

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 07/02/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with residents and staff, the facility failed to ensure dependent residents could access the light switch located behind the bed for 2 of 2 residents reviewed for accommodation of needs (Resident #32 and Resident #39).</p> <p>The findings included:</p> <p>a. Resident #32 was admitted to the facility on [DATE].</p> <p>Review of Resident #32's medical records revealed she had stayed in her current room since 05/23/2023.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 was cognitively intact. The MDS indicated walking between locations inside the room for more than 10 feet did not occur for Resident #32 during the assessment period.</p> <p>During an observation conducted on 06/29/2025 at 10:19 AM, the switch for the light fixture behind Resident #32's bed was attached with a cord 24 inches in length. The cord was 4 feet from the floor and 5 feet from Resident #32's bed. Resident #32 was unable to reach the cord from the bed if needed.</p> <p>An interview was conducted with Resident #32 on 06/30/2025 at 9:06 AM. She stated she was bedbound and had been in her room for a very long time. Resident #32 stated she had never been able to reach the light cord to turn her overhead light on. She revealed she did not have any control of the light fixture behind her bed as she could not stand up to reach the broken switch cord on the wall. Resident #32 explained she had to rely on nursing staff to control the light fixture, and it was very inconvenient to her because she enjoyed using her computer and needed the overhead light to see the computer screen. She wanted the maintenance staff to fix the switch cord to accommodate her needs as soon as possible.</p> <p>Subsequent observations conducted on 06/30/2025 at 2:00 PM, 07/01/2025 at 8:31 AM, and 07/01/2025 at 3:59 PM revealed the switch cord for the light fixture behind Resident #32's bed remained inaccessible.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation and interview were conducted with Nurse Aide (NA)#1 on 07/02/2025 at 9:12 AM. The switch cord for the light fixture behind Resident #32's bed remained inaccessible from her bed. NA#1 acknowledged that the switch cord was too short for Resident #39 to reach, and it needed to be fixed. NA #1 stated she had never thought about the light cord being too short for Resident #39 to reach but stated that she did turn the overhead light on for Resident #32 when she made her morning rounds so Resident #32 could use her computer. NA #1 also stated that she had not reported the light cord to anyone at the facility.</p> <p>An interview was conducted with Unit Manager (UM) #1 on 07/02/2025 at 9:32 AM. She acknowledged that the switch cord for the light fixture behind Resident #32 bed was broken. UM #1 stated the light cord needed to be fixed immediately to ensure Resident #32 had full accessibility to the light fixture.</p> <p>b. Resident #39 was admitted to the facility on [DATE].</p> <p>Review of Resident #39's medical records revealed she had stayed in her current room since 02/01/2024.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. The MDS indicated walking between locations inside the room for more than 10 feet did not occur for Resident #39 during the assessment period.</p> <p>During an observation conducted on 06/29/2025 at 11:11 AM, the switch for the light fixture behind Resident #39's bed had a broken cord. The broken cord was 2 inches in length and was 6 feet from the floor and 5 feet from Resident #39's bed. Resident #39 was unable to reach the switch cord from the bed if needed.</p> <p>An interview was conducted with Resident #39 on 06/30/2025 at 9:06 AM. She stated she had never been able to reach her light cord to turn the overhead light on and she had been in her current room for a very long time. Resident #39 stated she would like to be able to turn the light on and off when she needed it because she enjoyed reading and doing word puzzles while lying in bed. Resident #39 stated she did not have any control of her overhead light, and she had to rely on the nursing staff to turn the light on and off because she had a stroke and could not stand up and reach the light switch cord. Resident #39 also stated that it was inconvenient to her, and she would like the light switch cord repaired as soon as possible.</p> <p>Subsequent observations conducted on 06/30/2025 at 2:15 PM, 07/01/2025 at 9:01 AM, and 07/01/2025 at 3:49 PM revealed the switch cord for the light fixture behind Resident #39's bed remained inaccessible.</p> <p>An observation and interview were conducted with NA#1 on 07/02/2025 at 9:12 AM. The switch cord for the light fixture behind Resident #39's bed remained inaccessible from her bed. NA#1 acknowledged that the switch cord was broken, and it needed to be fixed. NA #1 stated she had not noticed the switch cord behind Resident #39's bed was broken and that she had not reported the broken switch cord to anyone at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Unit Manager #1 on 07/02/2025 at 9:32 AM. She acknowledged that the switch cord for the light fixture behind Resident #39's bed was broken. UM #1 stated the light cord need to be fixed immediately to ensure Resident #39 had full accessibility to the light fixture.</p> <p>During an interview conducted on 07/02/2025 at 10:06 AM with the Maintenance Supervisor, he stated the nursing staff would let him know if anything in the facility needed repair including the overhead lights and light switch cords. The Maintenance Manager stated he depended on the staff to report repair needs by completing work orders and leaving them at the nursing station or by verbal notification. He explained that he checked the nursing station several times a day for any work orders to ensure all repair needs were addressed in a timely manner. He stated he did not know the switch cords for Resident #32 and Resident #39 needed repairing.</p> <p>An interview was conducted with the Director of Nursing (DON) on 07/02/2025 at 10:30 AM. The DON stated she was not aware Resident #32 and Resident #39 could not access their light switch cords, but she did expect staff to notify maintenance if anything in the facility needed repair. The DON also stated that she expected staff to be more attentive to residents' living environment, and to report repair needs in a timely manner to accommodate the residents' needs.</p> <p>An interview was conducted with the Administrator on 07/02/24 at 10:35 AM. The Administrator stated he expected the nursing staff to pay attention to residents' rooms and report all repair needs to the maintenance department in a timely manner. It was his expectation for all dependent residents to have full accessibility and control of the light fixture behind the bed all the time.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews the facility failed to provide a resident with the opportunity to participate in the review and revision of his care plan for 1 of 3 residents reviewed for care plans (Resident #80).</p> <p>The findings included:</p> <p>Resident #80 was admitted to the facility on [DATE].</p> <p>Resident #80's significant change Minimum Data Set (MDS) dated [DATE] noted he was cognitively intact and required maximum assistance or was dependent on staff for most activities of daily living.</p> <p>Review of Resident #80's electronic health record noted no care plan meeting had been conducted since 1/8/25.</p> <p>An interview on 6/29/25 at 12:25 PM with Resident #80's revealed he had not been invited to a care plan meeting. He had attended in the past and felt like he should have had an opportunity to attend.</p> <p>An interview on 7/01/25 at 10:53 AM with the Social Worker revealed her assistant scheduled the care plan meetings and Resident #80's care plan meeting was not on her paper copy of June or July 2025 calendar of meetings. She stated the MDS nurse scheduled the care plan meetings.</p> <p>An interview on 7/01/25 at 10:58 AM with the Social Services Assistant revealed she scheduled resident care plan meetings via a scheduling software based on a schedule provided by the Minimum Data Set (MDS) nurse. She did not remember if Resident #80 had been invited to a care plan meeting or not.</p> <p>An interview on 7/01/25 at 11:04 AM with the MDS Nurse revealed Resident #80 had not had a care plan meeting since 1/08/25. She was unable to say why he had not had a care plan meeting in April but did state he should have had a care plan meeting in April. She looked in the care plan software system and stated he did not have an invitation in the system. She looked at her paper copies of the June and July care plan meetings and was unable to locate his name on the schedule.</p> <p>An interview on 7/02/25 at 8:40 AM with the Administrator revealed he was new to the facility and unaware of the resident care plan schedules. He stated that residents should be invited to the care plan meetings as required by the regulation.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 6 of 6 residents reviewed for activities (Resident #65, #64, #71, #10, #25, #105). The residents expressed not being able to leave the facility since admission made them feel sad, mad or depressed and they missed going shopping and participating in activities they enjoyed.</p> <p>The findings included:</p> <p>A review of the facility activity calendars from July 2024 to July 2025 revealed scheduled activities inside of the facility during the week and on the weekends. There were no activities scheduled outside of the facility.</p> <p>Observation on 7/1/2025 at 4:20 PM revealed the facility was located in a rural area that was within a 5-to-10- minute driving distance to numerous local and commercial shops, grocery stores, fast food and sit-down restaurants.</p> <p>During a resident council meeting on 7/01/25 at 1:30 PM the residents indicated they did not get to go on trips outside of the facility for activities because the facility did not have a van.</p> <p>a. Resident #65 was admitted to the facility on [DATE].</p> <p>Review of Resident #65's annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #65 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #65 was cognitively intact.</p> <p>An interview was conducted with Resident #65 on 6/30/2025 at 9:40 AM. Resident #65 stated the facility did not have a van for trips outside the facility, but it would be nice to get out of the facility.</p> <p>During a follow-up interview on 7/2/2025 at 9:45 AM, Resident #65 stated she would love to be able to go shopping, and stated it bothered her she could not do that anymore, and that she missed going out to shop. Resident #65 stated she had not gone out of the facility for an activity since she was admitted because the facility did not have a van.</p> <p>b. Resident #64 was admitted to the facility on [DATE].</p> <p>Review of Resident #64's annual MDS assessment dated [DATE] indicated it was not very important to participate in group activity or go outside the facility. The quarterly MDS assessment dated [DATE] indicated Resident #64 was moderately cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with Resident #64 on 7/2/2025 at 9:48 AM. Resident #64 stated she would like to be able to go on activities outside of the facility. Resident #64 stated it got old sitting in the same building all the time and it was enough to make anyone depressed. Resident #64 stated she had not been on an activity outside the facility since she was admitted since the facility did not have a van for activities outside the facility.</p> <p>c. Resident #71 was admitted to the facility on [DATE].</p> <p>Review of Resident #71's annual MDS assessment dated [DATE] indicated it was not very important to participate in group activities and to go outside the facility and indicated Resident #71 was cognitively intact.</p> <p>An interview was conducted with Resident #71 on 7/2/2025 at 9:50 AM. Resident #71 stated had not participated in activities at the facility, but she would have participated if the activity involved going outside of the facility on a trip. Resident #71 stated she missed going shopping and would love to be able to do her own shopping. Resident #71 stated it was sad that residents could not go out and do some of the things they enjoyed. Resident #71 stated she was not aware of any activities offered that involved leaving the outside of the facility since she was admitted .</p> <p>d. Resident #10 was admitted to the facility on [DATE].</p> <p>Review of Resident #10's annual MDS assessment dated [DATE] revealed it was very important to Resident #10 to participate in activities with a group and to go outside the facility, it also indicated Resident #10 was cognitively intact.</p> <p>An interview was conducted with Resident #10 (Resident Council President) on 7/2/2025 at 12:48 PM. Resident #10 stated the residents can't go out to eat because the facility did not have a van. Resident #10 stated she would like to go out to eat and that it made her sad and sometimes mad that residents can't go to a restaurant or out somewhere.</p> <p>e. Resident #105 was admitted to the facility on [DATE].</p> <p>Review of Resident #105's admission MDS assessment revealed it was somewhat important to Resident #105 to participate in group activities and go outside the facility, it also indicated Resident #105 was cognitively intact.</p> <p>An interview was conducted with Resident #105 on 7/2/2025 at 12:53 PM. Resident #105 stated she would love to go out shopping, or out to dinner as a group. Resident #105 stated it made her feel sad that she was always in the building, but the facility did not have a van, so residents were not able to go outside of the facility for activities.</p> <p>f. Resident # 25 was admitted to the facility on [DATE].</p> <p>Review of Resident #25's admission MDS assessment indicated it was not very important to participate in activities with groups and somewhat important to go outside the facility. The admission MDS indicated Resident #25 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with Resident #25 on 06/29/25 at 11:31 AM. Resident #25 stated she would love to go to the bookstore and go to a fast food restaurant, or at least go through the drive-through, on the way back, but the facility did not have a van, so they could only go out for medical appointments.</p> <p>During a follow up interview on 7/2/2025 at 12:57 PM, Resident #25 stated she did not participate in the in-house activities because she was not interested in any of them. Resident #25 stated if residents were able to get out of this building that would be great. Resident #25 stated staying inside the same walls all the time was depressing, and she thought residents should have the right to get out of the building.</p> <p>During an interview on 7/2/2025 at 8:49 AM the Activity Director stated the facility did not have any scheduled activities that were off the facility campus because the facility did not have a van. The Activity Director stated after 2020 (Covid) the facility had a new transport company that would charge \$60 per person. The Activity Director stated if residents needed anything she went shopping for them once a week, and the facility could arrange transport at the residents' expense. The Activity Director stated she thought the facility only had one company that was used for transport. The Activity Director stated the facility had not had an off campus activity since 2020 (before Covid) and prior to that they had two outings a month such as shopping or going out to eat. The Activity Director stated she thought the company that used to provide transport had gone out of business. The Activity Director agreed it would be good for the residents to be able to have activities outside of the facility and have the ability to interact with the community. The Activity Director could not provide a specific date for the last activity that was outside the facility campus.</p> <p>During a joint interview with the Director of Nursing (DON) and Administrator, the Administrator and DON both agreed it was important for residents to have interaction with the community and be able to participate in activities outside of the facility. The DON stated she was not aware any residents had voiced they wanted to go on activities outside the facility. The DON stated the facility did not have a van to use for outside activities. The DON stated the facility went shopping for the residents to get requested items. The Administrator and DON verified that residents had not been out for a personal shopping trip unless a family member had transported them, since prior to 2020.</p> <p>During an interview on 7/2/2025 at 1:40 PM the Director of Clinical Services stated the facility did not have a way to get residents to activities outside of the facility. The Director of Clinical Services stated they bring activities to the facility and the residents go outside of the building, and no residents had asked to go on trips outside the facility, and they did not have a van available. The Director of Clinical Services stated if they had knowledge they would have tried to make accommodations and stated that activities outside of the facility campus were provided at the company's other facilities.</p>		