STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL HEALTHCARE AND REHAB	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)
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** Based on record reviews, responsible party and staff interviews, the facility failed to notify the resident's responsible party regarding the details of a resident's intimate relationship with another resident (Resident #26 and Resident #27) for 1 of 3 residents reviewed for notification. The findings included: Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #26's quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was severely cognitively impaired. Resident #26 required limited assistance of one staff member for most activities of daily living (ADL). Resident #27 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #27's quarterly Minimum Data Set ((MDS) dated [DATE] revealed he was alert and oriented requiring limited assistance of one staff member for most ADL. Review of a progress note dated 6/19/20 at 6:37 AM revealed the Assistant Director of Nursing had talked with Resident #26's family member regarding her and Resident #27 having a relationship and affection touching. The resident's family member stated she was ok with that. Review of a progress note dated 8/6/20 revealed Resident #26 and Resident #27 were placed on every 15-minute monitoring due to an incident occurring where Resident #27 became aggressive towards staff over Resident #26. On 8/20/20 at 5:30 PM an interview was conducted with NA #9. She stated on 8/11/20 around 3:00 AM she had witnessed Resident #27 in Resident #26's bed. NA #9 walked in the room to do rounds and said she told Resident #27 that was inappropriate, and he told her to get out. She left the room to go get Nurse #8, but the nurse was outside smoking. NA #9 told Nurse #8 when she found her and by the time, they came back to the room Resident #27 had left Resident #26's room and returned to his room. NA #9 stated the Nurse did not do anything or say anything to Resident #27 because he was already back in his room when she got to Resident #26's room. NA #9 stated she told the ADON what had happened and had written a statement. On 8/19/20 at 10:18 AM an interview was conducted with Nurse #5. She stated Resident #26 and Resident #27 had developed a relationship which she felt was inappropriate due to Resident #26 being cognitively impaired. She stated the first occasion was on 8/6/20 when the two were observed holding hands in the hallway. The second occasion was on 8/16/20 when Resident #26 was observed in Resident #27's room. Resident #27 was undressed from the waist down with no sheet lying in bed. Nurse #5 pulled Resident #26 out of the room and notified the Director of Nursing, Administrator and family members to explain the extent of what happened. The interview revealed Nurse #5 worked 7:00 AM to 7:00 PM. She stated she texted the DON and the Administrator stating they needed to do something immediately. On 8/19/20 at 11:22 AM an interview was conducted with the Assistant Director of Nursing (ADON). She stated she had called the residents daughter when the relationship began in June. The interview revealed the daughter was ok with the resident having a friendship with Resident #27 but did not want her mother taken advantage of. She stated because the daughter was comfortable with them holding hands, they didn't see anything wrong with the relationship continuing. She stated she had come in early on 8/12/20 to speak with NA#9 and receive a statement because she had been notified of a situation between Resident #26 and Resident #27 that had occurred the day prior on 8/11/20. The ADON stated NA #9 had walked into Resident #26's room to find Resident #27 in her bed and the two residents were under the sheets. She stated Resident #27 had his arm around Resident #26 while lying in the bed. Resident #27 told NA #9 to get out. She then left the room for a period of time and when she came back, she saw Resident #27 coming out into the hall in his wheelchair from the room. The interview revealed she did not contact Resident #26's daughter after receiving the statement from NA #9. On 8/19/20 at 3:30 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated he was made aware of the relationship between Resident #26 and Resident #27 a couple of weeks ago. Staff reported the residents had been sitting in the hallway together and were holding hands. Nurse #5 had told him she had seen Resident #27 kissing Resident #26 in the hallway. He stated the staff weren't happy the residents were interested in each other. He stated the topic had come up during a morning interdisciplinary team meeting (IDT) discussing whether the residents had the right to have a relationship. He stated the Administrator had contacted Resident #26's daughter who stated it was ok for the resident to seek affection however he didn't talk to her, so he didn't know the extent of the conversation. The DON stated it was reported to him but could not recall the date that the residents were in the bed together from the ADON. He stated the ADON had informed him NA #9 had walked in and found Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the daughter, but he didn't know what the Administrator had told her. On 8/19/20 at 4:24 PM an interview was conducted with the Administrator. He stated both residents desired a relationship however Resident #26 was unable to consent. The residents liked to hold hands and hang out although encouraged not to by staff. He stated he was notified date unknown, that Resident #27 attempted to get in bed with Resident #26 by the ADON who had received a statement from NA #9. He stated NA #9 had observed the residents in bed together and suspected something may have happened. The interview revealed he never conducted a formal investigation into the incident nor had nursing staff complete a physical assessment of Resident #26 because he didn't feel like they needed to. He stated he had contacted Resident #26's family member and she was ok with the relationship, so he decided the allegation did not need to be investigated further. On 8/19/20 at 4:47 PM an interview was conducted with Resident #26's family member. She stated Nurse #5 had contacted her several times regarding the relationship between the two residents and to tell her Resident #26 was in a male resident's room when he was found naked from the waist down. She stated she then called the Administrator because he had not contacted her, wanting more details regarding the incident however he just stated the two residents had gotten too risqu. She stated he didn't go into further details nor was she aware the male resident was found in Resident #26's bed. The interview revealed she was absolutely not comfortable with them being in bed together. She stated she needed to keep her mother safe and the thought of the two residents together disgust her. She stated when she talked to the Administrator, she told him she was comfortable with the residents having a friendship and holding hands but nothing further. She stated the Administrator should have notified her of the extent of the relationship between the two residents. The interview revealed she felt staff weren't detailed enough with her discussing what was going on and she was unable to visit the facility due to COVID-19.
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident, family and staff interviews, the facility failed to make prompt efforts to resolve resident grievances and provide a written grievance investigation summary with resolution to the person filing the grievance for 3 of 3 sampled residents reviewed (Resident #'s 9, 1, and 12). Findings included: Review of the facilities

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Complaint/Grievance Policy and Procedure revised 12/20/2016 revealed the following: Purpose: To support each resident's right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of its progress toward resolution. Process: The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. 1. Resident #9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's annual Minimum Data Set ((MDS) dated [DATE] revealed he was cognitively intact and required extensive assistance of one with bathing. The MDS also revealed his upper extremity was impaired on one side. Review of a grievance form filed on 05/04/2020 by a family member on behalf of Resident #9 revealed in the Complaint/Grievance section of the form, the resident claimed he had not had a shower all week and said he was told it was due to a shortage in staff. In the Documentation of Investigation section of the form it was blank. In the Resolution section of the form it was blank. The form was assigned to the Administrator and Director of Nursing as responsible for the investigation. Review of Resident #9's admission Minimum Data Set ((MDS) dated [DATE] revealed he was cognitively intact and required extensive assistance of one staff with bathing. Review of Resident #9's care plan dated 07/13/2020 revealed he had a care plan for being at risk of decline in self-care/mobility due to [MEDICAL CONDITION], and decreased range of motion of the right shoulder. An interview on 07/22/2020 at 9:00 AM with Resident #9 revealed he had previously complained about a lack of Nurse Aides (NAs) and stated it was still going on and stated sometimes on the day shift there were only 2 NAs for the whole building, and he could not get his showers as scheduled. Resident #9 stated he was lucky if he got 1 shower per week but stated he had gone weeks with no shower. He stated he had refused showers before when the staff wanted to give them late in the evening and stated he preferred them early morning or afternoon but not in the evening. Resident #9 stated no one had spoken with him about his showers and stated he had not received anything in writing to address his grievances. An interview on 07/22/2020 at 2:20 PM with the Social Services Manager (SSM) revealed she had not received the grievance form back for Resident #9 with the investigation and resolution. She explained the normal process was for the grievance section to be filled out and the grievance to be given to her to record. The SSM stated she made copies of the form and then gave them to the Administrator for distribution to the appropriate department head. She went on to explain once the investigation is completed and the resolution is documented she crafts a follow up letter to the resident or family member or whomever filed the grievance and she files the letter with the copy of the grievance. According to the SSM, grievances were discussed in the morning meeting as well as the afternoon stand down meeting. She stated the Administrator asked if there were new concerns and her response had been yes or no and stated there were still outstanding complaints that had not been resolved. The SSM stated the grievances that were not returned to her with the investigation and resolution completed had not received follow up letters to the grievance. An interview on 07/22/2020 at 3:40 PM with the Director of Nursing (DON) revealed he was aware there was a 72-hour window for handling grievances. He stated he had issues with the process and stated he didn't recall receiving some of the forms he had been asked about for the residents. The DON stated he would like a more team approach to handling grievances and stated he had not followed their process in handling grievances assigned to him and had not completed the forms. He stated they had a morning call every morning and they needed to discuss the process as a team. The DON could not recall the specifics of Resident #1's grievances filed. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed grievances were discussed during their morning call meeting. He stated their process was anyone could complete a grievance form and once completed the form is given to the SSM to log in the grievance book. The Administrator explained once logged, the SSM gave the form to the Administrator to assign to the appropriate department head. He stated once completed, the SSM follows up with the resident and/or family member via written letter with the grievance attached to the letter. According to the Administrator, the grievances were discussed in the morning call meeting and in the afternoon stand down meeting. The Administrator recalled the SSM had mentioned unresolved grievances in the meetings and stated with all the extra work with COVID-19 some of the grievances had fell through the cracks and not been followed up on as needed. He stated he had not followed up on grievances as he should have done and stated with all the COVID-19 changes it had been difficult to prioritize duties but stated they could do better with their process. The Administrator stated he was aware grievances should be completed within 72 hours and resolution given to the resident or family member by letter. The Administrator could not recall the specifics of Resident #9's grievances and stated he had not followed up on it like he should have done. 2. Resident #1 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of Resident #1's admission Minimum Data Set ((MDS) dated [DATE] revealed she was severely cognitively impaired and required extensive assistance of 2 with most activities of daily living (ADL) including transfers, dressing, and bathing. In addition, the MDS revealed Resident #1 had impairment of both lower extremities. Review of Resident #1's care plan dated 04/17/2020 revealed she had a care plan for having an ADL care performance deficit related to her impaired balance and history of [MEDICAL CONDITION]. Review of a grievance form filed on 06/15/2020 by the Social Services Manager after a conversation with a family member of Resident #1 revealed in the Complaint/Grievance section of the form, the family member stated the resident was being left in the bed and not being dressed. In addition, the family member stated she wanted the resident up and dressed a minimum of Tuesday, Thursday, Saturday and Sunday. In the Documentation of Investigation section of the form it was blank. In the Resolution section of the form it was blank. The form was assigned to the Administrator and Director of Nursing as responsible for the investigation. An interview on 07/22/2020 at 2:20 PM with the Social Services Manager (SSM) revealed she had not received the grievance form back for Resident #1 with the investigation and resolution. She explained the normal process was for the grievance section to be filled out and the grievance to be given to her to record. The SSM stated she made copies of the form and then gave them to the Administrator for distribution to the appropriate department head. She went on to explain once the investigation is completed and the resolution is documented she crafts a follow up letter to the resident or family member or whomever filed the grievance and she files the letter with the copy of the grievance. According to the SSM, grievances are discussed in the morning meeting as well as the afternoon stand down meeting. She stated the Administrator asked if there were new concerns and her response had been yes or no and stated there were still outstanding complaints that had not been resolved. The SSM stated the grievances that were not returned to her with the investigation and resolution completed had not received follow up letters to the grievance. An interview on 07/22/2020 at 3:40 PM with the Director of Nursing (DON) revealed he was aware there was a 72-hour window for handling grievances. He stated he had issues with the process and stated he didn't recall receiving some of the forms he had been asked about for the residents. The DON stated he would like a more team approach to handling grievances and stated he had not followed their process in handling grievances assigned to him and had not completed the forms. He stated they had a morning call every morning and they needed to discuss the process as a team. According to the DON, he remembered the grievance and had started his follow up on it but stated it was not resolved. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed grievances are discussed during their morning call meeting. He stated their process was that anyone could complete a grievance form and once completed the form is given to the SSM to log in the grievance book. The Administrator explained once logged, the SSM gave the form to the Administrator to assign to the appropriate department head. He stated once completed, the SSM follows up with the resident and/or family member via written letter with the grievance attached to the letter. According to the Administrator, the grievances are discussed in the morning call meeting and in the afternoon stand down meeting. The Administrator recalled the SSM had mentioned unresolved grievances in the meetings and stated with all the extra work with COVID-19 some of the grievances had fell through the cracks and not been followed up on as needed. He stated he had not followed up on grievances as he should have done and stated with all the COVID-19 changes it had been difficult to prioritize duties but stated they could do better with their process. The Administrator stated he was aware grievances should be completed within 72 hours and resolution given to the resident or family member by letter. He stated he did not recall the grievance filed on behalf of Resident #1 and had not followed up on it like he should have done. 3. Resident #12 was admitted to the facility on [DATE] and discharged home on[DATE]. Her [DIAGNOSES REDACTED]. Review of a grievance form filed on 06/25/2020 by the Social Services Manager (SSM) on behalf of Resident #12 revealed in the Complaint/Grievance section of the form, the resident stated she had not had any assistance with ADL. In addition, the grievance stated she had washed herself off at the sink and had to wash her hair in the sink because she had no assistance from staff with bathing. In the Documentation of Investigation section of the form it was blank. In the Resolution section of the form it was blank. The form was assigned to the Administrator and Director of Nursing as responsible for the investigation. Review of Resident #12's admission Minimum Data Set ((MDS) dated [DATE] revealed she was cognitively intact and required limited assistance of one staff with bathing. An interview on 07/22/2020 at 2:20 PM with the Social Services Manager (SSM) revealed she had not received the grievance form back for Resident #12 with the investigation and resolution. She explained the normal process was for the grievance section to be filled out and the grievance to be given to her to record. The SSM stated she made copies of the

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F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) form and then gave them to the Administrator for distribution to the appropriate department head. She went on to explain once the investigation is completed and the resolution is documented she crafts a follow up letter to the resident or family member or whomever filed the grievance and she files the letter with the copy of the grievance. According to the SSM, grievances are discussed in the morning meeting as well as the afternoon stand down meeting. She stated the Administrator asked if there were new concerns and her response had been yes or no and stated there were still outstanding complaints that had not been resolved. The SSM stated the grievances that were not returned to her with the investigation and resolution completed had not received follow up letters to the grievance. An interview on 07/22/2020 at 3:40 PM with the Director of Nursing (DON) revealed he was aware there was a 72-hour window for handling grievances. He stated he had issues with the process and stated he didn't recall receiving some of the forms he had been asked about for the residents. The DON stated he would like a more team approach to handling grievances and stated he had not followed their process in handling grievances assigned to him and had not completed the forms. He stated they had a morning call every morning and they needed to discuss the process as a team. According to the DON, he did not recall receiving a grievance about Resident #12. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed grievances are discussed during their morning call meeting. He stated their process was that anyone could complete a grievance form and once completed the form is given to the SSM to log in the grievance book. The Administrator explained once logged, the SSM gave the form to the Administrator to assign to the appropriate department head. He stated once completed, the SSM follows up with the resident and/or family member via written letter with the grievance attached to the letter. According to the Administrator, the grievances are discussed in the morning call meeting and in the afternoon stand down meeting. The Administrator recalled the SSM had mentioned unresolved grievances in the meetings and stated with all the extra work with COVID-19 some of the grievances had fell through the cracks and not been followed up on as needed. He stated he had not followed up on grievances as he should have done and stated with all the COVID-19 changes it had been difficult to prioritize duties but stated they could do better with their process. The Administrator stated he was aware grievances should be completed within 72 hours and resolution given to the resident or family member by letter. According to the Administrator, he could not recall any specifics about Resident #12's grievance and stated he had not followed up on it like he should have done.
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, family interview, emergency medical services (EMS) interview and nurse practitioner interview the facility neglected to provide nursing and medical services to a resident who was unresponsive. This was for 1 of 1 resident reviewed for neglect (Resident #2). The resident was sent to the emergency room (ER) for evaluation and experienced cardiopulmonary arrest on 4 occasions. Resident #2 passed away at the hospital. The facility failed to protect a resident's right to remain free from sexual abuse for 1 of 3 sampled residents reviewed for abuse (Resident #26). Resident #27 who was cognitively intact was observed in bed with Resident #26 who was a cognitively impaired female resident on [DATE]. On [DATE] Resident #26 was observed sitting in her wheelchair with her hand on Resident #27's genitals. Immediate jeopardy began on [DATE] when Nurse #1 assessed Resident #2 as being unresponsive and failed to provide nursing and medical services for the resident. Immediate Jeopardy was removed on [DATE] when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of G (actual harm that is not immediate jeopardy) due to example #2. Findings included: 1. Resident # 2 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The initial nursing assessment dated [DATE], noted Resident #2 to be alert and oriented. Resident #2 had a code status of full code on admission into the facility. Resident #2 required extensive, two-person assistance with most activities of daily living (ADL). Review of nursing note dated [DATE] at 9:35 PM revealed Nurse #1 had written a late entry on the events that had occurred earlier in the day. The note stated Resident #2 was alert and verbally responsive and two Nurse Aides (NA) had assisted the resident up to her Geri-chair using a mechanical lift to assist her with the lunch meal. The NA left the room with Resident #2's lunch tray and later checked on the resident again and called for Nurse #1. At that point Resident #2 was noted to be unresponsive to tactile stimuli, unarousable to sternum rub with some facial grimacing and squeezing of her eyes shut. Resident #2's oxygen saturation level was at 84% on room air and oxygen was applied at 3 liters. The note revealed Resident #2 stopped breathing, no pulse was found, and cardiopulmonary resuscitation (CPR) was initiated by Nurse #1 and Nurse #2. Nurse #3 phoned 911 services and chest compressions were continued until emergency medical services (EMS) arrived and took over. EMS intubated Resident #2 started intravenous fluids and transported Resident #2 to the hospital. On [DATE] at 2:30 PM an interview was conducted with NA #1. NA #1 stated on [DATE] she had met Resident #2's family outside of the building when she arrived to work and told them she would keep an eye out for her during the day. She stated at 11:00 AM on [DATE] she was walking down 300 hall and heard a banging on Resident #2's window. When she entered the room Resident #2 had spit up onto her shirt and around her mouth and her family was outside of the window trying to get the staffs attention. NA #1 cleaned Resident #2 up and assisted her to the bed with help from NA #2. She stated Resident #2 was awake and communicating. NA #1 stated she told Nurse #1 the resident was nauseated and had spit up. Nurse #1 told her to sit the resident up and give her some ginger ale in which Resident #2 refused the drink. At lunch time NA #1 went back into the room to assist Resident #2 with her lunch meal. She stated the resident was alert and able to eat, NA #2 came into the room to finish helping the resident and NA #1 left the room. She stated about ,[DATE] minutes later around 1:00 PM she heard a loud sound coming from Resident #2's room. When she entered the resident's room Resident #2 was in her Geri chair with her mouth wide open making a loud noise. She stated she conducted a sternum rub and called the residents name with no response from the resident. She stated she left the resident's room to get Nurse #1 from 200 hall and when she reentered the resident's room, she discovered the resident was unresponsive. She stated Nurse #1 came to Resident #2's room conducted a sternum rub and wiped the residents face with a cold cloth. Nurse #1 asked NA#1 to get Nurse #2. Nurse #2 went back out of the room to get some items Nurse #1 asked for and Nurse #1 asked NA #1 to obtain vital signs. As NA #1 proceeded to gather her vital sign machine Nurse #2 handed her a needle and told her to take it to Nurse #1. NA #1 stated Resident #2's vital signs were blood pressure ,[DATE], pulse 61, oxygen saturation 84% on room air. NA #1 stated Nurse #1 took the needle from her and proceeded to stick the top, bottom and side of Resident #2's foot around ,[DATE] times in an attempt to gain a response. NA #1 stated she had seen red substance coming from the areas on Resident #2's foot in which Nurse #1 had placed the needle and Resident #2 was still unresponsive with no movement. Nurse #1 instructed NA #1 to get oxygen tubing and Nurse #1 placed oxygen at 2 liters on the resident. NA #1 stated that Nurse #1 told her , this is normal for her she ' s had a stroke I will have to go read her chart she also stated Nurse #1 believed Resident #2 did not have feeling in her body because she experienced a stroke. NA#1 stated that she told Nurse #1 that Resident #2 did have feeling because when she moved her earlier, and the resident complained of pain in her feet. NA #1 stated Nurse #1 left the room and went back to the nurse's station and left her alone with Resident #2. NA #1 stated she never left the resident after her oxygen level had dropped. She stated at 2:00 PM she checked Resident #2's vital signs and found her oxygen saturation level wouldn't read, and Resident #2 was still unresponsive. She stated she then left the resident's room to find Nurse #1 to assess Resident #2. NA #1 stated she found Nurse #1 in the breakroom. NA #1 stated Nurse #1 told her, Of course her oxygen level is dropping she's a mouth breather. NA #1 stated Nurse #1 went outside for a smoke break before returning to the hall to assess Resident #2. She stated when Nurse #1 returned she instructed the NAs to place Resident #2 in the bed so she could do an in and out urinary catheterization. NA #1 stated the residents color had changed a pale gray while in the bed and she stopped breathing. Nurse #1 yelled for another nurse to come to the resident's room and Nurse #2 responded. Nurse #2 stated to Nurse #1, Is she a full code. Nurse #1 stated she thought the resident was a do not resuscitate (DNR). Nurse #2 went to the nurse's station to check and yelled back stating the resident was a full code. Nurse #1 then stated to NA #1 to go get the supervisor Nurse #3 to start chest compressions on the resident. NA #1 stated neither Nurse #1 or Nurse #2 started chest compressions and by the time Nurse #3 got to the room to start compressions the resident's daughter had called EMS and they had arrived at the facility. On [DATE] at 10:00 AM a second interview was conducted with NA #1. NA #1 stated when she had found Resident #2 still unresponsive at 2:00 PM she had notified Nurse #1 who was in the breakroom and told her the resident's oxygen saturation level would not read because she was breathing through her mouth. NA #1 stated she then went to the nurse's station and could not find Nurse #2. She stated at that point she felt desperate and had called Resident #2's family to ask if it was normal for the resident to not respond and had asked them to come to the facility. She stated

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Nurse #1 and Nurse #2 were outside of the building smoking when she called Resident #2's family to come to the facility. She stated she wished she had just called 911 when she knew something was wrong with the resident instead of waiting on Nurse #1. On [DATE] at 7:30 PM an interview was conducted with NA #2. NA #2 stated she was working on Resident #2's hall on [DATE]. She stated during the morning of [DATE] Resident #2 was alert and oriented. She stated NA #1 wasn't assigned to the 300 hall however kept coming to check on the resident to help her. She stated after lunch around 1:00 PM she was picking up the trays and completing her incontinence rounding when NA #1 came and got her and said Resident #2 was unresponsive. NA #2 stated both she and NA #1 went and told Nurse #1 who stated it was fine and that was normal for Resident #2. She stated Nurse #1 had returned from break and entered Resident #2's room to find the resident unresponsive. She stated when Nurse #1 entered the room she saw her do a sternum rub and use a tool or needle to stick the bottom of Resident #2's feet to attempt to get her to respond, she did not see a red substance coming from the areas in which Nurse #1 had placed the object on Resident #2's foot. She stated Nurse #1 then left the room and returned to the nurse's station. NA #2 stated she, and NA #1 told Nurse #1 two times that something was wrong with Resident #2 from 1:00 PM to 2:30 PM however Nurse #1 never came to the room to assess the resident. She stated the resident's daughter was then at the window stating something was wrong with her mother, because she wouldn't respond at 2:30 PM. She stated she ran to get Nurse #1 who didn't know whether the resident was a DNR or full code and Nurse #2 had to check the resident's chart. She said the resident's daughter called 911. She stated Nurse #1 nor Nurse #2 started chest compressions. They asked NA #1 to go get the supervisor Nurse #3 to start compressions, when Nurse #3 arrived, she completed 5 minutes of compressions before the EMS arrived. NA #2 stated they had told Nurse #1 for 2 hours something was wrong with Resident #2, but she did not come down the hall to assess the resident. She stated she was on the hall the entire time and never saw Nurse #1 in the room prior to when the resident was coding. She stated Nurse #1 couldn't even tell the story of what had happened to EMS when they arrived. On [DATE] at 10:23 AM an interview was conducted with Nurse #1. She stated she was responsible for Resident #2 on [DATE]. The interview revealed Resident #2 had stated to her around 11:00 AM she was nauseated, and she instructed NA #1 to get the resident a ginger ale to drink in which the resident refused. She stated after lunch she did not recall the NAs coming to her to tell her the residents vital signs had been obtained and her oxygen level was low. She stated the NAs never came to the break room to get her. Nurse #1 then stated after lunch on [DATE], but could not recall a specific time, she had obtained vital signs herself and noticed Resident #2's oxygen saturation level was low; she asked the NAs to move her to the bed and she applied oxygen but could not recall what the residents oxygen saturation level was. She stated Resident #2's oxygen level dropped quickly, and her objective was to get the resident stable and out of the facility. She stated she then checked the residents blood pressure and pulse in which she was unable to obtain. Nurse #1 stated she ran out of the room to get Nurse #2 to verify code status of the resident and get the crash cart. Nurse #2 verified code status as full code and when the two got back to the room Nurse #3 was in the room checking Resident #2's pulse and began compressions. Nurse #1 stated she was using the ambu bag when EMS arrived after being called by the resident's daughter who was at her window. She stated she could not recall exact times of when the incident occurred however it was only a matter of minutes from the time the resident was unresponsive until action was taken by the two nurses. She stated she never used a needle or any other object to stick or poke the resident's feet when she found her unresponsive. On [DATE] at 10:34 AM a second interview was conducted with Nurse #1. She stated she did recall the NAs coming to her after lunch stating Resident #2's oxygen level was low because she had placed supplemental oxygen on the resident at 2 liters. She stated she did not notify the Physician after placing Resident #2 on supplemental oxygen due to a low oxygen saturation level nor did she notify the residents family of the change in condition. The interview revealed she normally would have but on [DATE] the resident declined so quickly she did not have a chance to call either of them. On [DATE] at 6:00 PM an interview was conducted with Nurse #2. She stated on [DATE] Nurse #1 came down the 100 hall where she was working to get her because Nurse #1 had a resident who was unresponsive. She stated she looked up the resident's code status for Nurse #1 which was full code. When she entered the room Resident #2 was unresponsive with her eyes glazed over. NA #1, NA #2, Nurse #1, and Nurse #3 were in the room. The interview revealed the supervisor Nurse #3 had initiated compressions roughly 5 minutes prior to EMS arriving. She stated she had heard NA #1 tell Nurse #1 the residents oxygen level was low earlier in the day but could not recall a specific time and Nurse #1 had the NAs lay the resident down in the bed. She stated she had not gone into Resident #2's room prior to when the resident was coding and had not seen Nurse #1 sticking the resident's foot with a needle. On [DATE] at 5:31 PM an interview was conducted with Nurse #3. She stated she had just gotten back to the nurse's station from taking the residents who smoke outside of the building. Smoking time was at 1:30 PM. The interview revealed she saw NAs going into Resident #2's room so she walked down the hall to see what was going on. She stated when she walked into the room, she saw Nurse #1 trying to get a blood pressure and pulse on Resident #2. Nurse #2 asked if she would try and find a pulse. Nurse #3 stated she tried to find a pulse but immediately saw Resident #2 was not breathing and could not find a pulse. She stated she heard someone say the resident was a full code and started chest compressions. The interview revealed neither Nurse #1 or Nurse #2 started compressions or used the ambu bag. Nurse #3 stated she performed two rounds of compressions until EMS arrived. Nurse #3 stated she believed Nurse #1 had not started chest compressions because she was waiting on a second opinion. On [DATE] at 10:00 AM an interview was conducted with Resident #2's family member. She stated on [DATE] at 8:00 AM she had called the facility and spoke with Nurse #1 regarding how Resident #2 had faired through the night. She stated Nurse #1 told her she did not know and that she would text the third shift nurse and ask her. She stated the third shift nurse had replied stating the resident had done well but hadn't worn her continuous positive airway pressure ([MEDICAL CONDITION]) much during the night. She stated the family visited Resident #2 around 9:30 AM until 11:00 AM that morning through the window and Resident #2 was alert and talking. Around 11:12 AM she stated they noticed Resident #2 coughing and saying, help me. The resident began gagging, coughing and yelling to help her. The family began beating on the windows of the facility in order to gain staff's attention. NA #1 entered the room and cleaned the resident up wiping her face. The family member stated Nurse #1 entered the room shortly after and they asked Resident #2 if she wanted to get up in her Geri chair for lunch, she stated she left the facility at 12:00 PM before lunch to go home. Around 2:20 PM she received a phone call from another family member stating NA #1 had called them and had asked if Resident #2 was hard to wake up, when the family member replied no NA #1 directed the family to come to the facility quickly. She stated at 2:28 PM she arrived at the facility to find Resident #2 lying in bed with supplemental oxygen on, unresponsive and no staff members in the room. She stated she picked up her phone to dial 911 then saw NA #1 run into Resident #2's room, open the window and stated to her to call 911 at 2:34 PM. She stated Nurse #1 entered the room and attempted to pull the blinds down to block her view of Resident #2 however the family member told her to stop. The interview revealed she did not see any nurses performing CPR or a crash cart in the room. She stated once EMS arrived Nurse #1 pulled the blinds down so she could no longer see into the room and Resident #2 was taken to the hospital shortly after. She stated she felt Resident #2 had experienced a change of condition after lunch and the family wasn't notified by Nurse #1 nor had the Nurse called 911 in a critical situation. Review of the 911 communications call log dated [DATE] revealed one phone call was placed at 2:34 PM requesting assistance at the facilities location. The 911 communications log confirmed the one call was placed by the residents family member. On [DATE] at 1:00 PM an interview was conducted with EMS responder #1. He stated when he arrived at the facility on [DATE] at 2:40 PM he observed an upset woman standing outside of the facility which he later learned was Resident #2's family member. The interview revealed when entering Resident #2's room he observed 2 staff members doing chest compressions and nobody using an ambu bag to ventilate the resident. He stated he grabbed a ventilation mask and threw it to the two staff members and asked them to put it on the resident immediately. EMS found a femoral pulse however Resident #2 was not breathing so they intubated the resident. He stated a staff member (unsure of their title) told him Resident #2 was found at 2:15 PM lethargic and placed in bed in a supine position with oxygen applied. EMS responder #1 stated if a resident is in respiratory distress the last thing that should have been done was place them in a supine position. Review of hospital records revealed Resident #2 was taken to the Emergency Department (ED) on [DATE] at 2:40 PM. She was intubated by EMS prior to her arrival in the ED. Resident #2 experienced cardiopulmonary arrest on 4 occasions while in the ED and was pronounced deceased around 6:20 PM on [DATE] in the hospital. On [DATE] at 4:12 PM an interview was conducted with the Director of Nursing (DON). He stated Nurse #1 had notified him of the situation on [DATE] that Resident #2 was awake and alert at lunch time however she had been asked to come back to the room by NA's at 2:00 PM to find the resident unresponsive. Nurse #1 had told him she checked the residents code status, initiated CPR and called 911. The interview revealed NA#1 had told him she tried to notify Nurse #1 earlier in the day on [DATE] that something was wrong with Resident #2. The DON stated he expected the nurses to check the residents code status and immediately call for assistance if a resident was experiencing a critical episode. Nurses were expected to conduct CPR until EMS services

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	345385	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) arrived. He stated he had conducted an in-service on CPR and code status on [DATE] related to the incident following reopening of the investigation. On [DATE] at 3:44 PM a second interview was conducted with the DON. The interview revealed if a resident had previously not had an order for [REDACTED]. On [DATE] at 3:35 PM an interview was conducted with the Nurse Practitioner. The interview revealed she had concerns of the facility accepting care of residents who were too acute for the staff to care for. She stated regarding a change of condition in a resident requiring the use of supplemental oxygen she would want the nurse on duty to notify her immediately after identifying the need for oxygen and assess the resident. She also stated the practice of using a needle to poke an unresponsive patients' foot was unacceptable. The Administrator was notified of the Immediate Jeopardy on [DATE] at 5:30 PM. On [DATE] at 1:19 PM the facility provided the following credible allegation of Immediate Jeopardy removal. F600- Free from Abuse and Neglect Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On [DATE] around 10:55 am Resident's #2 family member arrived to facility. Nurse Aide (NA) #1 arrived around 10:55 am for her scheduled shift and was approached by Resident #2's family member before entering the facility for her scheduled shift. Resident#2's family member asked NA#1 to help un-cover Resident's #2 arms since she is unable to do so herself. NA#1 arrived to Resident's #2 room shortly after clocking into work and assisted Resident #2 with un-covering her arms and ensuring she was comfortable. Resident #2 stated she was comfortable but not feeling well. At 11:05 AM Resident #2's family member banged on the window a few minutes after NA#2 exited the room. Nurse #1 arrived in the room. Resident #2's family member stated Resident #2 was throwing up. Nurse #1 stated Resident #2's head was elevated in the bed and did not notice any sign of her throwing up. Nurse#1 instructed NA#1 and NA#2 to assist Resident#2 into a Geri chair and to sit up. Nurse#1 offered Resident#2 a ginger ale to help if she was nauseous. Resident#2 declined the ginger ale. At around 11:45 AM Resident #2's family member left the facility. At 12:30 PM NA#1 assisted feeding Resident#2. NA#1 held a conversation with Resident#2 the entire duration of the meal. Resident #2 stated she was not very hungry but would eat her salad. NA#1 stated, she was eating fine just slow, she told me she had always ate and chewed slowly. No complaint of nausea made. After lunch around 1:00 PM NA#2 picked up lunch trays and was completing incontinence rounds when NA #1 came and got NA #2 and said Resident #2 was unresponsive. Both NA#1 and NA #2 reported to the Nurse #1 change in condition. Nurse #1's response was it is fine that is her normal. Nurse #1 did not go to Resident #2 ' s room. Around ,[DATE] minutes later NA #1 entered Resident #2's room, Resident #2 was sitting up in geri-chair with eyes closed and mouth open. NA#1 called Resident #2's name several times and conducted a sternum rub with no response. NA #1 attempted to get a response by rubbing a cool washcloth on her face. Resident #2 did not respond. Around 1:10pm Nurse#1 was notified Resident#2 was unresponsive. Nurse #1 went to Resident #2's room. Vital signs obtained; O2 saturation 84% at Room Air. Oxygen applied and Resident #2 assisted to bed. Nurse #1 left the room while Resident#2 was unresponsive. At 2:00 PM NA #1 checked Resident #2's vital signs which her oxygen saturation level wouldn't read and was still unresponsive. NA #1 went to find Nurse #1 who was in the breakroom. NA #1 asked Nurse #1 to come assess Resident #2. Between 2:00 PM to 2:30 PM Nurse #1 came to Resident #2's room and instructed NA #1 and NA #2 to assist the resident back to bed. During time in Resident #2's room, Nurse #1 yelled for Nurse #2 to check Resident #2's chart to determine code status. Nurse #2 went to nurse's station to check and yelled back stating Resident #2 was a Full Code. Nurse #1 asked NA #1 to get the Nurse Supervisor (Nurse #3). Nurse #3 was returning into facility from taking out residents to smoke. Nurse #3 stated she saw Nurse Aides (NA #1 and NA #2) going into Resident #2's room so Nurse #3 walked down the hall to see what was going on. When Nurse #3 entered the room Nurse #1 was trying to get a blood pressure and pulse on Resident #2. Nurse #3 tried to obtain pulse but immediately saw Resident #2 was not breathing and could not find a pulse. Nurse #3 heard another nurse state Resident #2 is a full code. Nurse #3 started compressions until EMS arrived. Also, during the 2:00 PM to 2:30 PM time Resident #2's family member arrived at the facility to see Resident #2 with oxygen on in the bed. Resident #2's family knocked on the window to find resident unresponsive. Resident #2's family member called 911 at 2:34 PM. At 2:38 PM EMS arrived and took over chest compressions. Pulse obtained, but resident was still unresponsive. Resident #2 was intubated. Resident #2 left facility with EMS and was transferred to Atrium Health Lincoln. Resident #2 expired at the hospital on [DATE]. Based on the investigation Nurse #1 failed to notify Physician/Nurse Practitioner and Responsible Party of change in condition. Nurse #1 did not notify anyone to include the Physician and Responsible Party that Resident #2 was unresponsive. The Nurse#1 also failed to respond timely to resident having an acute episode. On [DATE] DHHS in facility for Complaint Survey. On [DATE] during visit a surveyor made Regional Director of Clinical Services and Administrator aware of an allegation of abuse/neglect for Resident #2. The Administrator submitted a 24-hour report for allegation of abuse/neglect and suspended Nurse#1. Law enforcement was also notified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Current residents have the potential to be affected by this alleged deficient practice. On [DATE] the facility Social Worker conducted resident interviews of all interviewable residents (BIMS greater than 8) to ensure free from abuse and neglect. Any negative findings will be addressed immediately according to the facility abuse and neglect policy and reported to the appropriate agencies. On [DATE], the Regional Director of Clinical Services completed a review of current residents Code Status to ensure accurate to include: physician's orders [REDACTED]. Any issues identified were addressed. On [DATE], current resident skin assessments completed by Registered Nurse, no new issues noted. On [DATE], current resident assessments were completed by a Registered Nurse to ensure the following was in place for any change in conditions identified, no new changes in condition noted. Family/Responsible Party Notification Physician Notification Physician order [REDACTED]. Appropriate documentation (SBAR/progress note if indicated) Interventions to prevent further changes and /or worsening of Appropriate Care Plan and Nursing Assistant Kardex On [DATE], the Regional Director of Clinical Services educated the Nurse Managers (Director of Nursing and Assistant Director of Nursing) regarding Abuse and Neglect, Notification of a Change of Condition, How to Identify and Respond/Manage a change in condition and Code Status/Code Blue to include recognition and response to include the following: The nurse must notify the Attending Physician and Resident Representative as soon as possible when the resident has a change in condition. For acute change in condition stay with resident, do not leave resident unattended. Take appropriate actions by following physician orders. Reassess resident call physician back and follow MD orders that may include to transfer resident out to hospital. Nurses and Certified Nursing Assistants to report on change in residents ' condition during shift change. In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. Document resident/patient change in condition on 24 Hour Report CNAs must notify licensed nurse with any change in condition. If nurse does not respond or take action CNA is to report concern to another nurse/house supervisor and/or call DON immediately. Upon discovering, or being made aware of, an unresponsive resident: One nurse to stay with resident at all times and another staff member to bring chart to resident ' s room to verify Code Status (2 Nurses) at bedside. Initial approach to a full code resident to follow CPR training May include: - Verbal stimulus to rouse resident - Gentle shaking of shoulders to rouse resident - Sternal rub to rouse resident WILL NOT include: - Poking the feet with a needle - Using any object to poke or prod any body part - Using any other stimuli that may reasonably be expected to cause damage to the body Only nurses will perform CPR, other staff may: o Call 911 o Open door of facility for responders o Bring chart to Nurse for review o Bring crash cart to Code Blue Education was initiated by the Nurse Managers (Director of Nursing and Assistant Director of Nursing) on [DATE] and will be on-going, no staff will return to work until they have completed the mandatory education on abuse and neglect and notification of change in condition. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All staff currently working will be educated on abuse and neglect immediately. On [DATE], the Nurse Managers then initiated education with licensed nurses regarding Abuse and Neglect, Notification of a Change of Condition, How to Identify and Respond/Manage a change in condition and Code Status to include recognition and response to include the following: Abuse and Neglect policy reviewed with staff to include education timely response to resident's change in condition. The nurse must notify the Attending Physician and Resident Representative when the resident has a change in condition. For acute change in condition stay with resident, do not leave resident unattended. Take appropriate actions by following physician orders. Reassess resident call physician back and follow MD orders that may include to transfer resident out to hospital. Nurses and CNAs to report on change in residents ' condition during shift change. In the event of an emergency situation, 911 to be called and the attending physician and the Resident Representative to be notified as soon as possible. The nurse to complete an evaluation of the Patient/Resident. Document evaluation in the medical record. Document resident/patient change in condition on 24 Hour Report CNAs must notify licensed nurse with any change in condition. If nurse does not respond or take action CNA is to report concern to another

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) nurse/house supervisor and/or call DON immediately. Upon discovering, or being made aware of, an unresponsive resident: One nurse to stay with resident at all times and another staff member to bring chart to resident ' s room to verify Code Status (2 Nurses) at bedside. Initial approach to a full code resident to follow CPR training May include: Verbal stimulus to rouse resident Gentle shaking of shoulders to rouse resident Sternal rub to rouse resident WILL NOT include: Poking the feet with a needle Using any object to poke or prod any body part Using any other stimuli that may reasonably be expected to cause damage to the body Only nurses will perform CPR, other staff may: o Call 911 o Open door of facility for responders o Bring chart to Nurse for review o Bring crash cart to Code Blue On [DATE], the Nurse Managers then initiated education with Certified Nursing Assistants regarding Abuse and Neglect, Notification of a Change of Condition, How to Identify and Respond/Manage a change in condition and Code Status to include recognition and response to include the following: Abuse and Neglect policy reviewed with staff to include education timely response to resident's change in condition. Nurses and CNAs to report on change in residents ' condition during shift change CNAs must notify licensed nurse with any change in condition. If nurse does not respond or take action CNA is to report concern to another nurse/house supervisor and/or call DON immediately. On [DATE], Certifie
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to report a sexual abuse allegation to the state agency within a two-hour time frame of the abuse allegation being made for one (Resident #26) of three abuse investigations reviewed. Findings included: Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #26's quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was severely cognitively impaired. Resident #26 required limited assistance of one staff member for most activities of daily living (ADL). Review of Resident #26's care plan dated initiated on 5/3/20 and current through 8/22/20 revealed no focus area for sexual behaviors. Resident #27 was admitted to the facility on [DATE]. Review of Resident #27's quarterly Minimum Data Set ((MDS) dated [DATE] revealed he was alert and oriented requiring limited assistance of one staff member for most ADL. Review of Resident #27's care plan dated initiated on 5/3/20 and current through 8/22/20 revealed no focus area for sexual behaviors. On 8/20/20 at 5:30 PM an interview was conducted with NA #9. She stated on 8/11/20 around 3:00 AM she had witnessed Resident #27 in Resident #26's bed. NA #9 walked in the room to do rounds and said she told Resident #27 that was inappropriate, and he told her to get out. She left the room to go get Nurse #8, but the nurse was outside smoking. NA #9 told Nurse #8 when she found her and by the time, they came back to the room Resident #27 had left Resident #26's room and returned to his room. NA #9 stated the Nurse did not do anything or say anything to Resident #27 because he was already back in his room when she got to Resident #26's room. NA #9 stated she told the ADON what had happened and had written a statement. She stated following the incident she received no training on abuse nor did any other staff besides the ADON contact her. The interview revealed the only in-service training she had on abuse was from her agency company. On 8/19/20 at 11:04 AM an interview was conducted with Nurse #8. She stated she worked night shift from 7 PM to 7 AM. The interview revealed she had seen Resident #26 holding hands with Resident #27 in the hallway and had received reports that things had went on between the two during the day. She stated she had heard on 8/16/20 that Resident #26 was in Resident #27's room when he was undressed with her hand on his leg. She stated the facility had moved Resident #27 to 200 hall on 8/17/20 to get him away from Resident #26 however that night he came back to the 100 hall and wouldn't leave. She stated Resident #26 and Resident #27 were sitting on the 100-hall talking while she kept a close eye on them. The interview revealed they had started every 15-minute monitoring on both of the residents 2 weeks prior and on 8/17/20 she had both of the residents monitoring sheets. She stated no one had told her to keep the two residents separated. Nurse #8 stated Resident #26 was very confused, one night asking staff 13 times to get her up and then put her back in bed. The interview revealed she did not remember NA #9 coming to her to say she had seen Resident #26 and Resident #27 in bed together on 8/11/20. In the interview she stated she had worked with NA #9 on 8/11/20. She stated Resident #26 was too confused to have a relationship. On 8/19/20 at 11:22 AM an interview was conducted with the Assistant Director of Nursing (ADON). She stated she had called the resident's family member when the relationship began in June. The interview revealed the family member was ok with the resident having a friendship with Resident #27 but did not want her mother taken advantage of. She stated because the family member was comfortable with them holding hands, they didn't see anything wrong with the relationship continuing. She stated she had come in early on 8/12/20 to speak with NA#9 and receive a statement because she had been notified of a situation between Resident #26 and Resident #27 that had occurred the day prior on 8/11/20. The ADON stated NA #9 had walked into Resident #26's room to find Resident #27 in her bed and the two residents were under the sheets. She stated Resident #2 had his arm around Resident #1 while lying in the bed. Resident #27 told NA #9 to get out of the room. She then left the room for a period of time and when she came back, she saw Resident #27 coming out into the hall in his wheelchair from the room. Resident #27 was then yelling for Resident #26 to come into his room. She stated NA #9 described the residents as spooning in the bed. The ADON stated she obtained the statement and placed it under the Administrator's door on 8/12/20 however it had somehow gotten lost. Resident #27 was placed on every 15-minute monitoring and moved to another hall. She stated Resident #26 was severely demented and she had seen Resident #27 holding her hand and kissing her on the check. The ADON stated on one occasion she saw Resident #27 kiss Resident #26 on the cheek and Resident #26 turned to get away from him, but he still had kissed part of her mouth. The interview revealed Resident #27 would attempt to get Resident #26 to come into his room. She stated she had spoken with Resident #26's family member who said to let her know if the relationship escalated. The interview revealed she did not contact Resident #26's family member after receiving the statement from NA #9. The DON, Administrator and ADON had discussed the allegation of the residents being in bed together in the morning meeting along with the Social Worker on how to get the residents away from each other to keep anything else from happening. The interview revealed the ADON did not examine Resident #26 after receiving the allegation because she had left it up to the DON and Administrator to investigate. On 8/19/20 at 3:30 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated he was made aware of the relationship between Resident #26 and Resident #27 a couple of weeks ago. The DON stated it was reported to him but could not recall the date that the residents were in the bed together from the ADON. He stated he thought Resident #26 was in Resident #27's room however had realized this morning it was the other way around. He stated the ADON had informed him NA #9 had walked in and found Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the family member however decided it was not abuse and a 24-hr. report was not completed. The interview revealed no physical assessment was completed for Resident #26 nor was an investigation initiated after the allegation was received. He stated he never knew the ADON had received a statement from NA #9. On 8/19/20 at 4:24 PM an interview was conducted with the Administrator. He stated both residents desired a relationship however Resident #26 was unable to consent. The residents liked to hold hands and hang out although encouraged not to by staff. He stated he was notified but did not recall the date or by who that Resident #27 attempted to get in bed with Resident #26 by the ADON who had received a statement from NA #9. He stated NA #9 had observed the residents in bed together and suspected something may have happened. The interview revealed he never conducted a formal investigation into the incident nor had nursing staff complete a physical assessment of Resident #26 because he didn't feel like it was needed. He stated he had contacted Resident #26's family member and she was ok with the relationship, so he decided the allegation did not need to be reported and investigated. He stated the facility protected Resident #26 by completing every 15-minute monitoring which started on 8/6/20 when they noticed the residents spending more time together and was on going. The interview revealed he had not placed Resident #27 on one-on-one monitoring.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to develop a comprehensive, individualized, and person-centered care plan in the area of behaviors for 2 of 3 sampled residents reviewed for sexual abuse (Resident #26 and Resident #27). The findings included: 1. Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) Review of Resident #26's quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was severely cognitively impaired. Resident #26 required limited assistance of one staff member for most activities of daily living (ADL). Review of Resident #26's care plan dated initiated on 5/3/20 and current through 8/22/20 revealed no focus area for sexual behaviors. Review of an email dated 6/18/20 from the Social Worker to the Administrator revealed Resident #27 was being inappropriate with Resident #26. The email revealed Resident #27 was being touchy and kissing Resident #26. Review of a progress note dated 6/19/20 at 6:37 AM revealed the Assistant Director of Nursing had talked with Resident #26's family member regarding her and Resident #27 having a relationship and affectionately touching. Review of a progress note dated 8/6/20 at 6:37 PM revealed Resident #26 had been going into Resident #27's room stating she was in love with him. The note revealed Resident #26 was following Resident #27 around the building. Review of a progress note dated 8/6/20 revealed Resident #26 and Resident #27 were placed on every 15-minute monitoring due to an incident occurring where Resident #27 became aggressive towards staff over Resident #26. Review of a progress note dated 8/9/20 at 6:55 PM revealed Resident #26 continued to go in Resident #27's room hold hands and attempted to kiss Resident #27. Review of a progress note dated 8/16/20 at 6:44 PM revealed Resident #26 had been going into Resident #27's room numerous times during the day. The note stated Resident #27 was lying naked in his bed and Resident #26 went into his room and was sitting by the bed holding the resident's hand. On 8/20/20 at 5:30 PM an interview was conducted with NA #9. She stated on 8/11/20 around 3:00 AM she had witnessed Resident #27 in Resident #26's bed . NA #9 walked in the room to do rounds and said she told Resident #27 that was inappropriate, and he told her to get out. She left the room to go get Nurse #8, but the nurse was outside smoking. NA #9 told Nurse #8 when she found her and by the time, they came back to the room Resident #27 had left Resident #22's room and returned to his room. On 8/20/20 at 10:24 AM an interview was conducted with the Social Worker. She stated Resident #26 did not have a care plan for behaviors or cognition. The interview revealed usually the MDS Nurse would initiate the care plans. She stated she had overheard the MDS Nurse ask the Administrator and Director of Nursing if she needed to add a care plan however, they told her to wait and it was never done. On 8/20/20 at 10:28 AM an interview was conducted with the MDS Nurse. She stated she had discussed the care plan with the Director of Nursing and Administrator when the two residents initially started having a relationship. The interview revealed she was told they wanted to speak with the corporate nurse prior to initiating a care plan and that they would get back with her. She stated she brought it up again on Monday 8/17/20 to the Administrator however he told her again to wait. She stated she didn't want to put a care plan in place without running it by the Administrator first. The interview revealed the Director of Nursing and Administrator never got back with her regarding the approval of adding a care plan for the resident. On 8/19/20 at 3:30 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated he was made aware of the relationship between Resident #26 and Resident #27 a couple of weeks ago. Staff reported the residents had been sitting in the hallway together and were holding hands. Nurse #5 had told him she had seen Resident #27 kissing Resident #26 in the hallway. He stated the staff weren't happy the residents were interested in each other. He stated the topic had come up during a morning interdisciplinary team meeting (IDT) discussing whether the residents had the right to have a relationship. The DON stated it was reported to him but could not recall the date that the residents were in the bed together from the ADON. He stated he thought Resident #26 was in Resident #27's room however had realized this morning it was the other way around. He stated the ADON had informed him NA #9 had walked in and found Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the daughter however decided it was not abuse and a 24-hr. report was not completed. The interview revealed no physical assessment was completed for Resident #26 nor was an investigation initiated after the allegation was received. He stated he never knew the ADON had received a statement from NA #9. The interview revealed there was another situation on 8/16/20 in which he was notified. He stated the Administrator had talked with Resident #27 and they moved Resident #27 to the 200 hall as a result of it. The DON stated Resident #26 was unable to consent to a relationship due to her BIMs score however she did not have a care plan related to cognition or sexual behaviors. He stated it was the MDS Nurse who initiated the care plans for residents, and he did not know why this hadn't been completed. 2. Resident #27 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #27's quarterly Minimum Data Set ((MDS) dated [DATE] revealed he was alert and oriented requiring limited assistance of one staff member for most ADL. Review of Resident #27's care plan dated initiated on 5/3/20 and current through 8/22/20 revealed no focus area for behaviors. On 8/19/20 at 1:46 PM an interview was conducted with the Social Worker. She stated In June 2020 the ADON came to her and asked if Resident #26 could have a relationship with Resident #27. She stated she told the ADON no, because Resident #26 had a low BIMS score. She stated the next day a nurse told her they're going to have to do something because Resident #27 had been caught kissing Resident #26. She also said Resident #27 was seen in the bed telling Resident #26 to come over into his room and when she did, he had her hand under the cover rubbing his genitals date unknown. Review of a progress note dated 8/6/20 written by Nurse #26 at 6:42 PM revealed Resident #27 was trying to remove Resident #26 from her room for supper. Resident #27 grabbed the wheelchair arm of Resident #26. When asked to let go of the chair by a Nurse Resident #27 swung his arm at Nurse #5 and almost hit Resident #26. Resident #27 was agitated stating Resident #26 could stay with him and do whatever they wanted to. The note revealed Resident #26 and Resident #27 had went all of the way to the front door earlier in the day. Resident #27 was placed on every 15-minute monitoring due to stating he wanted to leave the facility. Resident #26 was removed from the situation and taken with Nurse #5 to the nurse's station. On 8/20/20 at 5:30 PM an interview was conducted with NA #9. She stated on 8/11/20 around 3:00 AM she had witnessed Resident #27 in Resident #26's bed. NA #9 walked in the room to do rounds and said she told Resident #27 that was inappropriate, and he told her to get out. She left the room to go get Nurse #8, but the nurse was outside smoking. NA #9 told the Nurse when she found her and by the time, they came back to the room Resident #27 had left Resident #26's room and returned to his room. On 8/20/20 at 10:24 AM an interview was conducted with the Social Worker. She stated Resident #27 did not have a care plan for behaviors. The interview revealed usually the MDS Nurse would initiate the care plans. She stated she had overheard the MDS Nurse ask the Administrator and Director of Nursing if she needed to add a care plan however, they told her to wait and it was never done. On 8/20/20 at 10:28 AM an interview was conducted with the MDS Nurse. She stated she had discussed the care plan with the Director of Nursing and Administrator when the two residents initially started having a relationship. The interview revealed she was told they wanted to speak with the corporate nurse prior to initiating a care plan and that they would get back with her. She stated she brought it up again on Monday 8/17/20 to the Administrator however he told her again to wait. She stated she didn't want to put a care plan in place without running it by the Administrator first. The interview revealed the Director of Nursing and Administrator never got back with her regarding the approval of adding a care plan for the resident. On 8/19/20 at 3:30 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated he was made aware of the relationship between Resident #26 and Resident #27 a couple of weeks ago. Staff reported the residents had been sitting in the hallway together and were holding hands. Nurse #5 had told him she had seen Resident #27 kissing Resident #26 in the hallway. He stated the staff weren't happy the residents were interested in each other. He stated the topic had come up during a morning interdisciplinary team meeting (IDT) discussing whether the residents had the right to have a relationship. The DON stated it was reported to him but could not recall the date that the residents were in the bed together from the ADON. He stated he thought Resident #26 was in Resident #27's room however had realized this morning it was the other way around. He stated the ADON had informed him NA #27 had walked in and found Resident #27 in Resident #26's bed under the sheets. NA #9 left the room and when she returned, she saw Resident #27 leaving Resident #26's room. He stated the Administrator knew about the incident and had notified the daughter however decided it was not abuse and a 24-hr. report was not completed. The interview revealed no physical assessment was completed for Resident #26 nor was an investigation initiated after the allegation was received. He stated he never knew the ADON had received a statement from NA #9. The interview revealed there was another situation on 8/16/20 in which he was notified. He stated Resident #26 had been moved and placed on every 15-minute monitoring however did not have a care plan in place to reflect his behaviors. He stated it was the MDS Nurse who initiated the care plans for residents, and he did not know why this hadn't been completed.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on record review, staff interview, and nurse practitioner interview a nurse poked an unresponsive resident with a needle over twenty times to check for responsiveness for 1 of 1 resident reviewed (Resident #2) for providing care in accordance to professional standards. Findings included: On 07/21/20 at 2:30 PM an interview was conducted with NA #1. NA #1 stated on 6/6/20 around 1:00 PM she heard a loud sound coming from Resident #2's room, when entering the room Resident #2 was in her Geri chair with her mouth wide open making a loud noise. She stated she conducted a sternum rub and called

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	345385	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL HEALTHCARE AND REHAB	931 N ASPEN STREET LINCOLNTON, NC 28092

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) the residents name with no response. She went to get Nurse #1 when she discovered the resident was unresponsive. Nurse #1 conducted a sternum rub and wiped the residents face with a cold cloth but there was no response from the resident. Nurse #1 asked NA#1 to go get Nurse #2, who came to the room and was asked by Nurse #1 to get some items. Nurse #1 asked NA #1 to obtain vital signs. As NA #1 proceeded to gather her vital sign machine Nurse #2 handed her a needle and told her to take it to Nurse #1. Nurse #1 took the needle from NA #1 and proceeded to stick the top, bottom and side of Resident #2's foot around 6-8 times to gain a response. NA #1 stated she had seen blood coming from the areas on Resident #2's foot in which Nurse #1 had placed the needle and Resident #2 was still unresponsive with no movement. On 7/21/20 at 7:30 PM an interview was conducted with NA #2. NA #2 stated she was working on Resident #2's hall on 06/06/20. She stated NA #1 came to her and said Resident #2 was unresponsive. She went with her to Resident #2's room and stated Nurse #1 entered the room and she saw her do a sternum rub and use a tool or needle to stick the bottom of Resident #2's feet to attempt to get her to respond. She stated Nurse #1 then left the room and returned to the nurse's station. On 07/21/20 at 10:23 AM an interview was conducted with Nurse #1. She stated she was responsible for Resident #2 on 06/06/20. She reported she obtained Resident #2's vital signs and noticed her oxygen saturation level was low; she asked NA #1 and NA #2 to move her to the bed and she applied oxygen but could not recall what the resident's oxygen saturation level was. She stated Resident #2's oxygen level dropped quickly, and her objective was to get the resident stable and out of the facility. She stated she never used a needle or any other object to stick or poke the resident's feet when she found her unresponsive. On 7/21/20 at 6:00 PM an interview was conducted with Nurse #2. She stated she had not gone into Resident #2's room prior to when the resident was coding and had not seen Nurse #1 sticking the resident's foot with a needle or given Nurse #1 a needle. On 07/22/20 at 10:00 AM an interview was conducted with Resident #2's family member. The interview revealed when Resident #2 was taken to the ED and the Physician was questioning as to why the resident had over 20 holes on the top and bottom of her feet. The family member stated the areas on Resident #2's feet were small, dark purple filled holes directly in a line across the top of the resident's foot and bottom and had not been present the day before on 6/05/20 when Resident #2 was admitted into the facility. On 07/22/20 photos were provided by the residents family member dated 06/06/20 of Resident #2's feet. The photos revealed Resident #2 had 29 small purple holes located in a straight line on the top of her right foot and bottom of her left foot. On 7/23/20 at 3:44 PM an interview was conducted with the Director of Nursing (DON). He stated in regard to Nurse #1 sticking the resident's feet with a needle it was not the best nursing practice and was wrong. The DON stated there were other ways to get a response from an unresponsive resident and that was not what the facility wanted nurses to do. On 7/23/20 at 3:35 PM an interview was conducted with the Nurse Practitioner. She stated the practice of using a needle to poke an unresponsive patients' foot was unacceptable
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers and complete bed baths as scheduled to maintain the personal hygiene for 3 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident # 9, #10 and #11). Findings included: 1. Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with [MEDICAL CONDITION] and a history of falls. Resident #9's annual Minimum Data Set ((MDS) dated [DATE] revealed he was cognitively intact. The MDS further revealed Resident #9 was totally dependent on one staff with bathing. A grievance filed on 05/04/2020 by Resident #9's family member revealed the resident told the family member he had not received a shower in a week, and it was due to a shortage of staff. Resident #9's admission Minimum Data Set ((MDS) dated [DATE] revealed he was cognitively intact. The MDS further revealed Resident #9 required extensive two-person assistance with bathing. The shower schedule for July 2020 revealed Resident #9 was scheduled to receive showers during the second shift on Tuesday and Friday. A second grievance filed on 07/20/2020 by Resident #9's family member revealed the resident told the family member again he had not had a shower in a week. The grievance specified Resident #9 told the family member it was because there were not enough nurse aides (NAs) to do showers. Resident #9's nurse aide (NA) documentation from 05/04/2020 through 07/22/20 revealed staff had given Resident #9 at least one shower a week. Review of the nursing progress notes for the same time period did not reflect Resident #9 had refused his showers. An observation and interview were conducted with Resident #9 on 07/22/2020 at 10:00 AM. Resident #9's hair appeared to be dirty and he was noted to have dry, flaky skin on his face. Resident #9 stated he had not received his two showers per week as scheduled which were to be provided on Tuesday and Friday on second shift. Resident #9 stated he had requested to have his shower time changed to first shift, but it had not been changed. Resident #9 further stated, staff usually offered to provide his showers later in the evening and he was not used to having showers at that time, so he refused his showers when they were offered later in the evening. He specified he was not receiving his showers because there was not enough nurse aides (NAs) in the building to provide care for the residents. Resident #9 stated he had previously complained about not getting his scheduled showers twice a week and said, I am lucky if I get one a week. The interview revealed Resident #9 felt much better when he was clean and stated he felt clean with two showers per week. An interview conducted on 07/22/2020 at 11:30 AM with NA # 3 revealed she worked on Resident #9's hall 7:00 AM to 7:00 PM. NA #3 stated they try to get everything done but just are not able to complete some of the scheduled showers. NA #3 stated she was assigned to care for Resident #9 and when she had to care for residents on two halls it was not possible to give residents their showers as scheduled. An interview was conducted on 07/22/2020 at 4:00 PM with the Director of Nursing (DON). The DON said they should be providing showers according to the resident's preference and they needed to do a full audit of showers to determine preferences of the residents. He stated once they were fully staffed with NAs there should not be a problem with residents getting their showers. The DON explained they used to have a shower team, but those positions had been eliminated. He stated regardless of staffing, showers should be given as scheduled whenever possible. The DON also stated they should check with the residents on a regular basis to ensure they were receiving their showers on a day and time of their preference. According to the DON Resident #9 should have received showers twice a week as scheduled. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed staff members were expected to work around the resident's preference and time they wanted a shower. He stated if a resident wanted a first shift shower instead of second shift they should be scheduled as a first shift shower. The interview revealed the staff were expected to give the best care possible as residents were at the facility to be provided skilled care. The Administrator stated he expected staff to tag-team and make sure the care was completed for the residents and showers should be provided for residents according to their preference for days and time. 2. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #11's admission Nursing assessment dated [DATE] revealed Resident #11 was cognitively intact. The assessment further revealed Resident #11 was dependent on two staff for bed mobility and for toileting and was dependent on one staff for bathing. Resident #11's baseline care plan dated 07/08/2020 was not marked for the type of assistance needed for grooming, personal hygiene or bathing and there was no goal marked and no interventions listed. The shower schedule for July 2020 revealed Resident #11 was scheduled to receive showers on Wednesday and Saturday during the second shift. The nurse aide (NA) documentation from 07/08/2020 through 07/22/20 revealed Resident #11 had not received a complete bed bath and had only been cleaned with toileting. Review of the nursing progress notes for the same time period did not reflect Resident #11 had refused a complete bed bath. An observation and interview were conducted with Resident #11 on 07/22/2020 at 9:30 AM. Resident #11 was observed to have dry flaky skin on her arms and legs, and her hair was disheveled and dirty. An interview with Resident #11 revealed she had a small heart monitor on her right upper chest and was not allowed to take a shower because the monitor could not get wet. She stated the NA had told her she could not give her a bath because the monitor could not get wet. Resident #11 went on to say that she had not had a complete bed bath since admission to the facility on [DATE]. The interview revealed Resident #11 did not feel clean and stated she would like to be clean all over her body. She stated they had washed her back one time when she had a loose stool that spread out of her brief onto her back and stated it was because they had to clean the stool off my back. Resident #11 stated her arms and legs had not been washed since admission to the facility on [DATE] and her skin was dry and itching. An interview conducted on 07/22/2020 at 11:30 AM with NA # 3 revealed she worked on Resident #11's hall from 7:00 AM to 7:00 PM. NA #3 stated they try to get everything done but just are not able to complete some of the showers. NA #3 stated she was assigned to Resident #11 and when she had to care for residents on two halls it was not possible to give residents their showers as scheduled. She stated she had been told not to get the heart monitor wet and the resident could not be showered but stated she did not know why the resident had not

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) had a complete bed bath since her admission. An interview was conducted on 07/22/2020 at 4:00 PM with the Director of Nursing (DON). The DON said they should be providing showers according to the resident's preference and they needed to do a full audit of showers to determine preferences of the residents. He stated once they were fully staffed with NAs there should not be a problem with residents getting their showers. The DON explained they used to have a shower team, but those positions had been eliminated. He stated regardless of staffing, showers should be given as scheduled whenever possible. The DON also stated they should check with the residents on a regular basis to ensure they were receiving their showers on a day and time of their preference. The DON stated Resident #11 should have been given a complete bed baths as scheduled. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed staff members were expected to work around the resident's preference and time they wanted a shower. He stated if a resident wanted a first shift shower instead of second shift they should be scheduled as a first shift shower. The interview revealed the staff were expected to give the best care possible as residents were at the facility to be provided skilled care. The Administrator stated he expected staff to tag-team and make sure the care was completed for the residents and showers should be provided for residents according to their preference for days and time. According to the Administrator residents should not be going a week without a shower or bed bath and it was unacceptable Resident #11 had not been bathed completely since admission. 3. Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #10's annual Minimum Data Set ((MDS) dated [DATE] revealed Resident #10 was cognitively intact. The MDS further revealed Resident #10 required extensive one-person assistance with bathing. Resident #10's care plan dated 07/09/2020 revealed she had a care plan for ADL due to being at risk for ADL self-care performance decline related to her lung mass, hip pain and impaired balance. The shower schedule for July 2020 revealed Resident #10 was scheduled to receive showers on Wednesday and Saturday during the second shift. Resident #10's nursing assistant (NA) documentation from 07/01/2020 through 07/22/20 revealed Resident #10 had not received a shower three times per week as requested and on all three weeks she had only received one shower per week. An observation and interview were conducted on 07/22/2020 at 9:08 AM with Resident #10. Resident #10's hair was disheveled and dirty and she had dry flaky skin on her arms and legs. Resident #10 stated she was not getting enough showers. She stated she had told staff she wanted showers on Monday, Wednesday and Friday and stated it had been over a week since she had a shower. Resident #10 stated her last shower was on Monday 07/13/2020 and stated when she asked about getting a shower, she was told they did not have enough staff to provide showers. The interview revealed Resident #10 did not feel clean when she only had one shower per week and stated she felt better when she felt clean. Resident #10 stated she had told staff on admission she wanted three showers per week but stated they had not provided three and most of the time she was only given one per week. According to Resident #10 the facility seemed to be short staffed most days and the staff did not have time to provide the care needed by the residents. An interview conducted on 07/22/2020 at 11:30 AM with NA # 3 revealed she worked on Resident #10's hall 7:00 AM to 7:00 PM. NA #3 stated they try to get everything done but just are not able to complete some of the showers. NA #3 stated she was assigned to Resident #10 and stated when she had to care for residents on two halls it was not possible to give residents their showers as scheduled. She stated she must have overlooked Resident #10's shower on the previous Monday. An interview was conducted on 07/22/2020 at 4:00 PM with the Director of Nursing (DON). The DON said they should be providing showers according to the resident's preference and they needed to do a full audit of showers to determine preferences of the residents. He stated once they were fully staffed with NAs there should not be a problem with residents getting their showers. The DON explained they used to have a shower team, but those positions had been eliminated. He stated regardless of staffing, showers should be given as scheduled whenever possible. The DON also stated they should check with the residents on a regular basis to ensure they were receiving their showers on a day and time of their preference. The DON stated Resident #10 should have received showers three times per week as requested. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed staff members were expected to work around the resident's preference and time they wanted a shower. He stated if a resident wanted a first shift shower instead of second shift they should be scheduled as a first shift shower. The interview revealed the staff were expected to give the best care possible as residents were at the facility to be provided skilled care. The Administrator stated he expected staff to tag-team and make sure the care was completed for the residents and showers should be provided for residents according to their preference for days and time.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on record reviews and staff interviews, the facility failed to provide sufficient nursing staff to accommodate scheduled showers and complete bed baths for 3 of 3 sampled dependent residents (Resident #9, #10 and #11). Findings included: This tag was cross referred to F 677: F 677 - Based on observations, record reviews, resident and staff interviews, the facility failed to provide resident showers and complete bed baths as scheduled to maintain the personal hygiene for 3 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #9, #10 and #11). A review of the Daily Staffing Assignment revealed: 1. 07/13/2020 - One Nurse Aide (NA) assigned to 300 hall and the top of 200 hall from 7:00 AM to 3:00 PM and from 3:00 PM to 11:00 PM 2. 07/14/2020 - One NA assigned to the 300 hall and the top of 200 hall from 7:00 AM to 7:00 PM 3. 07/15/2020 - One NA assigned to the 300 hall and the top of 200 hall from 7:00 AM to 7:00 PM 4. 07/16/2020 - One NA assigned to the 300 hall and the top of 200 hall from 7:00 AM to 7:00 PM 5. 07/17/2020 - One NA assigned to the 300 hall and the 200 hall from 7:00 AM to 3:00 PM 6. 07/18/2020 - One NA assigned to the 300 hall, and to do all vital signs (VS) and pass ice to all halls from 7:00 AM to 7:00 PM 7. 07/19/2020 - One NA assigned to the 300 hall and the top of 200 hall and to do all VS and pass ice to all halls from 7:00 AM to 3:00 PM 8.07/20/2020 - One NA assigned to 300 hall and top of 200 hall from 7:00 AM to 7:00 PM An interview on 07/21/2020 at 10:20 AM with Nurse Aide (NA) #4 revealed staffing was better on some days rather than others. NA #4 further stated she had worked on 07/17/20 and 07/21/20 and stated she had not been able to complete all showers and bed baths as scheduled. NA #4 stated on bad days they were not able to get all the showers done as scheduled. NA #4 could not recall if she had reported not getting showers done to the Nurse or DON. An interview on 07/21/2020 at 11:30 AM with NA #3 revealed there were good days and bad days with staffing. NA #3 indicated on the bad days they were not able to get all the showers done as scheduled. She stated the nurses did help as time allowed with answering call lights and assisting residents. NA #3 further stated she had worked on 07/14/20, 07/16/20, 07/17/20. 07/18/20, 07/20/20, 07/21/20 on the 300 hall and had not been able to complete her showers or bed baths. She said she had not reported the showers not being done to the nurse and stated she tried to make the showers up but was just not able to do so. A telephone interview on 07/20/2020 at 5:00 PM with Nurse #2 revealed staffing was horrible and stated no one wanted to work. She stated there were numerous call outs and they were always trying to get help in the building. The interview further revealed when Nurse #2 had worked 7:00 AM to 7:00 PM and there were only three or four NAs they were not able to complete all the showers and bed baths scheduled on their shift. According to Nurse #2 she had not reported to the Director of Nursing (DON) that showers and bed baths were not completed for all residents as scheduled. A telephone interview on 07/21/200 at 8:00 AM with Nurse #1 revealed staffing was poor. She stated sometimes their relief for 7:00 PM to 7:00 AM did not show up and they would have to stay until relief was found. Additionally, Nurse #1 stated on bad days when there is not enough help, showers were not completed for residents as scheduled. Nurse #1 could not recall if she had reported showers and bed baths not being given to the DON. An interview on 07/21/2020 at 10:00 AM with Nurse #6 revealed there were good days and bad days with staffing. Nurse #6 stated on bad days showers did not get done as scheduled. Nurse #6 could not recall having reported showers not being done to the DON. An interview on 07/21/2020 at 12:10 PM with Nurse #5 revealed there were some days that were good and some not with staffing. Nurse #5 stated on the days there were not enough NAs working the showers and bed baths were not completed as scheduled. According to Nurse #5 she had not reported showers not being done to the Director of Nursing (DON) because he knew there was not enough help. An interview was conducted on 07/22/2020 at 4:00 PM with the Director of Nursing (DON). According to the DON there were 4 vacant positions for NAs, and 2 vacant positions for Nurses and they were working to interview and fill those positions. He said they had recently acquired a contract with another Agency that had been responsive to their needs when they called for NAs to work. The DON stated he was aware of the current staffing numbers with 4 NAs and 2 nurses and stated ideally, they needed 4-6 NAs depending on the residents and at least one Nurse per hallway or 3 nurses. He stated once they were fully staffed with NAs there should not be a problem with residents getting their showers especially since the residents did not have that high of an acuity. He stated he recalled Resident #9 was not getting showers as scheduled and stated he was

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	345385	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL HEALTHCARE AND REHAB	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.

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) working on a plan for that resident. He further stated he was not aware of the other two residents but stated he would follow up with staff. According to the DON if he had known the residents were upset about not getting a shower, he could have called NAs in just specifically to give showers to the residents. The daily staffing assignment for 7/13/20 through 7/20/20 were reviewed during the interview. The DON indicated there were probably not many days the residents were bathed or showered according to their scheduled time, given the number of staff and their assignments particularly on the 300 hall where Resident #9, #10 and #11 resided, The DON further explained he wanted staff to tell him or their nurse when they were not able to complete their assigned work. An interview conducted on 07/22/2020 at 4:34 PM with the Administrator revealed he and the Human Resources Representative were doing the schedule for the Nurses and NAs. The Administrator stated he expected staff to tag-team and make sure the care was completed for the residents and showers should be provided for residents according to their preference for days and time. According to the Administrator, on paper the facility was not short staffed but stated it was hard to anticipate call outs. He further stated the residents had a high acuity and some of the staff were not used to working with residents with such an acuity. According to the Administrator, just this week they had contracted with another agency to provide NAs as needed at the facility to cover call outs and stated they were working with yet another agency to provide nurses as needed. The Administrator indicated he was not aware of the showers and bed baths not being completed as scheduled and stated he expected the residents to receive their showers as scheduled. The Administrator also indicated the staff were used to a shower team but stated they had eliminated those positions due to needing the staff to work on the floor providing care. He further indicated he would follow up with the Director of Nursing to evaluate their current bathing schedule to see what adjustments could be made to ensure residents received their showers or bed baths.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, nurse practitioner (NP), and physician (MD) interviews the facility failed to administer [MEDICATION NAME] (an [MEDICAL CONDITION] mediation), Sodium Chloride and Potassium Chloride as ordered for 1 of 3 residents (Resident #4) reviewed for medication administration. Findings included: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 was cognitively intact and had the ability to make herself understood and understood others. The MDS further revealed Resident #4 had moderate difficulty hearing, impaired vision, and received antidepressants 7 out of 7 days in the look back period. Resident #4's care plan last updated 07/15/2020, revealed she had a care plan for metabolic-[MEDICAL CONDITION] due to being at risk for complications of [MEDICAL CONDITION]. The interventions included obtaining and reporting labs for sodium levels as ordered by the provider. Resident #4 had a care plan for mood due to being at risk for mood decline related to her history of depression. The interventions included administration of medications as ordered and monitoring and documenting any side effects and effectiveness of medications. The resident had a care plan for [MEDICAL CONDITION] due to having a [DIAGNOSES REDACTED]. The interventions included giving medications as ordered and monitoring for effectiveness and side effects. The medical record revealed no assessment for self-administration of medications and no order for self-administration for Resident #4. Resident #4's nursing progress note dated 07/19/2020, written by Nurse #5, documented pills were found in Resident #4's room while Nurse Aide (NA) #6 was making the bed. NA #6 notified Nurse #5 and further search of the resident's room resulted in additional pills being found in various places in Resident #4's room. Nurse #5 obtained vital signs (VS) and notified the Nurse Practitioner (NP) and Director of Nursing (DON). The NP ordered labs for complete metabolic panel (CMP), complete blood count (CBC), and [MEDICATION NAME] level for the following morning on 07/20/2020. Resident #4's vital signs were blood pressure 118/66, heart rate 76, respiratory rate 18, and temperature 97.8. Resident #4's July 2020 Medication Administration Record [REDACTED]#6 revealed she was working on Resident #4's hall on 07/19/2020. She stated she assisted Resident #4 to the bathroom and was making her bed and found a pill cup filled with medications at the foot of the bed. She stated she told the nurse (Nurse #5) who was taking care of the resident. She stated she was in the resident's room when the nurse searched the room and found additional pills in Resident #4's slippers and dresser. She stated she did not know the total number of pills found in Resident #4's room, but a medium plastic cup was over half full of pills. A phone interview conducted on 07/20/2020 at 3:22 PM with Nurse #5 revealed she was working on Resident #4's hall on 07/19/2020. NA #6 was making up the resident's bed and found a medication cup filled with pills under her blankets. She stated that she searched Resident #4's room and found over 200 pills including the pills in the cup and others found in her room in her nightstand, in plastic wrappings of food items, in her slippers, and in her shoes. Nurse #5 stated she identified the pills as medications that were prescribed for Resident #4. She stated she notified the DON, Resident #4's family, and the NP. The NP ordered labs for CBC, CMP, and [MEDICATION NAME] level to be drawn the morning of 07/20/2020. She stated that Resident #4 preferred to sleep late and didn't like to get up early to take medications and sometimes refused to take medications due to having nausea, especially in the mornings. Nurse #5 stated she would never leave medications or medication cups in residents' room and watched residents swallow medications before leaving the room. An interview conducted on 07/21/2020 at 9:06 AM with NP revealed she frequently found pills on the bedside table in resident rooms and on the dietary trays during her rounds twice a week. She stated she didn't remember specifically if she had seen pills or cups in Resident #4's room. She stated when she found medications in a resident's room, she took the medications to the nurses. She stated she saw the pills that were found in Resident #4's room on 7/19/20 and the pills totaled approximately 240. She stated Resident #4 was not taking her mediation because nurses were not watching her take her medication and her sodium was low because of this reason. A phone interview conducted on 07/21/2020 at 3:12 PM with Nurse #1 revealed she worked on Resident #4's hall and was very familiar with the resident. She stated she was aware of pills being found in the resident's room on 07/19/2020. She stated after the pills were found, she talked to Resident #4 and explained to her that she can refuse medications. She explained she doesn't ask the resident to open her mouth after she administers medications to her but plans to ask Resident #4 to open her mouth after she administers medications to her in the future. She stated that she doesn't leave medications in Resident #4's room. She stated she had not received any education or in-servicing regarding medication administration after the pills were found in Resident #4's room. An interview conducted on 07/21/2020 at 4:24 PM with the DON revealed Resident #4 did not have an assessment or an order to self-administer medications. He stated he was unsure of how over 200 pills were found in Resident #4's room on 7/19/2020. He stated, I don't know how she is doing it, but I don't think they were left at the bedside and she may have collected them over time. He stated that lab results except for [MEDICATION NAME] level had been resulted and reported to the provider on call. Review of Resident #4's lab results for CMP and CBC drawn on 07/20/2020 revealed her sodium level was 130 milliequivalents per liter (mEq/L) which was below normal (normal range for sodium level being 136-144 mEq/L) and her potassium level was 4.2 millimoles per liter (mmol/L) which was within normal range. A phone interview conducted on 07/22/2020 at 10:58 AM with the facility's Medical Director (MD) revealed not taking medications as ordered would contribute to decreased sodium and potassium levels and a subtherapeutic [MEDICATION NAME] level for Resident #4. The MD stated he had not been notified of the medications found in Resident #4's room or that she had refused to take her medications recently. The MD stated he was not aware of Resident #4 having any [MEDICAL CONDITION] activity. An interview conducted on 7/22/2020 at 4:48 PM with the facility's Nurse Consultant revealed she was aware of greater than 200 pills being found in Resident #4's room on 7/19/2020. She stated that it was not acceptable for medications to be left in any resident's room and it was expected for nurses to ensure the medications are swallowed by the resident at the time of administration. An interview conducted on 07/22/2020 at 10:04 AM with the NP revealed she had reviewed some of the lab results for Resident #4 and [MEDICATION NAME] level was pending. She stated that Resident #4's sodium level was low because she was not receiving her medications including her sodium and potassium. She stated she talked to Resident #4 to see if she would prefer for medications to be crushed if possible, but the resident did not want medications crushed. The NP stated she expected nurses to stay with residents and watch them take medications at the time of administration. A phone interview conducted on 07/27/2020 at 5:51 PM with the NP revealed she had reviewed the results of the [MEDICATION NAME] level and other lab results ordered on [DATE] for Resident #4. The NP stated that the resident's [MEDICATION NAME] level was sub-therapeutic with a value of 3.7 micrograms/milliliter (mcg/ml) and therapeutic range is 12-46 mcg/ml. She stated the low [MEDICATION NAME] level was caused by her not taking her medication. The NP stated the nurses did not watch Resident #4 take her medicine and if she had been supervised, she would have taken the medication or if Resident #4 had refused medications, it should have been documented. The NP stated she had been notified that Resident #4 had refused some of her medications only a few times. She stated that she had not been notified of any [MEDICAL CONDITION], but that Resident #4 had incurred some falls. The NP stated the falls Resident #4 experienced may have been related to a low sodium

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) level. The NP stated that Resident #4 was at risk for [MEDICAL CONDITIONS] (low sodium), [DIAGNOSES REDACTED] (low potassium), falls, and possible death due to not receiving her medications appropriately. She stated that Resident #4 was on a fluid restriction and if she had received her sodium chloride tablet four times a day as ordered, she would not have had to be on this restriction. The NP stated, I feel so badly, because she is always saying she is thirsty. A phone interview conducted on 08/07/2020 at 1:22 PM with the DON revealed he did not count the pills found in Resident #4's room on 7/19/2020 but observed them and was able to identify some of the pills as [MEDICATION NAME] but was unable to identify most of the medications due to the markings on the pills were unreadable or missing. The DON stated he did not document an investigation of the incident of the medications found in Resident #4's room.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with staff and two Health Department staff members, the facility failed to implement the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 by not placing enhanced droplet contact precautions signs up and not requiring staff to wear all recommended PPE (Personal Protective Equipment) when caring for 2 of 2 newly admitted residents (Resident #11 and Resident #25) and 1 of 1 readmitted resident (Resident #18) and not cohorting and quarantining on the designated quarantine hall (300 hall) 3 of 15 newly admitted residents (Resident #15, Resident #17 and Resident #19) and 2 of 3 readmitted residents (Resident #16 and Resident #18). Immediate jeopardy began on 6/22/20 when the facility failed to place newly admitted and readmitted residents on enhanced droplet contact precautions and failed to quarantine the newly admitted and readmitted residents on the designated quarantine hall (300 hall). Immediate jeopardy was removed on 7/27/20 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: The CDC guideline entitled Responding to Coronavirus (COVID-19) in Nursing Homes last reviewed on 4/30/20 indicated the following statements: * Place signage at the entrance to the COVID-19 care unit that instructs HCP (healthcare personnel) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. * All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (goggles or a disposable face shield that covers the front and sides of the face), gloves and gown. * A single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g. date of admission). A review of the facility's COVID-19 Pandemic Plan revised on 6/29/20 indicated the following statements: * Infection prevention and control policies require staff to use Standard, Contact and Droplet precautions, including eye protection - unless otherwise directed by local, state health department. * The center will designate an area and cohort new admissions/readmissions for 14 days. a. The patient will then be moved to a different room/area of the center. b. If the resident's COVID-19 status is unknown (no available test) - resident placed in a private room or cohort with another resident whose status is unknown, initiate transmission-based precautions (standard, contact and droplet) for 14 days. During the entrance conference on 7/20/20 at 8:45 AM, the Administrator indicated the 300 hall was the isolation/dedicated hall for COVID-19. A review of the facility's list of Admissions/Readmissions from 6/17/20 to 7/22/20 indicated: 1. Resident #15 was admitted on [DATE] from the hospital to room [ROOM NUMBER] (private room). 2. Resident #16 was readmitted on [DATE] from the hospital to room [ROOM NUMBER] (private room). 3. Resident #17 was admitted on [DATE] from the hospital to room [ROOM NUMBER] (private room). 4. Resident #11 was admitted on [DATE] from the hospital to room [ROOM NUMBER] (private room on quarantine hall). 5. Resident #18 was readmitted on [DATE] from the hospital to room [ROOM NUMBER] (private room). 6. Resident #25 was admitted on [DATE] from the hospital to room [ROOM NUMBER] (private room on quarantine hall). 7. Resident #19 was admitted on [DATE] from the hospital to room [ROOM NUMBER] (private room). Review of the medical records of the above-listed residents revealed all of them had a negative test for COVID-19 prior to coming to the facility. The medical records further revealed that none of the residents listed above were placed on enhanced droplet/contact precautions when they were admitted or readmitted to the facility. Observations made on 7/20/20 at 12:40 PM, 7/21/20 at 10:15 AM, and 7/22/20 at 9:00 AM on the 100 hall revealed no residents were on transmission-based precautions and there were no PPE supplies available for use outside any resident door. Nurse aide (NA) #4 was observed on 7/20/20 at 12:45 PM wearing a mask and gloves while providing care to Resident #6 on the 100 hall. Observations made on 7/20/20 at 12:40 PM, 7/21/20 at 10:15 AM, and 7/22/20 at 9:00 AM on the 200 hall revealed no residents were on transmission-based precautions and there were no PPE supplies available for use outside any resident door. Nurse #6 was observed on 7/20/20 at 4:05 PM wearing a mask and gloves while administering medications to Resident #7 on the 200 hall. Observations made on 7/20/20 at 12:40 PM, 7/21/20 at 10:15 AM, and 7/22/20 at 9:00 AM on the 300 hall revealed no residents were on transmission-based precautions and there were no PPE supplies available for use outside any resident door. NA #3 was observed on 7/21/20 at 3:00 PM going into Resident #25's room on the 300 hall while wearing a mask. On 7/20/20 at 12:50 PM, Nurse #7 was observed on the 200 hall entering Resident #18's room while wearing a mask and gloves. No signage for any transmission-based precautions was on the door and Nurse #7 did not wear a gown prior to entering the room. On 7/20/20 at 4:09 PM, an interview with Nurse #7 revealed she was aware that Resident #18 had recently been readmitted to room [ROOM NUMBER]. She did not know why Resident #18 was not placed on the 300 hall which was considered the facility's quarantine hall. Nurse #7 stated she only wore a mask and gloves when going inside the room and that a gown was not required because she was not on any transmission-based precautions. On 7/20/20 at 4:24 PM, NA #7 was observed entering Resident #18's room on the 200 hall while wearing a mask. After entering the room, she put on gloves and closed the door. After 5 minutes, NA #7 came out of room [ROOM NUMBER] with a mask on and gloves which she removed and disposed of in the trash bin parked outside room [ROOM NUMBER] in the hallway. NA #7 was further observed using hand sanitizer from a dispenser in the hallway. On 7/20/20 at 4:30 PM, an interview with NA #7 revealed Resident #18 was not on any transmission-based precautions so she had not been wearing a gown prior to entering her room. NA #7 stated she only wore a mask and gloves when she provided personal care to Resident #18. On 7/21/20 at 12:04 PM, a phone interview was conducted with NA #8 who usually worked on the 300 hall and helped out on the first half of the 200 hall. NA #8 confirmed that new admissions went to the 300 hall where they were quarantined for 14 days but they were not placed on any transmission-based precautions. NA #8 stated she only wore a mask and gloves when providing personal care to the residents on 300 hall and that a gown was not required. On 7/21/20 at 1:49 PM, an interview with the Assistant Director of Nursing (ADON) revealed the facility quarantined their new admissions and readmissions for 14 days on the 300 hall. The ADON clarified that quarantine meant the residents were kept inside their rooms for 14 days. She stated that none of the currently admitted and readmitted residents were placed on transmission-based precautions unless they came to the facility with certain medical conditions that required it. They did not put up signs for precautions because they did not require all new admissions and readmissions to be placed on any transmission-based precautions. Staff who provided care to the newly admitted and readmitted residents were only required to wear a mask and gloves. She stated the facility's policy did not specify what to do with incoming residents who had tested negative for COVID-19 prior to coming to the facility. She thought having been tested negative once for COVID-19 was enough to prevent possible transmission of COVID-19. She said she was not sure why some of the newly admitted and readmitted residents were not placed on the 300 hall. On 7/21/20 at 3:27 PM, an interview conducted with the Regional Director of Clinical Services (RDCS) revealed she had questioned the Director of Nursing (DON) about new admissions and readmissions not being placed on transmission-based precautions and she said she was told that these residents had tested negative for COVID-19 at the hospital 48 hours prior to coming to the facility. During the interview, she referred to the facility's COVID-19 Pandemic Plan which did not include directions on what to do for incoming residents who were tested negative for COVID-19 prior to entering the facility. She further stated that they should follow the CDC guidelines and state and local health department directives which they tried to incorporate into the facility's policies. On 7/21/20 at 5:22 PM, an interview conducted with the DON revealed they made sure the newly admitted and readmitted residents were tested negative for COVID-19 within 24 to 48 hours prior to coming to the facility. These residents continued to be screened for COVID-19 by the nurses who checked their vital signs including temperatures at least twice a day and none had exhibited any signs or symptoms of COVID-19. On 7/22/20 at 1:57 PM, a phone interview with

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) Health Department staff member #1 revealed new admissions and readmissions should be placed on droplet precautions using all recommended PPE and quarantined for 14 days even though they did not exhibit any signs or symptoms of COVID-19. They should be placed in a separate unit and away from the general facility population until after 14 days of coming to the facility. She also stated having been tested negative one time for COVID-19 did not guarantee that these residents had not been exposed to COVID-19. She stated she had sent the CDC guideline entitled Responding to Coronavirus (COVID-19) in Nursing Homes to the Administrator on 6/30/20. The CDC guideline entitled Responding to Coronavirus (COVID-19) in Nursing Homes last reviewed on 4/30/20 indicated the following statements: * Place signage at the entrance to the COVID-19 care unit that instructs HCP (healthcare personnel) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. * All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (goggles or a disposable face shield that covers the front and sides of the face), gloves and gown. * A single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g. date of admission). On 7/22/20 at 2:42 PM, a phone interview conducted with Health Department staff member #2 revealed the local health department had provided guidance to the facility on [DATE] and that he expected them to quarantine their new admissions and readmissions for 14 days and place them on droplet precautions. This information was provided to the facility due to a call to the Health Department on 6/30/20 when the facility had identified their first staff member who tested positive for COVID-19. On 7/22/20 at 3:27 PM, a follow-up interview with the DON revealed the residents who were newly admitted and readmitted to the facility were tested on ly one time at the hospital prior to coming to the facility. These residents were quarantined for 14 days which meant they were not supposed to go outside of their rooms. Staff who provided care to the newly admitted and readmitted residents were supposed to wear either goggles or face shield, mask and gloves. The DON stated gowns were not required to be worn when providing care to these residents as the use of gowns was not specified in the facility's COVID-19 Pandemic Plan. Since they did not require staff to wear gowns prior to entering the rooms of newly admitted and readmitted residents, they were not readily available outside each room. Gloves were located inside each room and each staff member was provided her own face shield or goggles which were reused after disinfection at the end of the day. The DON further stated that the facility had not stopped accepting admissions even with the COVID-19 pandemic. They had designated the 300 hall for newly admitted residents but the readmitted residents went back to their previous rooms. On 7/22/20 at 4:33 PM, an interview was conducted with the Administrator with RDCS present. The Administrator stated he had reviewed the CDC guidelines which were sent to him by the Health Department staff member and admitted that he had misinterpreted the guidance and thought that a single negative test was enough to consider the resident as not exposed to COVID-19. The Administrator further stated that he was trying to conserve his resources for when there was an outbreak of COVID-19 at the facility. The RDCS stated the corporation had experienced a shortage of supplies such as gowns and face shields and had been trying to share their resources with sister facilities. On 7/23/20 at 2:13 PM, a phone interview with the Administrator revealed the new admissions were supposed to go to the 300 hall so they could be quarantined for 14 days. He stated Resident #15 was admitted to room [ROOM NUMBER] because there were no available rooms on the 300 hall on 6/22/20 and 214 was the only private room available. She was not placed on transmission-based precautions. Resident #17 was admitted to room [ROOM NUMBER] because there were no available rooms on the 300 hall on 7/2/20 and 103 was the only private room available. She was not placed on transmission-based precautions. Resident #19 was admitted to room [ROOM NUMBER] on 7/21/20 because they wanted to separate her from another resident with the same name. She was not placed on transmission-based precautions. Resident #16 and Resident #18 were readmitted back to their original rooms, but they were not placed on transmission-based precautions. The Administrator stated he realized he did not follow the facility's COVID-19 Pandemic policy of cohorting new admissions and readmissions by placing them on other halls aside from the 300 hall and not separated from other residents who had remained at the facility. He was also not sure if the staff member assigned to care for the new admissions and readmissions had cared for other residents at the facility at the same time. The Administrator further stated that he did not think about halting admissions due to lack of space. The Administrator was notified of the immediate jeopardy on 8/13/20 at 1:13 PM. On 8/17/20 at 11:46 AM, the facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Review of medical records revealed the following admissions and readmissions: On 6/22/20, Resident #15 was newly admitted to the facility into room [ROOM NUMBER]-A. Resident #15 was tested for COVID-19 while in hospital on [DATE], the results were negative. Resident #15 was tested on [DATE] and 8/5/20 in-house, test results were negative. On 6/30/20, Resident #16 was newly admitted to the facility into room [ROOM NUMBER]-A. Resident #16 had a rapid COVID-19 test completed the day of discharge from the hospital on [DATE], the results were negative. Resident #16 was tested on [DATE] and 8/5/20 in-house, test results were negative. On 7/2/20, Resident #17 was newly admitted to 103-A. Resident #17 was tested for COVID-19 while in hospital on [DATE], the results were negative. Resident #17 was tested on [DATE] and 8/5/20 in-house, test results were negative. On 7/10/20, Resident #18 was readmitted back into her private room [ROOM NUMBER]-A. Resident #18 had rapid COVID-19 test completed the day of discharge from the hospital on [DATE], the results were negative. Resident #18 was tested on [DATE] and 8/5/20 in-house, test results were negative. Resident #18 was not moved on 7/21/20 but was placed on enhanced droplet precautions. Enhanced droplet precaution sign was posted on resident's door. Resident #18 transferred out to hospital on [DATE] and readmitted on [DATE] to room [ROOM NUMBER] on the quarantine unit. On 7/21/20, Resident #19 was newly admitted to the facility into room [ROOM NUMBER]-A. Resident #19 was tested for COVID-19 while in hospital on [DATE], the results were negative. On 7/21/20, Resident #19 stayed in private room [ROOM NUMBER]-A and was placed on enhanced droplet precautions, until moved to quarantine unit on 7/23/20 into room [ROOM NUMBER]-A. Resident #19 no longer resides in facility. Resident #19 was discharged from facility to the hospital on [DATE]. Admissions and readmissions #15 on 6/22/20, #16 on 6/30/20, #17 on 7/2/20, #18 on 7/10/20 and #19 on 7/21/20 were monitored for COVID-19 symptoms to include: fever, cough, shortness of breath, sore throat, vomiting, diarrhea, muscle pain, headache, new loss of taste or smell, chills and repeated shaking with chills. However, Residents #15, #16, #17, #18 and #19 were not quarantined for a period of 14 days on the 300 hall, which was the designated hall for new admissions and readmissions to the facility. On 7/21/20 and prior to that date, staff members were wearing surgical masks to care for all residents. However, Residents #15, #16, #17, #18 and #19, at the time of their admission/readmission, had not been placed on enhanced droplet contact precautions (to include staff wearing additional Personal Protective Equipment (PPE) of gowns, gloves and face shields/goggles when having encounters with these residents). On 7/21/20 during visit, a surveyor made the Regional Director of Clinical Services (RDCS) aware of an Infection Control issue involving new admissions and readmissions process. The surveyor expressed concern that new admissions and readmissions were not being quarantined on the designated quarantine hall (300 hall); and not placed on enhanced droplet contact precautions. The Regional Director of Clinical Services immediately posted signage on the 300 hall to communicate enhanced droplet contact precautions for residents who needed to be quarantined, along with the need to wear Personal Protective Equipment when caring for these residents to include enhanced droplet precautions. At that time, RDCS ensured gowns, gloves, masks and face shields/goggles were provided to unit, and initiated education with current staff working on the unit. On 7/21/20, Personal Protective Equipment to include gowns, gloves, masks and face shields/goggles were provided to 300 hall. The nurses and nurse aides were educated at that time to utilize this PPE when caring for newly admitted and readmitted residents by the Director of Nursing. On 7/24/20, Regional Director of Clinical Services reeducated the Administrator, Director of Nursing, Assistant Director of Nursing, Admissions Director and Social Worker on the COVID-19 to include the instruction for residents who are admitted or readmitted to the center as follows: The center will designate an area and cohort new admissions/readmissions for 14 days on 300 hall. a. The patient will then be moved to a different room/area of the center. b. If the resident's COVID-19 status is unknown (no available test) - resident placed in a private room or cohort with another resident whose status is unknown, initiate transmission-based precautions (standard, contact and droplet) for 14 days. Specify the action the entity will take to alter the process of system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. New Admissions, Readmissions and current residents have the potential to be affected by this alleged deficient practice. On 7/21/20, the Director of Nursing and Assistant Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARDINAL HEALTHCARE AND REHAB	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)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) reviewed Residents #15, #16, #17, #18 and #19 as well as the current residents on 100, 200 and 300 halls to determine if they needed any precautions. Residents #15, #16 and #17 were beyond the 14-day period of requiring quarantine or enhanced droplet contact precautions and showed no signs or symptoms of COVID-19, nor did other current residents on 100 or 200 halls require quarantine or additional enhanced droplet contact precautions. On 7/21/20, six long-term care residents were identified as residing on the 300 hall. On 7/23/20, the six long-term care residents residing on 300 hall were moved off the unit into rooms on other side of facility to accommodate new admissions and readmissions. The six long-term care residents remained on the 300 hall while the Administrative Team worked on bed management and notification to residents and family. On 7/27/20 and 8/5/20, current residents residing at the center on those dates were tested for COVID-19, and all resident test results were negative to include the six long-term care residents that were on the quarantine hall until 7/23/20. On 7/21/20, the Director of Nursing and the Assistant Director of Nursing initiated staff reeducation to include the following staff: Nursing Department, Therapy Department, Housekeeping Department, Dietary Department and Administrative Team (Social Worker, MDS, Business Office Manager, Human Resource Coordinator, Admissions Director, Medical Records, Activities, Maintenance and Administrator) on Infection Control to include the following: * The center will designate a quarantine unit (300 hall) and cohort new admissions/readmissions whose COVID-19 status is known (negative) or who has been removed from transmission-based precautions prior to admission/readmission for 14 days. * Newly admitted or readmitted residents will be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * After 14 days of quarantine and if resident is not experiencing symptoms, the resident will then be moved to a different room/area of the facility. * The Director of Nursing will decide when residents are ready to be moved off quarantine unit. The Director of Nursing will consult with the Nurse Practitioner and/or Medical Director before moving residents off quarantine unit. * The facility will make every effort to staff unit with dedicated staff. * Wearing (PPE) mask and face shield/goggles, gowns and gloves * Infection Control to include: process for new admissions and readmissions, enhanced droplet precautions and PPE (donning and doffing). Education will be ongoing; no staff could return to work until they had completed the mandatory education. On 7/24/20, the Nursing Management Team (Director of Nursing and Assistant Director of Nursing) initiated reeducation to staff to include: Nursing Department, Therapy Department, Housekeeping Department, Dietary Department and Administrative Team (Social Worker, MDS, Business Office Manager, Human Resource Coordinator, Admissions Director, Medical Records, Activities, Maintenance and Administrator) on proper use of PPE including competency with return demonstration. Staff will not be allowed to work until they received the mandatory education. Additionally, this education will be provided to all new employees as part of new hire orientation, including contract staff and agency staff. As of 7/27/20, the Center's Pandemic Plan for COVID-19 was revised per CDC guidelines to clarify and include the following: The center will designate an area and cohort new admissions/readmissions whose COVID-19 status is known (negative) or who has been removed from transmission-based precautions prior to admission/readmission for 14 days. (The resident will remain in their room during this time). * Newly admitted or readmitted residents will be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * The patient will then be moved to a different room/area of the center. 1. The Center will designate an area (Person Under Investigation unit) for residents who: * Upon admission the COVID-19 status is unknown or is awaiting test results * Resident with possible exposure and awaiting test results * Resident with possible signs and symptoms awaiting test results * Place resident in a private room or cohort with another resident whose status is unknown, initiate transmission-based precautions (standard, contact and droplet). The Admissions Director will work in conjunction with the Administrator and Director of Nursing to ensure new admits and readmits are placed on the designated quarantine unit. The Administrator and Director of Nursing will ensure that the residents are quarantined for 14 days. The Director of Nursing will decide when residents are ready to be moved off quarantine unit. The Director of Nursing will consult with the Nurse Practitioner and/or Medical Director before moving residents off quarantine unit. The Central Supply person will ensure PPE is stocked and available on all units. The Admissions Director and/or the Director of Nursing will be responsible for checking if new admits/readmits had a negative test in the hospital or if they were quarantined already 14 days in the hospital. The center Executive Director alleges abatement of immediate jeopardy on 07/27/20. On 08/19/20 at 9:00 AM the facility's plan for immediate jeopardy removal was validated by the following. Review of in-service training records revealed staff from all shifts and all disciplines had been inserviced on 7/21/20 and 7/24/20 regarding designated area for residents admitted and readmitted and COVID-19 positive residents on the 300 hall, proper PPE, donning and doffing PPE with return demonstrations, signage for COVID presumptive and positive residents, signage for 300 hall, clean and dirty rooms on designated COVID hall, testing of residents and staff, quarantine of residents for 14 days for unknown COVID status. Observation of the COVID hall revealed residents admitted /readmitted quarantined and signage present on all doors. Observed clean and dirty rooms and dedicated staff to the unit interviewed. The facility's Pandemic Plan was reviewed and revisions were noted. Long term residents previously on the 300 hall were moved to another hallway. The facility's date of immediate jeopardy removal of 07/27/20 was validated.