

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2024
NAME OF PROVIDER OR SUPPLIER Lincolnton Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 East Gaston Street Lincolnton, NC 28092	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476</p> <p>Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #80). Resident #80 stated it made her upset to sit in a soiled brief and made her feel like a third-class citizen and she paid her bill like everyone else.</p> <p>The Findings included:</p> <p>Resident #80 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #80 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period.</p> <p>An observation conducted on 04/08/24 at 10:30 AM revealed Resident #80 yelled into the hall and notified NA #1 she had a soiled brief. NA #1 was observed entering the room.</p> <p>Resident #80 was interviewed in her room on 04/08/24 at 10:45 AM. During the interview she stated she had been sitting in a soiled brief since 9:30 AM and knew this because she had been looking at the clock on the wall. She stated she had told NA #1 that she was sitting in a soiled brief and NA #1 acknowledged her and left the room. She stated she was still sitting in bowel movement and needed to be changed. During the interview Resident #80 stated, It makes me feel like a third-class citizen, I pay my bill like everyone else. She went on to say it made her upset having to sit in a soiled brief filled with bowel movement.</p> <p>On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief. An observation was conducted at 10:57 AM of Unit Manager #1 and Assistant Director of Nursing (ADON) providing incontinence care to Resident #80. Resident #80's top sheet, bed pad and fitted sheet were observed to be soiled with feces. Resident #80 was observed to have feces extending down onto the thighs and covering her urinary catheter. A complete bed change was observed after the nurses provided incontinence care to Resident #80.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/24 at 9:49 AM an interview was conducted with Nurse Aide (NA)#1. During the interview she stated Resident #80 had told her she needed to be changed however she had already started running water down the hall for another resident's bed bath. The interview revealed she had planned on completing the bed bath prior to changing Resident #80. NA #1 stated she did not know Resident #80 had been sitting in a soiled brief since 9:30 AM.</p> <p>On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated once you see a call light on you should provide the care or let another staff member know so the care was provided. Unit Manager #1 stated she had to complete an entire bed change for Resident #80 due to incontinence and that was not common in the facility. She stated typically the Nurse Aides were good about providing care. She stated no resident should feel upset, like a third-class citizen or have to sit in bowel movement.</p> <p>On 04/11/23 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she did assist Resident #80 with incontinence care and had to complete a bed change due to the incontinence. The ADON stated Nurse Aides should be providing care upon resident request. The interview revealed no resident should feel upset or have to ask twice to be changed while sitting in a brief with bowel movement.</p> <p>On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the resident asked. The DON stated Resident #80 should never feel like a third-class citizen or upset because staff would not change her brief.</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on record review and resident, Resident Representative, staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide a safe and orderly discharge for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not provided with discharge paperwork or discharge instructions and did not understand what was happening. The discharge location was not verified, home health services were not ordered at the time of discharge, and the resident was not followed up with to ensure his needs were met. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad.</p> <p>Findings included:</p> <p>Review of the hospital discharge summary dated 08/26/23 revealed Resident #1 was admitted to the hospital on 08/07/23 due to Resident #1 having generalized body weakness and the family had also taken him to the hospital for placement. Resident #1 was admitted with throat cancer and a tracheostomy and was diagnosed with adult failure to thrive and increased general weakness. Resident #1 was discharged from the hospital on 08/26/23 and referred to the facility for skilled services.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness.</p> <p>Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy.</p> <p>A phone interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM revealed Resident #1 was assessed on 08/27/23 and revealed Resident #1 had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy because uncuffed tubes allow airway clearance but provide no protection from aspiration and cuffed tracheostomy tubes allow secretion clearance and offer some protection from aspiration. The RT revealed nursing staff was not familiar with caring for a resident with a cuff tracheostomy. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated he did not write physician orders and that the Nurse Practitioner (NP) or Medical Director (MD) would have to be notified to obtain the order to change the tracheostomy type. The RT indicated Resident #1 was not in distress and could have waited to have his trach changed when supplies were obtained but the Director of Nursing (DON) made the RT aware the decision was made to send Resident #1 to the ED after the infusion appointment on 08/28/23.</p> <p>Review of a progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was at the emergency room (ED).</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility and a staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 indicated once he arrived at the infusion appointment with his bag the infusion staff nurse revealed to Resident #1 they had received a message from the facility to send the resident to the ED after his appointment. The infusion staff nurse explained to him that they could not send him to the ED because Resident #1 did not have an order. Resident #1 stated at this time he felt he was being discharged without knowledge and he felt like he was being thrown out, abandoned and was mad. Resident #1 revealed the Infusion Nurse contacted the facility Admissions Director and was told Resident #1 could not return to the facility. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had nowhere else to go. Resident #1 indicated the facility had his personal phone number and did not attempt to contact his Resident Representative (RR) until 08/30/23 after Resident #1's primary care office reached out to the facility. Resident #1 stated the facility did not provide any discharge information, discharge services, medicines, or supplies once he left the facility. Resident #1 indicated he was able to perform self trach care and had medications and tube feeding formula when he returned home.</p> <p>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.</p> <p>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 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 upset for Resident #1.</p> <p>A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an ugly conversation but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of what had occurred with Resident #1 from 08/28/23 through 08/31/23.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview conducted with Resident #1's Resident Representative (RR) on 04/11/24 at 10:15 AM revealed Resident #1 was admitted to the facility after his hospital stay due to needing more care than the family could assist with. It was further revealed on 08/28/23 the RR was not notified prior that Resident #1 was being sent out for an infusion appointment but was contacted by the facility Admissions Director that Resident #1 was on his way to an infusion appointment and would have to be sent to the ED because the facility could not care for the resident's tracheostomy. The RR stated the facility Admissions Director revealed Resident #1 could not return to the facility. The RR revealed she arrived at Resident #1's infusion appointment and the Infusion Center Nurse #1 had contacted the facility as well and had reiterated the same information that the resident could not return to the facility. It was further revealed Resident #1 had a bag with his belongings and was very mad about being discharged without notice. The RR further revealed she took Resident #1 home because she felt like the facility had dumped him and she had no other choice.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 04/10/24 at 3:05 PM revealed she assisted in getting Resident #1 ready for his appointment on 8/28/23 and had given him a folder that had information for his appointment. The ADON indicated she did not recall the resident having a bag packed or having any concerns. The ADON stated Resident #1 was admitted with a cuffed trach that the facility did not have supplies for, and staff did not have the training to care for. The ADON stated she believed Resident #1 was admitted by accident because the facility normally would not accept a resident with a cuffed trach. The ADON indicated she had thought Resident #1 had been sent to the ED to have Resident #1's trach changed and was not aware until Resident #1's primary care office reached out on 08/30/23 that the resident was at home. The ADON revealed then she reached out to Resident #1's RR and it was revealed Resident #1 did not have the preferred liquid form of metformin and insulin. The ADON indicated she contacted the on-call provider on 08/30/24 and obtained orders for Resident #1's medications. The ADON was not aware that no staff from the facility had reached out to Resident #1 and was not sure why he did not return to the facility.</p> <p>An interview conducted with the facility Social Worker (SW) on 04/11/24 at 9:25 AM revealed he did not become involved with Resident #1 until 08/30/23 when Resident #1's primary care office contacted the facility to let them know Resident #1 was at home. The SW further revealed at that time he completed an Adult Protective Services (APS) report to make sure Resident #1 was safe and completed referrals for in home health but did not follow up to see if Resident #1 had been accepted for services.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed trach. The DON further revealed Resident #1 had an appointment at the infusion center on 08/28/23 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders to do so. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON revealed nursing staff failed to follow up with the whereabouts of Resident #1 during second and third shift on 08/28/23 with the thought Resident #1 was still at the hospital, and no one realized he wasn't there on 8/29/23 either. The DON indicated on 08/30/23 it was found out that Resident #1 went home from his appointment on 08/28/23 when the facility received a phone call from Resident #1's primary care office. The DON indicated an APS report was completed, referrals from in home health were completed, and orders were obtained for Resident #1 to receive medicine. The DON stated she was not aware the prior Admissions Director told Resident #1 that he could not return to the facility.</p> <p>An interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and did not recall any conversation with the facility that Resident #1 was being sent out to have their trach changed. The NP indicated she could not recall who and on what date, but she was notified Resident #1 had left against medical advice (AMA).</p> <p>A phone Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility. The MD further revealed he could not recall who had reported that Resident #1 had left against medical advice (AMA) on 08/30/23.</p> <p>Interview with the Administrator on 04/11/23 at 4:00 PM revealed he was made aware by the DON on 8/28/23 that Resident #1 was being sent out to the infusion center on 8/28/23 and then heading to ED for trach change. The Administrator further revealed it was RT's recommendations and was not aware the RT could not write orders. The Administrator revealed he was unsure if Resident #1 had left with his belongings and was not aware of who was responsible for following up with Resident #1's whereabouts after he did not return from his appointment.</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on record review and resident, Resident Representative, staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to permit a resident to return to the facility from therapeutic leave for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not allowed to return to the facility following the appointment. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad.</p> <p>Findings included:</p> <p>Review of the hospital discharge summary dated 08/26/23 revealed Resident #1 was admitted to the hospital on 08/07/23 due to Resident #1 having generalized body weakness and the family had also taken him to the hospital for placement. Resident #1 was admitted with throat cancer and a tracheostomy and was diagnosed with adult failure to thrive and increased general weakness. Resident #1 was discharged from the hospital on 08/26/23 and referred to the facility for skilled services.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness.</p> <p>Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy.</p> <p>A phone interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM that Resident #1 was assessed on 08/27/23 and revealed Resident #1 had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy because uncuffed tubes allow airway clearance but provide no protection from aspiration and cuffed tracheostomy tubes allow secretion clearance and offer some protection from aspiration. The RT revealed nursing staff was not familiar with caring for a resident with a cuff tracheostomy. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated he did not write physician orders and that the Nurse Practitioner (NP) or Medical Director (MD) would have to be notified to obtain the order to change the tracheostomy type. The RT indicated Resident #1 was not in distress and could have waited to have his trach changed when supplies were obtained but the Director of Nursing (DON) made the RT aware the decision was made to send Resident #1 to the ED after the infusion appointment on 08/28/23.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility a facility staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 indicated once he arrived at the infusion appointment with his bag the infusion staff nurse revealed to Resident #1 they had received a message from the facility to send the resident to the ED after his appointment. The infusion staff nurse explained to him that they could not send him to the ED because Resident #1 did not have an order. Resident #1 stated at this time he felt he was being discharged without knowledge and he felt like he was being thrown out, abandoned and was mad. Resident #1 revealed the Infusion Nurse contacted the facility Admissions Director and was told Resident #1 could not return to the facility. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had no other place to go. Resident #1 indicated he was able to care for himself and contact 911 in case of an emergency.</p> <p>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 but did not explain what Resident #1 was being sent to the ED for. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director directly and it was explained by the Admissions Director Resident #1 needed a trach change. The Infusion Center Nurse #1 explained to the Admissions Director 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 and the resident could not return to the facility. 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 confused on not being able to return to the facility.</p> <p>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 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.</p> <p>A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an ugly conversation but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of what had occurred with Resident #1 from 08/28/23 through 08/31/23.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview conducted with Resident #1's Resident Representative (RR) on 04/11/24 at 10:15 AM revealed Resident #1 was admitted to the facility after his hospital stay due to needing more care than the family could assist with. It was further revealed on 08/28/23 the RR was contacted by the facility Admissions Director that Resident #1 was on his way to an infusion appointment and would have to be sent to the ED because the facility could not care for the resident's tracheostomy. The RR stated the facility Admissions Director revealed Resident #1 could not return to the facility. The RR revealed she arrived at Resident #1's infusion appointment and the Infusion Center Nurse #1 had contacted the facility as well and had reiterated the same information that the resident could not return to the facility. It was further revealed Resident #1 had a bag with his belongings and was very mad about being discharged without notice. The RR further revealed she took Resident #1 home because she felt like the facility had dumped him and she had no other choice.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on 04/10/24 at 3:05 PM revealed she assisted in getting Resident #1 ready for his appointment on 8/28/23 and had given him a folder that had information for his appointment. The ADON indicated she did not recall the resident having a bag packed or having any concerns. The ADON stated Resident #1 was admitted with a cuffed trach that the facility did not have supplies for, and staff did not have the training to care for. The ADON stated she believed Resident #1 was admitted by accident because the facility normally would not accept a resident with a cuffed trach. The ADON indicated she had thought Resident #1 had been sent to the ED to have Resident #1's trach changed and was not aware until Resident #1's primary care office reached out on 08/30/23 that the resident was home. The ADON was not aware that no staff from the facility had reached out to Resident #1 and was not sure why he did not return to the facility.</p> <p>An interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed trach. The DON further revealed Resident #1 had an appointment at the infusion center on 08/28/23 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders to do so. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON revealed nursing staff failed to follow up with the whereabouts of Resident #1 during second and third shift on 08/28/23 with the thought Resident #1 was still at the hospital, and no one realized he wasn't there on 8/29/23 either. The DON indicated on 08/30/23 it was found out that Resident #1 went home from his appointment on 08/28/23 when the facility received a phone call from Resident #1's primary care office. DON stated she was not aware the prior Admissions Director told Resident #1 that he could not return to the facility.</p> <p>An interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and was not notified Resident #1 had been assessed by the RT and required an order to be obtained to have the resident's trach changed.</p> <p>A phone Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility and was not notified Resident #1 had been assessed by the RT and required an order to be obtained to have the resident's trach changed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lincolnton Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 East Gaston Street Lincolnton, NC 28092	
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F 0626 Level of Harm - Actual harm Residents Affected - Few	Interview with the Administrator on 04/11/23 at 4:00 PM revealed he was made aware by the DON on 8/28/23 that Resident #1 was being sent out to the infusion center on 8/28/23 and then heading to ED for trach change. The Administrator further revealed it was RT's recommendations and was not aware the RT could not write orders and the physicians had not been notified about Resident #1.		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476</p> <p>Based on observations, record review, and resident and staff interview the facility failed to provide incontinence care when requested for 2 of 3 residents reviewed for activities of daily living care (Resident #53 and Resident #80). Resident #53 was noted to have a new open area to the right buttocks when incontinence care was provided, and Resident #53 reported the area was sore.</p> <p>Findings included:</p> <p>1. Resident #53 was admitted to the facility on [DATE] with diagnoses of hip fracture and diabetes mellitus.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #53 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period.</p> <p>Resident #53 was interviewed in her room on 04/08/24 at 9:49 AM. During the interview she stated she had been sitting in a soiled brief since after breakfast at 8:45 AM. She stated Nurse Aide (NA) #1 had answered her call light around 8:45 AM and stated she was picking up breakfast trays on the hall and could not provide incontinence 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.</p> <p>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.</p> <p>An observation was conducted on 04/08/24 at 10:18 AM of incontinence care for Resident #53 with NA #1 and Unit Manager #1. 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's skin.</p> <p>On 04/08/24 at 11:11 AM an interview was conducted with NA #1. During the interview she stated 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 had forgotten.</p> <p>On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. During the interview she stated no staff member had ever told Nurse Aides that they could not provide incontinence care while meal trays were on the halls. She stated unless the Nurse Aides were actively assisting someone with a meal, they should stop what they're doing and provide incontinence care. She stated Resident #53 had redness to her bottom when she was assisting NA #1 with incontinence care, and she notified the wound nurse.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/24 at 5:15 PM a nursing progress note written by the Assistant Director of Nursing (ADON) revealed Resident #53 was noted with a new open area to the right buttocks which was caused by excoriation. A new order for zinc oxide (a cream used to treat minor skin irritations) was applied and the ADON left a message for the wound Physician to see Resident #53.</p> <p>A physician order dated 04/08/24 revealed Resident #53 received an order for zinc oxide to be applied to the residents buttocks every shift three times a day for a duration of 30 days.</p> <p>On 04/11/24 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview she stated she was the acting wound nurse in the facility. She stated she went in and assessed Resident #53 on 04/08/24. She stated she noted excoriation (scraped or abraded skin) on the resident's buttocks. The ADON stated she initiated Zinc Oxide for treatment of the area. She stated she felt the area was caused by the way the resident sat in the bed and not from sitting in a soiled brief because she had this issue prior while being in the facility.</p> <p>A wound note written by the wound physician dated 04/09/24 revealed Resident #53 had a new wound care assessment completed. Resident #53 was noted to have a non-pressure wound of the right upper buttock measuring 1.4-centimeter (cm) length by 0.6 cm width by 0.1 cm depth. The duration of the wound was noted to be at least 2 days.</p> <p>On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the resident asked. The interview revealed staff were able to provide care regardless of if meal trays were on the hall. The interview revealed she did not feel like having residents wait for incontinence care was an acceptable practice.</p> <p>2. Resident #80 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #80 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period.</p> <p>An observation conducted on 04/08/24 at 10:30 AM revealed Resident #80 yelled into the hall and notified NA #1 she had a soiled brief. NA #1 was observed entering the room.</p> <p>Resident #80 was interviewed in her room on 04/08/24 at 10:45 AM. During the interview she stated she had been sitting in a soiled brief since 9:30 AM and knew this because she had been looking at the clock on the wall. She stated she had told NA #1 that she was sitting in a soiled brief with bowel movement and NA #1 acknowledged her and left the room. She stated she was still sitting in bowel movement and needed to be changed.</p> <p>On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An observation was conducted on 04/08/24 at 10:57 AM of Unit Manager #1 and Assistant Director of Nursing (ADON) providing incontinence care to Resident #80. Resident #80's top sheet, bed pad and fitted sheet were observed to be soiled with feces. Resident #80 was observed to have feces extending down onto the thighs and covering her urinary catheter. A complete bed change was observed after the nurses provided incontinence care to Resident #80.</p> <p>On 04/08/24 at 9:49 AM an interview was conducted with NA #1. During the interview she stated Resident #80 had told her she needed to be changed however she had already started running water down the hall for another resident's bed bath. The interview revealed she had planned on completing the bed bath prior to changing Resident #80. NA #1 stated she did not know Resident #80 had been sitting in a soiled brief since 9:30 AM.</p> <p>On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated once you see a call light on you should provide the care or let another staff member know so the care was provided. Unit Manager #1 stated she had to complete an entire bed change for Resident #80 due to incontinence and that was not common in the facility. She stated typically the Nurse Aides were good about providing care.</p> <p>On 04/11/23 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she did assist Resident #80 with incontinence care and had to complete a bed change due to the incontinence. The ADON stated Nurse Aides should be providing care upon resident request.</p> <p>On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the residents asked. The interview revealed she did not feel like having residents wait for incontinence care was an acceptable practice.</p>		