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	345250	A. BUILDING _____ B. WING _____	C 03/14/2024

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THE GREENS AT LINCOLNTON	515 S GENERALS BOULEVARD LINCOLNTON, NC 28093

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted on 03/13/24 to 03/14/24. The facility was found to be in compliance with 42 CFR 43.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# VTL311.	E 000		
F 000	INITIAL COMMENTS An onsite revisit, complaint investigaton and Focused Infection Control Survey was conducted 03/13/24 to 03/14/24. Tag(s) F609 and F761 were corrected as of 03/14/24. New tags were cited as a result of the complaint investigation survey that was conducted at the same time of the revisit. The facility is still out of compliance. The following intakes were investigated: NC00211344, NC00208100, NC00211432, NC00206917, NC00206235, NC00210127, NC00205708, NC00211544, NC00209512, and NC00205742. 7 of 24 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		3/16/24

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

Electronically Signed | 03/29/2024

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, Family Member and staff interviews, the facility failed to maintain a resident's dignity by not answering their call light when toileting assistance was requested for 1 of 4 sampled residents (Resident #13). The reasonable person concept was applied to this deficiency as an individual would not want to feel like they were being ignored when assistance with care was requested.	F 550	F550 1. On 3/14/24 a separate nursing staff member was observed assisting Resident #13 within 10 minutes of the call light with all needs met at that time. 2. All residents have the potential to be affected by deficient practice. Interview with residents with a Brief Interview Mental Score (BIMS) of 11 and higher regarding Customer Service and care	

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F 550	Continued From page 2 Findings included: Resident #13 was admitted to the facility on 09/20/21 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 02/02/24 assessed Resident #13 with severe cognitive impairment. Resident #13 required substantial/maximal assistance with toileting hygiene and displayed no rejection of care during the MDS assessment period. An Activities of Daily Living (ADL) care plan, last revised on 03/15/23, revealed Resident #13 had an ADL self-care performance deficit related to weakness and confusion. Interventions included: requires extensive assistance of one staff member for toileting and moving between surfaces. A continuous observation was conducted of Resident #13's room on 03/13/24 from 3:00 PM to 3:10 PM. Nurse Aide (NA) #5 was observed standing at the top of the hall charting on the KIOSK (computer screen) that was mounted on the wall when the call light for Resident #13's room, located at the bottom of the hall, was engaged at 3:00 PM. NA #5 continued charting and did not acknowledge the call light. At 3:05 PM Resident #13's Family Member stood in the doorway and called out to NA #5 requesting assistance with Resident #13. While remaining at the KIOSK, NA #5 told Resident #13's Family Member that her (NA #5) shift was ending, and she had to finish charting. Resident #13's Family Member then asked NA #5 who was available to help, and NA #5 responded she was not sure as	F 550	needs being met was conducted by the Social Services Director on 3/15/24. No other concerns were noted. Residents with a BIMS of 10 and under were assessed by the Director of Nursing and Designee on 3/15/24 to ensure needs being met in a respectful manner and psychosocial wellbeing with no concerns noted. The Director of Nursing interivewed family members with residents that had a BIMS of 10 or under and no concerns were noted. 3. Current staff, including contract and agency, have been educated on promptly attending to resident needs in a respectful manner by the Director of Nursing and/or Designee on 3/15/24. New hired staff, contract, and agency staff will receive education prior to their first assignment. 4. Administrator/ designee will audit 10 random Resident rooms per week for Call Light responsiveness X 4 weeks, then 5 Resident rooms per week for 4 weeks, then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. The Administrator and Department Heads are responsible to implement this plan of correction with completion date of 3/16/24.	

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F 550	Continued From page 3	F 550		

the oncoming NA had not arrived yet. The Family Member then turned and went back into the bathroom of Resident #13's room. The entire conversation between NA #5 and Resident #13's Family Member occurred while NA #5 was standing at the KIOSK located at the top of the resident hall and the Family Member stood in the doorway of Resident #13's room located at the bottom of the hall. At 3:09 PM, NA #5 finished charting at the KIOSK and walked down the hall to another resident's room located beside Resident #13's room. At 3:10 PM, another staff member was observed entering the room and turned off the call light. NA #5 was not observed attempting to find another staff member to assist Resident #13 or going into the room to check on Resident #13.

During an interview on 03/13/24 at 3:10 PM, NA #5 revealed she was assigned to the resident rooms on the top half of the 500 Hall and was not sure who was assigned to the rooms on the bottom half of the hall (which included Resident #13). NA #5 stated she was not sure who the person was that was asking for help in Resident #13's room or what they had wanted. NA #5 could not explain why she did not go to the room when the call light was engaged or when assistance was requested by Resident #13's Family Member. NA #5 stated it was her first day working at the facility and she had to finish her charting before the shift ended.

During an interview on 03/13/24 at 3:15 PM, Resident #13's Family Member explained when she visited, she preferred to try and assist Resident #13 as much as possible and only called for staff to assist when needed. The Family Member stated she had turned on the call

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F 550	Continued From page 4	F 550		

light for staff to help her with cleaning Resident #13 up after she used the bathroom and when no one responded, she looked out into the hall for a staff member. The Family Member was visibly upset when stating she had called out to NA #5 for assistance but was told by the NA she had to finish her charting. The Family Member explained she knew staff were busy which was why she tried to help Resident #13 as much as she could but there were times she needed staff assistance, like today. The Family Member added there had been other times in the past when staff had not responded when she requested assistance with Resident #13 but was unable to recall specific details. The Family Member stated it bothered her when NA #5 did not come to the room when she requested assistance, and it made her feel like staff did not care or that Resident #13 didn't matter. When asked if she still needed assistance, the Family Member stated another staff member came into the room to answer the call light and offered assistance but by that time, she (Family Member) had already cleaned Resident #13 up and put her back to bed.

During an interview on 03/14/24 at 4:28 PM, the Director of Nursing (DON) stated NA #5 should have stopped charting to respond to Resident #13's call light and/or when assistance was requested by Resident #13's Family Member. The DON stated nursing staff were expected to respond to a resident's call light even when it was not their assigned room and felt there was the need for some reeducation.

During an interview on 03/14/24 at 5:01 PM, the Administrator stated she would have expected NA #5 to have stopped charting, answer Resident

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F 550	Continued From page 5 #13's call light and provide the requested assistance.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family and staff interviews, the facility failed to provide assistance with shaving and dentures for 2 of 4 residents reviewed for activities of daily living (Resident #11 and Resident #12). Findings included: 1. Resident #11 was admitted to the facility on 01/30/24 with diagnoses that included chronic obstructive pulmonary disease (trouble breathing), shortness of breath, and anxiety disorder. The admission Minimum Data Set (MDS) dated 02/01/24 assessed Resident #11 with severe cognitive impairment and requiring partial to moderate staff assistance with personal hygiene. Resident #11 displayed verbal behaviors toward others 1 to 3 days and did not reject care during the MDS assessment period. A review of Resident #11's comprehensive care plans last revised 02/12/24 revealed no plan that addressed Activities of Daily Living (ADL).	F 677	1. Resident #11 was provided with grooming on 3/14/24 inclusive of hair removal. On 3/14/24 Resident # 12 had her dentures placed prior to lunch to faciltate eating. 2. All residents have the potential to be affected by deficient practice. On 3/15/24 Director of Nursing (DON) and/or Designee completed an audit on all residents that may require grooming inclusive of facial hair which was completed 3/15/24. On 3/15/24 DON and/or Designee completed an audit of residents with Dentures to assure dentures placed per residents preference. 3. Current staff, including contract and agency, have been educated on the resident grooming needs, such as shaving, Activities of Daily Living (ADL) care, Nail care, and Oral and Denture Care by the DON & Staff Development Coordinator on 3/15/24. New hired staff, contract, and agency staff will receive education prior to their first assignment. 4. Director of Nursing/ designee will audit 5 random Residents per week for	3/16/24

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F 677	Continued From page 6 During an observation and interview on 03/13/24 at 12:23 PM, Resident #11 was lying in bed with the head of bed slightly elevated. Resident #11 was observed to have several hairs on the right and left sides of her chin that were approximately ½ inches long, curled and gray in color. Resident #11 stated she felt the hairs on her chin yesterday and asked herself, "What is going on with my chin?" Resident #11 stated did not like having chin hairs and would like them removed. During an observation and interview on 03/13/24 at 4:04 PM, the Director of Nursing (DON) confirmed Resident #11 had several visible hairs on the right and left sides of her chin. The DON asked Resident #11 if she would like a shave and Resident #11 stated, "Yes, I was in total shock yesterday when I realized they were there. I've never had facial hair in my life." The DON explained shaving was part of the bathing process and if the resident was agreeable, they should be shaved per their preference. During an interview on 03/14/24 at 11:05 AM, Nurse Aide (NA) #3 revealed she was routinely assigned to provide care to Resident #11 on the 500 Hall. NA #3 explained shaving was part of the bathing process or as needed. NA #3 stated she had not noticed Resident #11's chin hairs when she provided her care. During an interview on 03/14/24 at 3:20 PM, NA #4 confirmed she had provided care to Resident #11 when she resided on 200 Hall. NA #4 stated she assisted residents with shaving on shower days and as needed. NA #4 stated she had provided care to Resident #11 but did not recall noticing she had chin hairs and if she had, she would have offered to give her a shave.	F 677	Grooming/Denture/ Shaving/ Nail care X 8 weeks, then 5 Resident per month for 1 month, then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. The Administrator and Department Heads are responsible for implenting this Plan of Correction with completion date of 3/16/24.	

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F 677	Continued From page 7	F 677		

During an interview on 03/14/24 at 5:01 PM, the Administrator stated she would expect for staff to offer and provide shaving assistance for residents when needed and if the resident would allow.
2. Resident #12 was admitted to the facility on 10/12/18 with diagnoses that included chronic gout, arthritis and chronic pain.

Review of Resident #12's care plan revised on 01/29/24 revealed a self-care deficit performance with interventions requiring supervision assistance of eating, set up assistance to rinse dentures and encourage her participation in the task.

The quarterly Minimum Data Set (MDS) assessment dated 02/06/24 revealed Resident #12's cognition was severely impaired, and not coded as having moods and behaviors. The Resident required supervision or touching assistance with transfers, ambulation, personal and oral hygiene (helper provides verbal cues or touching/steadying assistance as resident completes activity).

Review of Resident #12's breakfast meal ticket for 03/14/24 revealed bacon, scrambled eggs, puffed rice cereal, milk and coffee.

On 03/14/24 at 8:30 AM an observation was made of Resident #12 lying in bed being fed breakfast by Nurse Aide (NA) #1. The Resident's top denture plate was noted to be in the denture cup sitting on her bedside table. On the Resident's breakfast tray was scrambled eggs, bacon, puffed rice cereal and milk. The NA was feeding the Resident scrambled eggs and cereal but not the bacon. The NA explained that when

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F 677	Continued From page 8	F 677		

she offered the Resident bacon, she acted as if she did not like the smell of it. When the NA was asked about the Resident's dentures the NA stated that she did not have dentures. The NA was shown the Resident's top denture in her denture cup sitting on the bedside table and the NA remarked that she did not think the Resident had dentures because she would have had them in before she came into her room to feed her. When the NA was asked how she knew what to do for the residents, she reported through word of mouth (verbal report). The NA stated she had only been at the facility for a week and was still getting to know the residents. The NA took the Resident's tray and left the room without putting her dentures in.

An interview was conducted with Nurse Aide #2 on 03/14/24 at 8:46 AM who stated that she worked the hall that Resident #12 resided on and worked with the Resident. The NA explained that the Resident required one staff assist to get her up in the morning. She continued to explain that the Resident had top dentures and needed them to eat. In fact, the NA explained that Resident #12 would ask for her dentures.

During an interview with Nurse Aide #3 on 03/14/24 at 9:00 AM the NA stated she was the full time NA for Resident #12's hall and explained that Resident #12 required verbal cueing of one staff assist for her ADL including putting her top denture in. She stated the Resident wore top dentures and usually fed herself 100% of her meals if she liked what was served to her. The NA stated the Resident loved bacon.

On 03/14/24 at 2:00 PM an interview was conducted with Resident #12's family member

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F 677	Continued From page 9 who stated that the Resident needed her top denture to eat and was able to feed herself her meals. The family member stated the Resident loved bacon but needed her top denture in so that she could chew the bacon. An interview was conducted with the Director of Nursing (DON) on 03/14/24 at 4:20 PM who explained that Resident #12 should have been prepared for the breakfast meal according to her normal routine which meant she should have had her denture in for the meal.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to ensure a resident's toenails were trimmed for 1 of 4 sampled residents (Resident #11). Findings included: Resident #11 was admitted to the facility on 01/30/24 with diagnoses that included chronic	F 687	1. Resident #11 had toenails trimmed and foot care performed on 3/15/24 by charge nurse. 2. All residents have the potential to be affected by deficient practice. On 3/15/24 current residents were checked and completed for toenail care needs by facility staff. Foot care provided to residents without diagnosis requiring	3/16/24

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F 687	Continued From page 10 obstructive pulmonary disease (trouble breathing), shortness of breath, and anxiety disorder. A physician's order dated 01/31/24 for Resident #11 read, may be seen and treated by a Podiatrist. The admission Minimum Data Set (MDS) dated 02/01/24 assessed Resident #11 with severe cognitive impairment and requiring partial to moderate staff assistance with personal hygiene. Resident #11 displayed verbal behaviors toward others 1 to 3 days and did not reject care during the MDS assessment period. A review of Resident #11's medical record revealed no documentation she was seen by a Podiatrist since her admission to the facility. During an observation and interview on 03/13/24 at 12:23 PM, Resident #11 was lying in bed with her feet uncovered. The toenails of both big toes extended approximately ¼ inch past the tip and curved outward. The toenails on the remaining toes were long and thick with some starting to curve over the tip of the toe. When asked about her toenails, Resident #11 looked at her feet and stated she noticed they were long and needed a good trim. Resident #11 could not recall if anyone had asked her if she wanted her toenails trimmed. An interview and observation of Resident #11's toenails was conducted with the Director of Nursing (DON) on 03/13/24 at 4:04 PM. Resident #11 was lying in bed with both feet uncovered. The DON confirmed Resident #11's toenails were long, thick and curved and the toenails of the big	F 687	Podiatry care by licensed staff. Toenails requiring Podiatry services were scheduled for Podiatry care on 3/18/24 and will continue to be scheduled as needed. 3. Current staff, including contract and agency, have been educated on the resident grooming needs, such as shaving, Activities of Daily Living (ADL) care, Nail care, and Oral Care by the Staff Development Coordinator on 3/15/24. New hired staff, contract, and agency staff will receive education prior to their first assignment. 4. Director of Nursing/ designee will audit 5 random Residents per week for Podiatry needs X 8 weeks, then 5 Resident per month for 1 month, then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee (QAPI) monthly with the QAPI Committee responsible for ongoing compliance. 5. The Administrator and Department Heads are responsible for implementing this Plan of Correction with a completion date of 3/16/24.	

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F 687	Continued From page 11	F 687		

toes extended approximately ¼ inch past the tip of the toe. The DON explained Resident #11's toenails would need to be trimmed by the Podiatrist and she would check to see if Resident #11 had been seen.

During an interview on 03/14/24 at 11:05 AM, Nurse Aide (NA) #3 revealed Resident #11 had resided in a room on the 500 Hall, moved to a room on the 200 Hall and was recently moved back to a room on the 500 Hall. NA #3 stated she was routinely assigned to provide care to Resident #11 on 500 Hall. NA #3 stated she did not recall observing Resident #11's toenails but when she did notice a resident with long, thick toenails, she informed the nurse.

During an interview on 03/14/24 at 2:36 PM, the Social Worker (SW) revealed Podiatry services typically maintained their own schedule for facility clinics and she received an email letting her know the date of the upcoming clinic and which residents would be seen. The SW stated she added residents to the list when nursing staff informed her a resident needed to be seen. The SW stated the Podiatrist was at the facility in February 2024; however, no one had mentioned anything to her that Resident #11 needed to be seen.

During an interview on 03/14/24 at 3:20 PM, NA #4 revealed when she noticed a resident's toenails were long, she informed the nurse. NA #4 confirmed she had provided care to Resident #11 when she resided on 200 Hall but did not recall observing her toenails.

During an interview on 03/14/24 at 3:45 PM, Nurse #6 revealed Resident #11 was recently

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F 687	Continued From page 12 moved back to 500 Hall. She explained when a resident had long, thick toenails, she notified the SW for the resident to be put on the list to be seen by the Podiatrist. Nurse #6 stated she had not observed Resident #11's toenails and no one had mentioned anything to her that Resident #11's toenails needed trimmed. During a follow-up interview on 03/14/24 at 4:28 PM, the DON confirmed Resident #11 was not seen by the Podiatrist when a clinic was held at the facility in February 2024 but she was on the list for the next scheduled clinic on 04/14/24. The DON explained the NAs should have noticed Resident #11's toenails were long and thick when providing care and reported to the nurse that Resident #11's toenails needed trimmed.	F 687		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Pharmacist, Medical Director and family member interviews, the facility failed to administer scheduled narcotic pain medication causing the resident (Resident #12) to experience increased pain for 1 of 3 residents reviewed for pain management. The finding included:	F 697	1. Resident #12 has been receiving pain medication as ordered. On 3/14/24 pain assessment completed by Director of Nursing without any evidence of pain. The Director of Nursing reviewed Resident #12 ,March Medication Administration Record to ensure all pain medications administered per orders. 2. All Residents have the potential to be affected by deficient practice. On 3/15/24	3/16/24

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F 697	Continued From page 13 Resident #12 was admitted to the facility on 10/12/18 with diagnoses that included chronic gout, arthritis and chronic pain. Review of Resident #12's revised care plan dated 03/18/23 revealed a risk for developing complications related to the use of opioid pain medication. The goal that the Resident would remain free of adverse effects of the opioid would be attained by utilizing interventions such as monitoring for signs and symptoms of pain, monitoring for signs of overdose and monitoring for effectiveness. The quarterly Minimum Data Set (MDS) assessment dated 10/10/23 revealed Resident #12's cognition was severely impaired, and not coded as having moods and behaviors. The Resident required supervision to limited assistance with her activities of daily living (ADL). The MDS indicated Resident #12 received scheduled pain medication. The pain assessment was conducted but there was no pain present. A review of Resident #12's physician orders revealed the following orders: *08/23/23 Hydrocodone/Acetaminophen 5/325 milligrams (mg) one tablet by mouth every eight hours for pain. *08/28/23 Aspercream Lidocaine 4% pain patch applied to lower back one time a day for pain. *09/10/23 Acetaminophen 500 mg one tablet by mouth one time a day for pain. *09/10/23 Acetaminophen 500 mg one tablet by mouth one time a day for pain. *10/28/23 Hold until medication arrives in building one time only for pain one time only until 10/30/23.	F 697	the Director of Nursing completed pain assessment for all facility residents. No significant findings noted. 3. Current licensed staff, including contract and agency, have been educated on Pain Assessment and Management by the Staff Development Coordinator on 3/15/24. New hired staff, contract, and agency staff will receive education prior to their first assignment. 4. Director of Nursing/ designee will audit 5 random Residents per week for Pain evaluation X 8 weeks, then 5 Resident per month for 1 month, then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. The Administrator and Department Heads are responsible to implement this Plan of Correction with a completion date of 3/16/24.	

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A review of the Controlled Drug Record indicated Resident #12's last dose of Hydrocodone/Acetaminophen 5/325 mg tablet by mouth every eight hours was given on 10/28/23 at 2:30 PM by Nurse #1. The Record also indicated the final count of 0 was verified by Nurse #1 and the Staff Development Coordinator (SDC).

A review of Resident #12's Medication Administration Record (MAR) dated 10/2023 revealed the Resident's narcotic pain medication was scheduled to be given every eight hours assigned at 6:00 AM, 2:00 PM and 10:00 PM. The MAR indicated the medication was not given:
*10/28/23 at 10:00 PM by the SDC
*10/29/23 at 2:00 PM by Nurse #4
*10/29/23 at 10:00 PM by the SDC
*10/30/23 at 6:00 AM by Nurse #5
The MAR also indicated that a pain level assessment was conducted on all three shifts and from the month of 10/2023 and on 10/04/23 a pain level of 2 was documented on third shift and on 10/05/23 a pain level of 2 was documented on first shift.

A review of a progress note written by the SDC on 10/28/23 at 11:35 PM revealed she received an order to hold Resident #12's narcotic pain medication until it arrived in the building due to the pharmacy will not take call.

A review of a progress note written by Nurse #4 on 10/29/23 at 1:22 PM revealed to hold the Hydrocodone until the medication was delivered by the pharmacy.

A review of a progress note written by the SDC on 10/29/23 at 10:55 PM revealed that the Hydrocodone was on hold.

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A review of Resident #12's progress notes on 10/30/23 to indicate Nurse #5 did not give the Hydrocodone.

During an interview with Nurse Aide (NA) #3 on 03/14/24 at 9:00 AM the NA stated she was the full time first shift NA assigned to Resident #12. The NA explained that the Resident had a lot of complaints of pain, and it was always in her back. She stated the Resident had routine pain medication and also had a pain patch that she wore every day on her lower back.

On 03/14/24 at 10:53 AM an interview was conducted with Nurse #4 who confirmed that she worked on 10/29/23 and stated she did not recall not having Hydrocodone to give to Resident #12 and explained that if she did not have the medication, she would have called the pharmacy to see if she could obtain it from the pyxis as long as there was a second nurse to verify the procedure. Nurse #4's progress note was read to her, and she stated she did not remember the occasion but that if she gave the medication then there would be a check mark on the MAR that would indicate that it was given. The Nurse explained that Resident #12 did not seem to be in pain because she received other routine pain medications besides Hydrocodone.

An interview was conducted with the SDC on 03/13/24 at 11:43 AM. The SDC reviewed the progress note that she had written on 10/28/23 at 11:35 PM and explained that October 28th, 2023, was on a Saturday and when she counted the controlled medications at shift change with the previous nurse (Nurse #1) she realized Resident #12 did not have Hydrocodone for the 10:00 PM

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F 697	Continued From page 16	F 697		

dose so she called the pharmacy that supplied the facility's medications and left a message, but she never received a return call from the pharmacy. The SDC continued to explain that when it came time to give the 10:00 PM dose and she had no return call from the pharmacy she called the on-call geriatrics consultants afterhours and got an order to hold the Hydrocodone until it arrived from the pharmacy. She did not respond to why she did not ask for a script for the Hydrocodone from the on-call provider. When asked why she did not pull the medication from the pyxis (a supply of medications used for back up) the Nurse explained that in order to remove controlled medications from the pyxis it required two facility nurses to verify the procedure and she was the only facility nurse on duty for 10/28/29 and 10/29/23. The SDC stated that on 10/29/23 at 10:00 PM she made a progress note about the medication being on hold because she had obtained that order on 10/28/23 for the medication to be held until the supply was delivered from the pharmacy. The SDC was asked if Resident #12 experienced increased pain related to not having her narcotic pain control medication and she stated that she checked the Resident's range of motion in her arms and legs and she did not complain of pain.

On 03/14/24 at 2:00 PM during an interview with Resident #12 family member the family member explained that on 10/29/23 she went to visit the Resident and she was acting different than normal like she was more confused and agitated and complained of pain in her lower back. The family member asked the nurse on duty (who was an agency nurse that she had not seen since that day) about giving her the Hydrocodone and the nurse reported that the Resident did not have any

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Hydrocodone available because the facility failed to reorder it from the pharmacy, and she had run out of the pain medication. The family member continued to explain that Resident #12 has had chronic back pain for years and when her back was hurting the way she showed the pain was through increased confusion more than her normal confusion. The family member stated the nurse offered Tylenol to Resident #12, but she told her that the Resident was already on Tylenol 500 mg twice a day and it did not help control her pain and that was why she was on Hydrocodone three times a day. The family member expressed that it was unacceptable for Resident #12 to go without her ordered pain regimen.

An interview was conducted with Nurse #5 on 03/14/24 at 2:45 PM. The Nurse stated she had no recollection of working on 10/30/23 and not having Hydrocodone to give Resident #12 at 6:00 AM. The Nurse explained that if she did not have the medication in the medication cart, she would have obtained the medication from the pyxis along with another facility nurse and if there was no Hydrocodone in the pyxis then she would have called the on-call and reported not having the medication. When asked why she did not do that the Nurse stated she did not recall the incident.

During an interview with Pharmacist on 03/14/24 at 10:05 AM she explained the facility should reorder medications when there was about 3 days left of the supply on hand. If the situation occurred when they needed a medication before the pharmacy delivered to the facility, they could pull the medication from the pyxis as long as they have 2 facility nurses to verify the procedure. If there was not a supply in the pyxis they could fax a script to the pharmacy and the pharmacy would

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F 697	Continued From page 18 set up an immediate delivery from the local pharmacy. The Pharmacist continued to explain that Resident #12's new Hydrocodone prescription was obtained on 10/16/23 and 30 tablets were delivered to the facility and there were refills available on the prescription. She stated if the facility had called the pharmacy and ordered the medication the pharmacy could have sent it to the facility without a new prescription. The Pharmacist reviewed the phone call logs over the weekend of 10/28/23 through 10/30/23 and reported the only calls the pharmacy received pertaining to Resident #12's Hydrocodone was on 10/29/23 at 6:51 AM and 10/30/23 at 2:33 PM when the facility was provided with codes to remove the Hydrocodone from the pyxis. During an interview with the former Medical Director (MD) on 03/14/24 at 3:00 PM he stated he did not remember the specific situation in question but explained the facility should not have run out of Resident #12's pain medication but if they did then they should have obtained the medication from the emergency supply or notified the on-call provider and obtained a prescription for the medication. An interview was conducted with the Director of Nursing (DON) on 03/14/24 at 4:20 PM. The DON explained that the nurses should be reordering the medications before they run out of the medicine, and they did have a backup system to where they could pull the medication from the pyxis. She stated the SDC did assess the Resident for pain and even offered an as needed Tylenol for pain, but the family refused the Tylenol stating if did not work for her.	F 697		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		3/16/24

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F 755	Continued From page 19 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Pharmacist and Medical Director interviews the facility failed to obtain a narcotic pain medication from the pharmacy which caused a resident to miss 4	F 755	1. Resident #12 has had her pain medication available. On 3/14/24 pain assessment completed by Director of Nursing without any evidence of of pain.	

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F 755	Continued From page 20 doses of the pain medication for 1 of 3 residents (Resident #12) reviewed for pain. The finding included: Resident #12 was admitted to the facility on 10/12/18 with diagnoses that included chronic gout, arthritis and chronic pain. Review of Resident #12's revised care plan dated 03/18/23 revealed a risk for developing complications related to the use of opioid pain medication. The goal that the Resident would remain free of adverse effects of the opioid would be attained by utilizing interventions such as monitoring for signs and symptoms of pain, monitoring for signs of overdose and monitoring for effectiveness. The quarterly Minimum Data Set (MDS) assessment dated 10/10/23 revealed Resident #12's cognition was severely impaired, and not coded as having moods and behaviors. The Resident required supervision to limited assistance with her activities of daily living (ADL). The MDS indicated Resident #12 received scheduled pain medication. The pain assessment was conducted but there was no pain present. A review of Resident #12's physician orders revealed the following orders: *08/23/23 Hydrocodone/Acetaminophen 5/325 mg one tablet by mouth every eight hours for pain. *10/28/23 Hold until medication arrives in building one time only for pain one time only until 10/30/23. A review of the Controlled Drug Record indicated	F 755	The Director of Nursing reviewed Resident #12 ,March Medication Administration Record to ensure all pain medications administered per orders and available. 2. All residents have the potential to be affected by deficient practice. On 3/15/24 an audit was completed by the Unit Manager to ensure pain medication was available for the the residents with no additional concerns noted. 3. Current licensed staff, including contract and agency, have been educated on the process of ordering and receiving pain medication by the Staff Development Coordinator on 3/15/24. New hired staff, contract, and agency staff will receive education prior to their first assignment. Pharmacy off hours information placed on medication carts. 4. Director of Nursing/ designee will audit 5 random Residents with orders for pain medications to ensure prescriptions are requested so all ordered medications are available X 8 weeks, then 5 Resident per month for 1 month, then randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. The Administrator and Department Heads are responsible for implementing this Plan of Correction with completion date of 3/16/24.	

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Resident #12's last dose of Hydrocodone/Acetaminophen 5/325 mg tablet by mouth every eight hours was given on 10/28/23 at 2:30 PM by Nurse #1. The Record also indicated the final count of 0 was verified by Nurse #1 and the Staff Development Coordinator (SDC).

A review of Resident #12's Medication Administration Record (MAR) dated 10/2023 revealed the Resident's narcotic pain medication was scheduled to be given every eight hours assigned at 6:00 AM, 2:00 PM and 10:00 PM. The MAR indicated the medication was not given:
*10/28/23 at 10:00 PM by the SDC
*10/29/23 at 2:00 PM by Nurse #4
*10/29/23 at 10:00 PM by the SDC
*10/30/23 at 6:00 AM by Nurse #5

A review of a progress note written by the SDC on 10/28/23 at 11:35 PM revealed she received an order to hold Resident #12's narcotic pain medication until it arrived in the building due to the pharmacy will not take call.

A review of a progress note written by Nurse #4 on 10/29/23 at 1:22 PM revealed to hold the Hydrocodone until the medication was delivered by the pharmacy.

A review of a progress note written by the SDC on 10/29/23 at 10:55 PM revealed that the Hydrocodone was on hold.

A review of Resident #12's progress note on 10/30/23 to indicate Nurse #5 did not give the Hydrocodone.

A review of a Nurse Practitioner progress note dated 11/06/23 revealed Resident #12 was being

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reviewed for pain management. The Resident received Hydrocodone/Acetaminophen 5/325 mg by mouth every 8 hours for her chronic pain management and prescription written for refill of 90 tablets.

An interview was conducted with the SDC on 03/13/24 at 11:43 AM who explained that she had been at the facility for three years and in October and November of 2023 it was necessary for her to work the medication cart a lot. The SDC reviewed the progress note that she had written on 10/28/23 at 11:35 PM and explained that she remembered that night because she was the administrative nurse who had to cover the shifts for the weekend. She continued, October 28th, 2023, was on a Saturday and when she counted the controlled medications at shift change with the previous nurse (Nurse #1) she realized Resident #12 did not have Hydrocodone for the 10:00 PM dose so she called the pharmacy that supplied the facility's medications and left a message, but she never received a return call from the pharmacy. She stated the pharmacy closed at 12:00 PM on Saturday and was closed all day on Sunday. The SDC continued to explain that when it came time to give the 10:00 PM dose and she had no return call from the pharmacy she called the on-call geriatrics consultants afterhours and got an order to hold the Hydrocodone until it arrived from the pharmacy. She did not respond to why she did not ask for a script for the Hydrocodone from the on-call provider. When asked why she did not pull the medication from the pyxis (a supply of medications used for back up) the Nurse explained that in order to remove controlled medications from the pyxis it required two facility nurses to verify the procedure and she was the

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only facility nurse on duty for 10/28/29 and 10/29/23. The SDC stated that on 10/29/23 at 10:00 PM she made a progress note about the medication being on hold because she had obtained that order on 10/28/23 for the medication to be held until the supply was delivered from the pharmacy.

On 03/14/24 at 10:53 AM an interview was conducted with Nurse #4 who confirmed that she worked on 10/29/23 and stated she did not recall not having Hydrocodone to give to Resident #12 and explained that if she did not have the medication, she would have called the pharmacy to see if she could obtain it from the pyxis as long as there was a second nurse to verify the procedure. Nurse #4's progress note was read to her, and she stated she did not remember the occasion but that if she gave the medication then there would be a check mark on the MAR that would indicate that it was given. The Nurse explained that Resident #12 did not seem to be in pain because she received other routine pain medications besides Hydrocodone.

An interview was conducted with Nurse #5 on 03/14/24 at 2:45 PM. The Nurse stated she had no recollection of working on 10/30/23 and not having Hydrocodone to give Resident #12 at 6:00 AM. The Nurse explained that if she did not have the medication in the medication cart, she would have obtained the medication from the pyxis along with another facility nurse and if there was no Hydrocodone in the pyxis then she would have called the on-call and reported not having the medication. When asked why she did not do that the Nurse stated she did not recall the incident.

Attempts were made to interview Nurse #1, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345250	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT LINCOLNTON	515 S GENERALS BOULEVARD LINCOLNTON, NC 28093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the attempts were unsuccessful.

During an interview with Pharmacist on 03/14/24 at 10:05 AM she explained the facility should reorder medications when there was about 3 days left of the supply on hand and they reorder medications through the electronic reordering system. If the situation occurred when they needed a medication before the pharmacy delivered to the facility, they could pull the medication from the pyxis as long as they have 2 facility nurses to verify the procedure. If there was not a supply in the pyxis they could fax a script to the pharmacy and the pharmacy would set up an immediate delivery from the local pharmacy. The Pharmacist continued to explain that Resident #12's new Hydrocodone prescription was obtained on 10/16/23 and 30 tablets were delivered to the facility and there were refills available on the prescription. She stated if the facility had called the pharmacy and ordered the medication the pharmacy could have sent it to the facility without a new prescription. The Pharmacist reviewed the phone call logs over the weekend of 10/28/23 through 10/30/23 and reported the only calls the pharmacy received pertaining to Resident #12's Hydrocodone was on 10/29/23 at 6:51 AM and 10/30/23 at 2:33 PM when the facility was provided with codes to remove the Hydrocodone from the pyxis. She informed the pharmacy was open Saturdays from 9:00 AM to 3:00 PM and on Sundays their call service would direct the Pharmacist on call to return the call to the facility.

During an interview with the former Medical Director (MD) on 03/14/24 at 3:00 PM he stated he did not remember the specific situation in question but explained the facility should not have

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	345250	A. BUILDING _____ B. WING _____	C 03/14/2024

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run out of Resident #12's pain medication but if they did then they should have obtained the medication from the emergency supply or notified the on-call provider and obtained a prescription for the medication.

An interview was conducted with the Director of Nursing (DON) on 03/14/24 at 4:20 PM. The DON explained that the nurses should be reordering the medications before they run out of the medicine, and they did have a back up system to where they could pull the medication from the pyxis. She continued to explain that it was the pharmacy's policy to have 2 facility nurses be able to pull from the pyxis. The DON indicated since the SDC obtained an order from the on-call provider to hold the medication until it was delivered from the pharmacy was sufficient. The DON stated she had developed a system to where a nurse would conduct a weekly audit of the status of the controlled medications and if they needed a new prescription, they would obtain it within time before the current supply ran out.