a safe, sanitary and ent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at		880			9/14/20

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
		345385	B. WING			08/20/2		
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CARDINA	L HEALTHCARE AND RE	HAB			931 N ASPEN STREET LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	reporting, investigatin and communicable di staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab- infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact with residents contact with residents	g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of the or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: att not limited to: att not fine isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable in lesions from direct to or their food, if direct ne disease; and procedures to be followed rect resident contact. m for recording incidents	F	880				

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	FIPLE	E CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · ·	IPLETED
							С
		345385	B. WING _			0	8/20/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND R	ЕНАВ	931 N ASPEN STREET LINCOLNTON, NC 28092				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880			F	880			
	corrective actions tak	ken by the facility.					
		dle, store, process, and s to prevent the spread of					
	§483.80(f) Annual re The facility will condu IPCP and update the This REQUIREMEN by:						
	Based on record rev interviews with staff a staff members, the fa	riew, observations, and and two Health Department acility failed to implement the Control and Prevention			F-880 Infection Control 1.On 7/21/2020 a Root cause analysis was conducted the Executive Director Director of Clinical Services and Regio	,	
	(CDC) recommended not placing enhanced	d practices for COVID-19 by d droplet contact precautions uiring staff to wear all			Director of Clinical Services and Regit Director of Clinical Services to determine deficient practice. It was identified that facility failed to establish a quarantine	ine the	
	,	ring for 2 of 2 newly admitted			within the facility for new admissions a readmissions. On 7/21/2020, a quarantine unit was	nd	
	of 1 readmitted resid cohorting and quarar	#11 and Resident #25) and 1 ent (Resident #18) and not ntining on the designated			established within the facility for admissions and re admissions.	147	
	quarantine hall (300 hall) 3 of 15 newly admitted residents (Resident #15, Resident #17 and Resident #19) and 2 of 3 readmitted residents (Resident #16 and Resident #18).				On 7/21/20 Residents #11, #15, #16, # #18, #19, and #25 were reviewed to determine if they needed any precauti Residents #15, #16, and #17 were bey the 14 day period of requiring guaranti	ons. /ond	
	facility failed to place readmitted residents	Immediate jeopardy began on 6/22/20 when the facility failed to place newly admitted and readmitted residents on enhanced droplet contact			or enhanced droplet contact precautio and showed no signs or symptoms of COVID-19. Residents #11, #18, #19, a	ns, and	
	admitted and readmi designated quarantir	e hall (300 hall). Immediate			#25 were placed on enhanced droplet precautions.		
	facility implemented immediate jeopardy	ed on 7/27/20 when the a credible allegation of removal. The facility remains a lower scope and severity			2. New Admissions, Readmissions, current residents have the potential to affected by this alleged deficient pract	be	

Facility ID: 923059

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ATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) D	ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	C	OMPLETED
						С
		345385	B. WING			08/20/2020
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	PCODE	
				931 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE			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 (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From page	s 02	F 88	30		
1 000			FOO		of Nuraing and	
		narm with the potential for arm that is not immediate		On 7/21/20 the Director Assistant Director of Nu	•	
		e employee education and		quality review of Reside	-	
	• • • •	stems in place are effective.		#17, #18, #19, and #25		
				current residents on 100		
	The findings included			halls to determine if they		
	-			precautions. Residents	#15, #16, and	
		ntitled "Responding to		#17 were beyond the 14		
		19) in Nursing Homes" last		requiring quarantine or e		
		indicated the following		contact precautions, and	-	
	statements:			or symptoms of COVID-		
		e entrance to the COVID-19		current residents on 100		
	care unit that instructs	•		require quarantine or ad		
		wear eye protection and an espirator (or facemask if a		droplet contact precaution	515.	
	-	able) at all times while on the		On 7/21/21 a quality rev	iew for Personal	
		es should be added when		Protective Equipment (F		
	entering resident roor			conducted to ensure ap	,	
	0	OVID-19 PPE should be		include: gowns, gloves,	•	
	worn during care of re	esidents under observation,		shields/goggles were av		
	which includes use of	f an N95 or higher-level		utilize when caring for re	sidents on	
		sk if a respirator is not		enhanced droplet preca	utions.	
	available), eye protec					
		d that covers the front and		On 7-21-20, a quality re		
	sides of the face), glo			conducted on residents	-	
		st upon admission does not nt was not exposed or will		300 hall (designated qua determine placement. T		
	not become infected i	•		term care residents iden	-	
		d residents should still be		on the 300 hall. Those 6		
		ce of COVID-19 for 14 days		residents residing on 30	-	
	after admission and c			off the unit into rooms or		
	recommended COVIE	-		facility to accommodate	admissions and	
	* New residents could	be transferred out of the		new admissions.		
	observation area or fr	-				
		they remain afebrile and		Issues or concerns were	addressed as	
		14 days after their last		they were identified.		
	exposure (e.g. date o	f admission).		0 0 7/04/00 // 5:	-tow of New 1	
				3. On 7/21/20 the Dire	ctor of Nursing	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/24/20 FORM APPROVI OMB NO. 0938-03
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345385	B. WING		C 08/20/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE
				931 N ASPEN STREET	
CARDINA	L HEALTHCARE AND R	ERAD		LINCOLNTON, NC 28092	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE CIENCY)
F 880	Continued From page		F 88		an da in chada dh a
		/20 indicated the following		initiated staff reeducation	
	statements:	and control policies require		following staff: Nursing Therapy Department, H	-
		, Contact and Droplet		Department, Dietary De	
		g eye protection - unless		Administrative Team (S	•
	otherwise directed by	/ local, state health		MDS, Business Office I	
	department.			Resource Coordinator,	
		gnate an area and cohort		Director, Medical Reco	
		Imissions for 14 days.		Maintenance, and Adm	
	a. The patient will different room/area o	ill then be moved to a		Infection Control to incl	signate a quarantine
		's COVID-19 status is		unit (300 Hall) and coh	-
		le test) - resident placed in a		admissions/re-admissio	
		rt with another resident		19 status is known (neg	
	whose status is unkn	own, initiate		been removed from tra	- ,
		precautions (standard,		precautions prior to	
	contact and droplet)	for 14 days.		admission/re-admission	n for 14 days.
	During the entrance	conference on 7/20/20 at		" Newly admitted or	
		strator indicated the 300 hall		residents will be monito	
	was the isolation/ded	licated hall for COVID-19.		COVID-19 for 14 days	
	A			and cared for using all	recommended
	A review of the facility	s list of signal from 6/17/20 to		COVID PPE.	usrantine and if
	7/22/20 indicated:			resident is not experier	
				the resident will then be	
	1. Resident #15 was	admitted on 6/22/20 from		different room/area of t	
	the hospital to room 2			" The Director of Nu	rsing will decide
		readmitted on 6/30/20 from		when residents are rea	-
	the hospital to room 2	,,		quarantine unit. The Di	-
		admitted on 7/2/20 from the		will consult with the Nu	
	hospital to room 103	(private room). admitted on 7/8/20 from the		or Medical Director before residents off quarantine	5
		(private room on quarantine		" The facility will ma	
	hall).			staff unit with dedicated	-
	,	readmitted on 7/10/20 from		" Wearing (PPE) ma	
	the hospital to room 2			shield/goggles, gowns,	
		admitted on 7/20/20 from		" Infection Control to	-
	the hospital to room 3	310 (private room on		for new admissions and	d readmissions,

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		MEDICAID SERVICES					0.0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		E SURVEY PLETED
		345385	B. WING				C 6/20/2020
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		20/2020
					31 N ASPEN STREET		
CARDINA	L HEALTHCARE AND R	EHAB			INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pag	e 94		380			
1 000		6 34	FC	000	onhoneed dreplet pressutions, and DD	-	
	quarantine hall).	admitted on 7/21/20 from			enhanced droplet precautions, and PP (DONNING and DOFFING).		
	the hospital to room				On 7/24/20 the Nursing Management		
					Team (Director of Nursing and Assistar	nt	
	Review of the medica	al records of the above-listed			Director of Nursing) initiated re-educate		
	residents revealed al	l of them had a negative test			to staff to include: Nursing Department		
	for COVID-19 prior to	o coming to the facility. The			Therapy Department, Housekeeping		
		er revealed that none of the			Department, Dietary Department, and		
		e were placed on enhanced			Administrative Team (Social Worker,		
		autions when they were			MDS, Business Office Manager, Huma	in	
	admitted or readmitte	ed to the facility.			Resource Coordinator, Admission		
		7/00/00 1 40 40 DM			Director, Medical Records, Activities,		
		on 7/20/20 at 12:40 PM, , and 7/22/20 at 9:00 AM on			Maintenance, and Administrator) on	0.4	
		no residents were on			proper use of PPE including competen with return demonstration.	Cy	
		precautions and there were			On 7/24/20 Regional Director of Clinica	al	
		ilable for use outside any			Services reeducated the Administrator		
		aide (NA) #4 was observed			Director of Nursing, Assistant Director		
		PM wearing a mask and			Nursing, Admissions Director, and Soc		
		g care to Resident #6 on the			Worker on the COVID-19 to include the	Э	
	100 hall.				instruction for residents who are admitt	ted	
					or readmitted to the center as follows:		
		on 7/20/20 at 12:40 PM,			The center will designate an area and		
		, and 7/22/20 at 9:00 AM on			cohort new admissions/readmissions fo	or	
		l no residents were on			14 days on 300 Hall.		
		precautions and there were			a. The patient will then be moved to a different room/area of the center.		
		ilable for use outside any #6 was observed on 7/20/20			b. If the resident's COVID-19 status is		
		a mask and gloves while			unknown (no available test) - resident		
		ations to Resident #7 on the			placed in a private room or cohort with		
	200 hall.				another resident whose status is		
					unknown, initiate transmission-based		
	Observations made of	on 7/20/20 at 12:40 PM,			precautions (standard, contact and		
		, and 7/22/20 at 9:00 AM on			droplet) for 14 days.		
		no residents were on					
		precautions and there were					
		ilable for use outside any			Education will be on-going; no staff wil		
		3 was observed on 7/21/20 at			allowed to return to work until they had		
	3:00 PM going into R	Resident #25's room on the			completed the mandatory education.		

Facility ID: 923059

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345385	B. WING _				C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				93	1 N ASPEN STREET		
CARDINA	L HEALTHCARE AND RE			LI	NCOLNTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	e 95	F	380			
	300 hall while wearin				Additionally, this education will be		
		y a mask.			provided to all new employees as part	of	
	On 7/20/20 at 12:50 I	PM, Nurse #7 was observed			new hire orientation, including contract		
	on the 200 hall enteri	ing Resident #18's room			staff and agency staff.		
		k and gloves. No signage for			The Admission Director will work in		
		sed precautions was on the			conjunction with the Administrator and		
		id not wear a gown prior to			Director of Nursing to ensure new adn	nits	
	entering the room.				and readmits are placed on the		
	On 7/20/20 at 1.09 P	M, an interview with Nurse			designated quarantine unit. The Administrator and Director of Nursing	will	
		aware that Resident #18			ensure that the residents are quaranti		
		admitted to room 201. She			for 14 days. The Director of Nursing v		
	-	sident #18 was not placed			decide when residents are ready to be		
		was considered the facility's			move off quarantine unit. The Director	of	
	-	se #7 stated she only wore a			Nursing will consult with the Nurse		
		en going inside the room and			Practitioner and or Medical Director	_	
	-	required because she was ion-based precautions.			before moving residents off quarantine unit. The Central Supply person will ensure PPE is stocked and available of		
		M, NA #7 was observed			all units.		
		8's room on the 200 hall					
		k. After entering the room,			4. The Director of Nursing/Assistant		
		d closed the door. After 5			Director of Nursing will conduct QI	Iro	
		e out of room 201 with a which she removed and			monitoring of regulation F-880 to ensu newly admitted and readmitted reside		
		sh bin parked outside room			are placed on enhanced droplet		
		VA #7 was further observed			precautions and are being quarantine	d on	
		from a dispenser in the			the designated quarantine hall (300 H		
	hallway.				Also to ensure enhanced droplet		
					precaution signs are posted and staff	are	
		M, an interview with NA #7			wearing all recommended PPE.	1.0	
	revealed Resident #1	5			These quality reviews will be complete		
		precautions so she had not n prior to entering her room.			x weekly for 1 month, then 2 x weekly 1 month, then 1 x weekly for 1 month,		
		y wore a mask and gloves			then 1 x monthly for 6 months.	anu	
		ersonal care to Resident			The findings of these quality reviews w	vill	
	#18.				be reported to the Quality		
					Assurance/Performance Improvement	t	
	On 7/21/20 at 12:04 I	PM, a phone interview was			Committee monthly until committee		

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLF	CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	MPLETED
							С
		345385	B. WING				08/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINAI	L HEALTHCARE AND RI	ЕНАВ			31 N ASPEN STREET		
				LI	INCOLNTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 96	F 8	380			
		8 who usually worked on the			determines substantial compliance ha	is	
		out on the first half of the 200			been met and recommends moving to		
		d that new admissions went			quarterly monitoring by the Regional		
		they were quarantined for			Director of Clinical Services when		
	14 days but they wer	e not placed on any precautions. NA #8 stated			completing their systems review.		
	•				5. Allegation of Compliance Date 9-	.14_	
she only wore a mask and gloves wh personal care to the residents on 300					20.	••	
	that a gown was not						
	On 7/21/20 at 1:49 P						
		Nursing (ADON) revealed					
		ed their new admissions and days on the 300 hall. The					
	ADON clarified that q	-					
		nside their rooms for 14					
		t none of the currently					
		tted residents were placed					
		ed precautions unless they					
	came to the facility w	red it. They did not put up					
	-	because they did not					
		ssions and readmissions to					
	be placed on any trar						
	-	no provided care to the newly					
		tted residents were only					
	-	ask and gloves. She stated d not specify what to do with					
		ho had tested negative for					
	•	ming to the facility. She					
		tested negative once for					
		gh to prevent possible					
	transmission of COV sure why some of the	ID-19. She said she was not					
	-	were not placed on the 300					
	hall.						
	On 7/21/20 at 3:27 P	M, an interview conducted					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345385	B. WING				20/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	of Nursing (DON) abore readmissions not bein transmission-based p was told that these re- for COVID-19 at the F coming to the facility. referred to the facility which did not include incoming residents with COVID-19 prior to em further stated that the guidelines and state a directives which they facility's policies. On 7/21/20 at 5:22 PI with the DON revealer admitted and readmit negative for COVID-1 to coming to the facilit continued to be screen nurses who checked temperatures at least exhibited any signs of On 7/22/20 at 1:57 PI Health Department st new admissions and placed on droplet pre recommended PPE a even though they did symptoms of COVID- in a separate unit and facility population unti the facility. She also negative one time for guarantee that these	had questioned the Director but new admissions and ing placed on recautions and she said she sidents had tested negative hospital 48 hours prior to During the interview, she is COVID-19 Pandemic Plan directions on what to do for ho were tested negative for tering the facility. She y should follow the CDC and local health department tried to incorporate into the M, an interview conducted d they made sure the newly ted residents were tested 9 within 24 to 48 hours prior ty. These residents ened for COVID-19 by the their vital signs including twice a day and none had r symptoms of COVID-19. M, a phone interview with aff member #1 revealed readmissions should be cautions using all nd quarantined for 14 days not exhibit any signs or 19. They should be placed I away from the general il after 14 days of coming to stated having been tested	F	880			

Facility ID: 923059

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345385	B. WING			-		C 20/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 28092	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	the Administrator on 6 The CDC guideline er Coronavirus (COVID- reviewed on 4/30/20 i statements: * Place signage at the care unit that instructs personnel) they must N95 or higher-level re respirator is not availa unit. Gowns and glow entering resident roor * All recommended C worn during care of re which includes use of respirator (or facemas available), eye protect disposable face shield sides of the face), glo * A single negative test mean that the resider not become infected i admitted or readmitte monitored for evidence after admission and co recommended COVID * New residents could observation area or fr multi-resident room if without symptoms for exposure (e.g. date o On 7/22/20 at 2:42 Pl conducted with Health #2 revealed the local	titled "Responding to .19) in Nursing Homes" to 5/30/20. Initiled "Responding to .19) in Nursing Homes" last indicated the following e entrance to the COVID-19 s HCP (healthcare wear eye protection and an espirator (or facemask if a able) at all times while on the ves should be added when ms. OVID-19 PPE should be esidents under observation, f an N95 or higher-level sk if a respirator is not tion (goggles or a d that covers the front and oves and gown. st upon admission does not it was not exposed or will in the future. Newly d residents should still be the of COVID-19 for 14 days eared for using all D-19 PPE. I be transferred out of the rom a single to a they remain afebrile and that days after their last f admission).	F	880				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 09/24/2020 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(3) DATE COMP	SURVEY LETED
		345385	B. WING				(()80	; 20/2020
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				93	31 N ASPEN STREET			
CARDINA	L HEALTHCARE AND RE	INAB		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE
TAG F 880	Continued From page that he expected then admissions and readr place them on dropled information was provic call to the Health Dep the facility had identifi who tested positive for On 7/22/20 at 3:27 PM the DON revealed the admitted and readmitt only one time at the h the facility. These res 14 days which meant go outside of their roc care to the newly adm residents were suppo or face shield, mask a stated gowns were no providing care to thes gowns was not specif COVID-19 Pandemic require staff to wear go rooms of newly admit residents, they were n each room. Gloves w room and each staff n own face shield or go after disinfection at th further stated that the accepting admissions pandemic. They had newly admitted reside	 99 n to quarantine their new missions for 14 days and t precautions. This ded to the facility due to a artment on 6/30/20 when led their first staff member or COVID-19. M, a follow-up interview with a residents who were newly ted to the facility were tested ospital prior to coming to sidents were quarantined for they were not supposed to oms. Staff who provided nitted and readmitted sed to wear either goggles and gloves. The DON of required to be worn when le residents as the use of ied in the facility's Plan. Since they did not gowns prior to entering the 		380			-	
	present. The Adminis	dministrator with RDCS						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			9	31 N ASPEN STREET			
CARDINA	L HEALTHCARE AND RE	HAB	L	INCOLNTON, NC 28092	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	admitted that he had and thought that a sin enough to consider th to COVID-19. The Ac that he was trying to o when there was an ou facility. The RDCS st experienced a shortag gowns and face shield share their resources On 7/23/20 at 2:13 Pf the Administrator rever were supposed to go be quarantined for 14 #15 was admitted to r were no available roo 6/22/20 and 214 was available. She was n transmission-based p was admitted to room available rooms on th 103 was the only prive was not placed on tra precautions. Resider 103 on 7/21/20 becau her from another resid She was not placed o precautions. The Adr he did not follow the f Pandemic policy of co and readmissions by aside from the 300 has	partment staff member and misinterpreted the guidance igle negative test was le resident as not exposed diministrator further stated conserve his resources for utbreak of COVID-19 at the ated the corporation had ge of supplies such as ds and had been trying to with sister facilities. M, a phone interview with ealed the new admissions to the 300 hall so they could days. He stated Resident room 214 because there ms on the 300 hall on the only private room ot placed on recautions. Resident #17 103 because there were no e 300 hall on 7/2/20 and ate room available. She nsmission-based at #19 was admitted to room use they wanted to separate dent with the same name. In transmission-based at #16 and Resident #18 to their original rooms, but on transmission-based ministrator stated he realized acility's COVID-19 borting new admissions placing them on other halls all and not separated from ad remained at the facility.	F 880				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345385	B. WING				C /20/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	assigned to care for the readmissions had care facility at the same time further stated that he admissions due to lace The Administrator wa jeopardy on 8/13/20 at 11:46 AM, the facility credible allegation of removal. Identify those recipient are likely to suffer, a se a result of the noncom Review of medical read admissions and read On 6/22/20, Resident the facility into room 2 tested for COVID-19 the results were negative On 6/30/20, Resident the facility into room 2 rapid COVID-19 test of discharge from the hor results were negative on 7/27/20 and 8/5/20 negative. On 7/2/20, Resident # 103-A. Resident #17 while in hospital on 6/ negative. Resident #	he new admissions and red for other residents at the ne. The Administrator did not think about halting ck of space. s notified of the immediate at 1:13 PM. On 8/17/20 at provided the following immediate jeopardy hts who have suffered, or serious adverse outcome as npliance. cords revealed the following missions: #15 was newly admitted to 214-A. Resident #15 was while in hospital on 6/21/20, tive. Resident #15 was a 8/5/20 in-house, test #16 was newly admitted to 201-A. Resident #16 had a completed the day of	F	880			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/24/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345385	B. WING		_		C 20/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	HAB		31 N ASPEN STREET INCOLNTON, NC 2809	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	9 102	F 880				
	into her private room rapid COVID-19 test of discharge from the hor results were negative on 7/28/20 and 8/5/20 negative. Resident # 7/21/20 but was place precautions. Enhance was posted on reside transferred out to hos readmitted on 7/27/20 quarantine unit. On 7/21/20, Resident the facility into room 1 tested for COVID-19 of the results were nega #19 stayed in private on enhanced droplet quarantine unit on 7/2 Resident #19 no long Resident #19 was dis hospital on 7/28/20. Admissions and read #16 on 6/30/20, #17 of and #19 on 7/21/20 w COVID-19 symptoms shortness of breath, s diarrhea, muscle pain taste or smell, chills a chills. However, Resi and #19 were not qua days on the 300 hall,	 appriation 7/10/20, the by Resident #18 was tested c) in-house, test results were 18 was not moved on ad on enhanced droplet ad on the droplet droplet ad on the droplet droplet droplet droplet ad on the droplet dro					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/24/2020 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345385	B. WING			_	08/	20/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARDINA	L HEALTHCARE AND RE	НАВ			31 N ASPEN STREET INCOLNTON, NC 2809	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	were wearing surgical residents. However, I #18 and #19, at the til admission/readmissio enhanced droplet con- staff wearing additional Equipment (PPE) of g shields/goggles when these residents). On 7/21/20 during vis Regional Director of C aware of an Infection admissions and readr surveyor expressed c and readmissions weat the designated quarant placed on enhanced of The Regional Director immediately posted sit communicate enhance precautions for reside quarantined, along wi Personal Protective E these residents to incl precautions. At that til gloves, masks and fac provided to unit, and i current staff working of On 7/21/20, Personal include gowns, gloves shields/goggles were nurses and nurse aide time to utilize this PPE	to that date, staff members masks to care for all Residents #15, #16, #17, me of their n, had not been placed on tact precautions (to include al Personal Protective owns, gloves and face having encounters with it, a surveyor made the Clinical Services (RDCS) Control issue involving new nissions process. The oncern that new admissions re not being quarantined on ntine hall (300 hall); and not droplet contact precautions. of Clinical Services gnage on the 300 hall to ed droplet contact nts who needed to be th the need to wear quipment when caring for ude enhanced droplet me, RDCS ensured gowns, ce shields/goggles were nitiated education with on the unit.	F	880				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/24/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345385	B. WING				C /20/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	reeducated the Admir Assistant Director of M Director and Social W include the instruction admitted or readmittee The center will design admissions/readmissi a. The patient will th room/area of the cent b. If the resident's C (no available test) - re room or cohort with an status is unknown, ini precautions (standard days. Specify the action the process of system fail adverse outcome from when the action will b New Admissions, Rea residents have the po alleged deficient prac Director of Nursing ar Nursing reviewed Res and #19 as well as the 200 and 300 halls to c any precautions. Res were beyond the 14-c quarantine or enhanc precautions and show COVID-19, nor did oth	Director of Clinical Services histrator, Director of Nursing, Nursing, Admissions Vorker on the COVID-19 to a for residents who are d to the center as follows: thate an area and cohort new ions for 14 days on 300 hall. then be moved to a different ter. COVID-19 status is unknown esident placed in a private nother resident whose itiate transmission-based d, contact and droplet) for 14 e entity will take to alter the lure to prevent a serious m occurring or recurring, and the complete. admissions and current otential to be affected by this stice. On 7/21/20, the nd Assistant Director of sidents #15, #16, #17, #18 e current residents on 100, determine if they needed sidents #15, #16 and #17 day period of requiring ted droplet contact ved no signs or symptoms of her current residents on 100 uarantine or additional	F	880			

Facility ID: 923059

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345385	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CARDINA	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				931 N ASPEN STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 880	On 7/21/20, six long-t identified as residing of the six long-term care hall were moved off th side of facility to acco and readmissions. Th residents remained of Administrative Team of and notification to res 7/27/20 and 8/5/20, c the center on those d COVID-19, and all res negative to include th residents that were of 7/23/20. On 7/21/20, the Direct Assistant Director of N reeducation to include Department, Therapy Department, Dietary I Administrative Team (Business Office Mana Coordinator, Admission Records, Activities, M Administrator) on Infer following: * The center will desig hall) and cohort new a whose COVID-19 star who has been remove precautions prior to a days. * Newly admitted or re- monitored for evidence after admission and c recommended COVIE * After 14 days of quar	erm care residents were on the 300 hall. On 7/23/20, e residents residing on 300 he unit into rooms on other mmodate new admissions he six long-term care in the 300 hall while the worked on bed management idents and family. On urrent residents residing at ates were tested for sident test results were e six long-term care in the quarantine hall until tor of Nursing and the Nursing initiated staff e the following staff: Nursing Department, Housekeeping Department and (Social Worker, MDS, ager, Human Resource ons Director, Medical laintenance and oction Control to include the gnate a quarantine unit (300 admissions/readmissions tus is known (negative) or ed from transmission-based dmission/readmission for 14 eadmitted residents will be we of COVID-19 for 14 days ared for using all	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED		
		345385	B. WING				C /20/2020		
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
CARDINA	L HEALTHCARE AND RE	НАВ			931 N ASPEN STREET LINCOLNTON, NC 28092	STREET N, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 880	* The Director of Nurse residents are ready to unit. The Director of I Nurse Practitioner and moving residents off of * The facility will make with dedicated staff. * Wearing (PPE) mas gowns and gloves * Infection Control to i admissions and readr precautions and PPE Education will be ong work until they had co education. On 7/24/20, the Nursi (Director of Nursing a Nursing) initiated reed Nursing Department, Housekeeping Depart and Administrative Te Business Office Mana Coordinator, Admissio Records, Activities, M Administrator) on proj competency with retu	oom/area of the facility. sing will decide when o be moved off quarantine Nursing will consult with the d/or Medical Director before quarantine unit. e every effort to staff unit k and face shield/goggles, include: process for new missions, enhanced droplet (donning and doffing). oing; no staff could return to ompleted the mandatory ing Management Team nd Assistant Director of ducation to staff to include: Therapy Department, tment, Dietary Department am (Social Worker, MDS, ager, Human Resource ons Director, Medical laintenance and per use of PPE including rn demonstration. ed to work until they ory education. Additionally, provided to all new new hire orientation,	F	880					
		nter's Pandemic Plan for d per CDC guidelines to							

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
							С
		345385	B. WING			08/	/20/2020
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 931 N ASPEN STREET		
CARDINA	IAL HEALTHCARE AND REHAB						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 880	Continued From page clarify and include the The center will desigr admissions/readmiss status is known (nega removed from transm prior to admission/rea resident will remain ir * Newly admitted or re monitored for evidence after admission and cor recommended COVII * The patient will ther room/area of the cent 1. The Center will do Under Investigation u * Upon admission the unknown or is awaitir * Resident with possii test results * Resident with possii awaiting test results * Place resident in a p another resident who	e 107 e following: nate an area and cohort new ions whose COVID-19 ative) or who has been ission-based precautions admission for 14 days. (The n their room during this time). eadmitted residents will be ce of COVID-19 for 14 days ared for using all D-19 PPE. n be moved to a different ter. lesignate an area (Person nit) for residents who: c COVID-19 status is		880	DEFICIENCY)		
	with the Administrator ensure new admits and the designated quara Administrator and Dir that the residents are The Director of Nursin residents are ready to unit. The Director of Nurse Practitioner an	ector of Nursing will ensure quarantined for 14 days.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 09/24/2020 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345385	B. WING			C 08/20/2020		
NAME OF PROVIDER OR SUPPLIER				s	STREET ADDRESS, CITY, STATE, ZIP CODE			
CARDINAL HEALTHCARE AND REHAB			931 N ASPEN STREET					
			LINCOLNTON, NC 28092					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI DEFICIENC'		N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 880 Continued From page 108		• 108	F	880				
	Supply person will ensure PPE is stocked and available on all units. The Admissions Director and/or the Director of Nursing will be responsible for checking if new admits/readmits had a negative test in the hospital or if they were quarantined already 14 days in the hospital. The center Executive Director alleges abatement of immediate jeopardy on 07/27/20. On 08/19/20 at 9:00 AM the facility's plan for immediate jeopardy removal was validated by the following. Review of in-service training records revealed staff from all shifts and all disciplines had been inserviced on 7/21/20 and 7/24/20 regarding designated area for residents admitted and readmitted and COVID-19 positive residents on the 300 hall, proper PPE, donning and doffing PPE with return demonstrations, signage for COVID presumptive and positive residents, signage for 300 hall, clean and dirty rooms on designated COVID hall, testing of residents and staff, quarantine of residents for 14 days for unknown COVID status. Observation of the COVID hall revealed residents admitted/readmitted quarantined and signage present on all doors. Observed clean and dirty rooms and dedicated staff to the unit interviewed. The facility's Pandemic Plan was reviewed and revisions were noted. Long term residents previously on the 300 hall were moved to another hallway. The facility's date of immediate jeopardy removal of 07/27/20 was validated.							

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