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 05/16/2024

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
F 000	INITIAL COMMENTS An onsite complaint investigation was conducted on 05/16/24. Event ID #SXH411. The following intakes were investigated: NC00216497, NC00215019, and NC00216272. Six (6) of the complaint allegations did not result in a deficiency. Past-noncompliance was identified at: CFR 483.45 at F760 at a scope and severity (G) Noncompliance began on 3/16/24. The facility came back into compliance effective 3/19/24.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Nurse Practitioner (NP) interview the facility failed to prevent a significant medication error by administering (Resident #1) a medication without following set parameters for 1 of 3 residents reviewed for assuring facility was free from significant medication errors. Resident #1 was administered a blood pressure medication with set parameters to only administer if blood pressure was greater or equal to 170. Prior to the medication being administered, Resident #1 blood pressure was 139/64, after being administered the medication Resident #1 blood pressure dropped to 70/40 and she was sent out to the hospital for low blood pressure and altered mental status. The facility also failed to prevent a significant medication error by administering (Resident #1) a medication listed as having an	F 760	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2024

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 05/16/2024

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
F 760	Continued From page 1	F 760		

allergy to for 1 of 3 residents reviewed for assuring facility was free from significant medication errors. Resident #1 was prescribed and administered a reflux medication that was listed as having an allergy to on the electronic medical record and admission paperwork.

The findings included:

1a. Per the manufacturer label warnings for Clonidine HCL (Hydrochloride), failure to administer this medication within parameters could cause low blood pressure, dizziness, lightheadedness, fainting, and nausea.

Resident #1 was admitted to the facility on 01/16/18. Resident #1's diagnoses included primary hypertension and congestive heart failure.

Review of quarterly Minimum Data Set (MDS) dated 1/25/24 revealed Resident #1 was cognitively intact and was coded for active diagnosis of hypertension and heart failure.

Review of current physician order dated 11/30/23 revealed Resident #1 was to receive Hydralazine HCl (medication to treat high blood pressure) oral tablet 25 milligrams (MG), give 1 tablet by mouth every 8 hours for hypertension. Give even if heart rate below 50.

Review of physician order dated 2/07/24 revealed Resident #1 was to receive Clonidine HCl (medication to treat high blood pressure) oral tablet 0.1 MG, give 1 tablet by mouth every 12 hours for high blood pressure (BP), manual BP cuff only. Give when systolic BP is greater or equal to 170.

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 05/16/2024

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
F 760	Continued From page 2	F 760		

Review of Medication Administration Record dated March 2024 revealed on 3/16/24 Resident #1 BP was 139/64 and she was administered Clonidine by Nurse #1 at 9:00 PM.

Review of nursing note written by Nurse #1 dated 3/16/24 revealed Resident #1 was given Clonidine 0.1 MG with a blood pressure (BP) of 139/64 and pulse 60 along with Hydralazine 25mg. The Clonidine was given in error. It should have only been given if BP was 170 or greater systolic. On-call Nurse Practitioner (NP) notified immediately once mistake was realized and was ordered to monitor BP in an hour and continuously. If systolic BP drops to below 100 give 500 milliliters (ML) of fluids at 75 ML per hour. Resident had BP checked at 9:40 PM with BP at 70/40, Resident #1 alert and drowsy stating that she feels fine but is sleepy. On-call NP notified and received an order to send Resident #1 out. Daughter/ responsible person (RP) notified that Resident #1 would be sent out by emergency medical services (EMS) to the hospital for low BP. At around 10:00 PM Resident #1 able to stand and pivot with assistance to the stretcher still alert and oriented, transported out by EMS at around 10:15 PM.

Review of Resident #1 emergency room (ER) note dated 3/16/24 read in part "Resident #1 was brought into ER due to hypotension (low blood pressure) and altered mental status. Resident #1 was administered Clonidine at 8:48 PM and blood pressure at that time was already low. Staff were told to monitor Resident #1 blood pressure and when checked was 72/38. Resident #1 stated she was feeling okay but had elevated blood pressure this evening, she took both blood pressure

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 05/16/2024

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
F 760	Continued From page 3	F 760		

medications, afterwards she felt nauseated like she was going to pass out. Resident #1 denied any chest pain or shortness of breath and felt much improved after medications have started to wear off. It appeared Resident #1 did have a hypotensive episode suspected likely secondary to being administered Clonidine and Hydralazine at the same time. Resident #1 plan discharge back to facility in stable condition with outpatient physician and cardiologist follow-up."

Attempted to contact Nurse #1 with no return call.

An interview with the Director of Nursing (DON) on 5/16/24 at 11:18 AM revealed she was familiar with Resident #1. She stated on Saturday 3/16/24 Nurse #1 had taken Resident #1 blood pressure which read 139/ 64 and administered her regular scheduled Hydralazine. She revealed Nurse #1 then administered Resident #1 Clonidine which had parameters to only administer if blood pressure was higher than 170. She stated Nurse #1 realized the mistake with administering Resident #1 the Clonidine and contacted the on-call provider who gave orders to administer fluids, continue to monitor, and call back if any change of condition. The DON revealed while Nurse #1 was in the medication room retrieving the fluids for Resident #1, he was stopped by Nurse #2 who was the nursing shift supervisor and Nurse #1 informed her that he was going to administer fluids to Resident #1 but did not give any further details and when asked if he needed assistance Nurse #1 stated no. She stated Nurse #1 went back into Resident #1 room to administer fluids but was unable to get the IV (intravenous) line started, Nurse #1 called on-call again and informed that he was not able to administer Resident #1 fluids and her BP had dropped and

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 05/16/2024

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
F 760	Continued From page 4	F 760		

on-call ordered for Resident #1 to be sent out to the hospital. She revealed Nurse #2 was not aware of the condition of Resident #1 until the EMS arrived at the facility to transport her to the hospital and when she asked Nurse #1 about Resident #1's condition, he would not give her any details. The DON stated Nurse #1 contacted Resident #1 responsible person (RP) and informed Resident #1 was being sent out to the hospital due to her blood pressure, and both Nurse #1 and Nurse #2 failed to complete an incident report and notify herself or the administrator. She revealed on Monday 3/18/24 she had overheard staff discussing Resident #1 being sent out to the hospital over the weekend and when she asked Nurse #2 what happened she informed her about Nurse #1 retrieving fluids from the medication room and the EMS arriving to transport Resident #1 to the hospital but was unable to give any further details due to Nurse #1 refusing to give any details. She stated she reviewed Resident #1 March 2024 MAR and saw the medication error where Resident #1 had been administered Clonidine in error and immediately completed a grievance form and began an investigation. The DON stated she attempted to contact Nurse #1 to discuss the incident and he would not answer his phone and did not return to work. She revealed Resident #1 received fluids at the hospital and returned to the facility and followed up with their physician and her cardiologist with no issues noted. She stated they educated all nursing staff on following medication orders, documentation, and reporting. She also stated their physician changed medications with parameters to PRN (as needed) medications and they keep a daily BP log to be completed by nursing staff in Resident #1 room for herself and Resident #1 family to review. The DON revealed

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 05/16/2024

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
F 760	Continued From page 5	F 760		

that Nurse #1 and Nurse #2 should have completed an incident report, documented in Resident #1 medical chart, and notified herself or the Administrator of the incident.

An interview with the Nurse Practitioner (NP) on 5/16/24 at 1:10 PM revealed she had begun working at the facility on 5/01/24 and was not familiar with the incident with Resident #1. She stated if an order had set parameters on when to administer medications then she would expect nursing staff to follow those orders and administer medications accordingly. She revealed both Hydralazine and Clonidine were fast acting medications so within half an hour to an hour they could cause a significant decrease in blood pressure which could cause lightheadedness, dizziness, nausea, low blood pressure, decrease in cognition, and in more severe circumstances decrease in oxygen flow.

A telephone interview with Resident #1 RP on 5/16/24 at 1:46 PM revealed she had received a telephone call from a male nurse on the evening of Saturday 3/16/24 stating the Resident #1 blood pressure was low and she was being sent out to the hospital. She stated Nurse #1 never told her about giving her too much blood pressure medication and she was not made aware until the hospital staff informed her. She revealed when she saw Resident #1 at the hospital, she appeared tired and confused and stated she felt nauseas and weak and the hospital administered her fluids and discharged her back to the facility with a recommendation to follow-up with her physician and cardiologist. Resident #1 RP stated she spoke with the DON the following Monday and discussed the incident and now they keep a daily BP log in Resident #1 room and nursing

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 05/16/2024

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
F 760	Continued From page 6	F 760		

staff log her BP for each shift. She revealed Resident #1 was seen by the facility physician and her cardiologist with no issues.

An interview with Resident #1 on 5/16/24 at 2:50 PM revealed she could not recall the exact date but believed it was a couple of months ago, the nurse working had given her to much blood pressure medicine, and she started to feel exhausted, weak, and nauseated and had to be sent out to the hospital. She stated she believed she was given some fluids and then sent back to the facility with no further issues. She revealed she could not recall any further details about the incident, and to her knowledge it had not occurred again.

A telephone interview with Nurse #2 on 5/16/24 at 3:45 PM revealed she was familiar with Resident #1 and the incident with the medication. She stated she was working as the nurse shift supervisor for second shift on 3/16/23 and saw Nurse #1 in the medication room getting supplies to administer a fluid bag. She revealed she asked Nurse #1 what he was doing and if he needed any assistance with administering the fluid bag and he stated no. Nurse #2 stated a little while later the EMS arrived and informed her they were there to transport Resident #1 to the hospital and when she asked Nurse #1 why Resident #1 was being sent out to the hospital he stated that he had contacted the on-call NP about Resident #1 and was instructed to administer her fluids but was unsuccessful. She revealed Nurse #1 stated he called the on-call NP back and was told to send Resident #1 out to the hospital but would never give her any details about what had happened with Resident #1 or about her condition. She stated she assumed Nurse #1 had

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 05/16/2024

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
F 760	Continued From page 7	F 760		

contacted Resident #1 RP and the DON and had documented the incident, so she did not contact anyone or document the incident herself. Nurse #2 stated that when Resident #1 returned to the facility from the hospital her RP informed that she had been given too much blood pressure medication and was given fluids at the hospital. She revealed Resident #1 appeared fine upon her return from the hospital. Nurse #2 stated after the incident Nurse #1 would not answer his phone and did not return to work and all nursing staff received education on medication errors, documentation, and notifying DON or the Administrator about any resident being sent out to the hospital.

An interview with the Administrator on 5/16/24 at 4:31 PM revealed she was familiar with Resident #1 and the medication error incident from Saturday 3/16/24. She stated she was informed about the incident on Monday 3/18/24 by the DON and they immediately began an investigation, interviewed staff, educated staff on administering medications, documentation, and notifying herself or the DON when any resident was sent out to the hospital. She stated following the night of incident, Nurse #1 would not answer their telephone calls and did not return to work at the facility. The Administrator revealed she believed the incident to be human error and Nurse #1 handled the situation properly but should have informed Nurse #2 and the DON when the incident occurred, and she would expect moving forward nursing staff to notify their supervisor and the DON immediately anytime there was an incident involving a resident and to document appropriately.

The facility provided the following corrective

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 05/16/2024

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
F 760	Continued From page 8	F 760		

action plan with a compliance date of 03/19/24.

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:

Facility identified a medication error on 03/16/2024.

On 3/16/2024 resident was administered Clonidine 0.1 mg with a blood pressure outside of parameters for administration.

On 3/16/2024 the on-call MD, was notified of the administration by the charge nurse with new orders implemented, including transfer to emergency department (ED) for treatment and evaluation related to hypotension. On 3/16/2024, the resident's representative was notified of medication error and transfer to ED.

On 3/17/2024 Resident returned to facility with no additional orders and assessed by licensed nurse with blood pressure, and all vital signs noted to be within normal limits.

On 3/18/2024, the licensed nurse that was involved with the medication error was reported to his Agency as a "Do Not Return" to our facility. Reasoning provided to the Agency regarding the medication error and for the nurse to not return.

On 03/18/2024, the Director of Nursing and Staff Development Coordinator re-educated all licensed nurses and medication aides on procedures for medication administration to include the 10 rights of medication administration: Right Drug, Right Patient, Right Dose, Right Route, Time and Frequency, Documentation, History and Assessment, Drug Approach and

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 05/16/2024

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
F 760	Continued From page 9	F 760		

Right to Refuse, Drug to Drug interaction and Evaluation, Education and Information.

IDENTIFICATION OF OTHER RESIDENTS:

All residents receiving Clonidine with parameters for administration have the potential to be affected.

On 3/18/2024, DON completed an audit of current residents' medications to ensure that medications with parameters were entered correctly and followed according to order. Any concerns noted were corrected immediately.

MEASURES FOR SYSTEMIC CHANGE:
On 3/18/2024, a visual reminder (a handout) indicating the 10 rights of medication administration was placed at every medication cart by the Director of Nursing. Reminder has the following listed : Right Drug, Right Patient, Right Dose, Right Route, Time and Frequency, Documentation, History and Assessment, Drug Approach and Right to Refuse, Drug to Drug interaction and Evaluation, Education and Information.

In addition, all new orders are reviewed 5 days a week during morning clinical meetings to assure ongoing compliance.

HOW CORRECTIVE ACTION WILL BE MONITORED:

On 3/18/2024 the Administrator and Director of Nursing initiated an audit of resident ' s medication regimen to assure compliance. The DON/Designee will do random med pass observation and nurse competency to include the

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 05/16/2024

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
F 760	Continued From page 10	F 760		

rights of medication administration are being adhered to. The audits/med pass observations will be daily for 1 week, 3 times weekly for 1 week, 1 time weekly for one week and random twice monthly for 1 month and then monthly times 1 month then as needed. These audits will be initiated 3/18/24 for 3 months. QAPI team will review the audits to identify patterns/trends and will adjust the plan as needed to maintain compliance.

Date of Compliance: 03/19/2024.

On 6/05/24, the facility's corrective action plan effective 03/19/24 was validated by the following: Nursing staff interviews revealed they had received education on the 10 rights of medication administration, following parameters and administering medications correctly, reviewing resident medications orders to include parameters prior to administering medications, notifying the nursing supervisor, administrative staff, physician, and resident responsible party of any medications errors, documenting medications administered correctly on the medication administration record, and documenting any medication errors. The 10 rights of medication administration document were placed on every medication cart in the facility as a reminder to nurses. Administrative staff interviews revealed they had completed audits of all residents ' medications to assure those with parameters were being followed and documented correctly. They also performed audits with nurses and medication aides during medication pass to assure medication orders including those with parameters were being followed, documented, and administered correctly. Documents were reviewed from the facility Quality Assurance and

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 05/16/2024

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
F 760	Continued From page 11	F 760		

Performance Improvement (QAPI) committee meeting minutes of the audit results. The facilities medication error rate was 0% during the medication pass completed by the survey team on 5/16/24.

The compliance date of 03/19/24 was validated.

1b. Resident #1 was admitted to the facility on 1/16/18 with diagnosis that included reflux disease and significant gastroesophageal reflux disease (GERD).

Review of admission paperwork dated 1/16/18 revealed Resident #1 had listed an allergy to Reglan (treats symptoms of gastroesophageal reflux disease) medication. No origin of allergy or reaction was noted on paperwork.

Review of physician order dated 12/13/23 revealed Resident #1 was to receive Reglan oral tablet, give 2.5 milligrams (MG) by mouth one time a day related to reflux disease without esophagitis.

Review of Resident #1 December 2023 through March 2024 MAR revealed Resident #1 had received Reglan daily starting on 12/13/23 through 3/18/24.

Review of physician progress note dated 3/19/24 revealed Resident #1 allergy to Reglan with origin and reaction unknown and to discontinue since only taking once a day and risk of cardiac effects.

Review of physician order dated 3/19/24 for Resident #1 revealed discontinue Reglan oral tablet, give 2.5 MG by mouth one time a day related to reflux disease without esophagitis.

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 05/16/2024

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
F 760	Continued From page 12	F 760		

A telephone interview with Resident #1 RP revealed while Resident #1 had been at the hospital on 3/18/24 for her blood pressure issues, the hospital informed her that Resident #1 had been receiving a medication at the facility that was listed on her paperwork as her being allergic to. She stated that she was aware of Resident #1 being allergic to some medications but could not recall the names of the medications, when she became allergic to the medications or what her reactions were to the medications. She revealed when she spoke with the facility on the Monday following Resident #1 hospital visit, she notified them of Resident #1 receiving the medication she was allergic to, and the DON stated they had contacted their physician's supervisor and was going to have the order stopped and look at another medication that could be administered in its place. The RP revealed the DON was not aware of why the physician at the facility would have ordered a medication knowing Resident #1 was allergic to it but that she would get it changed as soon as possible. She stated if the facility had notified her of the medication being ordered she would not have remembered the name, and she never would have thought to ask if any new medication was one that Resident #1 was allergic to, but she will make sure she asks in the future.

A telephone interview with Nurse #2 on 5/16/24 at 3:45 PM revealed she was familiar with Resident #1. She stated Resident #1 had been ordered to receive Reglan for her reflux disease daily and that her chart clearly showed she was allergic to the medication but the physician at the time had ordered for her to receive it anyways. She revealed she had never brought up to anyone Resident #1 receiving the medication she was

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 05/16/2024

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
F 760	Continued From page 13	F 760		

listed as being allergic to and to her knowledge was not aware of her having any side effects from the medication although it was not clear as to what reactions they should have been looking for.

An interview with the DON on 5/16/24 at 4:16 PM revealed she started in her position with the facility on February 2024 and while reviewing resident medications she found Resident #1 had been ordered Reglan in December 2023 to treat her on-going reflux disease but on her medical chart it was documented that she was allergic to Reglan. She stated when she addressed the concern with the previous Medical Director (MD) he stated that he was aware that Resident #1 had documented in her medical chart that she was allergic to Reglan but that was his order, and he was not going to change it. She revealed she and the Administrator discussed the concern with the previous MD's supervisor who was also a physician, and she discontinued the order on 3/19/24 for Reglan and the facility then chose to part ways with the previous MD. The DON stated Resident #1 allergy to Reglan was listed on her admission paperwork but there was no documentation on the origin of the allergy or what reactions to be looking for. She revealed to her knowledge Resident #1 had not suffered any reactions from being administered the Reglan and if there had been any reactions they were not documented as being caused from that. She stated she had discussed the issue with Resident #1 receiving the Reglan medication with Resident #1 RP on 3/18/24 and she could not recall when Resident #1 had become allergic to the medication or what reactions it had caused. The DON she explained to Resident #1 RP the situation with the previous MD, and they had notified his supervisor who was also a physician

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 05/16/2024

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
F 760	Continued From page 14	F 760		

about discontinuing the order and Resident #1 RP stated she was fine with that as long as Resident #1 stopped receiving the medication and she was notified on 3/19/24 when they received the discontinue order.

An interview with the Administrator on 5/16/24 at 4:31 PM revealed she was familiar with Resident #1 and her receiving a medication she was listed as being allergic to. She stated right after the DON had started in February 2024, she had brought to her and the previous Medical Director (MD) about Resident #1 being ordered in December 2023 to receive a daily dose of Reglan medication for her reflux disease which was listed on her medical chart as her being allergic to. She revealed the MD stated that he was aware of what Resident #1 chart stated but that was his order, and he wasn't changing it. The Administrator stated after that meeting, she and the DON were able to discuss the issue with the MD's supervisor who was also a physician, and she discontinued the order for Reglan on 3/19/24. She revealed after that incident, the facility parted ways with the previous MD.

A telephone interview with the NP on 5/16/24 at 5:09 PM revealed she had begun her position as the facility NP on 5/01/24 and was not familiar with Resident #1 receiving a medication that was listed on her medical chart as being allergic to. She stated administering any medication to a resident with a possible allergy to the drug can cause serious side effects especially if the origin and reactions are unknown. She revealed side effects from taking Reglan could be anything from itchiness, rash, swelling of face, tongue, and throat to more serious side effects of developing tardive dyskinesia (serious movement disorder)

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 05/16/2024

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
F 760	Continued From page 15	F 760		

and there are other medications that can be used for the treatment of reflux disease. The NP stated without knowing the origin or reaction to a medication that a resident has been listed as having allergy to, best practice would be to steer clear of that medication and prescribe an alternative medication for the issue.

The facility provided the following corrective action plan with a compliance date of 3/19/24.

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:

The facility identified concern with medication listed as allergy ordered and administered to resident.

Licensed nurse obtained order to place medication on hold pending provider assessment on 3/18/2024.

Resident assessed by licensed nurse on 3/18/2024 with no adverse effect or signs or symptoms of allergic reaction noted.

Nurse entering order for medication is no longer employed at the facility.

The Medical Director that ordered this medication was addressed by the administration and was removed from the center and replaced with a new Medical Director.

Beginning 3/18/2024, the Director of Nursing, Unit Manager/supervisor-initiated education for licensed nurses regarding appropriate new medication orders, reviewing documented allergies. Will notify provider of any discrepancy

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 05/16/2024

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
F 760	Continued From page 16 prior to administration of medication. IDENTIFICATION OF OTHER RESIDENTS: On 3/18/2024 the Director of Nursing conducted a 100% audit via Point Click Care Medication Administration Record and Admitting Hospital Documentation. No other concerns noted. Measures for Systemic Change: The Regional Nurse provided education to the Director of Nursing on 3/18/2024 regarding reviewing new orders to ensure that there are no related allergies to ordered medication. Each new order is reviewed by the Director of Nursing, Unit Managers/Clinical team during Clinical Morning Meeting. In the absence of the Director of Nursing, the Unit Managers/Clinical team will continue to review all new orders. The review is via order listing report in Point Click Care and cross referenced with the residents' medication administration record. If a current resident had an identified new allergy, there would be a change of condition assessment, and this would be reviewed during Clinical Morning Meeting. New Residents Medication orders are reviewed at the daily Clinical Morning meeting and cross referenced with hospital records to assure any potential allergies. HOW CORRECTIVE ACTION WILL BE MONITORED: On 3/18/2024 the Administrator and Director of Nursing initiated 100% audit of Medication	F 760		

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 05/16/2024

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
F 760	Continued From page 17	F 760		

Administration Record to assure no further concerns with allergies. The DON, Unit Managers/supervisor will validate all new medication orders in clinical morning meeting that is ongoing 5 days a week. The Weekend Supervisor will notify the Director of Nursing or Designee regarding weekend admissions if there are any allergy concerns.

The Administrator and Director of Nursing/Designee will review the clinical morning meeting audits to identify patterns/trends and will adjust the plan to maintain compliance as needed.

The Administrator and Director of Nursing/Designee will review the plan during the monthly QAPI meeting for 3 months and then as needed.

The facility provided the following corrective action plan with a compliance date of 03/19/24.

On 6/05/24, the facility's corrective action plan effective 3/19/24 was validated by the following: Nursing staff interviews revealed they had received education on the 10 rights of medication administration, administering medications correctly, reviewing resident medications orders prior to administering medications, reviewing resident allergy listings, notifying the nursing supervisor, administrative staff, physician, and resident responsible party of any medications errors, documenting medications administered correctly on the medication administration record, documenting any medication errors, and monitor and document side effects of medications . The 10 rights of medication administration document were placed on every medication cart in the

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 05/16/2024

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
F 760	Continued From page 18 facility as a reminder to nurses. Administrative staff interviews revealed they had completed audits of all residents' medications to assure no related allergies to ordered medications, resident allergies were listed correctly on the medical chart, and daily review of any new medication orders, new allergy, or change of condition for residents. Documents were reviewed from the facility Quality Assurance and Performance Improvement (QAPI) committee meeting minutes of the audit results. The facilities medication error rate was 0% during the medication pass completed by the survey team on 5/16/24. The compliance date of 03/19/24 was validated.	F 760		