

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Cardinal Healthcare and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 931 N Aspen 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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019</p> <p>Based on record review and staff interviews, the facility failed to accurately code a significant change Minimum Data Set (MDS) assessment in the area of special treatments, procedures, and programs for 1 of 3 residents reviewed for Dialysis treatments and Hospice care (Resident #13).</p> <p>The findings included:</p> <p>Resident #13 was readmitted to the facility on [DATE] with diagnoses which included cerebral vascular accident, and dementia.</p> <p>Review of the significant change MDS assessment dated [DATE] for Resident #13 revealed she was moderately cognitively impaired. Under the section for Health Conditions/prognosis Resident #13 did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. Under the section for Special Treatments, Programs and Procedures Resident #13 was checked as being on Dialysis treatments while a resident and checked as being on Hospice care while a resident.</p> <p>An interview on 05/05/25 at 11:20 AM with Resident #13 revealed she was not on dialysis and had never had dialysis treatments. Resident #13 stated she was not on hospice care but was on palliative care for pain management. Resident #13 stated she had been on hospice care in the past but it was discontinued in 2022.</p> <p>An interview on 05/08/25 at 12:14 PM with the MDS Coordinator at the facility revealed she had just started at the facility in April of 2025 and was not at the facility when the significant change MDS was completed. The MDS Coordinator stated the resident was under palliative care and should not have been coded as Hospice care. Additionally, the MDS Coordinator stated she did not see any reason Resident #13 would have been coded for Dialysis care and said it must have been a keying error. The MDS Coordinator further stated she would modify the assessment and resubmit.</p> <p>An interview on 05/08/25 at 12:31 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident.</p> <p>An interview on 05/08/25 at 12:40 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006</p> <p>Based on record review and staff interviews, the facility failed to develop an individualized comprehensive care plan in the area of anticoagulant (blood thinner) medication use for 1 of 2 residents whose comprehensive care plans were reviewed (Resident #8).</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on [DATE] with diagnoses that included a left femur fracture with surgical repair and dementia.</p> <p>A review of the active medication orders for Resident #8 revealed an order for Enoxaparin Sodium (an anticoagulant medication) 40 milligrams (mg.) subcutaneously (method of administering medication by injecting a drug into the fatty tissue layer beneath the skin) at bedtime for deep vein thrombosis (blood clot) prophylaxis. The medication had a start date of 04/09/2025.</p> <p>Review of the admission Minimum Data Set (MDS) assessment for Resident #8 dated 04/16/2025 indicated Resident #8 was severely cognitively impaired and was receiving an anticoagulant.</p> <p>A review of Resident #8's comprehensive care plan dated 04/29/2025 did not reveal any care plan focus area or interventions related to Resident #8 receiving an anticoagulant medication.</p> <p>A review of Resident #8's Medication Administration Record from 4/09/2025 through 5/07/2025, revealed Resident #8 received Enoxaparin Sodium 40 mg subcutaneously every night at bedtime.</p> <p>On 05/08/2025 at 12:25 PM an interview with the MDS Coordinator revealed Resident #8's care plan did not address anticoagulant medication. The MDS Coordinator explained the care plan should include the use of an anticoagulant medication.</p> <p>An interview was conducted on 05/08/2025 at 12:30 PM with the Director of Nursing (DON). The DON indicated anticoagulant medications were considered high-risk medications. The DON stated the anticoagulant medication should be addressed in Resident #8's comprehensive care plan so all staff caring for her would be aware she was at risk for side effects like bleeding or bruising.</p> <p>An interview was conducted with the Administrator on 05/08/2025 at 12:45 PM. The Administrator stated he expected all resident care plans to be reflective of their clinical condition including the use of anticoagulant medications.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37019</p> <p>Based on observation, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when Nurse #1 did not doff her gloves, perform hand hygiene and don clean gloves prior to applying wound treatment and a clean dressing during wound care to Resident #2. The deficient practice occurred for 1 of 9 staff members observed for infection control practices (Nurse #1).</p> <p>The findings included:</p> <p>Review of the facility's policy entitled Handwashing/Hand Hygiene last updated August 2019 read in part:</p> <p>Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.</p> <p>7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:</p> <p>b. Before and after direct contact with residents;</p> <p>g. Before handling clean or soiled dressings, gauze pads, etc.;</p> <p>j. After contact with blood or body fluids;</p> <p>k. After handling used dressings, contaminated equipment, etc.;</p> <p>m. After removing gloves;</p> <p>An observation of Nurse #1 providing wound care on Resident #2's coccyx wound was made on 05/06/25 at 11:08 AM. Nurse #1 gathered her dressing supplies and placed them on wax paper on the overbed table. The old dressing was removed by Medication Aide #1 who was assigned to the resident. Nurse #1 doffed her gloves and washed her hands with soap and water and donned clean gloves and proceeded to clean the wound inside outward with normal saline-soaked gauze and patted the wound dry with dry gauze. After cleaning the wound and without doffing her gloves, sanitizing her hands, and donning clean gloves, Nurse #1 proceeded to pack the wound with normal saline-soaked gauze and applied bordered foam dressing with date and initials over the wound. Nurse #1 gathered her supplies and trash, doffed her gown and gloves, washed her hands with soap and water, and left the room.</p> <p>An interview on 05/06/25 at 4:55 PM with Nurse #1 revealed she felt like she could have done a better job with the wound care on Resident #2. She stated she should have doffed her gloves, sanitized her hands, and donned clean gloves after cleansing the wound and prior to applying the treatment to Resident #2's wound. She stated she knew that you were supposed to doff, sanitize and don clean gloves after cleansing a wound and before applying the treatment because that was going from a dirty to clean procedure. Nurse #1 further stated it was an oversight on her part because she was nervous about being watched during wound care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 05/07/25 at 9:16 AM with the Infection Preventionist (IP) revealed all the nurses had been in-serviced on handwashing and dressing changes and said anytime they were going from a dirty procedure to clean procedure they were supposed to doff their gloves, sanitize their hands and don clean gloves. The IP also revealed that anytime they doffed their gloves they were supposed to sanitize their hands before donning clean gloves.</p> <p>An interview on 05/08/25 at 12:29 PM with the Director of Nursing (DON) revealed it was her expectation that Nurse #1 follow the facility's policy and procedure for Handwashing/Hand Hygiene during wound care.</p> <p>An interview on 05/08/25 at 12:36 PM with the Administrator revealed he would have expected Nurse #1 to follow their Handwashing/Hand Hygiene policy and procedure while providing wound care.</p>