STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gastonia Health & Rehab Center	1770 Oak Hollow Road Gastonia, NC 28054

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to provide incontinence care to a resident prior to her wetting through her brief, turn sheet, and bed sheet for 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #1). The findings included:Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included atrial fibrillation, diabetes mellitus, decreased mobility, osteoarthritis and non-Alzheimer's dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact with no behaviors and no impairment of her upper or lower extremities and used a wheelchair for mobility. The assessment also revealed the resident was dependent for toileting, required 2 persons assistance with toileting and was incontinent of both bladder and bowel.A urinary incontinence care plan last revised on 10/14/25 revealed Resident #1 was incontinent of urine. The goal was for Resident #1 to receive assistance with toileting, be maintained comfortable, clean and dry and free from skin breakdown. The interventions included providing incontinence care as needed and monitoring peri-area for redness, irritation, skin excoriation and breakdown. An activity of daily living self- care performance deficit care plan last revised on 10/14/25 revealed Resident #1 required assistance with all ADL related to limited mobility. The goal was for Resident #1's needs to be met with staff assistance as needed. The interventions included encourage Resident #1 to use bell to call for assistance, and 2 persons assist with bed mobility and with all care while resident is in bed.An observation of incontinence care on 10/14/25 at 10:30 AM, revealed Resident #1 was being assisted with a brief change by Nurse Aide (NA) #5 and NA #6. When NA #5 and NA #6 pulled back Resident #1's bed covers, the bed sheet was visibly wet under the resident. NA #5 pulled back the resident's brief and it was saturated from the front of the brief to the back of the brief with urine and the inside of the brief had begun to bunch up. NA #6 cleaned the resident from front to back and then NA #5 and NA #6 assisted the resident to turn on her side so NA #6 could clean her back side. NA #6 then placed a clean brief under the resident and she and NA #5 turned the resident to get the brief placed on her and get the soiled brief off the resident. When NA #5 threw the soiled brief in the trash can it made a loud thud. NA #5 and NA #6 then placed clothing on the resident so she could get up in her wheelchair. Once the resident had been transferred to her wheelchair there was a visible wet spot on the turn sheet and the bed sheet under it was visibly wet with urine as well. NA #7 came in and stripped the wet turn sheet and bed sheet from the bed.An interview on 10/14/25 at 10:55 AM with Resident #1 revealed she had not been provided incontinence care since 1:30 AM on 10/14/25 until she received it at 10:30 AM. Resident #1 stated NA #8 who was caring for her during the 7:00 PM to 7:00 AM shift had come in and told her that she would be back to change her brief around 6:00 AM but said NA #8 never came back to change her. Resident #1 further stated NA #7 who was assigned to care for her during the 7:00 AM to 7:00 PM shift on 10/14/25 had come into her room and told her she would be back with another NA to change her but said she never came back before NA #5 and NA #6 came in to get her ready to get up in the wheelchair and they had changed her brief. Resident #1 stated they usually changed her two to three times during the night because she urinated frequently but said they had only changed her once after midnight at 1:30 AM. Resident #1 indicated she knew she was wet because when she woke up sometime between 5:30 AM and 6:00 AM she felt her wet sheet against her leg and it was cold. The resident further indicated she had eaten her breakfast in bed in her wet brief but said she was more concerned with eating because her blood sugar had been low earlier at 6:00 AM. A telephone interview on 10/14/25 at 3:20 PM with NA #8 who was assigned to care for Resident #1 during the night shift on 10/14/25 revealed she had not changed Resident #1 after 1:30 AM. She stated it had been a busy night and she had gone to change the resident around 6:00 AM and the resident was shaking and told NA #8 she thought her blood sugar was low and asked her to get the nurse. NA #8 stated she was going back to change Resident #1 around 6:30 AM to 6:45 AM and said her coworker had left shift early and was not available to assist her so she had reported off to 1st shift (could not recall who she reported off to) that Resident #1 needed to be changed. NA #8 further stated Resident #1 should have been changed one additional time during the night but said it was difficult when there were only 2 NAs working to get both NAs in one room to change the resident. NA #8 indicated she had not asked the nurse for assistance because she had been busy with other tasks but said that she probably should have asked her to assist and changed the resident.An interview on 10/14/25 at 11:10 AM with NA #5 and NA #6 revealed they were not assigned to care for Resident #1 but

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident, staff, manufacturer ‘s representative, Nurse Practitioner (NP) and Medical Director interviews, the facility failed to: a.) supervise Resident #1 during a shower when Nurse Aide (NA) #1 turned away from Resident #1 to gather supplies on 09/18/25 and Resident #1 fell from the shower chair to the shower room floor. No pain or injury was noted from this incident; b.) provide a safe transfer for Resident #1 when NA #1 was transferring the resident from the bed to wheelchair using the mechanical lift. During the transfer and while Resident #1 was suspended approximately 4 to 5 feet from the floor, the lift tilted to one side and the resident fell while still in the sling onto the floor on her back. Then the mechanical lift fell on top of Resident #1 with the lift bar striking her on the top of her head. Resident #1 was evaluated at the hospital and diagnosed with a left calcaneal fracture (fracture of the heel bone) and a left anterior talus (the bone in the foot that connects the ankle to the leg) fracture and returned to the facility with a leg immobilizer and non-weight bearing orders pending orthopedic evaluation; c.) transfer Resident #1 safely when NA #5 and NA #6 had to manually stabilize the mechanical lift when the left back lift wheel lifted off the floor while the resident was suspended in the lift sling. Two additional staff assisted in completing the transfer safely with no injuries to the resident. It was observed after the transfer, the brand of lift sling used for the transfer was not the same brand as the mechanical lift utilized by the facility which does not align with the manufacturer's recommendations; and d.) transfer Resident #1 out of bed with the mechanical lift using a lift sling that was the same brand as the brand of mechanical lift utilized by the facility. In addition, an interview revealed the NAs were responsible for determining the sling size a resident required for mechanical lifts. This deficient practice affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included:1. Resident #1 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, decreased mobility, osteoarthritis, diabetes mellitus, morbid obesity, and non-Alzheimer's dementia.A Care Area Assessment summary dated 12/02/24 revealed Resident #1 was at risk for falls due to her dementia, incontinence, medications, lack of mobility, and functional decline in her activities of daily living (ADL). The summary indicated interventions were in place and updated, changed and/or added as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was cognitively intact with no behaviors and no impairment of upper or lower extremities and used wheelchair for mobility. The assessment also revealed the resident was dependent for toileting, bathing, dressing and transfers, and required substantial to maximal assistance with personal hygiene, bed mobility, and partial to moderate assistance with mobility in her wheelchair. In addition, the resident's weight was documented as 304 pounds.An activity of daily living care plan dated 07/24/25 revealed Resident #1 had an ADL self-care performance deficit related to limited mobility. The goal was for Resident #1 to have needs met with staff assistance as needed. The interventions included two staff assistance with bed mobility and with care while in bed, required assist bars to aid in bed mobility, required two staff assist with mechanical lift and encourage the resident to use call bell for assistance.A falls care plan dated 07/24/25 revealed Resident #1 was at risk of falls characterized by history of falls/injury, multiple risk factors related to: dementia, confusion, medication use, incontinence, poor safety awareness and psychiatric disorder. The goal was to minimize falls with injuries through the next review. The interventions included fall prevention program per facility routine, encourage resident to get out of bed for meals as she agrees and/or wishes, bed in lowest position and fall risk assessments quarterly and as needed.a. During an interview with Resident #1 on 10/08/25 at 2:25 PM she revealed that on 09/18/25, NA #1 and NA #2 transferred her from her wheelchair into a bariatric shower chair. The resident stated she was not all the way back in the chair so NA #1 requested assistance from Nurse #3 to reposition the resident in the shower chair. Resident #1 further stated she could tell that she was not positioned all the way back in the chair and said it was a different chair than she was used to because her feet did not touch the floor in the chair. She explained that the other bariatric chair allowed her to keep her feet on the floor and gave her a sense of balance while in the shower chair. Resident #1 indicated she told NA #1 that she was in the wrong shower chair because her feet did not touch the floor and said NA #1 told her she was okay in the chair she was in. Resident #1 stated NA #1 turned away from her to get supplies and the shower chair started to tip but NA #1 was able to turn back around and catch her and the chair before she fell. Resident #1 further stated NA #1 turned away from her again to get supplies and this time Resident #1 said the chair tipped forward and she fell out of the chair onto the floor on her left side