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 02/01/2024

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 The survey team entered the facility on 01/30/24 to conduct a complaint survey and exited on 01/31/24. Additional information was obtained on 02/01/24. Therefore, the exit date was changed to 02/01/24. Event ID# XB3511. The following intake was investigated NC00212527. One (1) of 1 allegation did not result in deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		2/15/24

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

Electronically Signed | 02/14/2024

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F 609	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, local police interview, and record review, the facility failed to report a suspicious white powder in a little zip bag found in the room of Resident #1 to local law enforcement. The facility also failed to preserve potential evidence when they destroyed the white powder. Resident #1 experienced a potential drug overdose on 1/21/24 which responded with Naloxone (medication designed to rapidly reverse opioid overdose) given by the Emergency Medical Services (EMS) and was sent to the hospital for treatment. This deficient practice occurred for 1 of 1 resident reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 1/18/24 and she was readmitted on 1/26/24. Interview with the Nursing Assistant (NA #1) on 1/30/24 at 11:15 AM stated that she worked several days with Resident #1, and she found the Resident #1 slumped in her wheelchair after her breakfast around 10 AM on 1/21/24. NA #1 stated that she was going around taking Vital Signs (VS) for her assigned residents when she saw Resident #1. NA #1 stated she was not able to get Blood Pressure (BP) from the BP machine and noted she got Oxygen Saturation (O2 Sat) of 72% (normal range 95% - 100%). She then called Nurse #1 to come check on the resident. Review of the progress notes dated 1/21/24 at 10:50 AM showed a SBAR (Situation, Background, Assessment, Recommendation)	F 609	F609 1. Resident #1 was discharged home on February 9, 2024 per her rehabilitation goals and no longer resides in the facility. 2. By 2/13/24 all other resident's rooms, to the extent that residents allow in compliance with resident's rights, were checked for any unknown substance by the Administrator, Minimum Data Set-RN, Activity Director, Social Workers, Admissions Coordinator, Business Office manager, Assistant Business Office Manager, Staff Development Coordinator, Food Service Manager. No further concerns discovered. The facility clinical capabilities grid was adjusted to add referrals with known drug or substance use or abuse. This will allow for facility leadership to review prior to admission. 3. On 2/13/24 Education completed for all staff by the Staff Development Coordinator regarding the notification to the Administrator and Physician if medications or suspicious substances are found in a resident's room without a prescription. Agency staff, contracted staff and new hires in all departments will receive the education prior to beginning their shift. All staff are to contact the Administrator prior to removing an unknown substance from the facility. The Administrator's phone number is available at both nursing stations, all managers	

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F 609	Continued From page 2 note revealed Resident #1 had changed of condition and that the VS were; BP of 70/50 (normal range 90/60 - 120/80), Heart Rate (HR) was 50 Beats Per Minute (BPM)(normal range of HR 60 - 100) and was found slumped in her wheelchair after breakfast. The Medical Doctor (MD) was called by Nurse #1. The MD gave an ordered to send the resident to hospital Emergency Room (ER) for treatment. A telephone interview with Nurse #1 on 1/30/24 at 11:36 AM stated that the NA #1 called her attention to Resident #1's for low VS. She then assessed Resident #1 and noticed that Resident #1 was not responding to verbal stimuli. The BP was low, and the respirations were shallow at 11 Breaths per minute (BPM) (normal range 12 - 16). She then called the MD, and got orders to send to ER via EMS. Nurse #1 stated Resident #1 looked dazed, pupils were dilated, and only woke up with sternal rub. She stated Resident #1 did not respond verbally when she woke briefly after sternal rub. A telephone interview with Charge Nurse on 1/30/24 at 12:06 PM stated that on 1/21/24 she saw Resident #1 slumped in her wheelchair while walking in the hall. She stated that Resident #1 had shallow breathing and was not moving. When the EMS came, they did VS and EMS told her they suspected a drug overdose. Interview with Nurse #2 on 1/30/24 at 10:50 AM revealed she came to help on 1/21/24 with Resident #1 when she heard that they needed help. She stated that Resident #1 was slumped in her wheelchair, snoring, and woke up with sternal rub but would go right back to being slumped. She stated that Resident #1 was not	F 609	have the Administrators phone number. Education included the requirements of the regulation for the center to report any concerns of this nature and that the Administrator will be responsible for providing notification to law enforcement as required. 4. Administrator/ designee will randomly ask 10 staff members weekly “Who do you notify if you find medications without a prescription or any unknown/ suspicious substances in a resident room?” for 4 weeks and then 10 times monthly for 2 months. The Director of Nursing/ designee will randomly audit 5 resident rooms per week for four weeks to ensure no medications without a prescription or unknown substance are in the rooms, rooms audits include observation for obvious signs of illegal substances- i.e. unmarked, labeled substances powders that have the appearance of illegal drugs and then will randomly audit three resident rooms per week for two months. All audits will be brought to the monthly Quality Assurance Process Improvement Committee by the Administrator and Director of Nursing for recommendation and review to ensure compliance. 5. Date of Compliance 2/15/24	

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coherent, and they called 911. She further stated that she took a course on emergency certification and that she knew the signs and symptoms of drug overdose. She stated that Resident #1 showed a similarity with opioid overdose.

Review of the Emergency Medical Services (EMS) notes revealed that on 1/21/24, they were called to the facility and found Resident #1 in wheelchair with Oxygen (O2) via nasal cannula. VS were taken at 10:50 AM with BP 82/62, HR 86, RR 12, and O2 Sat 90%. The resident was then given Intravenous (IV) Naloxone 2 milligrams (mgs) and the resident's response improved. She was alert to self when they transported her to the ER. The EMS note included the chief complaint of overdose.

Interview with the Nursing Assistant (NA #1) on 1/30/24 at 11:15 AM revealed she noticed on 1/21/24 around 1:30 PM white powder on a little zip bag between the bedside table and Resident #1's bed while NA #1 was picking up the meal tray. She stated the little zip bag measured about an inch by an inch with a little larger zip bag (double bagged) with about halfway full of white powder. She stated that she wore gloves to keep her safe because it looked like a dangerous drug. She took the little zip bag to Nurse #1.

A telephone interview with Nurse #1 on 1/30/24 at 11:36 AM she stated that NA #1 came and gave her a little zip bag with white powder on 1/21/24 around 1:30 PM. Nurse #1 stated she gave the little zip bag to the Charge Nurse to follow up with nursing administration. She stated that it was an unusual white powder and she never saw a packaging like it.

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A telephone interview with Charge Nurse on 1/30/24 at 12:06 PM stated that on 1/21/24 she received the little zip bag from Nurse #1 and she called the Director of Nursing (DON) to report what was found in Resident #1's room. The DON instructed her to lock the little zip bag inside the medication cart in her office. She stated there was visible white powder in the little zip bag, and it was a third (1/3) full. The Charge Nurse stated the hospital ER Nurse called on 1/21/24 after the Resident #1 was admitted and asked the facility to check Resident #1's room for any drug. She stated that there were no drugs aside from the white powder they found.

A telephone interview with the DON on 1/30/24 at 4:58 PM revealed that on 1/21/24 she received a call from the Charge Nurse and it was reported to her they found a little zip bag with white powder. She instructed the Charge Nurse to lock the little zip bag in the medication cart in her office. She stated that on Monday morning (1/22/24) she called her Assistant DON (ADON) and a supervisor to assist her and they went to the 500 hall Unit to get a drug buster (a solution that dissolves medications and pills on contact) bottle. She then poured the medication inside the drug buster bottle to discard the white powder. The DON stated that she didn't know what the white powder was, and "she didn't have no desire and didn't care to report." She further stated that there was not enough powder in the little zip bag for her to call the police.

Interview with the Supervisor on 1/31/24 at 9:47 AM stated she was approached by the DON on 1/22/24 in her office to go with them to do something. She stated they went to 500 hall and the DON got a drug buster bottle. The Supervisor

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stated she suggested calling the police because the white powder was unknown, and it could be narcotic or controlled substance. The DON said not to call the police and she witnessed the destruction from a distance.

Interview with the Police Officer on 1/30/24 at 9:55 AM stated the police department received an anonymous report from their internet portal of an overdose resident on 1/22/24 in the facility. The Police Officer stated that they didn't receive any call from the facility staff.

Interview with the Administrator on 1/30/24 at 5:25 PM stated that she didn't know about the white powder in the little zip bag. She stated that she would call the police to report the white powder because it was an unknown substance and wanted to be safe.

Interview with the Regional Director of Operations on 1/31/24 at 10:08 AM stated that the DON should have consulted the administrator before destroying the little zip bag with white powder so they could decide on what to do.