	-	ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE & I				CONCEPTION		0.0938-0391	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345250		B. WING _			11/07/2024			
NAME OF PF	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	01/2024	
				515	S GENERALS BOULEVARD			
THE GREE	ENS AT LINCOLNTON			LIN	ICOLNTON, NC 28093			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
		,			DEFICIENCY)			
E 000	Initial Comments		EC					
E 000								
	An unannounced Re	certification survey was						
		24 through 11/7/2024. The						
	facility was found in c							
	requirement CFR 483 Preparedness. Event							
F 000	INITIAL COMMENTS		FC	000				
	A recertification surve	ey was conducted from						
	-	/7/2024. Event ID# MRTG11						
F 582		overage/Liability Notice	F 5	582			11/13/24	
SS=B	CFR(s): 483.10(g)(17)(18)(1)-(V)						
	§483.10(g)(17) The fa							
		aid-eligible resident, in						
		admission to the nursing resident becomes eligible for						
	Medicaid of-	resident becomes eligible for						
		rvices that are included in						
		es under the State plan and						
	for which the resident							
		and services that the which the resident may be						
	-	ount of charges for those						
	services; and							
		aid-eligible resident when						
	-	the items and services g)(17)(i)(A) and (B) of this						
	section.							
	8/83 10(a)(18) The fe	acility must inform each						
		the time of admission, and						
		e resident's stay, of services						
	available in the facility	/ and of charges for those						
		y charges for services not						
	covered under Medica facility's per diem rate	are/ Medicaid or by the						
		coverage are made to items						
LABORATORY I		SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>		TITLE		(X6) DATE	

Electronically Signed

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.

11/26/2024

PRINTED: 12/02/2024

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 12/02/2024 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345250	B. WING		11/	07/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
				515 S GENERALS BOULEVARD			
THE GREE	ENS AT LINCOLNTON			LINCOLNTON, NC 28093			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 582	Medicaid State plan, t notice to residents of reasonably possible. (ii) Where changes ar items and services that facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the resided or reserved o facility, regardless of a discharge notice requi- (iv) The facility must r resident representative the resident within 30 date of discharge from (v) The terms of an ac- behalf of an individual facility must not confli- these regulations. This REQUIREMENT by: Based on record revi- facility failed to provid Medicaid Services (C Facility Advanced Ber prior to discharge from services for 2 of 3 res- beneficiary protection and Resident # 253). Findings included:	by Medicare and/or by the the facility must provide the change as soon as is e made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the any minimum stay or irements. efund to the resident or re any and all refunds due days from the resident's in the facility. dmission contract by or on I seeking admission to the ct with the requirements of is not met as evidenced ew and staff interviews, the e Centers for Medicare and MS)-10055 Skilled Nursing heficiary Notice (SNF ABN) in Medicare Part A skilled idents reviewed for notification (Residents #60	F 58	 On 11/8/2024 Resident #60 was issued a Skilled Nursing Facility Adv Beneficiary Notice (SNF ABN) to the resident and her Responsible Party i by the Business Office Manager (BC As of 11/8/2024 Resident #253 was receiving Medicare Part A services. All residents have the potential 1 affected by this deficient practice. Or 11/8/2024 an audit was conducted b BOM for the last 30 days for residen 	anced ssued M). o be n y ts		
	1. Resident #60 was a	admitted to the facility on		who should have received an SNF A	BN,		

Event ID: MRTG11

Facility ID: 922998

If continuation sheet Page 2 of 9

	IDENTIFICATION NUMBER:		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345250		A. BUILDING			
		B. WING		11/07/2024	
NAME OF PROVIDER OR SUPPLIER					
THE GREENS AT LINCOLNTON					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTIO	
Summary Statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 Continued From page 2 08/28/2024 A review of the Notice of Medicare NON-Coverage form dated 08/12/24 revealed the facility initiated Resident #60 discharge from Medicare Part A services on 10/28/24 and continued to stay in the facility. A Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) form was not issued to Resident #60 or her Responsible Party (RP). A joint interview was conducted with the Social Worker and the Business Manager on 11/06/24 at 9:00am. They revealed they were both trained in how to complete the discharge forms. They stated they issued the NOMNC to the residents and/or RP at least 2 days prior to discharge. They stated they were not aware they were supposed to issue the SNF ABN to the residents and/or RP prior to termination of Medicare Part A services for residents remaining in the facility. They revealed that they had explained to the residents and/or their RP that Medicare would no longer be paying for resident's therapy and if the resident wished to continue to stay at the facility and receive services resident would have to pay a per day cost of care privately or through Medicaid, but they did not issue an SNF ABN.		F 582	and no other concerns were noted. 3. The Business Office Manager, S Services Director and the Administra were educated on Beneficiary Notice Guidelines by the Regional Director of Business Office Services on 11/12/20 Education will be provided to newly h business office personnel and social workers by Administrator upon hire. 4. The Administrator or designee w audit discharges daily for 4 weeks fo proper use of the SNF ABN prior to discharge from Medicare Part A serv then weekly for 2 months. Results o these audits will be brought before th Quality Assurance and Performance Improvement Committee monthly wit QAPI Committee responsible for ong compliance.	tor of 024. nired vill r ice f ne ch the joing	
	T LINCOLNTON SUMMARY ST (EACH DEFICIENC REGULATORY OR tinued From page 8/2024 view of the Notice N-Coverage form ity initiated Resid licare Part A servi- inued to stay in the lity Advanced Be to stay in the lity Advanced Be to stay in the ponsible Party (R int interview was ker and the Busin the He SNF ABN r to termination of esidents remaining the SNF ABN r to termination of esidents remaining the continue to site the SNF ABN r to termination of esidents remaining the continue to site services resid cost of care privator of the sum and the try was continue to the sum and the sum and the sum and the sum and the services resident and the sum and the sum	ER OR SUPPLIER T LINCOLNTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 2 18/2024 view of the Notice of Medicare N-Coverage form dated 08/12/24 revealed the ity initiated Resident #60 discharge from licare Part A services on 10/28/24 and inued to stay in the facility. A Skilled Nursing lity Advanced Beneficiary Notice (SNF ABN) n was not issued to Resident #60 or her ponsible Party (RP). int interview was conducted with the Social ker and the Business Manager on 11/06/24 at vam. They revealed they were both trained in to complete the discharge forms. They ed they issued the NOMNC to the residents for RP at least 2 days prior to discharge. They ed they were not aware they were supposed sue the SNF ABN to the residents and/or RP r to termination of Medicare Part A services esidents remaining in the facility. They aled that they had explained to the residents for their RP that Medicare would no longer be ng for resident's therapy and if the resident ed to continue to stay at the facility and two services resident would have to pay a per cost of care privately or through Medicaid, but of did not issue an SNF ABN.	ER OR SUPPLIER T LINCOLNTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG tinued From page 2 F 582 18/2024 F 582 view of the Notice of Medicare N-Coverage form dated 08/12/24 revealed the ity initiated Resident #60 discharge from licare Part A services on 10/28/24 and inued to stay in the facility. A Skilled Nursing lity Advanced Beneficiary Notice (SNF ABN) or was not issued to Resident #60 or her ponsible Party (RP). int interview was conducted with the Social ker and the Business Manager on 11/06/24 at tam. They revealed they were both trained in to complete the discharge forms. They ed they issued the NOMNC to the residents for RP at least 2 days prior to discharge. They ed they were not aware they were supposed sue the SNF ABN to the residents and/or RP r to termination of Medicare Part A services esidents remaining in the facility. They staled that they had explained to the residents for their RP that Medicare would no longer be ng for resident's therapy and if the resident ed to continue to stay at the facility and ive services resident would have to pay a per cost of care privately or through Medicaid, but r did not issue an SNF ABN.	ROR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T LINCOLNTON STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Three Summary Statement OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPROP DEFICIENCY) PROVIDERS PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPROP DEFICIENCY) tinued From page 2 B/2 //2/24 //2 //2/24 revealed the tip initiated Resident #60 discharge from licare Part A services on 10/28/24 and incer Part A services on 10/28/24 and incer Part A services on 11/06/24 at lam. They revealed the Business Manager on 11/06/24 at lam. They revealed the guere both trained in to complete the discharge forms. They ad they was conducted with the Social ker and the Business Manager on 11/06/24 at lam. They revealed they were both trained in to complete the discharge forms. They aled that they had explained to the residents for their RP that Medicare would no longer be ng for resident's therapy and if the resident sort of care privately of through Medicaid, but did not issue an SNF ABN. 5. Date of Compliance is 11/13/20 5. Date of Compliance with the inistrator on 11/07/24 at 8:29am. The 5. Date of Compliance with the inistrator on 11/07/24 at 8:29am. The	

If continuation sheet Page 3 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2024 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345250	B. WING			11/	07/2024	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	ENS AT LINCOLNTON			5	515 S GENERALS BOULEVARD			
				L	LINCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 582	and correctly. He stat and will provide retrai and the Business Man the required discharge 2. Resident # 253 was 07/01/24. A review of the Notice NON-Coverage form facility initiated Reside Medicare Part A servir resident continued to Nursing Facility Advan (SNF ABN) form was or her Responsible Par A joint interview was Worker and the Busin 9:00am. They reveale how to complete the of stated they issued the and/or RP at least 2 of stated they were not a to issue the SNF ABN prior to termination of for residents remainin revealed that they had and/or their RP that M paying for resident's to continue to stay at the services resident would cost of care privately they did not issue an An interview was cond	he required forms timely ed he was new to this facility ning to the Social Worker nager to properly complete e paperwork going forward. s admitted to the facility on e of Medicare dated 08/12/24 revealed the ent # 253 discharge from ces on 08/15/24 and the stay in the facility. A Skilled need Beneficiary Notice not issued to Resident #253 arty (RP). conducted with the Social less Manager on 11/06/24 at ed they were both trained in discharge forms. They e NOMNC to the residents lays prior to discharge. They aware they were supposed I to the residents and/or RP Medicare Part A services of in the facility. They d explained to the residents Medicare would no longer be herapy and if the wished to e facility and receive and have to pay a per day or through Medicaid, but SNF ABN.	F	582				
	paying for resident's t continue to stay at the services resident wou cost of care privately they did not issue an An interview was com Administrator on 11/0	herapy and if the wished to e facility and receive Ild have to pay a per day or through Medicaid, but SNF ABN. ducted with the						

Facility ID: 922998

If continuation sheet Page 4 of 9

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY
ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·	A. BUILDING		
		345250	B. WING _		11/07/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
THE GREE	ENS AT LINCOLNTON			515 S GENERALS BOULEVARD LINCOLNTON, NC 28093	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETIN HE APPROPRIATE DATE
F 582	Continued From page	e 4	F 5	82	
		een completed and issued.			
		ealed the SBF ABN should			
		he Resident and/or RP. He			
	stated he expected his staff to complete the required forms timely and correctly. He stated he				
	was new to this facilit	y and will provide retraining			
		and the Business Manager			
	to properly complete to paperwork going forw	the required discharge			
F 745		/ Related Social Service	F 7	45	11/13/24
SS=E					
	§483.40(d) The facility must provide				
	-	ial services to attain or			
		practicable physical, mental I-being of each resident.			
		is not met as evidenced			
	by:				
		ew, and resident, staff, and		1. A new sleep study app	
		aff interviews, the facility		Resident #64 was schedule 12/9/2024.	ed for
	failed to schedule a sl Pulmonologists recon	nmendations for 1 of 3		2. All residents with providents	der
	0	r respiratory care (Resident		recommendations for appoi	
	#64).			the potential to be affected	by deficient
	The findings included:			practice. On 11/8/2024 an appointment schedule for the	ne last 30 days
	Resident #61 was ad	mitted to the facility on		was conducted by Social	
		es that included chronic pain		Appointments were schedu	
	and atrial fibrillation.	····· F -····		identified residents by the S	SSD
	A quarterly Minimum	Data Set for Resident #64		3. The Director of Nursing Social Services Director, Ad	-
	dated 8/23/24 reveale			and nursing unit managers	
	cognitively intact with	no respiratory issues noted.		importance of ensuring all r appointments scheduled pe	esidents have
	Review of pulmonolog	gist note dated 7/03/24		recommendations on 11/8/2	-
	revealed Resident #6	4 had been seen for		Education will be provided t	-
	scheduled office visit	on 7/03/24 for the following		hired social workers, appoir	ntment

Event ID: MRTG11

Facility ID: 922998

If continuation sheet Page 5 of 9

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		B. WING	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		7/2024	
				515 S GENERALS BOULEVARD			
THE GRE	ENS AT LINCOLNTON		1	LINCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 745	breath, chronic rhiniti referrals were made is scheduled a pulmonal sleep study test by a A telephone interview at 1:43 PM with the F The Office Manager is seen for a scheduled pulmonologist on 7/00 infection, shortness of and chronic rhinitis at recommended a pulm sleep study to be com He stated their office #64 a sleep study at and that appointment and rescheduled for sleep study appointm was also cancelled by again for 7/31/24 and cancelled by the facil further sleep study appointm of the facility staff wh the sleep studies for Resident #64 had a p completed at their offi pulmonology appoint to review the sleep st by the provider due to available. An interview conduct with Resident #64 rev by her pulmonologist	tory infection, shortness of s and morbid obesity. Order for Resident #64 to have ary function test and split sleep provider only. was conducted on 11/06/24 Pulmonology Office Manager. revealed Resident #64 was office visit with the 3/24 for acute respiratory of breath, morbid obesity,	F 745	schedulers and transportation p by the DON or Administrator up Nurse Managers will input cons follow-up appointment orders in they receive them. The order s report will be reviewed in clinical meeting then given to the transportation/scheduler and So Services Director at that time to appointment and transportation scheduled with the appropriate 4. Director of Nursing or desig monitor 5 appointments each w weeks to ensure residents appo scheduled per provider recomm Results of these audits will be b before the Quality Assurance ar Performance Improvement Con (QAPI) monthly with the QAPI or responsible for ongoing complia 5. Date of compliance is 11/13	on hire. ult and to PCC as ummary al morning ocial ensure are provider. gnee will eek for 12 ointments nendations. prought nd nmittee committee ance.		

Facility ID: 922998

If continuation sheet Page 6 of 9

PRINTED: 12/02/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/02/2024 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE	
		345250	B. WING				11/	07/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP COD	E		
	ENS AT LINCOLNTON				515 S GENERALS BOULEVARD			
	INS AT LINCOLNTON			1	LINCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 745	Continued From page after that appointment cancelled and had ner revealed she was curr breathing, no respirate problems with sleepin any oxygen to assist f #64 stated her pulmon have a sleep study and should do to make su and would like for the appointment. A review of the facility 2024 through Novems scheduled appointme 8/27/24 completed for scheduled appointme 8/27/24 completed for scheduled appointme Attempt to contact the not successful. An interview was cond AM with the Unit Man revealed she was fam had not been made at referrals for a sleep st stated typically when to an outside provider that visit would be giv so she could upload tt inform the physician. facility transporter who first of August was als scheduling resident at have been the person sure Resident #64 sleep scheduled, cancelled,	e 6 t and the appointment was ver been rescheduled. She rently having no issues with ory issues or infections, no ag, and was not currently on her with breathing. Resident nologist ordered for her to ad she felt that was what she re there was nothing wrong facility to reschedule her transportation logs for July ber 2024 revealed a nt to pulmonologist on r Resident #64 and no nts for a sleep study. e previous scheduler was ducted on 11/07/24 at 11:31 ager (UM). The UM filiar with Resident #64 and ware of any orders or tudy to be obtained. The UM a resident was transported r, any notes or orders from en to her by the transporter hose into the computer and She revealed the previous o left at the end of July or so responsible for ppointments, so he would responsible for making eep study appointment was , and rescheduled. The UM		745	DEFICIENCY)			
	sure Resident #64 sle scheduled, cancelled, also revealed Resider	ep study appointment was						

If continuation sheet Page 7 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2024 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345250	B. WING			11/	07/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				5	15 S GENERALS BOULEVARD			
THE GREE	ENS AT LINCOLNTON			L	INCOLNTON, NC 28093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 745	appointment being ca no knowledge as to w Resident #64 had bee appointment had not the reason for the car documented. She sta have received her sle she would be calling to pulmonology office to sleep study appointm An interview was com PM with the Social W Director revealed the appointments and trat the first of August 202 filling in the role as the using a transport com hire a new facility sch Director stated typical seen for an appointme either the resident or the notes or orders fro give them to the UM or revealed if the resider return with any notes Director) or nursing st provider and ask for the the facility. The SW D currently responsible appointments, schedu and cancelling any ap Director revealed she #64 ever having an al sleep study and Resider reviewed the appoint July 2024 she could response to the could revealed the sleep st reviewed the appoint fuel she could revealed the sleep st reviewed the appoint fuel she could revealed the sleep st reviewed the appoint fuel she could revealed the sleep st reviewed the appoint fuel sleep st of the sleep st reviewed the appoint fuel sleep st fuel she could revealed she sleep st reviewed the appoint fuel sleep st fuel sleep st of the sle	ncelled. She stated she had thy the sleep study for en cancelled, why a new been rescheduled, and why ncellation had not been ted Resident #64 should ep study as ordered and to speak with the reschedule Resident #64's ent. ducted on 11/07/24 at 12:15 ork (SW) Director. The SW previous scheduler for nsportation had resigned at 24 and she was currently e scheduler and they were ipany until they were able to eduler/ transporter. The SW Ily when a resident was ent outside of the facility, transporter would bring back om the appointment and or nursing staff. She nt or transporter did not or orders then she (SW taff would contact the he visit notes to be sent to birector stated she was for scheduling resident uling transport company, opointments. The SW was not aware of Resident opointment scheduled for a	F	745				

Facility ID: 922998

If continuation sheet Page 8 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2024 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345250	B. WING			11/	07/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GRE	ENS AT LINCOLNTON				15 S GENERALS BOULEVARD INCOLNTON, NC 28093		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 745	office had called and appointment on 9/04/2 the appointment had Director stated Reside have been completed contact the pulmonold sleep study appointm An interview was com PM with the Director of DON stated she had facility since the first of aware of Resident #6 that her appointments stated Resident #64 h respiratory distress or not mentioned to her sleep study or missing DON revealed that she	vealed the pulmonology cancelled Resident #64 24 but she did not recall why been cancelled. The SW ent #64 sleep study should a sordered and she would ogy office to reschedule the ent. ducted on 11/07/24 at 12:20 of Nursing (DON). The only been employed at the of October 2024 and was not 4 requiring a sleep study or s had been cancelled. She had shown no signs of any r problems sleeping and had anything about needing a g her appointments. The he expected any orders or ed, appointments to be made and if a resident e rescheduled staff	F	745			

Facility ID: 922998

If continuation sheet Page 9 of 9