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 01/18/2024

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 unannounced complaint investigation was conducted 01/17/24 through 01/18/24. Intake NC00211254 was investigated. 4 of 4 allegations did not result in deficiency. Event ID# PKQT11.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to secure medications stored at the bedside for 3 of 3	F 761	1.On 01/17/2024, Resident #1 medicated powder removed by the Director of Nursing on 1/17/24. Resident #5	2/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/02/2024

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

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residents reviewed for medication storage (Resident #5, Resident #1, and Resident #3).

Findings included:

1. Resident #5 was admitted to the facility 11/01/23 with a diagnosis of gastroesophageal reflux disease (acid reflux).

The admission Minimum Data Set (MDS) assessment dated 11/04/23 revealed Resident #5 was cognitively intact.

Review of Resident #5's physician orders dated 12/01/23 revealed an order for calcium carbonate 1,250 milligrams (mg) one tablet twice a day.

An observation of Resident #5's overbed table on 01/17/24 at 1:00 PM revealed one round yellow pill in a medication cup sitting on top of the table. Resident #5 was not in her room.

An interview with Nurse #1 on 01/17/24 at 1:02 PM revealed the yellow pill on Resident #5's overbed table was calcium carbonate (an antacid). She stated she was training a Medication Aide (MA) #1 on how to perform a medication pass the morning of 01/17/24 and she thought MA #1 observed Resident #5 take the calcium carbonate. Nurse #1 confirmed she did not observe Resident #5 swallow the calcium carbonate and she had been trained to observe the resident take their medication at the time it was administered.

An interview with Medication Aide (MA) #1 on 01/17/24 at 1:11 PM revealed she was being trained on how to perform a medication pass by Nurse #1. She stated the morning of 01/17/24

F 761

medication was removed by the Assistant Director of Nursing on 1/17/24. Resident #3 ordered creams noted at bedside were removed by the Director of Nursing on 1/17/24.

2.All residents who receive medications are at risk of being affected by alleged deficient practice. On 01/17/2024, all resident rooms were inspected by members of facility management for any improperly stored medications or creams with unsecured medications discovered collected and returned to a licensed nurse for securing.

3.On 01/18/2024, all licensed nurses were educated to medication storage policy and medication administration, which includes ensuring the resident does take medication administered. Licensed nurses, including contracted agency staff and new hires, will be educated prior to accepting resident care assignments by a licensed charge nurse. Nursing staff were educated by the Staff Development Coordinator on no medication or treatments are to be left at resident bedside on 1/18/24, including agency staff and new hires will be educated prior to accepting resident care assignment. All residents wishing to keep medications at bedside will be assessed by a licensed nurse to determine if they can manage self-administration, if assessed as able, they will be provided a secure box for medication storage, physician’s order for self-administration obtained and care plan updated per policy.

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F 761	Continued From page 2 she placed the medication cup containing the calcium carbonate pill in Resident #5's hand but did not observe her take the medication. MA #1 confirmed she had been trained to observe residents take every single medication at the time it was administered. In an interview with the Director of Nursing (DON) on 01/17/24 at 2:39 PM she stated staff should have observed Resident #5 take the calcium carbonate at the time it was ordered or removed it from the resident's room. An interview with Resident #5 on 01/18/24 at 10:34 AM revealed she did not want to take the calcium carbonate at the time it was provided on 01/17/24 and planned to take the medication later in the day on 01/17/24. 2. Resident #1 was admitted to the facility 09/13/22. The significant change Minimum Data Set (MDS) assessment dated 12/29/23 revealed Resident #1 was severely cognitively impaired. Review of Resident #1's physician orders revealed an order dated 12/22/23 for miconazole nitrate powder 2% (an antifungal medication) to the groin every shift for redness. An observation of Resident #1's dresser on 01/17/24 at 12:04 PM revealed a bottle of miconazole nitrate 2% sitting on top. The dresser was positioned right beside Resident #1's bed and the medicated powder was not within her reach. Resident #1 was in the bed with her eyes closed.	F 761	4.The Director of Nursing/ designee will randomly audit 5 resident rooms per week for four weeks to ensure no medications or treatments are improperly stored on a resident bedside table, and then will randomly audit three resident rooms per week for two months. The Staff Development Coordinator will perform Medication Pass Audits with Licensed nurses randomly 5 times per week for four weeks to ensure no medications are left in a resident room, and then three times per week for two months. The audits will be reviewed in the monthly Quality Assurance and Process Improvement committee to identify patterns/ trends and will adjust the plan to maintain compliance. 5. Date of Compliance: 2/13/24	

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An observation and interview were conducted on 01/17/24 at 2:39 PM with the Director of Nursing (DON). The DON observed the bottle of miconazole powder on top of Resident #1's dresser and stated the powder should be stored in the treatment cart and not in the resident's room because it contained medication.

3. Resident #3 was admitted to the facility 11/24/23.

Review of Resident #3's physician orders revealed an order dated 11/29/23 for zinc oxide cream to her buttocks daily and prn (as needed).

The admission Minimum Data Set (MDS) assessment dated 11/30/23 revealed Resident #3 was cognitively intact.

An observation of Resident #3's dresser on 01/17/24 at 12:19 PM revealed a 15-ounce container of zinc oxide 20% (a protective skin ointment) sitting on top. The dresser was positioned right next to her bed. Resident #3 was up in her wheelchair at the time of the observation and not close to the dresser.

An interview with Resident #3 on 01/17/24 at 12:19 PM revealed staff placed the cream on her bottom at least once a shift.

An observation and interview were conducted on 01/17/24 at 2:41 PM with the Director of Nursing (DON). The DON observed the container of zinc oxide cream on top of Resident #3's dresser and stated the cream should be stored in the treatment cart and not in the resident's room because it contained medication.