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 06/21/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/19/23 through 06/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3IMK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/19/23 through 06/21/23. Event ID# 3IMK11. The following intakes were investigated NC00192876, NC00199149, and NC00203234. 20 of the 20 complaint allegations resulted in no deficiencies.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		7/11/23

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

Electronically Signed | 07/07/2023

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F 657	Continued From page 1 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to develop a comprehensive, individualized care plan in the areas of oxygen use, Diabetes Mellitus (DM) type 2, and daily anticoagulation use for 1 of 4 residents (Resident #4) reviewed for care plans. The findings include: 1. Resident #4 was admitted to the facility on 3/6/23 with the following diagnosis: history of Covid-19, Chronic Obstructive Pulmonary Disease (COPD), deep vein thrombosis (DVT), and insulin dependent DM type 2. Review of physician orders for Resident #4 revealed: - 3/6/23 for anticoagulation to be administered daily and dosage to change according to lab results for a history of deep vein thrombosis (DVT). - 3/13/23 for Insulin 14 units at bedtime and changed on 6/18/23 to 10 units at bedtime for DM type 2 -5/22/23 for Oxygen at 2 Liters per minute via nasal cannula for COPD	F 657	F657 1. Resident #4 care plan was updated to reflect current physician orders on 6/21/23 by the Minimum Data Set LPN Coordinator 2. Residents with new physician orders have the potential to be affected. All residents with new physician orders had their care plans audited by the Assistant Director of Nursing on 7/7/23 to ensure no further issues. 3. The Director of Nursing provided Care Plan education to the MDS LPN Coordinator on 6/21/23. Licensed nursing staff and the Interdisciplinary Team to be educated on the importance of the Plan of Care reflecting the current physician orders of the resident by the Staff Development Coordinator. Education completed on 6/30/23. New staff and/ or agency staff to be educated prior to the beginning of their first shift by the Staff Development Coordinator/ designee. 4. The Director of Nursing/ designee will audit 5 random new physician orders and care plans weekly for 4 weeks and then 5 care plans monthly for 2 months. Results of the audits will be presented to the Quality Assurance Process Improvement	

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F 657	Continued From page 2 Review of admission minimum data set (MDS) assessment dated 3/13/23 revealed Resident #4 had moderate cognitive impairment. She required extensive assistance with most of her activities of daily living (ADLs). Resident #4's MDS was marked for anticoagulation and insulin use during the review period. A review of Resident #4's care plan initiated on 3/6/23 and updated on 3/20/23 showed there was no care plan in place for anticoagulation therapy, insulin, or oxygen use. Observation and interview with Resident #4 on 6/20/23 at 8:56 AM revealed she was receiving oxygen via nasal cannula (nc). The setting on the oxygen concentrator was 2 liters (L) per minute. The resident reported she had been on oxygen for a long time because she had trouble breathing sometimes. Resident #4 also reported she received insulin daily but was unable to recall if she received anticoagulants. Interview with the MDS Coordinator on 6/21/23 at 4:20 PM revealed medications such as anticoagulants, oxygen, and insulin should have been care planned. The MDS Coordinator went on to say any changes involving the addition of medications or equipment were discussed during the morning meeting. She also stated she would review the 24-hour nursing report for changes to update resident care plans. The MDS Coordinator indicated care plans needed to be updated to reflect changes even if the resident was not in a review period. An interview was completed on 6/21/23 at 4:35	F 657	Committee by the Director of Nursing/ designee for review and recommendations. 5. Date of Compliance 7/11/23	

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F 657	Continued From page 3 PM with the Director of Nursing (DON) where she expressed her expectations regarding care plans. The DON indicated she expected all high-risk medications and equipment be care planned for each resident.	F 657		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		7/11/23

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F 880	Continued From page 4 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy when the Treatment Nurse did not perform hand hygiene after removing a	F 880	F880 1. Resident #152 had no ill-effect. The Treatment Nurse was educated on Hand Hygiene per CDC guidelines by Direction	

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F 880	Continued From page 5 soiled dressing with drainage on it and before cleansing the wound with wound cleanser-soaked gauze for 1 of 1 resident (Resident #152) reviewed for wound care. The findings included: The facility's policy entitled "Infection Control Guidelines for All Nursing Procedures" last revised on 12/29/20, under General Guidelines read in part: 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents, b. Before donning gloves, e. Before handling clean or soiled dressings, gauze pads, etc. h. After handling used dressings, contaminated equipment, etc. j. After removing gloves. An observation of wound care by the Treatment Nurse was made on 06/21/23 at 1:26 PM. The Treatment Nurse was observed washing his hands with soap and water and donning clean gloves. Resident #152 was sitting up in her wheelchair with her legs elevated up on her bed and a towel was placed under her legs. The Treatment Nurse removed the old dressing which had a moderate amount of serous drainage on the dressing. He then proceeded to cleanse the wound with wound cleanser-soaked gauze without washing or sanitizing his hands and changing his gloves. After cleansing the wound the Treatment Nurse doffed his gloves, washed	F 880	of Nursing (DON)on 6/28/23. 2. All residents receiving treatment for wounds have the potential to be affected. 3. All staff to be educated on Handwashing P&P by the Staff Development Coordinator/ Infection Preventionist in accordance with CDC guidelines. This education completed 6/30/23. New staff and/ or agency staff to receive education prior to their first shift by the Staff Development Coordinator/ designee 4. DON/ designee will observe 5 random employees during treatment application weekly for 4 weeks and then 5 random employees monthly for 2 months. . Results of the audits will be presented to the Quality Assurance Process Improvement Committee by the Director of Nursing/ designee for review and recommendations. 5. Date of Compliance 7/11/23	

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F 880	Continued From page 6	F 880		

his hands with soap and water and donned new gloves to apply sliver alginate (highly absorbent dressing that forms gel like covering over the wound to help maintain a moist environment to promote wound healing) to the wound and applied a foam border gauze over the alginate.

An interview on 06/21/23 at 1:43 PM with the Treatment Nurse revealed he was nervous and just forgot to wash his hands and change his gloves after removing Resident #152's socks and dirty dressing and before cleansing the wound. He stated he knew he should have cleansed his hands and changed gloves after removing the used dressing and before cleansing the wound with wound cleanser-soaked gauze. The Treatment Nurse further stated it was an oversight.

An interview on 06/21/23 at 3:23 PM with the Infection Preventionist (IP) revealed the Treatment Nurse should have doffed his gloves after removing the soiled dressing and washed his hands and donned new gloves prior to cleansing the wound. The IP stated any time a nurse went from a dirty to clean procedure they needed to wash their hands and don new gloves prior to starting the clean procedure.

An interview on 06/21/23 at 5:09 PM with the Director of Nursing (DON) revealed she expected the Treatment Nurse to clean his hands and don new gloves when moving from a dirty to a clean procedure. The DON stated the Treatment Nurse had been re-educated on infection control principles.