	-	ID HUMAN SERVICES			FORM	M APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345159	B. WING			C / 13/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER		1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation, and foll	hrough 04/13/24. The ompliance with the 3.73, Emergency t ID# Q7FU11.	F 000			
F 550 SS=G	complaint was condu 04/11/24. Additional in Therefore, the exit da The following intakes NC00215477, NC002 NC00209004, NC002 NC0020350, and NC 6 of the 23 allegations	215341, NC00211351, 208892, NC00207346, 206845, NC00206550, 199840. Event ID #Q7FU11. s resulted in deficiency. cise of Rights	F 550			5/14/24
	self-determination, an access to persons an	ght to a dignified existence, ad communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that e or enhancement of his or ognizing each resident's ity must protect and				
	§483.10(a)(2) The fac	sility must provide equal				
	DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 05/10/2024

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				FORM): 05/16/2024 (APPROVED): 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION		LETED
		345159	B. WING _				C 13/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	410 EAST GASTON STREET		
LINCOLN	TON REHABILITATION C	ENTER		L	INCOLNTON, NC 28092		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page		F	550			
	severity of condition, must establish and m practices regarding tr	regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					
		right to exercise his or her the facility and as a citizen					
	resident can exercise	ility must ensure that the his or her rights without , discrimination, or reprisal					
	free of interference, c reprisal from the facili rights and to be suppo exercise of his or her subpart.	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this					
	interviews the facility dignified manner by n when requested for 1 dignity (Resident #80 made her upset to sit her "feel like a third-cl her bill like everyone The Findings included				 F550 □ Resident Rights/Exercise of Rights 1 On 4/8/2024, resident #80 was provided with incontinent care by the U Manager and Assistant Director of Nursing upon notification of the resider need. On 4/8/2024, the Certified Nursi Assistant # 1 was verbally re-educated the Unit Manager on ensuring care and services are provided upon resident request. 	nts ng by	
		ses of diabetes mellitus and			2 On 4/15/2024, the Director		

Facility ID: 923312

If continuation sheet Page 2 of 39

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/16/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345159	B. WING				C / 13/2024
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				14	10 EAST GASTON STREET		
LINCOLN	LINCOLNTON REHABILITATION CENTER			LI	NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	Continued From page	a 9		550			
		5 2	' '	550	Nursing/designed interviewed all rea	donto	
	hypertension.				Nursing/designee interviewed all res and or responsible parties to ensure		
	The quarterly Minimu	m Data Set (MDS)			were receiving incontinent care upor	-	
	assessment dated 01				request. There were no other resider		
		gnitively intact, required			identified as not having incontinent c		
		with toileting, and was			provided upon request. By 4/19/2024		
	always incontinent of	bladder and bowel. No			Director of Nursing, Staff Developme	nt	
		oted during the assessment			Coordinator and Unit Managers		
	reference period.				re-educated 100% of the Licensed N	urses	
					and Certified Nursing Assistants on		
		ucted on 04/08/24 at 10:30			ensuring that a resident receives	dtha	
		nt #80 yelled into the hall and a soiled brief. NA #1 was			incontinent care upon request. Shou Nursing Assistant be unable to provide		
	observed entering the				incontinent care as requested they a		
					ask for assistance from another nurs		
	Resident #80 was int	erviewed in her room on			assistant and/or nurse. New hires wi	-	
	04/08/24 at 10:45 AM	1. During the interview she			educated by the Staff Development		
		sitting in a soiled brief since			Coordinator during General Orientati	on on	
	9:30 AM and knew th	is because she had been			ensuring residents receive incontine	nt	
		n the wall. She stated she			care upon request and should they b		
		he was sitting in a soiled			unable to provide care as requested		
		owledged her and left the			are to ask for assistance from anothe	er	
		e was still sitting in bowel			nursing assistant and/or nurse.		
		ed to be changed. During the 30 stated, "It makes me feel			3 Starting 4/22/2024, the Director	of	
	like a third-class citize				Nursing, unit managers and licensed		
		went on to say it made her			nurses will perform daily audits to en		
	-	a soiled brief filled with			the residents are provided with incor		
	bowel movement.				care upon request 5 times a week fo		
					weeks, then 3 times a week for 4 we	eks,	
		AM the surveyor told Unit			then 2 times a week for 4 weeks for	а	
		ident #80 was sitting in a			period of 3 months.		
		vation was conducted at			A The west of the most set		
		nager #1 and Assistant			4 The resident rights audits will be	•	
	Director of Nursing (A				brought by the Director of		
		Resident #80. Resident pad and fitted sheet were			Nursing/designee to the Quality Assurance and Assessment/Quality		
		with feces. Resident #80			Assessment and Performance		
		π man 10000. Resident π 00			Improvement meeting monthly. The		

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		3 NO. 0938-03 DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	COMPLETED	
					-	С	
		345159	B. WING			04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
LINCOLN	TON REHABILITATION O	CENTER		1410 EAST GASTON STR LINCOLNTON, NC 280			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 550	Continued From page	e 3	F 55	0			
		ng her urinary catheter. A		Quality Assurance	and		
	complete bed change	e was observed after the		Assessment/Qual	ity Assessment and		
		ntinence care to Resident			rovement committee will		
	#80.				and determine if further		
	On 04/08/24 at 9:49	AM an interview was			continent care being		
		e Aide (NA)#1. During the			quest for a minimum of 3		
		Resident #80 had told her			bstantial compliance		
		anged however she had		has been achieve	d.		
	· ·	ng water down the hall for			Data E/44/2024		
		ed bath. The interview Inned on completing the bed		5 Completion D	0ate 5/14/2024		
	-	g Resident #80. NA #1					
		ow Resident #80 had been					
	sitting in a soiled brie	ef since 9:30 AM.					
		PM an interview was					
		Manager #1. Unit Manager					
		ee a call light on you should et another staff member					
		s provided. Unit Manager #1					
		mplete an entire bed change					
		to incontinence and that					
		he facility. She stated					
		ides were good about					
		stated no resident should feel					
	bowel movement.	ss citizen or have to sit in					
	On 04/11/23 at 3:24 I						
		ssistant Director of Nursing					
	(ADON). The ADON	stated she did assist continence care and had to					
		ige due to the incontinence.					
	The ADON stated Nu						
		resident request. The					
		o resident should feel upset					
		to be changed while sitting in					
	a brief with bowel mo	ovement.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/16/202 MAPPROVE D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	COM	E SURVEY PLETED
		345159	B. WING			C 04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	ON REHABILITATION C	ENTER			1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 550	Continued From page	e 4	F	550	0		
	On 04/09/24 at 8:55 A	AM an interview was					
	conducted with the D	irector of Nursing (DON).					
		ould have provided care					
	when the resident asl Resident #80 should	never feel like a third-class					
		use staff would not change					
F 580	Notify of Changes (In	jury/Decline/Room, etc.)	F	580	0		5/14/24
SS=D	CFR(s): 483.10(g)(14	l)(i)-(iv)(15)					
	consult with the resid consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information	rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, tial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2)					
	physician. (iii) The facility must a	ded upon request to the also promptly notify the dent representative, if any,					

Facility ID: 923312

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/16/202 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345159	B. WING		04/13/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
	TON REHABILITATION C	ENTED		1410 EAST GASTON STREET	
LINCOLIN	TON REHABILITATION C			LINCOLNTON, NC 28092	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETION
F 580	as specified in §483. (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must in update the address (in phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specifi room changes betwe under §483.15(c)(9). This REQUIREMENT	or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and	F 5	80	
	Center Nurse, Nurse Director, and staff intr notify the physician o for 1 of 3 residents (F notification. On 8/28/3 scheduled medical ap appointment the resid packed by staff and v appointment. Findings included: Resident #1 was adm 08/26/23 with diagnos	erviews the facility failed to f a facility-initiated discharge Resident #1) reviewed for		F580 Notify of Change 1 On 8/30/2023, the p Resident #1, was notified not being allowed to retur after a therapeutic leave center. On 4/11/2024, th Nursing was re-educate Clinical Director on notified physician for any facility discharge related to a re- gone on a therapeutic leave appointment or leave of resident who would not return to the center after On 4/11/2024, the Vice Operations re-educated	physician for ed of the resident urn to the center e outside of the ne Director of ed by the Regional fication to the <i>v</i> -initiated esident who has eave, physician ⁱ absence for any be allowed to r the appointment. President of

Event ID: Q7FU11

Facility ID: 923312

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						<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY IPLETED
			A. BUILDING	3		С
		345159	B. WING _			U 13/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04	13/2024
			1410 EAST GASTON STREET			
LINCOLN	TON REHABILITATION C	ENTER		LINCOLNTON, NC 28092		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETIO DATE
F 580	Continued From page	e 6	F 58	0		
				Home Administrator, Director of	Nursing	
	Review of Resident #	1's admission Minimum		and Admissions Director on the o	•	
	Data Set (MDS) date	d 8/28/23 revealed the		policy allowing residents to return	n to the	
		d oriented. The MDS further		center from a physician appointn		
	revealed Resident #1	had a tracheostomy.		therapeutic leave or leave of abs	ence.	
	Interview conducted	with the Respiratory		2 On 4/16/2024, the Director of	of Nursing	
		led on 04/11/24 at 11:05 AM		and Unit Managers audited disch		
		was assessed on 08/27/23.		residents for the past 6 months to	•	
		l a cuffed tracheostomy and		physicians were notified of any re	esident	
		hanged to an uncuffed		who was not allowed to return fo	•	
	-	nursing staff not being		physician appointment, therapeu		
		or a resident with a cuffed		or leave of absence. No other re-		
		different cannula. The RT		were noted to be affected. By 4/		
		as unable to change the		Licensed Nurses, Unit Managers		
	-	the facility not having the e RT indicated Resident #1		Nursing Supervisors were re-edu the Director of Nursing on ensuri		
		nd could have waited to have		resident goes to a physician app	-	
		en supplies were obtained.		leave of absence or therapeutic l		
	nie daen enange mie			will be allowed to return to the ce		
	Review of progress r	ote completed by Nurse #1		New staff will be educated on the		
		ed Resident #1 was sent to		of notification to the resident⊡s p	•	
	the Emergency Roon			for a facility initiated discharge a		
				allowing residents to return to the		
		nducted with Resident #1 on		from a physician appointment, th	erapeutic	
		revealed on 08/28/23 he was		leave, or leave of absence.		
		e was going to an infusion				
		nt #1 further revealed while		3 Starting 4/22/2024, The Dire		
		e transporter at the front of mber (unable to recall		Nursing and/or Unit Managers w resident records daily during the		
	-	r) dropped a bag in his lap		clinical meeting to ensure the ph	-	
		s and reported he was going		notified on any resident leaving t		
		partment (ED) after his		for a therapeutic leave, physiciar		
		other information. Resident		appointment or leave of absence		
	#1 further revealed h			audit will be conducted daily duri		
		up and take him home from		morning clinical meeting for twelve		
	his infusion appointm					
	nowhere else to go.			4 The notification to physician	audits will	
	1		1	be brought by the Director of		1

Facility ID: 923312

	S FOR MEDICARE &				OMB NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
					С	
		345159	B. WING		04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER		1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO	
F 580			F 58			
	Nurse #1 on 04/10/24 08/28/23 the Infusion that Resident #1 nee after his infusion app was contacted the Ac Resident #1 did not h Infusion Center did n the resident to the EE Infusion Center Nurse Admissions Director care for Resident #1 go to the ED to help f indicated Infusion Ce Resident #1 had a ba belongings. A phone interview wit Director on 04/09/24 recalled having a cor care center staff and but could not recall a It was further reveale could not recall any p discharged on 08/28/	the facility was unable to and the resident needed to find placement. It was nter Nurse #1 indicated ag packed with his th the prior Admissions at 6:00 PM revealed she oversation with the infusion it was an "ugly conversation" nything that was discussed. d the Admissions Director part of Resident #1 being		Nursing/designee to the Quality Assurance and Assessment/Qual Assessment and Performance Improvement meeting monthly. T Quality Assurance and Assessment/Quality Assessment Performance Improvement comm review the audits and determine in recommendations are needed to physicians are notified on resider require an offsite physician appoint therapeutic leave or leave of abso- minimum of 3 months or when su compliance has been achieved.	he and hittee will f further ensure hts who ntment, ence for	
	Respiratory Therapis on 08/27/24 and reco his tracheostomy cha uncuffed tracheostom revealed Resident #1 infusion center on 08 the Resident #1 to ha	t (RT) assessed Resident #1 ommended Resident #1 have inged from a cuffed to an by. The DON further had an appointment to the /28/24 and she decided for ave his tracheostomy gency Department (ED)				

Facility ID: 923312

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345159	B. WING				_ 13/2024
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER			410 EAST GASTON 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 580 F 624 SS=G	(MD) to obtain orders tracheostomy change planned for Resident facility in the evening aware the resident ha him. The DON stated facility Admissions Dir infusion center that R to the facility. Interview with the Nur 04/11/24 at 10:35 AM assessed Resident # facility and did not red the facility that Reside have their trach chang could not recall who r had left against medic someone from the fac Interview with the Me 04/10/24 at 4:55 PM n assessed Resident # facility. The MD further notified that the reside emergency room to h changed. The MD fur to recall who notified AMA and was not retu 08/30/23.	P) or the Medical Director for ED transfer and a. The DON stated she had #1 to come back to the of 08/28/23 and was not ad taken his belongings with she was not aware the rector had reported to the esident #1could not return rse Practitioner (NP) on revealed she had not 1 during his stay in the call any conversation with ent #1 was being sent out to ged. The NP indicated she notified her that Resident #1 cal advice (AMA) but cility had reported it to her. dical Director (MD) on revealed he had not 1 during his stay in the er revealed he was not ent had been sent out to the ave his tracheostomy ther revealed he was unable the MD Resident #1 had left urning to the facility on Orderly Transfer/Dschrg		580			5/14/24
	discharge. A facility must provide	e and document sufficient tation to residents to ensure					

Facility ID: 923312

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		MEDICAID SERVICES					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		E SURVEY IPLETED
			A. BUILDI	NG _			С
		345159	B. WING			04/13/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-	13/2024
					410 EAST GASTON STREET		
LINCOLN	ON REHABILITATION C	ENTER		L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
E 624	Continued From non	- 0		004			
F 624	Continued From page		F	624			
		sfer or discharge from the					
	facility. This orientation	on must be provided in a					
	form and manner tha understand.	t the resident can					
		「 is not met as evidenced					
	by:						
Ba Re Pra	-	iew and resident, Resident			F624 Preparation for Safe/Orderly		
		Infusion Center staff, Nurse			Transfer/Discharge		
	•	lical Director interviews the					
	facility failed to provid	de a safe and orderly			1 On 8/28/2023, Resident #1 was		
	discharge for 1 of 3 r	esidents (Resident #1). On			discharged from the center. On 4/11/20)24,	
		had a scheduled medical			the Vice President of Operations		
		or to the appointment the			re-educated the Nursing Home		
		were packed by staff and			Administrator, Director of Nursing and		
		the appointment. Resident			Admissions Director on the centers pol	-	
	-	with discharge paperwork or			residents to return to the center from a		
	U	s and did not understand			physician appointment, therapeutic lea		
		. The discharge location was alth services were not			or leave of absence. On 4/17/2024, the Director of Nursing and social service	;	
		f discharge, and the resident			director were re-educated by the Regio	Inal	
		with to ensure his needs			Clinical Director on ensuring the reside		
	-	ed in Resident #1 feeling like			and/or responsible party has received	111	
		out, abandoned, and was			communication on the purpose of the		
	mad.	,			appointment, should the resident and/c	or	
					responsible party choose to discharge		
	Findings included:				from the appointment all discharge		
					paperwork and instructions have been		
		al discharge summary dated			arranged prior to leaving the center.		
		esident #1 was admitted to					
	-	/23 due to Resident #1			2 On 4/15/2024, an audit was		
		ody weakness and the family			completed by the Director of Nursing o		
		o the hospital for placement.			current residents to ensure any schedu		
		nitted with throat cancer and			appointments would have transportatio		
		was diagnosed with adult ncreased general weakness.			arranged for the resident to return to th	ie i	
		charged from the hospital on			center after the appointment, resident would be allowed to return to the cente	r	
		d to the facility for skilled			and ensure the physician, resident and		
	services.				responsible party are notified of the	, 01	
	001 110000.		1				1

Event ID: Q7FU11

Facility ID: 923312

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OLIVIEI		MEDICAID SERVICES				NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	OATE SURVEY	
			A. BUILDING	i			
		345159	B. WING			С	
		345159	B. WING			04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET		CODE		
LINCOLN	TON REHABILITATION (CENTER					
	l			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 C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 624	Continued From pag	e 10	F 62	4			
		nitted to the facility on		leave or leave of absence	e. No other		
		ses which included cancer,		residents were identified			
	-	ory failure, and muscle		further arrangements ma			
	weakness.			the discharge process O	n 4/17/2024, the		
				Social Services Director,			
		#1's admission Minimum		Director, Activities Director			
resident w revealed f		ed 8/28/23 revealed the		Director, Business Office			
		d oriented. The MDS further		Human Resource Manag			
	revealed Resident #7	1 had a tracheostomy.		Staff, Minimum Data Set			
	A phone interview or	inducted with the Deepiretery		Managers, Licensed Nurs Office Staff were re-educ			
	A phone interview conducted with the Respirat Therapist (RT) revealed on 04/11/24 at 11:05 A			Regional Clinical Director			
		1 was assessed on 08/27/23		President of Operations of			
	and revealed Reside			right to return to the center			
		commended it be changed to		physician appointment, th			
	an uncuffed tracheos	stomy because uncuffed		or leave of absence. On	5/2/2024, the		
		earance but provide no		Unit Managers, Minimum			
	protection from aspir			Coordinator, Business Of	•		
		allow secretion clearance		Staff Development Coord			
		ction from aspiration. The		Prevention Control Office			
		staff was not familiar with		Director, Medical Record	•		
		with a cuff tracheostomy. led he was unable to change		Program Manager, Admis and Director or Nursing e			
		e to the facility not having the		residents or their respons			
		e RT indicated he did not		ensuring they are aware			
	write physician order			right to return to the center			
		Medical Director (MD) would		appointment, therapeutic			
	have to be notified to	o obtain the order to change		absence on future therap			
	the tracheostomy typ						
		in distress and could have		3 Starting 4/22/2024, a			
		ach changed when supplies		completed daily during th			
		e Director of Nursing (DON)		clinical meeting 3 times a			
		the decision was made to the ED after the infusion		weeks on therapeutic lea discharges was complete			
	appointment on 08/2			residents on therapeutic l			
				physician appointment or			
	Review of a progress	s note completed by Nurse		absence have been perm			
		ealed Resident #1 was at the		the center and ensure the			
	Emergency Room (E			resident and/or responsib			

Facility ID: 923312

If continuation sheet Page 11 of 39

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
					с	
		345159	B. WING		04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
	TON REHABILITATION C	ENTED	1410 EAST GASTON STREET			
LINCOLN	TON REHABILITATION C	ENTER		LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLET	
F 624	Continued From page	e 11	F 62	4		
	A phone interview co 04/11/24 at 6:10 PM advised and aware he appointment. Resider he was waiting on the the facility and a staff specific staff member with all his belonging: to the Emergency De appointment with no #1 indicated once he appointment with his revealed to Resident message from the fac the ED after his appon nurse explained to hi him to the ED becaus an order. Resident #7 he was being dischar he felt like he was be and was mad. Resider facility. Resident #1 fa a family member to p home from his infusio had nowhere else to the facility had his pe did not attempt to cor Representative (RR) #1's primary care offic Resident #1 stated th discharge information medicines, or supplie Resident #1 indicated	nducted with Resident #1 on revealed on 08/28/23 he was e was going to an infusion int #1 further revealed while e transporter at the front of member (unable to recall r) dropped a bag in his lap is and reported he was going partment (ED) after his other information. Resident arrived at the infusion bag the infusion staff nurse #1 they had received a cility to send the resident to intment. The infusion staff is that they could not send se Resident #1 did not have I stated at this time he felt ged without knowledge and ing thrown out, abandoned ent #1 revealed the Infusion facility Admissions Director it #1 could not return to the urther revealed he contacted ick him up and take him on appointment because he go. Resident #1 indicated rsonal phone number and intact his Resident until 08/30/23 after Resident ce reached out to the facility. ie facility did not provide any		 notified of the reason for the appointment/therapeutic leave or absence. Should the resident and responsible party determine to be discharged from the appointment all discharge needs will be arrang to the resident leaving the center. 4 The therapeutic leave and/or discharge audits will be brought be Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assurance and Assessment/Quality Assurance at Assessment/Quality Assurance and Assessment/Quality Assessment Performance Improvement meeti monthly. The Quality Assessment Performance Improvement comm review the therapeutic leave and/discharge audits and determine if recommendations are needed for minimum of 3 months or when su compliance has been achieved. 	d/or to home ged prior by the ne and and and and tittee will or further	

Facility ID: 923312

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (M) PROVIDERSUPPLIERCLA DENTIFICATION NUMBER: 345159 (M) MULTIPLE CONSTRUCTION A BUILING B. WING (M) DENTIFICATION A BUILING B. WING (M) DENTIFICATION A BUILING B. WING (M) DENTIFICATION C 04/13/2024 INME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, ZP CODE 1410 EAST GASTON STREET LINCOLNTON REHABILITATION CENTER INCELONTON, NC 28092 IVX10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERSY PLAN OF CORRECTION REGULATORY OR US: DENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH ORDERSY PLAN OF CORRECTION (EACH ORDERSY PLAN OF CORRECTION DEFICIENCY WIST BE RECEDED TO THE APPROPRIATE DEFICIENCY WIST BE SENT ON THE DEFICIENCY TAG D PREFIX (EACH ORDERSY PLAN OF CORRECTION DEFICIENCY D O PREFIX TAG F 624 Continued From page 12 A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was turther revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion Center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident #1 had a bag packed within his belongings and Resident #1 and the review with Infusion Center Nurse #1 stated Resident #1 had a bag packed within this on Center Nurse #2 retrieved a small bag of Supplies to send home with him. A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his			ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/16/2024 MAPPROVED O. 0938-0391
345159 B. WHG 04/13/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE LINCOLNTON REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2/P CODE (Xi) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EXPCORPTORE) TWAID OF COMPECTIVE AND OF COMPECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) prefix PREFIX PROVIDER'S PLAN OF COMPECTIVE AND OF COMPECTIVE (EXPCORPECTIVE AND OF COMPECTIVE AND OF COMPECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) prefix PREFIX PROVIDER'S PLAN OF COMPECTIVE AND OF COMPECTIVE (EXPCORPECTIVE AND OF COMPECTIVE PREFIX Description prefix (EXPCORPECTIVE AND OF COMPECTIVE (EXPCORPECTIVE AND OF COMPECTIVE ADDRESSING ADDRESSING ADDRESSING ADDRESSING ADDRESSING (EXPCORPECTIVE AND OF COMPECTIVE PREFIX PREFIX (EXPCORPECTIVE AND OF COMPECTIVE (EXPCORPECTIVE AND OF COMPECTIVE (EXPCORPECTIVE (EXPC	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COM	E SURVEY PLETED
LINCOLNTON REHABILITATION CENTER 1410 EAST GASTON STREET LINCOLNTON, NC 28092 (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY ME BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG D PROVIDER ST LAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 000000000000000000000000000000000000			345159	B. WING				-
LINCOLNTON REHABILITATION CENTER LINCOLNTON, NC 28092 (X1) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EXA) DEFICIENCY MISTER PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS FULA OF CORRECTIVA CATION SHOULD BE (EXA) CORRECTIVA CATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 DME DME F 624 Continued From page 12 A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion center ruses #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with this belongings and Resident #1 was observed to be furstrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him.	NAME OF PI	ROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLITON, NC 28092 LINCOLITON, NC 28092 (X4) ID PREFIX TAG ID PREVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE AFFROMMATION) ID PREVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE AFFROMMATION) TAG F 624 A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident medded to go to the ED to help find placement. It was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 that Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center Nurse #2						1410 EAST GASTON STREET		
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION DATE F 624 Continued From page 12 A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED thar his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #11 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his Rt to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. Nurse #1 stated Resident #1 arrived at the infusion center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 retrieved a the infusion center Nurse #2	LINCOLN	TON REHABILITATION C	ENTER			LINCOLNTON, NC 28092		
A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
belongings with him, and reported he believed was being discharged without notice. It was further revealed Infusion Center Nurse #1 contacted the facility and it was reported Resident #1 could not return to the facility and had to be sent to the ED after his appointment. Infusion Center Nurse #2 indicated the infusion center staff did not feel comfortable sending the resident to the ED without orders and the resident did not observe to be in medical distress. Infusion Center Nurse #2 stated Resident #1 called his RR to come get him from the infusion center. Infusion Center Nurse #2 stated she felt like the facility had "dumped" Resident #1 and she was very	F 624	A phone interview cor Nurse #1 on 04/10/24 08/28/23 the infusion that Resident #1 need after his infusion apported Admissions Director I have any orders and feel comfortable send was reported by the f that the facility was u and the resident need find placement. It was Center Nurse #1 that packed with his below observed to be frustration being discharged with Nurse #1 stated Resi pick him up and Infus retrieved a small bag with him. A phone interview witt on 04/10/24 at 9:45 A arrived at the infusion belongings with him, was being discharged further revealed Infus contacted the facility #1 could not return to sent to the ED after h Center Nurse #2 indic staff did not feel comf to the ED without ord observe to be in med Nurse #2 stated Resi come get him from th Center Nurse #2 stated	nducted with Infusion Center 4 at 1:20 PM revealed on center received a message ded to be sent to the ED ointment. It was further inter Nurse #1 contacted the because Resident #1 did not the infusion center did not ding the resident to the ED. It acility Admission Director nable to care for Resident #1 ded to go to the ED to help is observed by Infusion Resident #1 had a bag ngings and Resident #1 was ated and was confused on nout notice. Infusion Center dent #1 contacted his RR to sion Center Nurse #2 of supplies to send home th Infusion Center Nurse #2 and reported he believed d without notice. It was sion Center Nurse #1 and it was reported Resident to the facility and had to be his appointment. Infusion cated the infusion center fortable sending the resident ers and the resident did not ical distress. Infusion Center dent #1 called his RR to e infusion center. Infusion ed she felt like the facility	F	624			

Facility ID: 923312

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/16/2024 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345159	B. WING					C 13/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	TON REHABILITATION C	ENTER			410 EAST GASTON STREE			
	1			L	INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From page upset for Resident #1		F	624				
	A phone interview with Director on 04/09/24 a recalled having a con- care center staff and i but could not recall ar- lt was further revealed could not recall any p with Resident #1 from A phone interview cor- Resident Representa- 10:15 AM revealed Re- the facility after his ho- more care than the fa- further revealed on 08 notified prior that Res- for an infusion appoint the facility Admissions was on his way to an would have to be sen facility could not care tracheostomy. The RI Admissions Director r not return to the faciliti arrived at Resident #7 the Infusion Center N facility as well and ha information that the re- the facility. It was furth had a bag with his be about being discharge further revealed she t because she felt like fa and she had no other	h the prior Admissions at 6:00 PM revealed she versation with the infusion it was an "ugly conversation" hything that was discussed. d the Admissions Director art of what had occurred n 08/28/23 through 08/31/23. Inducted with Resident #1's tive (RR) on 04/11/24 at esident #1 was admitted to ospital stay due to needing mily could assist with. It was 8/28/23 the RR was not ident #1 was being sent out tment but was contacted by s Director that Resident #1 infusion appointment and t to the ED because the for the resident's R stated the facility evealed Resident #1 could ty. The RR revealed she I's infusion appointment and urse #1 had contacted the d reiterated the same esident could not return to her revealed Resident #1 longings and was very mad ed without notice. The RR ook Resident #1 home the facility had dumped him						

Facility ID: 923312

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2024 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345159	B. WING			(04/	_ 13/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER		1410 EAST GASTON STRE LINCOLNTON, NC 2809			
(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 ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	ready for his appointing given him a folder that appointment. The AD recall the resident have any concerns. The AE admitted with a cuffed not have supplies for, training to care for. The believed Resident #1 because the facility more resident with a cuffed she had thought Resid the ED to have Resid was not aware until R office reached out on was at home. The AD reached out to Reside revealed Resident #1 liquid form of metform indicated she contact 08/30/24 and obtained medications. The AD staff from the facility f #1 and was not sure of facility. An interview conducted Worker (SW) on 04/11 did not become involv 08/30/23 when Reside contacted the facility f #1 was at home. The time he completed an (APS) report to make and completed referration	A in getting Resident #1 nent on 8/28/23 and had t had information for his ON indicated she did not ving a bag packed or having DON stated Resident #1 was a trach that the facility did and staff did not have the ne ADON stated she was admitted by accident ormally would not accept a trach. The ADON indicated dent #1 had been sent to ent #1's trach changed and esident #1's primary care 08/30/23 that the resident ON revealed then she ent #1's RR and it was did not have the preferred nin and insulin. The ADON ed the on-call provider on d orders for Resident #1's DN was not aware that no nad reached out to Resident why he did not return to the ed with the facility Social 1/24 at 9:25 AM revealed he red with Resident #1 until ent #1's primary care office to let them know Resident SW further revealed at that Adult Protective Services sure Resident #1 was safe als for in home health but ee if Resident #1 had been	F 624	4			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345159	B. WING				_ 13/2024		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
LINCOLN	TON REHABILITATION C	ENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 624	An interview conducter Nursing (DON) on 04, the Respiratory Thera Resident #1 on 08/27 Resident #1 have his a cuffed to an uncuffer revealed Resident #1 infusion center on 08/ the Resident #1 to hat changed at the Emerg afterwards since the f supplies to do so at the she could not recall w Nurse Practitioner (NII (MD) to obtain orders she had planned for F the facility in the even aware the resident hat him. The DON reveal follow up with the whe during second and this thought Resident #1 we appointment on 08/28 received a phone call care office. The DON was completed, refern were completed, and Resident #1 to receive she was not aware the told Resident #1 that facility. An interview with the 04/11/24 at 10:35 AM assessed Resident #7	ed with the Director of /10/24 at 3:35 PM revealed apist (RT) assessed /24 and recommended tracheostomy changed from ed trach. The DON further had an appointment at the /28/23 and she decided for ve his tracheostomy gency Department (ED) facility did not have the ne facility. The DON stated why she did not notify the P) or the Medical Director to do so. The DON stated Resident #1 to come back to hing of 08/28/23 and was not ad taken his belongings with ed nursing staff failed to pereabouts of Resident #1 ird shift on 08/28/23 with the was still at the hospital, and asn't there on 8/29/23 either. n 08/30/23 it was found out t home from his	F	624					

Facility ID: 923312

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345159	B. WING		C 04/13/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
	ON REHABILITATION C	ENTER		1410 EAST GASTON STREET LINCOLNTON, NC 28092	
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ION SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 624	Continued From page	e 16	F 62	4	
		ent #1 was being sent out to	1 02		
		ged. The NP indicated she			
		and on what date, but she			
	was notified Resident advice (AMA).	t #1 had left against medical			
	•	th the Medical Director (MD) PM revealed he had not			
		1 during his stay in the			
		er revealed he could not			
	-	ed that Resident #1 had left			
	against medical advid	ce (AMA) on 08/30/23.			
		ministrator on 04/11/23 at			
		was made aware by the			
		Resident #1 was being sent			
		nter on 8/28/23 and then			
	heading to ED for tra	ch change. The			
	Administrator further				
		d was not aware the RT			
		s. The Administrator revealed ident #1 had left with his			
		not aware of who was			
		ing up with Resident #1's			
		did not return from his			
	appointment.				
F 626 SS=G	0	-	F 62	6	5/14/24
		ting residents to return to			
	facility.				
		sh and follow a written policy ts to return to the facility			
	after they are hospita				
		e policy must provide for the			
	following.	, , ,			
		hospitalization or therapeutic			
		d-hold period under the	1		

Facility ID: 923312

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2024 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED
		345159	B. WING				C 1 3/2024
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				14	10 EAST GASTON STREET		
LINCOLNI	ON REHABILITATION C	ENTER		LII	NCOLNTON, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 626	State plan, returns to room if available or in availability of a bed in resident- (A) Requires the serv and (B) Is eligible for Med services or Medicaid nursing facility service (ii) If the facility that d who was transferred returning to the facilit facility, the facility mur requirements of parage discharges. §483.15(e)(2) Readm distinct part. When the returns is a composite § 483.5), the resident to an available bed in composite distinct par previously. If a bed is at the time of return, the option to return to availability of a bed the This REQUIREMENT by: Based on record rev Representative, staff, Practitioner, and Med facility from therapeur (Resident #1). On 8/2 scheduled medical ap appointment the reside packed by staff and w	the facility to their previous nmediately upon the first a semi-private room if the vices provided by the facility; licare skilled nursing facility es. letermines that a resident with an expectation of y, cannot return to the ust comply with the graph (c) as they apply to hission to a composite he facility to which a resident e distinct part (as defined in t must be permitted to return a the particular location of the rt in which he or she resided e not available in that location the resident must be given that location upon the first here. T is not met as evidenced iew and resident, Resident Infusion Center staff, Nurse dical Director interviews the t a resident to return to the tic leave for 1 of 3 residents 28/23 Resident #1 had a popointment and prior to the dent's belongings were vere sent with him to the	F	626	F 626 Permitting Residents to Return Facility 1 On 8/28/2023, Resident #1 was discharged from the center. On 4/11/2 the Vice President of Operations re-educated the Nursing Home Administrator, Director of Nursing and Admissions Director on the centers po	024, licy	
	appointment. Resider	nt #1 was not allowed to ollowing the appointment.			residents to return to the center from a physician appointment, therapeutic lea	1	

Facility ID: 923312

						B NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		,	DATE SURVEY COMPLETED
			A. BUILDING	·		С
		345159	B. WING			04/13/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	04/13/2024
				1410 EAST GASTON STREET		
LINCOLN	TON REHABILITATION C	ENTER		LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIOI DATE
F 626	Continued From page	o 18	Ге			
1 020	1.0		F 62		$O_{\rm m} 4/47/2024$ the	
		dent #1 feeling like he was andoned, and was mad.		or leave of absence. (Director of Nursing ar		
		and was mad.		director were re-educ		
	Findings included:			Clinical Director on er		
				and/or responsible pa	-	
	-	al discharge summary dated		communication on the		
		esident #1 was admitted to		appointment, should t		
		/23 due to Resident #1		responsible party cho	0	
		ody weakness and the family the hospital for placement.		from the appointment		
		nitted with throat cancer and		arranged prior to leav		
		was diagnosed with adult			ge eennen	
	-	ncreased general weakness.		2 On 4/15/2024, ar	n audit was	
		charged from the hospital on		completed by the Dire	-	
		d to the facility for skilled		current residents to e	-	
	services.			appointments would h		
	Booidont #1 was adn	nitted to the facility on		arranged for the resid center after the appoi		
		ses which included cancer,		would be allowed to r		
		bry failure, and muscle		and ensure the physic		
	weakness.	,		responsible party are		
				reason for the appoint		
		*1's admission Minimum		leave or leave of abse		
		d 8/28/23 revealed the		residents were identif	•	
		d oriented. The MDS further		further arrangements		
	revealed Resident #1	had a tracheostomy.		the discharge process Social Services Direc		
	A phone interview co	nducted with the Respiratory		Director, Activities Director		
		led on 04/11/24 at 11:05 AM		Director, Business Of		
		assessed on 08/27/23 and		Human Resource Ma		
		had a cuffed tracheostomy		Staff, Minimum Data		
		be changed to an uncuffed		Managers, Licensed I		
	-	se uncuffed tubes allow		Office Staff were re-e	-	
	-	provide no protection from tracheostomy tubes allow		Regional Clinical Dire President of Operatio		
		and offer some protection		right to return to the c		
		RT revealed nursing staff		physician appointmer		
	-	caring for a resident with a		or leave of absence.		
		he RT further revealed he		Unit Managers, Minim		

Facility ID: 923312

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FOR	D: 05/16/2024 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
	345159	B. WING			C / 13/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1410 EAST GASTON STREET		
	CENTER		LINCOLNTON, NC 28092		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
the facility not having RT indicated he did and that the Nurse F Director (MD) would the order to change RT indicated Reside could have waited to when supplies were Nursing (DON) made was made to send R the infusion appointr A phone interview co 04/11/24 at 6:10 PM advised and aware h appointment. Reside he was waiting on th the facility a facility s specific staff membe with all his belonging to the Emergency De appointment with no #1 indicated once he appointment with his revealed to Residen message from the fa the ED after his appo- nurse explained to h him to the ED becau an order. Resident # he was being discha he felt like he was be and was mad. Reside facility. Resident #1	the tracheostomy due to g the supplies needed. The not write physician orders tractitioner (NP) or Medical have to be notified to obtain the tracheostomy type. The nt #1 was not in distress and b have his trach changed obtained but the Director of the RT aware the decision the sident #1 to the ED after	F 6	 26 Coordinator, Business Office M Staff Development Coordinato Prevention Control Officer, Act Director, Medical Records, Rel Program Manager, Admissions and Director or Nursing educat residents or their responsible p ensuring they are aware of the right to return to the center afte appointment, therapeutic leave absence on future therapeutic 3 Starting 4/22/2024, an aud completed daily during the mod clinical meeting 3 times a weel weeks on therapeutic leaves a discharges was completed to e residents on therapeutic leave physician appointment or on le absence have been permitted the center and ensure the phys resident and/or responsible pa notified of the reason for the appointment/therapeutic leave absence. Should the resident a responsible party determine to discharge needs will be arra to the resident leaving the cent 4 The therapeutic leave and discharge audits will be brough Director of Nursing/designee to Quality Assurance and Assessment/Quality Assessme Performance Improvement me monthly. The Quality Assurance 	r, Infection ivities habilitation a Manager ted current party residents er an e or leave of leaves. dit will be rming c for twelve nd/or ensure g going to a eave of to return to sician, rty are or leave of and/or be ent to home anged prior ter. Vor nt by the p the ent and eting ee and	

Facility ID: 923312

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	OF DEFICIENCIES	MEDICAID SERVICES		ECONSTRUCTION		D. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:				PLETED	
			-			С	
		345159	B. WING		04	/13/2024	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LINCOLN	TON REHABILITATION C	ENTER		410 EAST GASTON STREET LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 626	Continued From page	e 20	F 626				
	had no other place to	go. Resident #1 indicated		review the therapeutic leave and	/or		
	he was able to care for himself and contact 911 in case of an emergency.			discharge audits and determine in	f further		
	Nurse #1 on 04/10/24 08/28/23 the infusion that Resident #1 need after his infusion approved what Resident #1 way was further revealed contacted the Admiss was explained by the Resident #1 needed a Center Nurse #1 expla Director Resident #1 the infusion center dive sending the resident the facility Admission unable to care for Re needed to go to the E and the resident coul- was observed by Infu Resident #1 had a ba- belongings and Reside frustrated and confus return to the facility.	a trach change. The Infusion ained to the Admissions did not have any orders and d not feel comfortable to the ED. It was reported by Director that the facility was sident #1 and the resident ED to help find placement d not return to the facility. It ision Center Nurse #1 that ag packed with his dent #1 was observed to be red on not being able to					
	on 04/10/24 at 9:45 A arrived at the infusion belongings with him, was being discharged further revealed Infus contacted the facility #1 could not return to	and it was reported Resident the facility and had to be is appointment. Infusion					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345159	B. WING			C 04/13/2024	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER			410 EAST GASTON STREET INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 626	observe to be in media A phone interview with Director on 04/09/24 a recalled having a con- care center staff and but could not recall and but could not recall any p with Resident #1 from A phone interview con- Resident Representa 10:15 AM revealed R the facility after his ho- more care than the fa- further revealed on 08 contacted by the facil Resident #1 was on h appointment and wou- because the facility co- resident's tracheostor facility Admissions Dii could not return to the she arrived at Reside and the Infusion Cent the facility. It was furth had a bag with his be about being discharge further revealed she to because she felt like a and she had no other	ers and the resident did not ical distress. h the prior Admissions at 6:00 PM revealed she versation with the infusion it was an "ugly conversation" nything that was discussed. d the Admissions Director art of what had occurred n 08/28/23 through 08/31/23. nducted with Resident #1's tive (RR) on 04/11/24 at esident #1 was admitted to ospital stay due to needing mily could assist with. It was 8/28/23 the RR was ity Admissions Director that his way to an infusion and have to be sent to the ED ould not care for the my. The RR stated the rector revealed Resident #1 e facility. The RR revealed nt #1's infusion appointment ter Nurse #1 had contacted d had reiterated the same esident could not return to her revealed Resident #1 longings and was very mad ed without notice. The RR ook Resident #1 home the facility had dumped him	F	626			
	of Nursing (ADON) or						

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X2) MULTIF			. 0938-0391
(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
3. WING		C 04/13/2024	
	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	1410 EAST GASTON STREET		
	LINCOLNTON, NC 28092		
ID PREFIX TAG			(X5) COMPLETION DATE
F 62			
	WING	BUILDING WING STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI,	BUILDING COMP WING 04/ STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON STREET LINCOLNTON, NC 28092 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Facility ID: 923312

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE	SURVEY PLETED
		345159	B. WING _				C 113/2024
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	TON REHABILITATION C	ENTER) EAST GASTON STREET COLNTON, 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 626	during second and the thought Resident #1 with no one realized he way The DON indicated of that Resident #1 wen appointment on 08/28 received a phone call care office. DON state prior Admissions Direcould not return to the An interview with the 04/11/24 at 10:35 AM assessed Resident # facility and was not ne assessed by the RT at obtained to have the A phone Interview with on 04/10/24 at 4:55 F assessed Resident # facility and was not ne assessed by the RT at obtained to have the Interview with the Adr 4:00 PM revealed he DON on 8/28/23 that out to the infusion cen heading to ED for trace Administrator further recommendations an could not write orders been notified about R	ereabouts of Resident #1 ird shift on 08/28/23 with the was still at the hospital, and asn't there on 8/29/23 either. In 08/30/23 it was found out t home from his 8/23 when the facility from Resident #1's primary ed she was not aware the ctor told Resident #1 that he e facility. Nurse Practitioner (NP) on I revealed she had not 1 during his stay in the otified Resident #1 had been and required an order to be resident's trach changed. In the Medical Director (MD) PM revealed he had not 1 during his stay in the otified Resident #1 had been and required an order to be resident's trach changed. In the Medical Director (MD) PM revealed he had not 1 during his stay in the otified Resident #1 had been and required an order to be resident's trach changed. In the Medical Director (MD) PM revealed he had not 1 during his stay in the otified Resident #1 had been and required an order to be resident's trach changed. In the match change for the resident #1 was being sent of the match of the the the the Resident #1 was being sent of the match of the the revealed it was RT's d was not aware the RT is and the physicians had not usident #1.	F6				
F 644 SS=D	Coordination of PASA CFR(s): 483.20(e)(1)	ARR and Assessments (2)	F 6	544			5/14/24

Facility ID: 923312

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2024 APPROVED 0: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345159	B. WING				C 13/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.0	
	ON REHABILITATION C			1	410 EAST GASTON STREET		
LINCOLN	ION REHABILITATION C	ENTER		L	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 644	pre-admission screen (PASARR) program u of this part to the max avoid duplicative testi includes: §483.20(e)(1)Incorpor from the PASARR lev PASARR evaluation r assessment, care pla care. §483.20(e)(2) Referrin all residents with new serious mental disord related condition for le a significant change in This REQUIREMENT by: Based on record revi	ion. hate assessments with the ing and resident review nder Medicaid in subpart C timum extent practicable to ng and effort. Coordination rating the recommendations rel II determination and the eport into a resident's nning, and transitions of ng all level II residents and ly evident or possible er, intellectual disability, or a evel II resident review upon n status assessment. ' is not met as evidenced ew and staff interviews the	F	644	F 644 Coordination of PASARR and		
	and Resident Review for resident with ment admission and reside	e a Preadmission Screening (PASRR) was completed al health diagnosis upon nts with new mental health esidents (Resident #67 and SRR.			Assessments 1 On 4/15/2024, the PASARR for resident #67 and 90 was reviewed with level II PASARR request by the social services director. On 4/15/2024, the so service director was re-educated by th Nursing Home Administrator on ensuri	ocial e	
	1. Review of Residen revealed the resident completed prior to he admitted to the facility had been diagnosed	r admission and was v on 02/10/22. The resident with anxiety disorder on ssive disorder on 6/22/23, disorder (PTSD) on			 all level II PASARR s are correctly applied for upon admission or with any new onset of behaviors. By 4/22/2024, an audit on current resident PASARR s was completed b the social services director ensuring al PASARR s are correct, and any level requests are completed. There were not service and the service of the serv	/ /y 	

Facility ID: 923312

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP	SURVEY LETED	
		345159	B. WING		C 04/13/2024		
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
	ON REHABILITATION C	ENTER		1410 EAST GASTON STREET LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 644	Continued From page	e 25 evel II had been completed	F 644	t other incomplete PASARR⊡s	found		
	per Resident # medic	al records.		during the audit. On 4/15/202 social service director was ed	4, the new lucated on		
	the Social Worker (S)	n 4/11/24 at 8:57 AM with W) revealed he had been ity SW over the past several		the importance of reviewing a PASARR s upon admission, new onset behavior and ensu	with any		
i	years and since that I for completing PASRI	time had been responsible R upon a resident admission		correctly completed. New hire social services department with	es into the ill be		
		ange in condition or behavior n there had been a new ed he would review a		educated on ensuring PASAF and II are completed correctly			
	resident's diagnosis a were admitted and sh	and PASRR level once they nould be notified by nursing if		3 Starting on 4/22/2024, th services director/designee wil	ll audit		
	there had been a cha	been added for a resident or inge in condition to rk for a level II PASRR		PASARR s 3 times a week for weeks to ensure all residents appropriately completed PAS	have a		
	would need to be con	npleted. The SW stated he ware of Resident #67 new		include a level II PASARR if in			
	depressive disorder,	sis of anxiety disorder, major PTSD, and mood (affective)		4 The PASARR audits will by the Director of Nursing/des			
	however based on ne	uld have been an oversight, ew diagnosis and the PASRR, paperwork for a		Quality Assurance and Assessment/Quality Assessm Performance Improvement m			
		d have been completed.		monthly. The Quality Assuran Assessment/Quality Assessm	ient and		
	the Administrator reve	n 4/11/24 at 5:35 PM with ealed a PASRR level II in a timely manner upon		Performance Improvement co review the audits and determined recommendations are needed	ine if further		
	diagnosis or anytime	ent with a mental health a resident has had a change ly added mental health		compliance for care and servi provided during mealtimes for 3 months or when substantial	r minimum of		
	diagnosis. He stated newly added diagnos depressive disorder,	based on Resident #67 is of anxiety disorder, major PTSD, and mood (affective) vel II should have been		has been achieved.			

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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 COMF	
		345159	B. WING				_ 13/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER			1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 644	was diagnosed with n 3/08/24 and unspecifi 3/08/24 upon admissi been completed per F records. During an interview of the Social Worker (SV employed as the facili had been responsible upon a resident admis change in condition o when there had been revealed he would rev and PASRR level on should be notified by had been added for a a change in condition for a level II PASRR v The SW stated Resid diagnosis and level of overlooked, however admission diagnosis of and unspecified mood preadmission PASRR PASRR level II should During an interview of the Administrator reve should be completed admission for a reside diagnosis or anytime of condition or a newl diagnosis. He stated I admission diagnosis of	r admission and was r on 3/08/24. The resident hajor depressive disorder on ed mood disorder on on. No PASRR level II had Resident #90 medical n 4/11/24 at 8:57 AM with N) revealed he had been ity SW and since that time for completing PASRR ssion if needed, when a r behavior had occurred, or a new diagnosis. He view a resident's diagnosis re they were admitted and nursing if a new diagnosis resident or there had been to determine if paperwork vould need to be completed. ent #90 admission f PASRR had simply been based on Resident #90 of major depressive disorder d disorder and the Elevel I, paperwork for a d have been completed. In 4/11/24 at 5:35 PM with ealed a PASRR level II in a timely manner upon ent with a mental health a resident has had a change y added mental health based on Resident #90 of major depressive disorder d disorder and the level I, paperwork for a d have been completed. If a timely manner upon ent with a mental health a resident has had a change y added mental health based on Resident #90 of major depressive disorder d disorder a PASRR level II in a timely manner upon ent with a mental health based on Resident #90 of major depressive disorder d disorder a PASRR level II	F	644			

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STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	O. 0938-039 E SURVEY PLETED	
		345159	B. WING			C 04/13/2024		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				1	410 EAST GASTON STREET			
LINCOLN	TON REHABILITATION C	ENTER		L	INCOLNTON, 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 B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 677 SS=G	ADL Care Provided fo CFR(s): 483.24(a)(2)	or Dependent Residents	F	677			5/14/24	
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio resident and staff inter provide incontinence of 3 residents reviews care (Resident #53 at #53 was noted to hav right buttocks when ir provided, and Reside was sore. Findings included: 1. Resident #53 was 10/02/23 with diagnos diabetes mellitus. The quarterly Minimu assessment dated 02 Resident #53 was con extensive assistance always incontinent of refusal of care was no reference period. Resident #53 was inte 04/08/24 at 9:49 AM. stated she had been after breakfast at 8:48 (NA) #1 had answere AM and stated she w	 is not met as evidenced is, record review, and erview the facility failed to care when requested for 2 ed for activities of daily living nd Resident #80). Resident is new open area to the nocontinence care was ent #53 reported the area admitted to the facility on ses of hip fracture and m Data Set (MDS) 			 F 677 □ ADL Care Provided for Dependent Residents 1 On 4/8/2024, resident #80 was provided with incontinent care by the L Manager and Assistant Director of Nursing upon notification of the resider need. On 4/8/30324, resident # 53 was provided incontinent care by the NA #' and the Unit Manager upon notification the residents need. On 4/8/2024, the Certified Nursing Assistant # 1 was verbally re-educated by the Unit Managon ensuring care and services are provided upon resident request. The Certified Nursing Assistant #1 no longer works at the center. 2 On 4/15/2024, the Director Nursing/designee interviewed all reside and or responsible parties to ensure the were receiving care upon request. The were no other residents identified as m having care and services provided upor request. By 4/19/2024, the Director of Nursing, Staff Development Coordinate and Unit Managers re-educated the nursing staff on ensuring that a resider receives care and services upon request. 3 Starting 4/22/2024, the Director of 	nts s 1 o of ger er er ents ley ere ot on or nt est.		

Facility ID: 923312

				OMB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>` `</i>		(X3) DATE SURVEY COMPLETED
				С
	345159	B. WING		04/13/2024
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ON REHABILITATION C	ENTER		1410 EAST GASTON STREET LINCOLNTON, NC 28092	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE COMPLETION
Continued From page	e 28	F 67	7	
care but would return Resident #53 stated I the room and she wa she knew NA #1 had upset over having to On 04/08/24 at 9:58 // that Resident #53 new #1 stated she was pa and that she knew the for incontinence care the room. An observation was of 10:18 AM of incontine with NA #1 and Unit N was noted to have bo the time of the observ redness on her bottor "sore". The stool was the resident's skin. On 04/08/24 at 11:11 conducted with NA #' stated Resident #53 h around 8:30-8:45 AM be changed. NA #1 si and turned the call lig provide incontinence on the halls. She stat to Resident #53's roo had forgotten. On 04/11/24 at 12:21 conducted with Unit N interview she stated r	after trays were off the hall. NA #1 had not returned to s sitting in feces. She stated a lot to do and she was not wait. AM the surveyor told NA #1 eded incontinence care. NA ssing out soap on the hall e resident had been waiting but had not been back in conducted on 04/08/24 at ence care for Resident #53 Manager #1. Resident #53 Manager #1. Resident #53 owel movement in her brief at vation. She was noted with m and stated the area was, not observed to be dried to AM an interview was 1. During the interview she had turned her call light on and stated she needed to tated she went into the room sht off because she could not care while meal trays were ed she was going to go back m and provide care but she PM an interview was Manager #1. During the no staff member had ever		 Nursing, unit managers and license nurses will perform daily audits 5 to week for 4 weeks, then 3 times a v 4 weeks, then 2 times a week for 4 for a period of 3 months to ensure residents are provided with care ar services upon request. 4 The resident rights audits will brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assurance and Performance Improvement meeting monthly. Th Quality Assurance and Assessment and Performance and Performance Improvement commit review the audits and determine if recommendations are needed to o compliance for care and services to provided upon request for a minim 	mes a veek for weeks the nd be y e nd tee will further btain peing um of 3
	S FOR MEDICARE & F DEFICIENCIES CORRECTION COVIDER OR SUPPLIER ON REHABILITATION C SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page care but would return Resident #53 stated I the room and she wa she knew NA #1 had upset over having to On 04/08/24 at 9:58 / that Resident #53 new #1 stated she was pa and that she knew the for incontinence care the room. An observation was continent with NA #1 and Unit I was noted to have bo the time of the observer redness on her botton "sore". The stool was the resident's skin. On 04/08/24 at 11:11 conducted with NA #1 stated Resident #53 I around 8:30-8:45 AM be changed. NA #1 s and turned the call lig provide incontinence on the halls. She stated r to Resident #53's roo had forgotten. On 04/11/24 at 12:21 conducted with Unit I interview she stated r told Nurse Aides that incontinence care wh	CORRECTION IDENTIFICATION NUMBER: 345159 SOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 care but would return after trays were off the hall. Resident #53 stated NA #1 had not returned to the room and she was sitting in feces. She stated she knew NA #1 had a lot to do and she was not upset over having to wait. On 04/08/24 at 9:58 AM the surveyor told NA #1 that Resident #53 needed incontinence care. NA #1 stated she was passing out soap on the hall and that she knew the resident had been waiting for incontinence care but had not been back in the room. An observation was conducted on 04/08/24 at 10:18 AM of incontinence care for Resident #53 was noted to have bowel movement in her brief at the time of the observation. She was noted with redness on her bottom and stated the area was, "sore". The stool was not observed to be dried to the resident*53 had turned her call light on around 8:30-8:45 AM and stated she needed to be changed. NA #1 stated she went into the room and turned the call light off because she could not provide incontinence care while meal trays were on the halls. She stated she was going to go back to Resident #53's room and provide care but she	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 345159 B. WING	S FOR MEDICARE & MEDICAID SERVICES P DEFICIENCIES (X1) PROVIDER/SUPPLIERCLIA A BUILDING A BUILDING A BUILDING A BUILDING CONDER OR SUPPLIER STREETADDRESS, CITY, STATE, ZIP CODE CONDER OR SUPPLIER D ON REHABILITATION CENTER D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 28 C care but would return after trays were off the hall. Resident #53 stated NA #1 had not returned to the room and she was siting in foces. She stated she knew INA #1 had a lot to do and she was not upset over having to wait. F 677 Continued From page 28 F 677 Continued From base assing out soap on the hall and that she knew the resident had been waiting for incontinence care for Resident #53 aduits and Utabate on 04/08/24 at 10:18 AM of incontinence care for Resident #53 awas noted to have bowel movement in her brief at the time of the observation. She was noted with redenses on her bottom and stated the area was, "core". The stold was not observed to be dried to the resident #53 had uthere her call light of for secause sh

If continuation sheet Page 29 of 39

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345159	B. WING				C 13/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
LINCOLN	TON REHABILITATION C	ENTER			410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	actively assisting som should stop what they incontinence care. Sh redness to her bottom NA #1 with incontinent the wound nurse. On 04/08/24 at 5:15 F written by the Assista (ADON) revealed Res new open area to the caused by excoriation (a cream used to treat applied and the ADOI wound Physician to st A physician order date Resident #53 receive be applied to the reside three times a day for On 04/11/24 at 3:24 F conducted with the Assi (ADON). During the in the acting wound nursi she went in and asse 04/08/24. She stated (scraped or abraded st buttocks. The ADON Oxide for treatment of felt the area was caus sat in the bed and not because she had this the facility. A wound note written dated 04/09/24 reveating wound care assessm	heone with a meal, they 're doing and provide he stated Resident #53 had h when she was assisting he care, and she notified PM a nursing progress note nt Director of Nursing sident #53 was noted with a right buttocks which was h. "A new order for zinc oxide t minor skin irritations) was N left a message for the ee Resident #53". ed 04/08/24 revealed d an order for zinc oxide to dents buttocks every shift a duration of 30 days.	F	677			

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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:			E CONSTRUCTION	(X3) DATE	
		345159	B. WING				C / 13/2024
NAME OF P	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LINCOLN	TON REHABILITATION C	ENTER			1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 677	the right upper buttoc (cm) length by 0.6 cm duration of the wound days. On 04/09/24 at 8:55 A conducted with the D She stated NA #1 sho when the resident asl staff were able to pro- meal trays were on th revealed she did not f wait for incontinence practice. 2. Resident #80 was 07/05/22 with diagnos hypertension. The quarterly Minimu assessment dated 01 Resident #80 was con extensive assistance always incontinent of refusal of care was no reference period. An observation condu AM revealed Resider notified NA #1 she ha observed entering the	AM an interview was irector of Nursing (DON). Duld have provided care ked. The interview revealed vide care regardless of if ne hall. The interview feel like having residents care was an acceptable admitted to the facility on ses of diabetes mellitus and m Data Set (MDS) /31/24 revealed that gnitively intact, required with toileting, and was bladder and bowel. No oted during the assessment	F	677			
	04/08/24 at 10:45 AM stated she had been 9:30 AM and knew th looking at the clock o	I. During the interview she sitting in a soiled brief since is because she had been n the wall. She stated she he was sitting in a soiled					

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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 PLETED
		345159	B. WING				C 13/2024
NAME OF P	ROVIDER OR SUPPLIER		1	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LINCOLN	TON REHABILITATION C	ENTER			1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 677	acknowledged her an she was still sitting in needed to be change On 04/08/24 at 10:50 Manager #1 that Res soiled brief. An observation was of 10:57 AM of Unit Mar Director of Nursing (A incontinence care to I #80's top sheet, bed observed to be soiled was observed to have the thighs and coverin complete bed change nurses provided incor #80. On 04/08/24 at 9:49 A conducted with NA # stated Resident #80 f be changed however running water down th bed bath. The intervie planned on completin changing Resident #80 h brief since 9:30 AM. On 04/11/24 at 12:21 conducted with Unit M #1 stated once you se provide the care or le know so the care was stated she had to cor	AM an interview was A an ager #1. Unit Manager be a call light on you should t another staff member a provided. Unit Manager #1 anplete an entire bed change to incontinence and that	F	677			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FOR	D: 05/16/2024 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345159	B. WING				C / 13/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
LINCOLN	TON REHABILITATION C	ENTER			110 EAST GASTON STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	typically the Nurse Aid providing care. On 04/11/23 at 3:24 F conducted with the As (ADON). The ADON s Resident #80 with inc complete a bed chang The ADON stated Nur providing care upon re On 04/09/24 at 8:55 A conducted with the Di She stated NA #1 sho when the residents as she did not feel like ha incontinence care was QAPI/QAA Improvem CFR(s): 483.75(c)(d)(§483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impro-	des were good about PM an interview was sistant Director of Nursing stated she did assist ontinence care and had to ge due to the incontinence. rse Aides should be esident request. AM an interview was rector of Nursing (DON). ould have provided care sked. The interview revealed aving residents wait for s an acceptable practice. ent Activities e)(g)(2)(i)(ii) eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and		377			5/14/24	

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345159	B. WING				C 13/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
LINCOLN	TON REHABILITATION C	ENTER			1410 EAST GASTON STREET LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 867	systems to identify, or information from all de not limited to the facili §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methodo development, monitor §483.75(c)(4) Facility including the methodo systematically identify analyze and use data adverse events in the facility will use the dat prevent adverse event §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff	bllect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, blogy and frequency for such ring, and evaluation. adverse event monitoring, by which the facility will r, report, track, investigate, and information relating to facility, including how the ta to develop activities to ts. systematic analysis and clility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained. clility will develop and dressing: a systematic approach to causes of problems	F	86	57		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		345159	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	TON REHABILITATION C	ENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	of its performance im- ensure that improvem §483.75(e) Program a §483.75(e)(1) The fac- performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sec	ill monitor the effectiveness provement activities to nents are sustained. activities. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the s of their performance s, the facility must conduct improvement projects. The ey of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data is described in paragraphs tion.	F	867			
	collection and analysi (c) and (d) of this sec §483.75(g) Quality as	is described in paragraphs tion. ssessment and assurance.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2024 / APPROVED) <u>. 0938-0391</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345159	B. WING_				C 13/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
			1410 EAST GASTON STREET					
LINCOLN	TON REHABILITATION C	ENTER		LI	NCOLNTON, NC 28092			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 867	assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under t resulting from drug re available data to mak This REQUIREMENT by: Based on observation resident and staff inte Assessment and Assu failed to maintain imp monitor interventions the areas of dignity ar notification of change facility's QAA Commit deficient practice for a 8/28/23 and implement ensure compliance was safe and orderly disch deficiencies were cite investigation survey of recited on the current complaint investigation facility's continued fail	reports to the facility's esignated person(s) rning body regarding its plementation of the QAPI er paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including he QAPI program and data gimen reviews, and act on e improvements. ' is not met as evidenced ns, record reviews and rviews, the facility's Quality urance (QAA) Committee lemented procedures and previously put in place in nd respect (F550) and (F580). Additionally, the tee failed to identify a discharge that occurred on nt corrective action to as sustained in the area of harge (F624). These 3 d on the complaint f 2/15/24 and subsequently recertification and n survey of 4/13/24. The lure during two surveys of ern of the facility's inability to AA program.	F	867	 F867 QAPI/QAA Improvement Activities 1 On 4/8/2024, resident #80 was provided with incontinent care by the U Manager and Assistant Director of Nursing upon notification of the residen need. On 8/28/2023, Resident #1 was discharged from the center. On 8/30/2023, the physician for Resident # was notified of the resident not being allowed to return to the center after a therapeutic leave outside of the center. On 4/11/2024, an ADHOC Quality Assessment and Performance Improvement/Quality Assessment and Assurance was conducted by the Vice President of Operations. 2 On 4/8/2024, the Certified Nursing Assistant # 1 was verbally re-educated the Unit Manager on ensuring care and services are provided upon resident request. The Certified Nursing Assistant #1 no longer works at the center. On # 	nit ts t1,		

Event ID: Q7FU11

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						10.0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>		
		345159	B. WING			С
		545159				4/13/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	TON REHABILITATION C	ENTER		1410 EAST GASTON STREET		
	1			LINCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From page	e 36	F 86	37		
		ord review and resident and		4/11/2024, the Director of	Nursing was	
		acility failed to treat a resident		re-educated by the Region	-	
		by not providing incontinent		Director on notification to t		
	care when requested			residents who have gone of		
		Resident #80). Resident #80		leave, physician appointm		
	stated it made her up	oset to sit in a soiled brief and		absence for any resident v	vho would not	
	made her "feel like a	third-class citizen" and she		be allowed to return to the		
	paid her bill like ever	yone else.		appointment. On 4/11/202		
				President of Operations re		
		investigation survey of		Nursing Home Administrat		
		ailed to treat a resident in a		Nursing and Admissions D		
	dignified manner when a Nurse Aide (NA) was rough and pushing on her during a transfer. This			centers policy allowing res		
				to the center from a a phys		
		el "unsafe" during the		appointment, therapeutic l		
		ed this was a dignity issue.		absence. On 4/17/2024, the Nursing and Social Service		
	Additionally, the facility failed to assist a resident at eye level during a meal reviewed for dignity.			re-educated by the Region		
	at eye level during a	mean reviewed for dignity.		Director on ensuring the re		
	An interview conduct	ed with the Administrator		responsible party has rece		
		A committee and Director of		communication on the pur		
		1/13/24 at 11:00 AM revealed		appointment and should th		
		ssed frequently at quarterly		and/or responsible party c		
		mer services and respect		discharge from the appoin		
	•	ne DON further revealed she		discharge paperwork and		
	did not know why the	se incidents had occurred.		have been arranged prior	-	
				center. By 4/17/2024, the	•	
	F 580: Based on record review, resident, Infusion			Clinical Director re-educate		
	Center Nurse, Nurse Practitioner, Medical			nurses, the Social Service		
	Director, and staff interviews the facility failed to			Rehabilitation Director, Ac		
	notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were			Maintenance Director, Bus		
				Manager, Human Resource		
				Receptionist Staff, Minimu Director, Unit Managers, L		
				and Business Office Staff		
		vere sent with him to the		re-educated on the resider		
	appointment.			return to the center after a		
				appointment, therapeutic		
	During the complaint	investigation survey of		absence.		
		ailed to notify the Physician				

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	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY	
	D PLAN OF CORRECTION		A. BUILDING			COMPLETED	
			_				с
		345159	B. WING			04/	13/2024
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				14	10 EAST GASTON STREET		
LINCOLN	TON REHABILITATION C	ENTER		LI	INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETIC DATE	
F 867	Continued From page	e 37	F 8	67			
		l upon admission and failed		.01	3 On 4/11/2023, a Quality Assuranc	e	
		n when the resident's wound			and Assessment/Quality Assurance an		
	had started to deterio			Performance Improvement meeting wa			
				conducted by the Vice President of			
	An interview conduct			Operations, Director of Clinical Service	es		
	who also headed QA			and Regional Clinical Director on the			
	Nursing (DON) on 04			components for citations F550, F580 a			
	the facility had discus			F624. The Nursing Home Administrato	r,		
	QAA meetings notific			Director of Nursing, Social services	-		
	revealed nursing staf			Director, Activity Director, Rehabilitatio			
	appropriate notification educate and put rules			Therapy Director, Admissions Director Maintenance Director, Staff Developm			
	notification.			Coordinator, Unit Managers, Infection	on		
	nounouton.				Preventionist, Minimum Data Set		
	F 624: Based on reco			Coordinators, Business Office Manage	er,		
	Resident Representa			Environmental Services Manager and			
	staff, Nurse Practitior			Certified Dietary Manager were			
	interviews the facility			re-educated in the process to review the	ne		
	orderly discharge for			audits and ensure future			
	#1). On 8/28/23 Resi			recommendations to improve the curre			
	medical appointment			practice and track performance ensuring	ng		
	the resident's belong			compliance is achieved through the monthly Quality Assurance and			
	and were sent with hi			Assessment/Quality Assurance and			
	Resident #1 was not provided with discharge paperwork or discharge instructions and did not				Performance Improvement process.		
		happening. The discharge			·		
		ied, home health services			4 Starting on 4/16/2024, the Nursing	9	
	were not ordered at t			Home Administrator will present the	-		
	the resident was not			findings of the Quality Assurance and			
	his needs were met.			Assessment/Quality Assurance and			
	feeling like he was being thrown out, abandoned,				Performance Improvement committee		
	and was mad.				meeting minutes monthly to the Vice		
	During the compleint	investigation survey of			President of Operation and Regional Clinical Director to ensure compliance		
	02/15/24 the facility			with agenda items to include F550, F5	80		
	-	charge by not communicating			and F624. This review will continue fo		
		wound care treatments and			period of 6 months.	. u	
		medical equipment was					
		nt reviewed for a safe and					1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 05/16/202 FORM APPROVE OMB NO. 0938-039	Ð
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345159		345159	B. WING		_	C 04/13/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	04/10/2024	
LINCOLNTON REHABILITATION CENTER				1410 EAST GASTON STRE			
	· • · · · • · • · • · • · • • • •			LINCOLNTON, NC 2809	92	1	
(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	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		I
F 867	who also headed QAA Nursing (DON) on 04 the facility had discus QAA meetings about The DON further reve why discharges had b would be put into place	e 38 ed with the Administrator A committee and Director of /13/24 at 11:00 AM revealed sed frequently at quarterly safe and orderly discharges. ealed she could not recall been an issue, but steps be to guarantee residents ged unsafe in the future.	F 86	7			

Facility ID: 923312

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