STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Gastonia	969 Cox Road Gastonia, NC 28054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident, staff, Nurse Practitioner (NP), and physician interviews, the facility failed to clarify and/or implement wound care orders as specified in the hospital discharge summary. In addition, the resident was seen by a Wound Care NP four days after admission and the wound care orders were not implemented until two days later. As a result, the resident was not provided wound care to three abdominal surgical wounds until six days after admission to the facility. The deficient practice occurred for 1 of 2 residents reviewed for wound care (Resident #1).The findings included:Resident #1's hospital Discharge summary dated [DATE] revealed the following wound care orders: May wash surgical incisions daily with soap and water using a fresh washcloth each time.Resident #1 was admitted to the facility on [DATE] with diagnoses which included laparoscopic incarcerated ventral hernia repair (a medical emergency where abdominal tissues (like the intestine) become trapped in a hernia sac and cannot be pushed back into the abdomen) and diabetes mellitus. The facility's admission nursing note dated 10/17/2025 at 2:00 PM by Nurse #1 revealed Resident #1 arrived at the facility via wheelchair. Resident #1 was alert and oriented and had three surgical incisions to her abdomen.Multiple unsuccessful attempts were made to contact and interview Nurse #1 (agency) who admitted Resident #1 on 10/17/2025.The care plan dated 10/18/2025 revealed Resident #1 was at risk for pressure ulcer development related to disease processes, impaired mobility, and the presence of an abdominal surgical wound. The interventions included to provide surgical wound care as ordered.Review of the Electronic Medical Record revealed Resident #1 was her own responsible party.Review of the Physician's admission visit note dated 10/18/2025 at 8:00 AM revealed Resident #1 had intact dressings to her right upper abdomen, lower mid-abdomen, and right lower abdomen.The 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1's cognition was moderately impaired. Resident #1 had no behaviors or refusals of care. The MDS also indicated Resident #1 had a surgical wound and was receiving surgical wound care.Review of the previous Wound Care NP's visit note dated 10/21/2025 revealed the following wound care orders: Clean abdominal surgical incisions with wound cleanser and apply a bordered dressing daily. Review of the Treatment Administration Record (TAR) dated October 2025 revealed Resident #1 had no wound care orders entered on the TAR until 10/23/2025 which specified to clean abdominal surgical incisions with wound cleanser and apply a bordered dressing daily. Review of the October and November 2025 TARs revealed the treatment was completed daily until 11/10/2025 when the Wound Care NP discontinued the order.Review of the Electronic Medical Record revealed Resident #1 was discharged on 11/17/2025. Resident #1 was interviewed via telephone on 5/5/2026 at 10:04 AM. She stated her abdominal surgical wound dressing changes were not done for about a week after she was admitted to the facility. Resident #1 explained that she had an incontinent episode the day after she was admitted to the facility around 9:00 PM and she soiled her abdominal dressings. Resident #1 further explained that she asked a nurse to change her abdominal dressings and the nurse refused (she could not recall the nurse's name). Resident #1 explained that she removed her abdominal dressings and cleaned the incisions with soap and water and left the incisions open to air and it was several days before she received any type of wound care for her abdominal incisions. (continued on next page)

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 also stated that her surgical incisions healed without any issues.An interview was conducted with Nursing Assistant (NA) #1 on 05/05/2026 at 2:19 PM who was assigned to care for Resident #1 on 10/18/2025 on the 7:00 am to 3:00 pm shift. NA #1 stated that she did not recall Resident #1 and did not remember anything about her.An interview was conducted with NA #2 on 05/06/2026 at 6:40 AM who was assigned to care for Resident #1 on 10/17/2025 and 10/18/2025 on the 11:00 pm to 7:00 am shift. NA #2 stated that she did not recall Resident #1.On 05/06/2026 at 8:10 AM an interview was conducted with NA #3 who was assigned to Resident #1 on 10/17/2025 and 10/18/2025 on the 3:00 pm to 11:00 pm shift. NA #2 stated that she remembered Resident #1 and that she was independent with her activities of daily living, but she did not remember anything about her incisions or her having an incontinent stool.Multiple unsuccessful attempts were made to interview Nurse #3 (agency) who was assigned to Resident #1 on 10/17/2025 on the 3:00 pm to 11:00 pm shift.On 05/06/2026 at 8:20 AM a telephone interview was conducted with Nursing Supervisor #1 who stated that she remembered Resident #1 but had no knowledge of her surgical incisions or her wound care orders.Multiple unsuccessful attempts were made to interview Nurse #4 (agency) who was assigned to Resident #1 on 10/18/2025 from 7:00 am to 11:00 pm.An interview was conducted with Nurse #2 on 05/06/2025 at 6:45 AM who was assigned to Resident #1 on 10/22/2025 on the 11:00 pm to 7:00 am shift. Nurse #2 stated that she did not remember Resident #1.On 05/06/2026 at 8:25 AM a telephone interview was conducted with Nursing Supervisor #2 who stated that she recalled Resident #1 and remembered talking to Resident #1's family member about her call bell on Sunday 10/19/2025. Nursing Supervisor #2 stated that she went to Resident #1's room and checked to see if her call bell was functioning properly and she also looked at her abdominal incisions which were open to air and clean and dry. Nursing Supervisor #2 stated that she did not recall if Resident #1 had any wound care orders, but she did not notice anything abnormal with her abdominal incisions.On 05/06/2026 at 9:20 AM an interview was conducted with Unit Manager #1 who explained that the facility has had 3 different Wound Nurses in the past 6 months. He also stated that the facility currently had a dedicated Wound Care Nurse working Monday-Friday. Unit Manager #1 also stated that if the facility had an extra nurse scheduled for the weekend, that nurse would be assigned to perform wound care, if not, the hall nurses were responsible for wound care on their assigned units. The Unit Manager #1 also stated that he did not recall Resident #1.On 05/06/026 at 9:34 AM an interview was conducted with the Wound Nurse. The Wound Nurse stated that she had only been in her position for two weeks and did not provide care for Resident #1. Multiple unsuccessful attempts were made to contact and interview the previous Wound Care Nurse who was employed by the facility at the time of Resident #1's stay.Multiple unsuccessful attempts were made to interview the previous Wound Care NP who initiated Resident #1's wound care orders.An interview was conducted with the Director of Nursing (DON) on 05/06/2026 at 11:00 AM who indicated she was not aware that Resident #1's wound care orders were not set up on the day of her admission on [DATE] as specified on her hospital discharge summary or on 10/21/2025 when the Wound Care NP provided new wound care orders. The DON verified that Resident #1's hospital discharge summary included wound care orders to wash the abdominal incisions daily with soap and water. The DON also verified that the Wound Care NP's orders dated 10/21/2025 were not entered into the computer system and initiated by the previous Wound Care Nurse until 10/23/2025. The DON reviewed Resident #1's TAR and confirmed that no surgical wound care was documented for Resident #1 until 10/23/2025. The DON stated that the discharge summary wound care orders and the Wound Care NP's treatment orders must have been overlooked and should have been initiated when the orders were written. She explained that the nursing staff would not know to complete the wound care unless the order was entered into the computer system. The DON stated that she expected all wound care orders to be entered into the computer system so the orders would flow to the TAR, and the nursing staff would know the resident had wound care orders. The DON further explained that she expected all residents' wound care to be completed as ordered. The DON further explained that Nurse #1 should have entered or discussed the wound care (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders with the physician and the previous Wound Care Nurse should have entered the orders from the Wound Care NP on 10/21/2025.Multiple unsuccessful attempts were made to interview the facility's previous NP.A telephone interview was conducted with the facility NP on 05/06/2026 at 12:32 PM. The NP stated that he was not familiar with Resident #1. The NP further stated that he expected the facility staff to follow all wound care orders as written. An interview was conducted with the facility Physician on 05/06/2026 at 12:52 PM who stated he was not aware Resident #1 had not received wound care during the first week of her admission to the facility. He stated that he expected the nursing staff to follow all orders for dressing changes and wound care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to follow their Infection Control policies and procedures for Hand Hygiene when the Wound Care Nurse failed to doff her gloves, sanitize her hands, and don clean gloves after cleaning a sacral wound. With the same gloves on after cleaning the sacral wound with wound cleanser the Wound Care Nurse applied the treatment to the sacral wound for Resident #5 with a sacral pressure ulcer who was on Enhanced Barrier Precautions (EBP). The deficient practice occurred for 1 of 7 staff observed for infection control practices (Wound Care Nurse).The findings included:Review of the facilities Hand Hygiene policy and procedure which is part of the Infection Control policies and procedures last revised 08/2015 revealed the following:Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection.Policy Interpretation and Implementation:2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations:b. Before and after direct contact with resident;g. Before handling clean or soiled dressings, gauze pads, etc.;h. Before moving from a contaminated body site to a clean body site during residentcare;i. After contact with a resident's intact skin;j. After contact with blood or bodily fluids;k. After handling used dressings, contaminated equipment, etc.; andm. After removing glovesAn observation on 05/05/26 at 11:30 AM of sacral wound care on Resident #5 was made with the Wound Care Nurse and Wound Nurse Practitioner (NP). The Wound Care Nurse had already cleaned the overbed table and placed a barrier on it with her wound care supplies on top of the barrier. The Wound Care Nurse began by washing her hands with soap and water and donning clean gloves, and a gown. She proceeded by removing the old dressing using wound cleanser to loosen the edges of the old dressing, removed it and discarded it in the trash. The Wound Care Nurse doffed her gloves, washed her hands with soap and water and donned clean gloves. The Wound Care NP with gloves and gown on measured the wound and with the permission of the resident debrided the wound. After the debridement was completed the Wound Care Nurse cleaned the wound with wound cleanser and gauze. After cleaning the wound, and without doffing her gloves, sanitizing her hands, and donning new gloves, the Wound Care Nurse cut the calcium alginate (highly absorbent wound dressing) and placed it on the wound and covered the wound with a bordered gauze dressing. She gathered her supplies along with the trash, doffed her PPE, washed her hands with soap and water and left Resident #5's room.An interview on 05/06/26 at 9:34 AM with the Wound Care Nurse revealed she had been doing the wounds at the facility for a short period. The Wound Care Nurse stated she had been making rounds weekly with the Wound Care NP and doing the wound care in the facility. She further stated she thought the wound care on Resident #5 had gone well on 05/05/26. When asked about cleansing the wound and then applying the treatment, the Wound Care Nurse agreed that she should have doffed her gloves, sanitized her hands, and donned clean gloves prior to applying the treatment to the wound. She stated she didn't know why she had left that step out but said she should have sanitized her hands and changed her gloves prior to applying the treatment to Resident #5's wound.The Infection Preventionist was not available for interview.An interview on 05/06/26 at 1:46 PM with the Director of Nursing (DON) revealed it was her expectation that the Wound Care Nurse follow the Hand Hygiene policy and procedure. The DON stated she should have doffed her gloves, sanitized her hands and donned clean gloves after she cleaned the wound and before applying the treatment to Resident #5's sacral wound.