STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. Building B. Wing	04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnton Rehabilitation Center	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)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 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. The Findings included: Resident #80 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and hypertension. 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. 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. 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. 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Findings included: Resident #1 was admitted into the facility on [DATE] with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. 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. 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. She indicated he had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy due to nursing staff not being familiar with caring for a resident with a cuffed tracheostomy with a different cannula. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated Resident #1 was not in distress and could have waited to have his trach change when supplies were obtained. Review of progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was sent to the emergency room (ED). 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 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 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. 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. She indicated she was 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 to the Infusion Center Nurse #1 from the facility Admissions Director the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was indicated Infusion Center Nurse #1 indicated Resident #1 had a bag packed with his belongings. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Resident #1 being discharged on [DATE]. 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 tracheostomy. The DON further revealed Resident #1 had an appointment to the infusion center on 08/28/24 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 for ED transfer and tracheostomy change. 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 stated she was not aware the facility Admissions Director had reported to the infusion center that Resident #1could not return to the facility. 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 notified her that Resident #1 had left against medical advice (AMA) but someone from the facility had reported it to her. 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 was not notified that the resident had been sent out to the emergency room to have his tracheostomy changed. The MD further revealed he was unable to recall who notified the MD Resident #1 had left AMA and was not returning to the facility on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 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. Findings included: 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. Resident #1 was admitted to the facility on [DATE] with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. 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. 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. Review of a progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was at the emergency room (ED). (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	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. A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him. A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his 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. 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. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	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. 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). 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. 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.

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F 0626 Level of Harm - Actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 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. Findings included: 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. Resident #1 was admitted to the facility on [DATE] with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. 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. 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. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	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. 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 #1explained 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. 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. 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnton Rehabilitation Center	1410 East Gaston Street Lincolnton, NC 28092

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F 0626 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. (continued on next page)

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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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for resident with mental health diagnosis upon admission and residents with new mental health diagnoses for 2 of 3 residents (Resident #67 and #90) reviewed for PASRR. The findings include: 1. Review of Resident #67's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on [DATE]. The resident had been diagnosed with anxiety disorder on 6/22/23, major depressive disorder on 6/22/23, post-traumatic stress disorder (PTSD) on 12/28/23, and mood (affective) disorder on 1/31/24. No PASRR level II had been completed per Resident # medical records. During an interview on 4/11/24 at 8:57 AM with the Social Worker (SW) revealed he had been employed as the facility SW over the past several years and since that time had been responsible for completing PASRR upon a resident admission if needed, when a change in condition or behavior had occurred, or when there had been a new diagnosis. He revealed he would review a resident's diagnosis and PASRR level once they were admitted and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition to determine if paperwork for a level II PASRR would need to be completed. The SW stated he had not been made aware of Resident #67 new mental health diagnosis of anxiety disorder, major depressive disorder, PTSD, and mood (affective) disorder and felt it could have been an oversight, however based on new diagnosis and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. During an interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #67 newly added diagnosis of anxiety disorder, major depressive disorder, PTSD, and mood (affective) disorder a PASRR level II should have been completed. 2. Review of Resident #90 medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on [DATE]. The resident was diagnosed with major depressive disorder on 3/08/24 and unspecified mood disorder on 3/08/24 upon admission. No PASRR level II had been completed per Resident #90 medical records. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/24 at 8:57 AM with the Social Worker (SW) revealed he had been employed as the facility SW and since that time had been responsible for completing PASRR upon a resident admission if needed, when a change in condition or behavior had occurred, or when there had been a new diagnosis. He revealed he would review a resident's diagnosis and PASRR level once they were admitted and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition to determine if paperwork for a level II PASRR would need to be completed. The SW stated Resident #90 admission diagnosis and level of PASRR had simply been overlooked, however based on Resident #90 admission diagnosis of major depressive disorder and unspecified mood disorder and the preadmission PASRR level I, paperwork for a PASRR level II should have been completed. During an interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #90 admission diagnosis of major depressive disorder and unspecified mood disorder a PASRR level II should have been completed.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 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. Findings included: 1. Resident #53 was admitted to the facility on [DATE] with diagnoses of hip fracture and diabetes mellitus. 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. 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. On 04/08/24 at 9:58 AM the surveyor told NA #1 that Resident #53 needed incontinence care. NA #1 stated she was passing out soap on the hall and that she knew the resident had been waiting for incontinence care but had not been back in the room. An observation was conducted on 04/08/24 at 10:18 AM of incontinence care for Resident #53 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. 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. 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. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. 2. Resident #80 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus and hypertension. 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. 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. 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. On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43643 Based on observations, record reviews and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place in the areas of dignity and respect (F550) and notification of change (F580). Additionally, the facility's QAA Committee failed to identify deficient practice for a discharge that occurred on 8/28/23 and implement corrective action to ensure compliance was sustained in the area of safe and orderly discharge (F624). These 3 deficiencies were cited on the complaint investigation survey of 2/15/24 and subsequently recited on the current recertification and complaint investigation survey of 4/13/24. The facility's continued failure during two surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to: F 550: 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. During the complaint investigation survey of 02/15/24 the facility failed to treat a resident in a dignified manner when a Nurse Aide (NA) was rough and pushing on her during a transfer. This made the resident feel unsafe during the transfer and she stated this was a dignity issue. Additionally, the facility failed to assist a resident at eye level during a meal reviewed for dignity. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings customer services and respect towards residents. The DON further revealed she did not know why these incidents had occurred. F 580: Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. During the complaint investigation survey of 02/15/24 the facility failed to notify the Physician of a resident's wound upon admission and failed to notify the Physician when the resident's wound had started to deteriorate. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings notification. The DON further revealed nursing staff had failed to make appropriate notification and would continue to educate and put rules in place for proper notification. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F 624: 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. During the complaint investigation survey of 02/15/24 the facility failed to meet the resident's care needs upon discharge by not communicating the physician ordered wound care treatments and ensuring the needed medical equipment was delivered for a resident reviewed for a safe and orderly discharge. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings about safe and orderly discharges. The DON further revealed she could not recall why discharges had been an issue, but steps would be put into place to guarantee residents would not be discharged unsafe in the future.