STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. Building B. Wing	10/24/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40200 Based on observations, record review and staff interviews, the facility failed to develop comprehensive individualized care plans in activities of daily living (ADL) for 1 of 4 residents (Resident #47). Findings included: Resident #47 was admitted to the facility on [DATE] with diagnoses which included non-Alzheimer's dementia. Resident #47's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had moderately impaired cognition and displayed no moods or rejection of care. He was coded for partial assistance with oral hygiene. Resident #47's care plan dated 6/30/24 had a problem category for ADL Functional Status related to weakness and limited mobility. Approaches included assisting with activities of daily living, dressing, grooming, toileting, feeding and oral care. There was no denture care noted on the care plan. Resident #47 was not interviewable. An interview with Nurse #1 conducted in conjunction with an observation of Resident #47 on 10/22/24 at 12:49 PM revealed she was unaware if Resident #47 had dentures. She stated if he had dentures, they should be on his care plan so the Nursing Assistants were aware they should provide denture care. Nurse #1 asked Resident #47 if he had dentures and the resident removed the upper plate but did not remove the lower plate. The upper plate was coated with food debris and had black areas between the teeth. She stated the Nursing Assistants should remove his dentures every night to be cleaned, placed in a cup to soak during the night, and they should be placed back in his mouth every morning before breakfast. An interview on 10/23/24 at 4:42 PM with the MDS Nurse revealed she was aware Resident #47 had dentures. She stated his denture should have been included in his care plan. The MDS Nurse stated it was human error and she had overlooked his dentures when she developed his care plan. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/23/24 at 11:22 AM with the Director of Nursing stated Resident #47 should receive oral, or denture care every morning and evening. She stated that he required assistance with his dentures which included cleaning and soaking them, but he could put them in and take them out of his mouth. She also stated that she was aware he had dentures based on his admission assessment, but it should have been on his care plan. An interview on 10/23/24 at 5:19 PM with the Administrator revealed she expected the care plan to be comprehensive and accurate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40200 Based on observations, record review and staff interviews, the facility failed to provide oral care for 1 of 4 dependent residents reviewed for activities of daily living (Resident #47). Findings included: Resident # 47 was admitted to the facility on [DATE] with diagnoses which included non-Alzheimer's dementia. Resident #47's quarterly Minimum Data Set (MDS) dated [DATE] revealed he had moderately impaired cognition. He was coded for partial staff assistance with oral hygiene. He was coded for no behaviors or rejection of care. Resident #47's care plan dated 6/30/24 had a problem category for ADL Functional Status related to weakness and limited mobility. Approaches included assisting with activities of daily living to include oral care. There was no other oral care or denture care noted on the care plan. Resident #47 was not interviewable. An interview with Nurse #1 conducted in conjunction with an observation of Resident #47 on 10/22/24 at 12:49 PM revealed she was unaware if Resident #47 had dentures. She stated if he had dentures, they should be on his care plan so the Nursing Assistants (NA) were aware they should provide oral denture care. Nurse #1 asked Resident #47 if he had dentures and the resident removed the upper plate but did not remove the lower plate. The upper plate was coated with debris and had black areas between the teeth. She stated the Nursing Assistants should remove his dentures every night, they should be cleaned, placed in a cup to soak during the night and they should be placed back in his mouth every morning before breakfast. An interview on 10/23/24 at 1:05 PM with Nursing Assistant (NA) #5 revealed she had been assigned to provide care for Resident #47 on the 7 PM to 7 AM shift which started at 7 PM on 10/21/24 and ended at 7 AM on 10/22/24. She stated she was frequently assigned to provide care for him. She stated she was unaware if he had dentures and had not provided oral care for him when she was assigned to him on 10/21/24 into 10/22/24 or any other night. She stated on 10/21/24 night shift she had not removed his dentures or provided him oral or denture care. She stated that she was able to tell if a resident had dentures by looking in their mouth, but she had not looked at his teeth and was unable to state if he had dentures. She was unable to clarify if he required assistance with oral or denture care. An interview on 10/22/24 at 3:28 PM with NA #6 revealed she was assigned to provide care for Resident #47 sometimes and was assigned to provide care for him on 10/22/24 on the 7 AM to 7 PM shift. She stated she did not know if he had dentures and had not provided oral care for him that morning. She stated she usually asked the resident if they had dentures or looked in the nightstand for the denture cup. NA #6 stated Resident #47 required assistance with oral care and residents should be given oral care in the morning and at bedtime. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/23/24 at 11:22 AM with the Director of Nursing revealed she was aware Resident #47 had not received oral care on 10/21/24 and 10/22/24. She stated he should receive oral or denture care every morning and evening. She stated that Resident #47 required assistance with his dentures which included cleaning and soaking them, but he could put them in and take them out of his mouth. She also stated that she was aware he had dentures based on his admission assessment. An interview on 10/23/24 at 5:19 PM with the Administrator revealed she expected Resident #47 to received oral care every morning and evening. She stated that dentures should be included on the resident's care plan to ensure staff were aware when residents have dentures, so they provide proper care. She felt lack of staff education had resulted in Resident #47 not receiving adequate oral hygiene.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37280 Based on observations and staff interviews the facility failed to remove an unidentified resident's medications, failed to remove loose and unsecure pills and failed to remove debris of paper shavings and rubber bands from medication cart (medication cart #2) and failed to remove loose and unidentified pills and debris of paper shavings and rubber bands from medication cart (medication cart #1) for 2 of 2 medication carts reviewed for medication storage. The findings included: a. On 10/23/24 at 3:12 PM an observation was made of medication cart #2 along with Nurse #1. Stored in the narcotic drawer was a resident's personal weekly medication container that contained no resident name or information that had 6 pills in the Thursday's slot, 7 pills in the Friday's slot and 7 pills in the Saturday's slot. The medication cart also had 21 loose and unidentifiable pills in the bottom of the drawers along with debris of paper shavings and rubber bands. An interview was conducted with Nurse #1 on 10/23/24 at 3:12 PM. The Nurse explained that the medication container was in the narcotic box when she accepted the keys to the medication cart that morning and when she asked the nurse who reported off to her who's medications they were, the nurse did not know. Nurse #1 stated she should dispose of the medications because they were unidentifiable, and she did not know who they belonged to. The Nurse also explained that every nurse was responsible for keeping the medication carts clean but that was the first time in a long time she was on medication cart #2 and did not have time to clean the medication cart. b. An observation was made on 10/23/24 at 3:39 PM of medication cart #1 along with Nurse #2. The cart yielded 4 loose and unidentifiable pills in the bottom of the drawers as well as debris of paper shavings and rubber bands. During an interview with Nurse #2 on 10/23/24 at 3:39 PM the Nurse explained that the night shift was responsible for keeping the medication carts clean and orderly. She indicated the loose pills should be discarded since she did not know who they belonged to. An interview was conducted with the Director of Nursing on 10/23/24 at 3:50 PM who explained that she thoroughly cleaned and organized both medication carts about a month ago. She stated there should not be any unidentified medications stored on the medication carts and each nurse should keep their medication carts clean and orderly. The DON also stated each nurse was responsible for keeping the medication carts clean and orderly