

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345441	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Gastonia Health & Rehab Center			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 Oak Hollow Road , Gastonia, North Carolina, 28054	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted 10/08/24 through 10/14/24. The survey team re-entered the building on 10/23/25 to gather additional information, therefore the exit date was changed to 10/23/25. Event ID#1D8E20-H1. The following intakes were investigated 2631107 and 2638314. 2 of the 3 complaint allegations resulted in deficiency.	F0000		10/31/2025
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide incontinence care to a resident prior to her wetting through her brief, turn sheet, and bed sheet for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/22/23 and readmitted on 09/29/25 with diagnoses which included atrial fibrillation, diabetes mellitus, decreased mobility, osteoarthritis and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) assessment dated 07/17/25 revealed Resident #1 was cognitively intact with no behaviors and no impairment of her upper or lower extremities and used a wheelchair for mobility. The assessment also revealed the resident was dependent for toileting, required 2 persons assistance with toileting and was incontinent of both bladder and bowel.	F0677	New POC Posted. Please see attached.	11/04/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0677 SS = D	<p>Continued from page 1</p> <p>A urinary incontinence care plan last revised on 10/14/25 revealed Resident #1 was incontinent of urine. The goal was for Resident #1 to receive assistance with toileting, be maintained comfortable, clean and dry and free from skin breakdown. The interventions included providing incontinence care as needed and monitoring peri-area for redness, irritation, skin excoriation and breakdown.</p> <p>An activity of daily living self- care performance deficit care plan last revised on 10/14/25 revealed Resident #1 required assistance with all ADL related to limited mobility. The goal was for Resident #1's needs to be met with staff assistance as needed. The interventions included encourage Resident #1 to use bell to call for assistance, and 2 persons assist with bed mobility and with all care while resident is in bed.</p> <p>An observation of incontinence care on 10/14/25 at 10:30 AM, revealed Resident #1 was being assisted with a brief change by Nurse Aide (NA) #5 and NA #6. When NA #5 and NA #6 pulled back Resident #1's bed covers, the bed sheet was visibly wet under the resident. NA #5 pulled back the resident's brief and it was saturated from the front of the brief to the back of the brief with urine and the inside of the brief had begun to bunch up. NA #6 cleaned the resident from front to back and then NA #5 and NA #6 assisted the resident to turn on her side so NA #6 could clean her back side. NA #6 then placed a clean brief under the resident and she and NA #5 turned the resident to get the brief placed on her and get the soiled brief off the resident. When NA #5 threw the soiled brief in the trash can it made a loud thud. NA #5 and NA #6 then placed clothing on the resident so she could get up in her wheelchair. Once the resident had been transferred to her wheelchair there was a visible wet spot on the turn sheet and the bed sheet under it was visibly wet with urine as well. NA #7 came in and stripped the wet turn sheet and bed sheet from the bed.</p> <p>An interview on 10/14/25 at 10:55 AM with Resident #1 revealed she had not been provided incontinence care since 1:30 AM on 10/14/25 until she received it at 10:30 AM. Resident #1 stated NA #8 who was caring for her during the 7:00 PM to 7:00 AM shift had come in and told her that she would be back to change her brief around 6:00 AM but said NA #8 never came back to change her. Resident #1 further stated NA #7 who was assigned to care for her during the 7:00 AM to 7:00 PM shift on 10/14/25 had come into her room and told her she would be back with another NA to change her but said she never came back before NA #5 and NA #6 came in to get</p>	F0677		

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F0677 SS = D	<p>Continued from page 2</p> <p>her ready to get up in the wheelchair and they had changed her brief. Resident #1 stated they usually changed her two to three times during the night because she urinated frequently but said they had only changed her once after midnight at 1:30 AM. Resident #1 indicated she knew she was wet because when she woke up sometime between 5:30 AM and 6:00 AM she felt her wet sheet against her leg and it was cold. The resident further indicated she had eaten her breakfast in bed in her wet brief but said she was more concerned with eating because her blood sugar had been low earlier at 6:00 AM.</p> <p>A telephone interview on 10/14/25 at 3:20 PM with NA #8 who was assigned to care for Resident #1 during the night shift on 10/14/25 revealed she had not changed Resident #1 after 1:30 AM. She stated it had been a busy night and she had gone to change the resident around 6:00 AM and the resident was shaking and told NA #8 she thought her blood sugar was low and asked her to get the nurse. NA #8 stated she was going back to change Resident #1 around 6:30 AM to 6:45 AM and said her coworker had left shift early and was not available to assist her so she had reported off to 1st shift (could not recall who she reported off to) that Resident #1 needed to be changed. NA #8 further stated Resident #1 should have been changed one additional time during the night but said it was difficult when there were only 2 NAs working to get both NAs in one room to change the resident. NA #8 indicated she had not asked the nurse for assistance because she had been busy with other tasks but said that she probably should have asked her to assist and changed the resident.</p> <p>An interview on 10/14/25 at 11:10 AM with NA #5 and NA #6 revealed they were not assigned to care for Resident #1 but said they had been asked to lift her out of bed into her wheelchair by Unit Manager #1. NA #5 and NA #6 both stated when they went into the room to get her ready for the lift, they found her wet through her brief and turn sheet and onto her bed sheet, so they had provided her with incontinence care prior to lifting her in the mechanical lift into her wheelchair. Both NAs stated they were not assigned to care for the resident but had been asked to get her up, so they had changed her prior to getting her up in the wheelchair.</p> <p>An interview on 10/14/25 at 2:08 PM with NA #7 who was assigned to care for Resident #1 during the 7:00 AM to 7:00 PM shift revealed she was working her way towards Resident #1 but had not gotten to her before NA #5 and NA #6 had changed her to get her up in her wheelchair. NA #7 stated Resident #1 had told her that she had not been changed since 1:30 AM and said the resident should</p>	F0677		

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F0677 SS = D	<p>Continued from page 3 have been changed twice more during the night shift. NA #7 stated she had to wait until there was another NA available to help her change Resident #1 and said Unit Manager #1 had pulled an NA from the rehabilitation floor to come assist with Resident #1's care and getting her up in the wheelchair. NA #7 further stated no one had reported off to her that the resident had not been changed but once during the night but said the resident had told her and she was waiting for another staff member's assistance to get her changed.</p> <p>An interview with Unit Manager #1 on 10/14/25 at 3:35 PM revealed she was not aware that Resident #1 had gone from 1:30 AM to 10:30 AM on 10/14/25 without being provided incontinence care. She stated no one had asked her for assistance and said she assisted with care to residents all the time. Unit Manager #1 stated NA #7 was an agency NA and probably was waiting until one of the other NAs was free to assist. Unit Manager #1 further stated it was their expectation that residents be rounded on every 2 to 3 hours and checked and changed as needed. She said that no resident should go from 1:30 AM to 10:30 AM without being checked and changed several times.</p> <p>The Director of Nursing (DON) was not available for interview.</p>	F0677		
F0689 SS = G	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and resident, staff, manufacturer 's representative, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to: a.) supervise Resident #1 during a shower when Nurse Aide (NA) #1 turned away from Resident #1 to gather supplies on 09/18/25 and Resident #1 fell from the shower chair to the shower room floor. No pain or injury was noted from this incident; b.)</p>	F0689	New POC completed. Please see attached.	11/04/2025

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F0689 SS = G	<p>Continued from page 4 provide a safe transfer for Resident #1 when NA #1 was transferring the resident from the bed to wheelchair using the mechanical lift. During the transfer and while Resident #1 was suspended approximately 4 to 5 feet from the floor, the lift tilted to one side and the resident fell while still in the sling onto the floor on her back. Then the mechanical lift fell on top of Resident #1 with the lift bar striking her on the top of her head. Resident #1 was evaluated at the hospital and diagnosed with a left calcaneal fracture (fracture of the heel bone) and a left anterior talus (the bone in the foot that connects the ankle to the leg) fracture and returned to the facility with a leg immobilizer and non-weight bearing orders pending orthopedic evaluation; c.) transfer Resident #1 safely when NA #5 and NA #6 had to manually stabilize the mechanical lift when the left back lift wheel lifted off the floor while the resident was suspended in the lift sling. Two additional staff assisted in completing the transfer safely with no injuries to the resident. It was observed after the transfer, the brand of lift sling used for the transfer was not the same brand as the mechanical lift utilized by the facility which does not align with the manufacturer's recommendations; and d.) transfer Resident #1 out of bed with the mechanical lift using a lift sling that was the same brand as the brand of mechanical lift utilized by the facility. In addition, an interview revealed the NAs were responsible for determining the sling size a resident required for mechanical lifts. This deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1).</p> <p>The findings included:</p> <p>1. Resident #1 was admitted to the facility on 12/22/23 with diagnoses which included atrial fibrillation, decreased mobility, osteoarthritis, diabetes mellitus, morbid obesity, and non-Alzheimer's dementia.</p> <p>A Care Area Assessment summary dated 12/02/24 revealed Resident #1 was at risk for falls due to her dementia, incontinence, medications, lack of mobility, and functional decline in her activities of daily living (ADL). The summary indicated interventions were in place and updated, changed and/or added as needed.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 07/17/25 revealed Resident #1 was cognitively intact with no behaviors and no impairment of upper or lower extremities and used wheelchair for mobility. The assessment also revealed the resident was dependent for toileting, bathing, dressing and transfers, and required substantial to maximal assistance with</p>	F0689		

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F0689 SS = G	<p>Continued from page 5 personal hygiene, bed mobility, and partial to moderate assistance with mobility in her wheelchair. In addition, the resident's weight was documented as 304 pounds.</p> <p>An activity of daily living care plan dated 07/24/25 revealed Resident #1 had an ADL self-care performance deficit related to limited mobility. The goal was for Resident #1 to have needs met with staff assistance as needed. The interventions included two staff assistance with bed mobility and with care while in bed, required assist bars to aid in bed mobility, required two staff assist with mechanical lift and encourage the resident to use call bell for assistance.</p> <p>A falls care plan dated 07/24/25 revealed Resident #1 was at risk of falls characterized by history of falls/injury, multiple risk factors related to: dementia, confusion, medication use, incontinence, poor safety awareness and psychiatric disorder. The goal was to minimize falls with injuries through the next review. The interventions included fall prevention program per facility routine, encourage resident to get out of bed for meals as she agrees and/or wishes, bed in lowest position and fall risk assessments quarterly and as needed.</p> <p>a. During an interview with Resident #1 on 10/08/25 at 2:25 PM she revealed that on 09/18/25, NA #1 and NA #2 transferred her from her wheelchair into a bariatric shower chair. The resident stated she was not all the way back in the chair so NA #1 requested assistance from Nurse #3 to reposition the resident in the shower chair. Resident #1 further stated she could tell that she was not positioned all the way back in the chair and said it was a different chair than she was used to because her feet did not touch the floor in the chair. She explained that the other bariatric chair allowed her to keep her feet on the floor and gave her a sense of balance while in the shower chair. Resident #1 indicated she told NA #1 that she was in the wrong shower chair because her feet did not touch the floor and said NA #1 told her she was okay in the chair she was in. Resident #1 stated NA #1 turned away from her to get supplies and the shower chair started to tip but NA #1 was able to turn back around and catch her and the chair before she fell. Resident #1 further stated NA #1 turned away from her again to get supplies and this time Resident #1 said the chair tipped forward and she fell out of the chair onto the floor on her left side hitting her left arm and shoulder on the shower floor. Resident #1 stated NA #1 tried to grab her right arm to stop her from falling but was unable to stop the fall. Resident #1 said she screamed as she was falling</p>	F0689		

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F0689 SS = G	<p>Continued from page 6 and then NA #1 screamed for help and three additional staff members came in the shower room. Resident #1 stated NA #1, NA #2, Nurse #3, and the Speech Therapist (ST) got her up with the lift and back in her wheelchair and then transferred her back to bed. Resident #1 further stated she had not gone out to the hospital after the fall because she had been assessed as having no injury from the fall. Resident #1 further indicated after the fall in the shower room she had two persons come in to provide her care.</p> <p>A telephone interview was conducted with NA #1 on 10/10/25 at 11:12 AM. She was assigned to care for Resident #1 on the 7:00 AM to 7:00 PM shift on 09/18/25. NA #1 stated Resident #1's first fall with her happened right after lunch time on 09/18/25 when she had the resident in the shower room. She and NA #3 had transferred the resident via mechanical lift into the shower chair from her wheelchair in the shower room and NA #3 left the shower room to care for her assigned residents. Resident #1 scooted forward in the shower chair to get her feet on the floor. NA #1 said she turned her back to the resident to get some supplies and the resident started going forward in the shower chair towards the floor. NA #1 went behind the resident and gently sat her down on the floor. NA #1 stated the resident screamed and she screamed for help. Nurse #3 and NA #2 and NA #3 came into the shower room. She stated NA #2 left the shower room to get the mechanical lift and NA #3 went to get the vital signs machine. NA #2 asked the Speech Therapist (ST) to come in and assist with getting Resident #1 up off the shower room floor and into her wheelchair with the lift. NA #1 stated she, NA #2, Nurse #3 and the ST got Resident #1 up with the lift and safely transferred her to her wheelchair and then transferred her from her wheelchair to her bed.</p> <p>An interview on 10/08/25 at 12:20 PM with NA #2 revealed she recalled Resident #1's fall on 9/18/25 in the shower room. NA #2 stated she heard the resident scream and went into the shower room, and she was on the floor curled up in a ball lying on her left side crying in the corner shower stall. She said the shower chair was being lifted back up by NA #1. NA #2 stated Resident #1 told her she fell out of the shower chair onto her left side, and the shower chair hit her on the back of the head as she was falling to the floor. NA #2 further stated Nurse #3 assessed Resident #1 on the floor of the shower room before they moved her and determined that she had no visible injuries. NA #2 indicated once the resident was assessed she, NA #1, Nurse #3 and the ST transferred Resident #1 from the floor to her wheelchair using the mechanical lift and</p>	F0689		

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F0689 SS = G	<p>Continued from page 7 then took her to her room and transferred lifted her from the wheelchair to the bed.</p> <p>An interview on 10/08/25 at 1:24 PM with the Speech Therapist (ST) revealed he was in the hallway on 09/29/25 and NA #2 asked if he could assist with getting Resident #1 up off the shower floor with the mechanical lift. The ST stated he was used to being asked to assist with residents because he was a big guy and could move residents that others were not able to move. He stated when he entered the shower room the resident was on the shower room floor lying on her left side. The ST assisted other staff (could not recall whom but said there were 3 other staff in the room) with getting the mechanical lift sling properly aligned under the resident and then assisted with lifting her from the floor to her wheelchair in the mechanical lift. The ST further stated Resident #1 was coherent and able to follow directions when he assisted with using the mechanical lift to move her from the floor to her wheelchair and then transferring Resident #1 back to bed she was not crying or complaining of any pain.</p> <p>Review of a fall report completed on 09/18/25 at 3:25 PM by Nurse #3 who was assigned to care for Resident #1 during the 7:00 AM to 7:00 PM shift revealed the following: "During shower, staff reported the resident was moving in an attempt to re-adjust self in shower chair, causing the shower chair to tilt forward. The resident began to slide requiring staff to lower her to floor and call for help." The inter-disciplinary team met following the fall and reviewed the fall based on the information provided by NA #1 that the resident was in the shower and attempted to reposition and slipped off the shower chair. The intervention put into place was for two-persons assistance in the shower. The resident was recorded as being at risk for falls related to morbid obesity, delusional disorder, hallucinations, unsteady gait, and abnormal posture. The resident's care plan was updated, notifications completed, and plan of care was to continue.</p> <p>A nurse progress note dated 09/18/25 and written by Nurse #3 revealed that during shower resident attempted to re-adjust self in shower chair and chair tilted. Staff had to lower the resident to ground and call for help per staff.</p> <p>A second nurse progress note dated 09/18/25 and written by Nurse #3 was an addendum to previous fall note that resident had no injury noted, vitals were obtained, unit manager, emergency contact and physician were notified of resident's fall.</p>	F0689		

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F0689 SS = G	<p>Continued from page 8</p> <p>A telephone interview on 10/08/25 at 5:07 PM, with Nurse #3 revealed 09/18/25 was her first day working at the facility and she was sitting at the desk charting and NA #1 opened the door to the shower room and asked for help in repositioning Resident #1 in the shower chair. Nurse #3 stated she helped try to reposition the resident in the chair but said the resident did not seem to be comfortable in the shower chair and kept saying that she was in the wrong chair and she was used to the other shower chair. Nurse #3 stated she asked NA #1 if they needed to switch her chair and NA #1 said no that Resident #1 was fine in the chair she was in. Nurse #3 said she left the shower room and said maybe five or so minutes later she heard a "boom" and then screaming. Nurse #3 further stated she ran back into the shower room and Resident #1 was on the floor and NA #1 and NA #2 were in the shower room and by the time she got in there the shower chair was sitting upright and away from the resident. She said by this time there were several staff in the shower room and NA #2 went to get the lift and NA #3 went to get the vital signs machine. Nurse #3 stated Resident #1 told her in the shower room that she had fallen out of the shower chair on her left side and hit her arm and shoulder on the shower floor but said that she was not injured just "shook up." Nurse #3 assessed the resident on the shower room floor and then she, NA #1, NA #2 and the Speech Therapist (ST) lifted the resident off the floor and into her wheelchair using the mechanical lift and then they transferred Resident #1 from the wheelchair back to bed. Nurse #3 explained that she reported the incident to Unit Manager #1, Director of Nursing (DON), called the emergency contact for the resident, called the physician, and completed a fall report and charted the incident. She stated Unit Manager #1 told her that was all she needed to do following the fall.</p> <p>During a telephone interview with NA #3 on 10/09/25 at 11:26 AM she revealed she recalled the day Resident #1 fell in the shower room. She stated she was not in the shower room at the time of the fall but had assisted NA #1 with getting Resident #1 from her wheelchair to the shower chair that day in the shower room. NA #3 recalled the resident kept complaining about "being in the wrong chair." She stated the resident was in a bariatric shower chair and she didn't understand what the resident was referring to about being in the wrong chair but said NA #1 told her she was fine in the chair that she was in. NA #3 stated that after Resident #1 fell, she had gotten the vital signs machine and checked her vitals while the nurse assessed Resident #1. NA #3 further stated after she checked Resident #1's vital signs she left the room with the machine and continued with care of her residents.</p>	F0689		

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F0689 SS = G	<p>Continued from page 9</p> <p>An observation of the shower room on 10/08/25 at 2:47 PM with NA #2 revealed there were three shower chairs and one shower bed in the shower room. Two of the three shower chairs were bariatric chairs. The bariatric chairs were placed side by side and the blue trimmed bariatric chair was approximately two inches higher than the white bariatric chair. The blue trimmed chair had a step stool that slid out from under the seat of the chair at the base that allowed for a resident who was ambulatory to step onto the stool and into the chair. The blue trimmed chair also had a blue cushion on the seat and the arms of the chair and the seat of the chair were approximately two inches higher than the arms and seat on the white bariatric chair and the back of the chair extended higher than the back of the white bariatric chair.</p> <p>An interview with the Director of Nursing (DON) on 10/09/25 at 1:25 PM revealed that after Resident #1's fall in the shower room, the interdisciplinary team held a huddle (short meeting held to share information, problem solve and manage resident safety). She stated in addition an interdisciplinary team meeting was held and it was determined that given the resident's size it would be safer for her and the staff if there were two staff present for her showers. The root cause of her fall in the shower room was determined to be that only one staff member was with her in the shower room and now they were going to implement two staff persons for her shower. The DON stated she was not aware Resident #1 had a preference for the shorter shower chair so she could keep her feet on the floor. She said she would update her care plan for the preference of the shorter shower chair.</p> <p>b. During an interview with Resident #1 on 10/08/25 at 2:25 PM she revealed that on 09/29/25 NA #1, who had let her fall in the shower room a few days prior, tried to transfer her from the bed to her wheelchair by herself using the mechanical lift and she fell to the floor and the lift fell on top of her with the top of the lift (boom) hitting her on the top of her head. Resident #1 stated she screamed as the lift was falling with her in the sling and said when she hit the floor her left ankle and back started hurting and her head started hurting where the lift had hit her on top of her head. Resident #1 said it was scary, and she was still scared to be transferred using the mechanical lift. Resident #1 stated when Nurse #2 came into the room, the nurse said one of the straps had come loose and was laying across her. Resident #1 said no one else had ever tried to get her up with the mechanical lift by themselves. Resident #1 explained she had gone to</p>	F0689		

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F0689 SS = G	<p>Continued from page 10 the hospital and had returned later in the evening on the same day. She said she had followed up with the orthopedic doctor in his office, and he had put a boot on her left lower leg to stabilize the fracture in her foot.</p> <p>A telephone interview on 10/08/25 at 11:11 AM with NA #1 confirmed she had attempted to transfer Resident #1 using a mechanical lift without additional staff assistance on 09/29/25. She stated Resident #1 had fallen to the floor along with the lift during the transfer. NA #1 recalled Resident #1 was being transferred to her wheelchair to go to the dining room for lunch. NA #1 stated she had requested assistance from NA #4 who was also working on the hall to assist her, but said NA #4 had been in the shower room giving a shower to another resident. NA #1 stated NA #2 was in another resident room providing care, so she had asked Nurse #1 for assistance because they had been instructed to always have 2-person assist when using the mechanical lift. She said Nurse #1 was busy with medications and treatments of other residents. NA #1 explained she positioned Resident #1 in her sling and made the decision to go ahead and transfer the resident by herself. NA #1 indicated after she had gotten Resident #1 positioned in the sling, she made sure the sling straps were all positioned correctly, and the clasps locked in place and then proceeded with the transfer. She recalled Resident #1's bed was in a low position, and she didn't have to lift her any higher and used the lift to move her horizontally off the bed. Resident #1 was suspended approximately 4 to 5 feet from the floor and as NA #1 moved the lift towards her wheelchair, the lift tilted, and Resident #1 fell onto the floor on her back. The lift fell on top of her with the lift bar striking her on the top of her head. NA #1 stated somehow the lift struck her on the forehead as it was falling and she had a big bump on her forehead. NA #1 restated she was instructed to always have 2-person assist when using the mechanical lift and she made the wrong decision to go ahead and transfer Resident #1 without waiting for help.</p> <p>An interview on 10/08/25 at 9:47 AM with NA #2 revealed on 9/29/25 she passed NA #1 in the hallway and saw her go into Resident #1's room and said about 10 minutes later she heard a "boom and screaming." NA #2 stated she ran into Resident #1's room and Resident #1 was lying on the floor and the resident said, "She dropped me." NA #2 stated that the lift pad was not properly positioned under the resident to provide adequate support and noted that the leg strap between the resident's legs was not crisscrossed as required. NA #2 stated the lift was lying on top of the resident and</p>	F0689		

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F0689 SS = G	<p>Continued from page 11</p> <p>Resident #1 told her the lift bar had hit her on the top of her head. NA #2 indicated the lift had somehow hit NA #1 on her forehead and she had a knot on her forehead from the lift. NA #2 stated NA #1 left the room to get ice to place on her head and NA #2 went and got the Director of Rehabilitation while Nurse #2 assessed the resident on the floor. NA #2 stated Resident #1 was crying and complaining of left ankle pain, pain on the top of her head and lower back pain. NA #2 explained that Resident #1 was transferred from the floor back to bed with the mechanical lift by the Director of Nursing, Director of Rehabilitation and herself with leg strap crisscrossed between her legs and she was transferred back to bed without incident. NA #2 went on to explain that all the staff knew that a mechanical lift required two staff members and said that NA #1 never asked her for assistance in getting Resident #1 up out of bed and into her wheelchair.</p> <p>An interview with Nurse #1 on 10/08/25 at 10:41 AM revealed that on 09/29/25 she was at the nurses' station and heard a "loud bang" and "screaming". She went into Resident #1's room and saw the resident on the floor on her back with the lift on top of her and the lift wheels in the air. She stated about that time Nurse #2 who was assigned to care for Resident #1 during the 7:00 AM to 7:00 PM shift came in and she and two other NAs (could not recall who they were) disconnected the lift pad from the lift and moved the mechanical lift off the resident. Nurse #1 stated she left the room to call Emergency Medical Services (EMS) and call the provider while Nurse #2 assessed the resident. Nurse #1 stated she got the paperwork ready for Resident #1 to go to the hospital and then returned to the room. The DON, NA #2, Nurse #2, and the Director of Rehabilitation transferred the resident off the floor and back to bed with the mechanical lift. Nurse #1 stated Resident #1 was crying and complaining of pain in her left ankle and back. She stated the Nurse Practitioner was in the building and came to the room to assess the resident and was going to order x-rays, but EMS arrived, and she gave orders for the resident to go out to the hospital for evaluation and treatment.</p> <p>Review of a fall report completed on 09/29/25 at 11:40 AM by Nurse #2 revealed the interdisciplinary team reviewed the fall. The staff member's action was negligent and unsafe. Immediate investigation, audits, orders completed and initiated. Intervention for two persons assistance with all care needs and transfers. Referral to physical therapy.</p> <p>A nurse progress note dated 09/29/25 at 11:40 AM written by Nurse #2 read in part, Resident was in</p>	F0689		

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F0689 SS = G	<p>Continued from page 12 mechanical lift transferring to wheelchair. Staff was using the mechanical lift and resident dropped to floor, mechanical lift turned over and landed on top of resident. Assessment left ankle pain, back pain and headache. Nurse Practitioner in building notified and order received to transfer to emergency room (ER).</p> <p>A second progress note dated 09/29/25 at 12:31 PM written by Nurse #2 read in part, Resident was transferred to the hospital by EMS for evaluation and treatment, after having a fall. NP ordered to transfer resident by EMS.</p> <p>During a telephone interview with Nurse #2 on 10/08/25 at 11:22 AM Nurse #2 stated she was assigned to care for Resident #1 on 09/29/25 during the 7:00 AM to 7:00 PM shift. She stated she was at her cart pulling medications for another resident when she heard someone hollering so she went down the hall and happened to look in Resident #1's room and saw her lying on the floor with the mechanical lift lying on top of her chest. Nurse #2 stated the legs of the lift were closed and NA #1 was pacing around in the room saying, "Oh my gosh, I have dropped her." Nurse #2 stated she and another NA (could not recall whom) took the straps of the lift sling out of the lift bar and got the mechanical lift off the resident. Nurse #2 stated she was assessing the resident, and Resident #1 was screaming with pain in her left foot and said when she assessed her left foot, she could see it was swelling. She stated Nurse #1 who was also in the room went out to call EMS and start Resident #1's paperwork so she could be transferred to the hospital. Nurse #2 stated she, NA #2, the DON and the Director of Rehab used the mechanical lift and got Resident #1 back into the bed. She further stated when they had gotten the resident back to bed the NP came in the room and was going to assess the resident, but EMS walked in right after and they took over and transported the resident to the hospital. Nurse #2 stated NA #1 was in the room to answer questions EMS had about the resident's fall and said after EMS left with the resident, NA #1 left the room with the DON.</p> <p>An interview with the Director of Rehabilitation on 10/08/25 at 12:29 PM revealed he came into the room on 09/29/25 to assist with getting Resident #1 off the floor and into her bed. He stated he assisted DON and NA #2 in getting the sling properly positioned under the resident and lifting her from the floor onto her bed. The Director of Rehab stated Resident #1 was tearful and complaining that her left ankle was hurting. He further stated they had done an evaluation of her after her first fall and were planning to pick</p>	F0689		

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F0689 SS = G	<p>Continued from page 13 her up for physical therapy but said she came back from the hospital with orders to be non-weight bearing so they were waiting until she could bear weight on her left foot and leg.</p> <p>A physician progress note dated 09/29/25 written by the facility's Nurse Practitioner (NP) indicated [Resident #1] seen for acute visit at facility request due to recent fall while being transferred to wheelchair via mechanical lift. Resident with complaints of left ankle pain and headache "where lift hit her on the head." EMS arrived while this provider was assessing resident. Acute status post fall while being transferred to wheelchair via mechanical lift. Resident reports lift hit her on the head and resident requires escalation to next level of care hospitalization for further evaluation and treatment.</p> <p>A telephone interview with the facility's NP on 10/09/25 at 4:12 PM revealed she had been at the facility on 09/29/25 when Resident #1 fell from the mechanical lift. She stated a staff member (could not remember whom) came and asked her to see the resident because she had fallen from the lift and was complaining of left foot pain, back pain and a headache. The NP stated she went into the room and was assessing the resident and was going to order x-rays when EMS walked in the room. She said once EMS walked in, she stepped aside and gave them the scene and ordered for the resident to be sent to the local hospital emergency department (ED) for evaluation and treatment.</p> <p>Resident #1's hospital records revealed the resident presented to the emergency department (ED) at the local hospital on 09/29/25 after falling about 5 feet from a mechanical lift and the lift fell on top of her but denied loss of consciousness. Resident #1 complained of lumbar back pain, left leg pain, and severe left foot pain. Resident was found to have possible acetabular (socket-shaped bone that forms the hip joint) fracture, a left calcaneal fracture (fracture of the heel bone) and a left anterior talus (the bone in the foot that connects the ankle to the leg) fracture. The fracture was discussed with orthopedic surgery who did not recommend acute surgical intervention and recommended follow up with a local orthopedic practice. It was documented that a lot of her symptoms were exacerbated by movement which was consistent with musculoskeletal strain/sprain from the fall. The ED physician considered hospitalization but on re-evaluation the resident appeared well, so she discharged back to nursing home with immobilizer and orders to follow up with orthopedics.</p>	F0689		

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F0689 SS = G	<p>Continued from page 14</p> <p>Review of a physician progress note dated 09/30/25 by the Medical Director revealed in part, the resident was seen following fall and visit to the local hospital ED. The resident was evaluated in the ED where she was informed of fractures in her foot and a possible fracture in her leg. She had not yet had a follow-up with an orthopedic specialist. The resident complained of significant pain, particularly in her lower back, and said she had been taking acetaminophen which had provided some relief but indicated it was not sufficient to manage her pain efficiently. The plan was for orthopedic evaluation required to confirm the fracture and decide on treatment plan, follow up required to confirm fractures in the left foot following fall, and prescription written for oxycodone for stronger pain relief.</p> <p>During a telephone interview with the Medical Director of the facility on 10/10/25 at 11:12 AM he revealed he had not been at the facility the day of Resident #1's fall but said the NP had been there and ordered her to be sent out to the local hospital. The Medical Director stated he evaluated the resident on 09/30/25 in the facility and said he understood she was in the mechanical lift and something happened with the lift, and she fell about five feet to the floor in her room. He stated he reviewed the ED notes and x-rays and scans completed on Resident #1 at the hospital and found the resident was having some pain that was not relieved by her acetaminophen. He ordered some stronger pain medication to be given every 8 hours as needed for pain and ordered follow-up with an orthopedic specialist as soon as possible. The Medical Director further stated the resident had not ambulated in over a year and while it was unfortunate she had been dropped from the lift, he didn't expect her to be able to ever ambulate again.</p> <p>Review of a consultation report dated 10/01/25 with an orthopedic specialist revealed in part the resident was seen and x-rays performed and the resident was diagnosed with left mildly displaced calcaneus (heel bone) fracture extending into the anterior talus joint (joint that connects the tibia and fibula to the ankle) and lumbar spine degenerative disc disease with right-sided radiculopathy (condition caused by compression or irritation of a nerve root where it exits the spine or pinched nerve). Recommendations included immobilization of the left foot and ankle in a tall walker boot, physical therapy and progression to touch down weight bearing if able to progress with therapy. Also recommended follow-up with orthopedics in three weeks for x-rays and to check progression.</p>	F0689		

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F0689 SS = G	<p>Continued from page 15</p> <p>An interview with the Director of Nursing (DON) on 10/09/25 at 1:25 PM revealed she was called in to assist at the time of Resident #1's fall on 09/29/25 by NA #2. She stated she and Nurse #2 evaluated Resident #1 while she was still on the floor and she complained of lower back pain, left foot pain and her head hurting where the mechanical lift hit the top of her head. The DON said she, Nurse #2, NA #2 and the Director of Rehabilitation transferred the resident with the mechanical lift from the floor back to bed and the resident told them she felt better now that she was in bed off the floor. The DON stated the NP was in the building and came in to assess the resident and shortly after EMS arrived and the NP gave orders to send Resident #1 out to the local hospital ED for evaluation and treatment. She stated Resident #1 was transported out to the hospital by EMS. The DON further stated NA #1 was immediately suspended after she talked with her and found out she had transferred the resident without a second staff member. She stated Resident #1 returned to the facility from the hospital on the evening of 09/29/25 and had a follow up appointment at the orthopedic specialist's office on 10/01/25. The DON further stated there had been no other incidents since 09/29/25 with mechanical lifts. The DON indicated the NAs were responsible for determining the sling size a resident required for mechanical lifts. She explained that each sling had a weight capacity on the tag inside the sling and the NAs measured the resident from the base of their spine to the top of their shoulder with a tape measure to determine if the sling was an appropriate fit for the resident. She further explained that a large sling had a maximum weight capacity of 500 pounds and an extra-large sling had a maximum weight capacity of 850 pounds and the extra-large sling was the one used for Resident #1. According to the DON the root cause of Resident #1's fall on 09/29/25 was only one staff member transferring the resident in the mechanical lift.</p> <p>c. Review of the manufacturer's information for the brand of mechanical lift used by the facility revealed it had a lift capacity of 600 pounds. There was also a placard on the mechanical lift that indicated the weight capacity as 600 pounds. In addition, the manufacturer's recommendations stated the following: "Slings are made specifically for use with the mechanical patient lifts. For the safety of the patient, DO NOT intermix slings and patient mechanical lifts of different manufacturers." According to the manufacturer's recommendations the slings for the brand of mechanical lift at the facility come in sizes extra-small through extra extra-large and come with their own identification information on the label. The</p>	F0689		

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F0689 SS = G	<p>Continued from page 16</p> <p>information on the label included model reference number, type of sling, size, date of manufacture, care instructions, weight capacity and an identification picture of the sling. The extra-small through large slings had a weight capacity of 500 pounds. The extra-large sling had a weight capacity of 550 pounds and the extra extra-large sling had a weight capacity of 650 pounds. Additionally, the manufacturer's recommendations indicated there were two measurements that should be utilized in determining the correct sling size. Those measurements were the resident's weight, and the height from the end of their spine to the top of their head.</p> <p>An observation on 10/14/25 at 10:30 AM was made of Resident #1 being transferred from the bed to her wheelchair by NA #5 and NA #6 using the mechanical lift. The sling was confirmed by NA #5 to be the correct size and was placed under her by NA #5 and NA #6. The resident was maneuvered by NA #6 and the lift was maneuvered by NA #5. Resident #1 was raised from the bed after the bed was lowered and was hanging from the boom and sling bar horizontally to the lift base. NA #6 was unable to turn Resident #1 vertically to the lift base to align her with the wheelchair because the sling bar was wedged tight against the boom and would not allow for the resident to be turned. The resident's head while suspended in the sling was about ten to twelve inches below the top of the sling. NA #5 positioned the wheelchair in between the lift legs sideways to get the resident in her wheelchair. As NA #5 and NA #6 moved the resident in the sling the back left wheel of the lift raised up off the floor due to the resident's weight being shifted to the right side of the lift. NA #6 quickly placed her foot on the bar above the lift's wheel to keep the lift wheel on the floor. About this time the Activity Director (who was also an NA) and Unit Manager #1 came into the room. It took all four staff members working together to maneuver the sling and the wheelchair to get the resident into her wheelchair safely. Once the resident was safely transferred into the wheelchair the resident's bed had to be moved to get the lift legs from under the wheelchair and get the lift out of the room. An observation of the tag inside the sling revealed the sling was a different brand than the brand of the mechanical lift utilized to transfer the resident to her wheelchair from the bed. The sling was a bariatric extra-large with a weight capacity of 850 pounds.</p> <p>During an interview on 10/14/25 at 11:10 AM with NA #5 and NA #6, NA #6 stated the sling in the resident's room was the sling that had been used for her since her</p>	F0689		

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F0689 SS = G	<p>Continued from page 17 admission. NA #5 stated she had confirmed the sling had a weight capacity of 850 pounds and was the sling that was in Resident #1's room to be used to transfer her out of bed. NA #6 stated while they were attempting to turn the resident in her sling, the left wheel on the back of the lift raised up off the floor when she and NA #5 could not get Resident #1's sling turned in the lift. NA #6 said she had to put her foot on the bar above the wheel to keep the lift from tilting off the floor. NA #5 stated they couldn't get the resident turned in the sling because the sling bar (where the sling is connected into the brackets) was wedged against the boom (the bar that extends out over the lift and holds the lift bar) and would not allow them to turn her. NA #6 said that caused all the resident's weight to shift to the right side of the mechanical lift causing the left wheel to raise up off the floor. NA #5 said she took the lift to the Maintenance Director and had him check it to make sure it was functioning properly. NA #5 and NA #6 stated they were not comfortable getting Resident #1 up in the lift again without four staff being present.</p> <p>An interview on 10/14/25 at 12:16 PM with Unit Manager #1 revealed she thought all in all the transfer with Resident #1 had gone well because she had been safely transferred to her wheelchair from the bed without injury. Unit Manager #1 stated she felt like Resident #1 would benefit from a bariatric mechanical lift because they have a sturdier base or she would need at least three to four staff members present for transfers. She further stated she had already had a conversation with the new Administrator that they needed a bariatric mechanical lift for Resident #1, or they were going to have to make her a three-to-four-person lift. Unit Manager #1 further indicated she had told the staff and Administrator that until they had a bariatric lift, Resident #1 would need 2 additional spotters for a total of 4 staff to transfer her in and out of bed. Unit Manager #1 stated she would make sure there were 4 staff present to transfer Resident #1 back to bed. She explained that the NAs measured the residents from the top of their shoulders to the end of their spine and used that measurement along with their weight to determine the sling size appropriate for them.</p> <p>An interview on 10/14/25 at 11:33 AM with the Maintenance Director revealed the mechanical lift used to transfer Resident #1 had been brought to him on 10/14/25 right after the resident was transferred to check for proper functioning. He stated he ran all the tests on the mechanical lift and all parts and functionality of the lift were properly functioning and</p>	F0689		

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F0689 SS = G	<p>Continued from page 18 it was placed back for use.</p> <p>The Director of Nursing was not available for interview.</p> <p>During an interview on 10/14/25 at 3:55 PM with the Interim Administrator, new Administrator, Regional Director of Clinical Services and Regional Vice President of Operations, the new Administrator stated Unit Manager #1 had discussed Resident #1's transfer with him and the need for a bariatric mechanical lift. The Administrator stated he would discuss the option of purchasing a bariatric lift with his supervisor and said the facility would do what was needed to ensure Resident #1 was transferred in and out of bed safely.</p> <p>d. Review of the manufacturer's information for the brand of mechanical lift used by the facility revealed it had a lift capacity of 600 pounds. There was also a placard on the mechanical lift that indicated the weight capacity as 600 pounds. In addition, the manufacturer's recommendations stated the following: "Slings are made specifically for use with the mechanical patient lifts. For the safety of the patient, DO NOT intermix slings and patient mechanical lifts of different manufacturers." According to the manufacturer's recommendations the slings for the brand of mechanical lift at the facility come in sizes extra-small through extra extra-large and come with their own identification information on the label. The information on the label included model reference number, type of sling, size, date of manufacture, care instructions, weight capacity and an identification picture of the sling. The extra-small through large slings had a weight capacity of 500 pounds. The extra-large sling had a weight capacity of 550 pounds and the extra extra-large sling had a weight capacity of 650 pounds. Additionally, the manufacturer's recommendations indicated there were two measurements that should be utilized in determining the correct sling size. Those measurements were the resident's weight, and the height from the end of their spine to the top of their head.</p> <p>An observation on 10/23/25 at 12:50 PM was made of the slings in the facility being utilized for residents requiring a mechanical lift for transfers. The observation revealed there were four residents on the 100 hallway that required mechanical lift for transfers and two residents had slings in their room that were compatible with the mechanical lift and two residents had slings in their room that were not compatible with the mechanical lift. In the clean utility closet on the 100 hallway, there were two slings available for use</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345441	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025
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F0689 SS = G	<p>Continued from page 19 that were not compatible with the mechanical lift and there were 2 slings with worn tags that the brand could not be determined. On the 200 hallway there were two residents that required mechanical lift for transfers and one resident had a sling that was compatible with the mechanical lift and one resident did not have a sling in his room. In the clean utility closet on the 200 hallway there was one sling that was not compatible with the lift and 1 sling with worn tags that the brand could not be determined.</p> <p>During an observation and interview on 10/23/25 at 9:35 AM Resident #1 was observed dressed and up in her wheelchair in her room. Resident #1 revealed two NAs had gotten her up that morning in the wheelchair. Resident #1 stated she had gotten up one day last week and then today. Resident #1 said she was still a little scared getting up in the sling but had not had any more accidents with the mechanical lift.</p> <p>An observation on 10/23/25 at 2:00 PM was made of Resident #1 being transferred from her wheelchair to bed in preparation for her shower by NA #9 and NA #10. The bariatric extra-large sling utilized to transfer Resident #1 was a different brand than the brand of mechanical lift utilized but there were no issues with the transfer.</p> <p>A follow-up interview on 10/23/25 at 11:00 AM with the Director of Nursing revealed the facility had 2 brands of lift slings and one brand of mechanical lift. She stated they had bariatric slings in a different brand than their mechanical lift in sizes medium, large and extra-large all with a maximum capacity of 850 pounds. She again stated the NAs measured residents from the top of their shoulders to the tailbone or end of their spine and their weight to determine the size sling needed to transfer residents with a mechanical lift. The DON said she was not sure why Unit Manager #1 had stated Resident #1 needed a bariatric lift because the lift they had was able to lift to 600 pounds and the resident only weighed 304 pounds. She stated they used bariatric slings so they would support a heavier person regardless of their height and they are made of stronger materials. The DON confirmed that the slings used in the facility supported the resident's head during transfers and that according to what she had read on 10/23/25 in the manufacturer's recommendations, the NAs should have measured the residents from the top of their head to their tailbone to determine the correct sling size. She stated she was aware of the risks to residents who were not transferred in the correct sling size and said she now knew equipment incompatibility and using incorrect sling size could</p>	F0689		

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F0689 SS = G	<p>Continued from page 20 lead to serious injury or death from falls.</p> <p>A telephone interview on 10/23/25 at 12:46 PM with a Customer Service Representative with the manufacturer of the mechanical lift brand utilized by the facility revealed that only the brand of slings made by the manufacturer should be used with the mechanical lift. The representative stated the manufacturer only tested their lift slings for safety with their mechanical lifts and they couldn't determine the safety of utilizing other brands of lift slings.</p> <p>A second follow up interview on 10/23/25 at 3:35 PM with the DON revealed they had used the extra-large sling manufactured by a different brand than the lift because they didn't have a sling manufactured by the same company as the lift in the correct size for the resident. She stated Resident #1 would need an extra-large sling in the brand that was compatible with their mechanical lift. The DON was not aware that the facility could not intermix slings and mechanical lifts or they would not have utilized the different slings. She admitted using a different brand of sling from the brand of mechanical lift along with one person trying to transfer the resident likely attributed to Resident #1's fall on 09/29/25 and the lift raising off the floor with Resident #1 on 10/14/25.</p>	F0689		