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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Lincolnton	515 S Generals Boulevard Lincolnton, NC 28093

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for residents with new mental health diagnoses for 4 of 5 residents (Resident #9, Resident #14, Resident #15, and Resident #68) reviewed for PASRR. The findings include:a. Review of Resident #9's medical record revealed PASRR level I was completed 8/23/24 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #9 was admitted to the facility on [DATE] and readmission on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #9's current active diagnoses included psychotic disorder (diagnosed on [DATE]) and major depressive disorder (diagnosed on [DATE]). There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. b. Review of Resident #14's medical record revealed PASRR level I was completed on 11/12/23 prior to admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #14 was admitted to the facility on [DATE] and readmission on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #14's current active diagnoses included anxiety disorder (diagnosed on [DATE]), major depressive disorder (diagnosed on [DATE]), and schizoaffective disorder, bipolar type (diagnosed on [DATE]). There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. c. Review of Resident #15's medical record revealed PASRR level I was completed on 7/16/14 prior to admission to the facility with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #15 was admitted to the facility on [DATE] and readmission on [DATE]. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #15's current active diagnoses included psychotic disorder (diagnosed on [DATE]), anxiety disorder (diagnosed on [DATE]), and major depressive disorder (diagnosed on [DATE]). There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. d. Review of Resident #68's medical record revealed PASRR level I was completed 10/25/23 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. Resident #68 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #68's current active diagnoses included autism and psychotic disorder (diagnosed on [DATE]) and anxiety disorder (diagnosed on [DATE]). There was no evidence in the medical record that a request was submitted for a Level II PASRR evaluation. An interview on 2/11/26 at 1:55 PM with the Social Worker (SW) revealed she had previously worked at the facility in admissions and had accepted her position as the Social Worker she believed in August 2025. She stated as the facility Social Worker she (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	believed she would be responsible for completing PASRR level II paperwork for residents, but due to scheduling conflicts, weather, and facility COVID outbreaks she had not been able to receive her Social Work training from the corporate office to include when and how to complete and submit PASRR level II paperwork. The Social Worker stated it was her understanding that residents were admitted to the facility with a PASRR level I or level II that had been completed prior to their admission and believed she would only be responsible for completing and submitting PASRR paperwork if the resident had a significant change such as a new diagnosis of dementia or possibly new behaviors. She revealed she was not aware PASRR level II paperwork was supposed to be completed for residents when they received a new mental health diagnosis, had a significant change, or when the resident received a temporary PASRR level II that required paperwork be resubmitted after 30, 60, or 90 days. The Social Worker stated she was not aware and did not know why the sampled residents did not have an evaluation for a Level II PASRR completed but after reviewing their mental health diagnoses, she believed Level II PASRR evaluations should have been completed. During an interview on 2/12/26 at 6:30 PM with the Administrator, he revealed the Social Worker would be responsible for completing and submitting PASRR paperwork. He stated the previous Social Worker had left in May 2025 and the new Social Worker had only been in the position for a few months and due to scheduling conflicts had not received the full training on completing and submitting PASRR paperwork. The Administrator revealed he was not aware of the sampled resident's diagnosis or that they did not have a PASRR level II evaluation paperwork completed and did not know why a PASRR level II evaluation request had not been submitted. He stated that his understanding was that a PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis and that according to the sampled resident's diagnoses a PASRR level II should have been completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to use a catheter tubing stabilization device to reduce the risk of pulling and tugging of indwelling urinary catheter tubing. This deficient practice occurred for 1 of 3 residents reviewed with a urinary catheter (Resident #2).Findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses that included bladder neck obstruction (urinary disorder).The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had an indwelling urinary catheter.An indwelling catheter care plan dated 11/17/25 was in place. The care plan goal was to remain free from catheter related trauma. The care plan interventions included, to secure catheter to prevent excess tension.An order dated 12/5/25 read, change [indwelling] catheter as needed for infection, dislodgement, or obstruction. Insert coude catheter (specialized curved urinary catheter) indwelling due to urinary retention with closed drainage system.An order date 12/23/25 read, flush [indwelling] catheter with 30 ml of sterile water every day and evening shift for increased sediment.An interview and observation was conducted on 2/9/26 at 2:13 PM with Resident #2. He stated he had an indwelling catheter. His indwelling urinary catheter was connected to a bedside drainage bag hanging on the frame of his bed. Yellow colored urine with sediment (solid particles) was visible in the drainage tubing with 200 (ml) of urine present in the drainage bag. Resident #2 asked for the surveyor to get a staff member to come assist him.On 2/9/26 at 2:17 PM the Assistant Director of Nursing (ADON) was present on Resident #2's hallway and was notified by the surveyor Resident #2's request for assistance.An observation was completed of the ADON assessing Resident #2's indwelling urinary catheter on 2/9/26 at 2:20 PM. During the observation it was observed Resident #2 did not have a catheter tubing stabilization device in place.An interview was conducted with the ADON on 2/9/26 at 2:34 PM and the ADON confirmed Resident #2 did not have a device in place to stabilize his catheter tubing. She said Resident #2 should have had a catheter tubing stabilization device in place to keep it secured so it does not get pulled. She reported she was not sure why he did not have a catheter tubing stabilization device in place.An interview was conducted with Nurse Assistant (NA) #1 on 2/12/26 at 10:43 AM. She reported she was Resident #2's assigned NA on day shift (7:00 am to 3:00 pm) on 2/9/26. NA #1 stated she noticed Resident #2 did not have a catheter tubing stabilization device in place on Monday (2/9/26) morning when she put him back to bed. She was not sure about the time but said it was sometime before lunch. NA #1 reported she told Nurse #1. NA #1 indicated Resident #2 usually had a catheter tubing stabilization device in place and that he should have one in place to prevent his catheter tubing from being pulled. She stated NAs were not allowed to change or replace the catheter tubing stabilization device.An interview was conducted with Nurse #1 on 2/12/26 at 11:00 AM. She reported she was Resident #2's assigned nurse on 2/9/26 day shift. Nurse #1 reported NA #1 had reported to her Resident #1 did not have a catheter tubing stabilization device on Monday (2/9/26). Nurse #1 stated she had assessed Resident #2's catheter on Monday but could not recall the time. Nurse #1 stated she spoke to the Nurse practitioner (NP) about Resident #2's catheter and was waiting to apply a new catheter tubing stabilization device until after she spoke with the NP in case she needed to change his catheter. Nurse #1 reported when she returned to Resident #2's room after speaking with the NP the ADON was already in the process of changing Resident #2's catheter. An interview was conducted with the Nurse Practitioner (NP) on 2/11/26 at 12:29 PM. The NP said she thought it was protocol for Resident #2 to have a catheter tubing stabilization device. She stated he should have had one in place to prevent pulling of his urinary catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing and said it could cause trauma or pain if his catheter tubing was pulled or tugged.The Director of Nursing (DON) was not available for interview.An interview was conducted with the Administrator on 2/12/26 at 6:13 PM. The Administrator stated if there was something recommended to be used to prevent Resident #2's catheter tubing from being pulled, then he should have had it in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, Nurse Practitioner (NP), Physician, COVID test manufacturer customer service representative, and Health Department (HD) Nurse interviews, the facility failed to follow their infection control policy and procedures during a COVID outbreak. The facility's COVID outbreak began on [DATE] when a Resident (Resident #12) tested positive for COVID. The facility had a total of 25 residents and 12 staff members who tested positive from [DATE] to [DATE]. During the facility's ongoing COVID-19 outbreak, staff failed to wear all personal protection equipment (PPE) required according to Centers for Disease Control and Prevention (CDC) guidance when 1 of 1 Nurse Aide (NA) (NA #2) entered a resident room under transmission-based precautions (TBP) for COVID without wearing eye protection. Additionally, 1 of 1 Unit Manager (UM) (UM#1) failed to wear all PPE required according to CDC guidance while performing resident COVID testing. The facility also failed to restrict 9 of 9 staff members from returning to work after testing positive for COVID in accordance with current CDC guidance. Furthermore, while using a broad-based COVID testing method for staff, the facility failed to maintain logs and records of staff COVID testing results during an outbreak, to ensure the staff were tested in accordance with CDC guidance. Additionally, the facility failed to maintain TBP for Residents who tested positive for COVID in accordance with current CDC guidance. The facility also failed to follow the manufacturer expiration date that was listed on the COVID test packaging, when they used expired tests for resident and staff testing. As of [DATE] the facility had one resident who was COVID positive. The facility conducted additional resident facility wide COVID testing on [DATE] that did not yield any additional positive cases. Findings included:A. A facility policy entitled Coronavirus Disease (COVID)- Identification and management of ill residents. Dated [DATE]. read in part: Staff who enter the room of a resident with suspected or confirmed COVID infection will adhere to standard precautions and use a particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or face shield that covers the front and sides of the face). Resident #127's medical record documented she tested positive for COVID on [DATE]. On [DATE] at 8:37 AM an observation was conducted of NA #2 entering Resident #127's room. There was a TBP sign on the outside of the door that read, special droplet contact precautions and specified when entering the room a gown, gloves, N95 and eye protection needed to be worn. A PPE caddy was hanging outside of the door and contained N95 masks, surgical masks, gloves, and gowns. Eye protection was not observed on the PPE caddy. NA #2 put on a gown, gloves, and mask and then entered Resident #127's room to deliver her breakfast meal tray; NA #2 did not put on eye protection. At 8:40 AM NA #2 exited the room. She removed her gown, gloves, and mask at the room entrance door and placed the used PPE into the trash. She performed hand hygiene using hand sanitizer. An interview was conducted on [DATE] at 8:41 AM with NA #2 upon her exiting Resident #127's room. NA #2 reported she did not put on eye protection before entering the TBP room because she wore eyeglasses and thought her eyeglasses were considered eye protection. An interview was conducted with the infection prevention (IP) nurse on [DATE] at 3:30 PM. She stated staff were supposed to wear all required PPE when entering a COVID positive TBP room. She stated all required PPE included an N95 mask, gown, gloves, and eye protection. The IP stated she had educated staff on what PPE to wear in COVID positive rooms, and she was not sure why NA #2 did not know to wear the correct PPE or that eyeglasses were not considered eye protection. The IP stated the facility had a good PPE supply including face shields. She was not sure why eye protection was not available outside Resident #127 door. An interview was conducted with the facility Physician on [DATE] at 4:50 PM. The Physician stated using and wearing correct PPE was important in preventing the spread and transmission of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COVID. She reported when she visited the facility, they had PPE readily available. The Physician stated every resident room she visited during the COVID outbreak had PPE available and easily accessible. An interview was conducted with the Assistant Director of Nursing (ADON) on [DATE] at 4:56 PM. The ADON stated NA #2 should have worn eye protection when she entered Resident #127's room who was COVID positive. She said staff had been trained on what PPE to wear when entering a COVID positive room. She did not know why NA #2 did not wear the correct PPE or thought eyeglasses could be used for eye protection. The ADON said the TBP sign on the door was clear and said what PPE was supposed to be worn when entering the room and she was not sure why NA #2 did not follow it. She thought the facility needed to provide some additional education. The ADON stated the facility had a good PPE supply that included face shields. An interview was conducted with the Administrator and Regional Nurse on [DATE] at 6:13 PM The Administrator stated staff should wear all recommended PPE when entering a COVID positive room. The Regional Nurse was not sure why NA #2 did not wear the correct PPE. The Administrator stated he was not sure why NA #2 did not wear the correct PPE, but said staff needed more education. B. The CDC Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID Testing dated [DATE] included:-For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher- level respirator (or face mask if a respirator is not available), eye protection, gloves, and a gown.-For healthcare providers who are handling specimens but are not directly involved in collection (e.g. handling self-collected specimens) and not working within 6 feet of the patient, follow Isolation Precautions. The facility did not have a policy on collecting and handling clinical specimens for COVID and what PPE was to be worn. An observation was conducted of UM #1 and UM #2 performing resident COVID testing on [DATE] at 2:44 PM. UM #1 was wearing an N95 mask, she performed hand hygiene using hand sanitizer and put on a gown and gloves. UM #2 was also wearing an N95 mask, she performed hand hygiene and put on gloves. UM #2 remained in the hallway outside of room [ROOM NUMBER]. UM #1 entered room [ROOM NUMBER] and swabbed each of Resident #53's nares with a nasal swab, UM #1 did not wear eye protection. UM #1 handed the nasal swab sample to UM #2 outside of the room door and UM #2 performed the COVID test according to manufacturer instructions. UM #1 removed her gown and gloves and placed the used PPE into a trash bag. After completing the COVID test UM #1 removed her gloves, placed them into the trash, and performed hand hygiene. An interview was conducted with UM #1 upon her exiting room [ROOM NUMBER] on [DATE] at 2:48 PM. UM #1 was not sure if she was supposed to wear eye protection for COVID test sample collection. UM #1 left and went to ask someone. She returned a few minutes later with a stack of face shields. UM #1 stated she asked someone from corporate, she could not remember who she asked but stated they told her eye protection was supposed to be worn. An interview was conducted with the infection prevention (IP) nurse on [DATE] at 3:30 PM. She stated staff were supposed to wear all required PPE when performing COVID testing. She said all required PPE included an N95 mask, gown, gloves, and eye protection. The IP stated she was not sure why UM #1 had not known to wear eye protection. The IP reported she told UM #1 today prior to UM #1 going to do COVID testing that she had to wear full PPE. The IP stated she had not told UM #1 to wear eye protection specifically but thought UM #1 would know full PPE included eye protection. The IP stated the facility had a good PPE supply including face shields. The Director of Nursing (DON) was not available for interview. An interview was conducted with the Assistant Director of Nursing (ADON) on [DATE] at 4:56 PM. The ADON reported staff should wear full PPE when performing resident COVID testing. She explained full PPE was the same PPE that should be worn if entering a COVID positive room and included gown, gloves, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	N95, and eye protection. The ADON said UM #1 had not remembered what exactly needed to be worn for testing and thought the facility needed to provide some additional education. The ADON stated the facility had a good PPE supply that included face shields. An interview was conducted with the Administrator and Regional Nurse on [DATE] at 6:13 PM. The Administrator stated staff should wear all recommended PPE when performing COVID testing. The Regional Nurse stated staff should wear the same PPE for COVID testing as they would if they were going into a COVID positive room. She explained that staff should wear an N95, gown, gloves, and face shield. The Administrator was not sure why UM #1 did not wear the correct PPE but stated staff needed more education. He stated the facility's policy and procedures should align with the CDC guidance. C. A facility policy entitled Coronavirus Disease (COVID)- Testing staff dated [DATE] read in part,see CDC's Interim Guidance for Managing Health Care Personnel with COVID infection or exposure to COVID. The CDC guidance for Interim Guidance for Managing Healthcare Personnel (HCP) with COVID (SARS-CoV-2) Infection or Exposure to SARS-CoV-2 last updated [DATE], read in part:Return to Work Criteria for HCP with SARS-CoV-2 InfectionThe following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immuno-compromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:- At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and-At least 24 hours have passed since last fever without the use of fever-reducing medications, and-Symptoms (e.g., cough, shortness of breath) have improved.*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours laterHCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met:- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours laterHCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:-At least 10 days and up to 20 days have passed since symptoms first appeared, and-At least 24 hours have passed since last fever without the use of fever-reducing medications, and-Symptoms (e.g., cough, shortness of breath) have improved.-The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction. The facility's COVID positive staff log was reviewed with the IP during an interview on [DATE] at 3:59 PM. The COVID log revealed 12 staff members had tested positive for COVID since the facility's COVID outbreak began on [DATE]. The log documented the date staff symptoms began, COVID positive test date, and the resolution of symptoms date. The log did not document any additional COVID testing prior to staff returning to work. The IP stated the symptoms resolution date listed on the log was the date staff returned to work after COVID illness. The log indicated 9 staff members returned to work prior to 10 days after the start of COVID symptoms. The IP further stated staff were tested using an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antigen (rapid) COVID test 5 days after their symptoms began. She said if a staff member tested negative then they were allowed to return to work 7 days after the COVID symptoms began. The IP reported if a staff member tested positive on day 5 then they had to wait the full 10 days to return to work. The IP said she did not test staff on day 7 prior to the staff member returning to work. The IP reported she was not aware staff needed to be tested on day 7. She said she was not aware that if using the testing method to determine when staff returned to work that staff needed to have 2 negative COVID tests 48 hours apart, the first on day 5 and the second on day 7 before they returned to work after COVID illness. The IP did not have a record of any staff negative return to work COVID tests. She said she did not keep a log for when COVID testing was performed for staff returning to work or of negative COVID test results for staff. The IP said staff performed self-testing for COVID during the outbreak and were supposed to test at least weekly. She reported she placed COVID tests in the staff break room for them to self-test at the facility prior to work or to take home and test. The IP reported if staff had a positive COVID test, then they were supposed to let her know. The IP did not have a process for keeping up with when staff performed COVID testing. She could not say how she knew if all staff tested when they were supposed to or if they performed the testing according to manufacturer instructions. The COVID positive log revealed the following staff had tested positive for COVID: -Medical Records was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.-Housekeeper #1 was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated he returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.-NA #4 was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (6 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.- Central Supply was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.-NA #5 was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.-Housekeeper #2 was COVID positive on [DATE]. Her symptoms began on [DATE]. The IP indicated she he returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.-NA#6 was COVID positive on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work.- NA #7 was COVID positive on [DATE]. Her symptoms began on [DATE]. The IP indicated she returned to work on [DATE] (7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work. -Maintenance Director was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated he returned to work on [DATE](7 days after symptoms began). There was no documentation of a negative COVID test on days 5 and 7 prior to returning to work. The DON was not available for interview. An interview was conducted with the facility Physician on [DATE] at 4:50 PM. The Physician stated the facility should follow their infection control policy and procedure and that their policies should align with CDC guidance. The Physician stated if staff returned to work earlier than recommended it could aid in the transmission and spread of COVID. An interview was conducted with the Regional Nurse on [DATE] at 10:00 AM. The Regional Nurse stated the facility followed the CDC interim guidance (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for managing health care personnel with COVID infection for when staff could return to work. She reviewed the guidance and stated that staff could return to work after 7 days if they had a negative rapid COVID test on day 5 and that was what the facility had been doing. The Regional Nurse stated the facility did not test staff on day 7 and that she had not been aware of that part of the guidance. She reported the facility needed to have a more unified system for staff COVID testing. The Regional Nurse did not know how it could be confirmed if staff were testing correctly, waiting for the correct amount of time for results, or testing when they should. An interview was conducted with the Administrator on [DATE] at 6:13 PM. The Administrator stated he was not aware a second COVID test was needed on day 7 prior to staff returning to work after COVID illness. The Administrator said a COVID test was considered a lab and if a lab was done the results should be documented. The Administrator stated the IP should keep up with COVID test results and when testing was completed even if the results were negative. He reported there would be no way to know when staff had tested or if staff performed the COVID test correctly according to manufacture instructions because there was no oversight. The Administrator thought there should be oversight of staff COVID testing and that test results should be logged. D. A facility policy entitled Coronavirus Disease (COVID)- Identification and Management of Ill Residents dated [DATE] read in part: - Residents with mild to moderate Illness who are not moderately to severely immunocompromised will remain on transmission-based precautions until: at least 10 days have passed since symptoms first appeared and at least 24 hours have passed since last fever without the use of fever reducing medications and symptoms (e.g., cough, shortness of breath) have improved.-Residents who were asymptomatic throughout their infection and are not moderately to severely immunocompromised will remain on transmission-based precautions until: At least 10 days have passed since the date of their first positive viral test. -Residents with severe to critical illness and who are not moderately to severely immunocompromised will remain on transmission based precautions until: at least 10 days and up to 20 days have passed since symptoms first appeared; And at least 24 hours have passed since last fever without the use of fever reducing medications; And symptoms (e.g., cough, shortness of breath) have improved; And the test based strategy as described for moderately to severely immunocompromised residents below are used to inform the duration of isolation. -The criteria for the test based strategy are: residents who are symptomatic: resolution of fever without the use of fever reducing medications; And symptoms (e.g , cough, shortness of breath) have improved; And results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. Residents who are not symptomatic; results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. The facility's COVID positive resident logs were reviewed with the IP during an interview on [DATE] at 3:59 PM. The COVID positive resident logs revealed the facility's COVID outbreak started on [DATE] when Resident #127 tested positive for COVID. The log included the date symptoms began, symptoms, the date of COVID positive test, and the resolution of symptoms. The IP stated the symptoms resolution date listed on the log was the date TBP were removed for the resident. The COVID log indicated 15 residents were removed from TBP prior to 10 days. The IP further stated residents were tested using an antigen (rapid) COVID test 5 days after their symptoms began. She said if a resident tested negative on day 5 then the resident was removed from TBP after 7 days. The IP reported if a resident tested positive on day 5 then they remained on TBP for the full 10 days. The IP said she did not test residents on day 7 prior to removing them from TBP. The IP reported she had not been aware a second negative COVID test was needed on day 7 prior to removing the residents from TBP if using the testing method (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Lincolnton	515 S Generals Boulevard Lincolnton, NC 28093

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to discontinue TBP.The facility COVID positive log revealed the following residents had tested positive for COVID:-Resident #12 in room [ROOM NUMBER] was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began). -Resident #87 in room [ROOM NUMBER] was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (9 days after symptoms began). -Resident #102 in room [ROOM NUMBER] was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (9 days after symptoms began).-Resident #43 in room [ROOM NUMBER] was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began).-Resident #2 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began).-Resident #83 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. IP indicated TBP were removed on [DATE] (9 days after symptoms began).-Resident #59 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began).-Resident #28 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began).-Resident #8 in room [ROOM NUMBER] was positive for COVID on [DATE]. Her symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (8 days after symptoms began).-Resident #4 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #16 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #36 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #32 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #66 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #67 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began).-Resident #27 in room [ROOM NUMBER] was positive for COVID on [DATE]. His symptoms began on [DATE]. The IP indicated TBP were removed on [DATE] (7 days after symptoms began). The facility conducted additional facility wide COVID testing on [DATE] that did not yield any additional positive results.An interview was conducted with the facility Physician on [DATE] at 4:50 PM. The Physician stated the facility should follow its infection control policy and procedures and said the facility's policies should align with the CDC guidance. The Physician said if Residents were taken off TBP earlier than recommended that it could aid in the transmission and spread of COVID.An interview was conducted with the Administrator and Regional Nurse on [DATE] at 6:13 PM. The Regional Nurse said COVID positive residents should remain on TBP for the full 10 days and thought that was what the facility had been doing. The Regional Nurse thought the IP needed additional education on the process. The Administrator stated the facility should follow their infection control policies.A follow up interview was conducted with IP and Regional Nurse on [DATE] at 7:15 PM. The IP stated again that she removed residents from TBP after 7 days if they tested negative for COVID on day 5. She reported she did not test Residents again on day 7 because she had not been aware she needed to. The IP said if a resident was positive on day 5 then TBP were continued for the full 10 days. The IP explained the orders for TBP were entered into the electronic computer system for 10 days in case they needed it for 10 days but said she did not go back and discontinue the TBP orders in the electronic (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	computer system when she took them off at 7 days. The IP said she probably should have discontinued the order but didn't. E. An observation was conducted of the staff break room testing area on [DATE] at 1:30 PM. The break room had a wall shelf that contained 2 different manufacture boxes of COVID tests. The expiration date listed on the box of [brand name] COVID test #2 was [DATE] and the expiration date listed on the box of [brand name] COVID test #3 was [DATE]. An interview was conducted with the IP on [DATE] at 3:59 PM. The IP stated [brand name] COVID test #1, [brand name] COVID test #2, and [brand name] COVID test #3 were used for staff and resident COVID testing during the COVID outbreak from [DATE] to present. The [brand name] COVID test # 1 expiration date was [DATE]. The IP stated the COVID tests had been received by the facility during the pandemic and she was trying to use up the supply. The IP said she was aware the expiration date listed on the COVID test boxes indicated the tests were expired but said she thought the tests could be used for 6 months past the expiration date. An interview was conducted with [brand name] COVID tests #1 customer service on [DATE] at 11:21 AM. She checked the lot number for the COVID test and said the lot number did not have an extension date. She reported the expiration date of [DATE] on the box was the expiration date and the test should not be used after that date. She stated the test results would not be considered accurate, and they could not guarantee the test would work as it should. She explained the test could produce a false negative result. An interview was conducted with [brand name] COVID tests #2 customer service on [DATE] at 11:31 PM. She checked the lot number for test and said that the COVID test expired in August of 2025. She reported there was no extension for the test to be used beyond the expiration date listed on the box. She stated if the test was used after the expiration date listed on the box the test would not be considered accurate or a valid test because all the components in the teste were expired. She further stated the test would not produce accurate results and could give a false negative or false positive test result. An interview was conducted with [brand name] COVID tests #3 customer service on [DATE] at 11:35 AM. She checked the lot number for the COVID test and said the expiration date listed on the box of [DATE] was the expiration date and the test should not be used beyond that date. She reported if the test was used after the expiration date listed on the box the test results would not be considered valid and inaccurate. She stated negative or positive results would be considered invalid. An interview was conducted with the Health Department (HD) Nurse on [DATE] at 12:52 PM. She stated the HD could only provide guidance to the facility and typically did that via email. She reported the facility had reached out to the HD recently, she said in the last few days but did not say which day about if expired COVID tests could still be used. The HD stated they were still working on finding the guidance for the facility. An interview was conducted with the facility Physician on [DATE] at 4:50 PM. The Physician stated using expired COVID test could affect the efficacy of the test and that the test results may not be valid. She explained the protein in the test solution used in the COVID test kit binds to the virus to produce results. She further explained that the protein became denatured (breaks down) over time. She said if the protein was denatured it would not bind to the virus and react to produce a positive test. The Physician reported an expired test could give a false negative result. The Physician thought a positive test result on an expired test could be trusted but that a negative result could not be trusted. A follow up interview was conducted with the IP on [DATE] at 1:28 PM. The IP stated the facility conducted facility wide testing of all residents today ([DATE]) because the COVID tests previously used had been expired. The IP reported she discarded the expired COVID tests and the tests used for COVID testing today were within date. She stated no additional residents had tested positive for COVID. An interview was conducted with Assistant Director of Nursing (ADON) on [DATE] at 4:56 PM. The ADON said the facility had called (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the manufacture of the expired COVID test today. She reported that the manufacturer said the tests were out of date and the expiration date listed on the box was the expiration date of the test. The ADON stated the tests should not have been used. She reported the facility had re-tested all residents today ([DATE]) with an in-date COVID test and all the residents were negative. An interview was conducted with the Administrator and Regional Nurse on [DATE] at 6:13 PM. The Administrator stated he was not aware the facility had been using expired COVID tests. The Administrator said the COVID test manufacture expiration date should be checked and that the facility should not use expired tests. The Administrator reported previously expiration dates on COVID test were extended and he was not aware that it had changed. He was not sure if the expired tests would give a valid result. The Regional Nurse said the COVID test manufacture was called for one of the [brand name] COVID tests, she was not sure which one but said the manufacture had said the test results would not be valid.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff, and Regional Nurse Consultant interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization and failed to offer COVID-19 vaccines to 5 of 5 residents reviewed for COVID-19 immunizations (Resident #3, #16, #99, #117 and #127).The findings included:Resident #3 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact and was coded No for Covid-19 immunization being up to date.Review of Resident #3's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #3 or education had been provided to Resident #3 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted on 2/12/26 at 10:40 AM with Resident #3. He stated he does not remember the facility talking to him about the COVID-19 vaccine, offering the vaccine, or providing any education on the benefits and potential side effects of the COVID-19 vaccine and he didn't think he would want it.b. Resident #16 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact and was coded No for Covid-19 immunization being up to date.Review of Resident #16's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #16 or education had been provided to Resident #16 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted on 2/12/26 at 10:45 AM with Resident #16. He stated he does not remember the facility talking to him about the COVID-19 vaccine, offering the vaccine, or providing any education on the benefits and potential side effects of the COVID-19 vaccine but he would not want to take it even if they did.c. Resident #99 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #99 was cognitively intact and was coded No for Covid-19 immunization being up to date.Review of Resident #99's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #99 or education had been provided to Resident #99 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted on 2/12/26 at 10:56 AM with Resident #99. She reported she did not remember the facility talking to her about the COVID-19 vaccine, offering the vaccine, or providing any education on the benefits and potential side effects of the COVID-19 vaccine and she wasn't sure she would want to take it.d. Resident #117 was admitted to the facility on [DATE].The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #117 was cognitively intact and was coded No for Covid-19 immunization being up to date. Review of Resident #117's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #117 or education had been provided to Resident #117 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted on 2/12/26 at 11:04 AM with Resident #117. He reported he did not remember the facility talking to him about the COVID-19 vaccine, offering the vaccine, or providing any education on the benefits and potential side effects of the COVID-19 vaccine. Resident #117 reported he probably would take it if it were offered.e. Resident #127 was admitted to the facility on [DATE].The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #127 was cognitively intact and was coded No for Covid-19 immunization being up to date. Review of (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #127's medical record revealed no history of a Covid-19 vaccination. There was no documentation in the medical record that indicated the COVID-19 vaccine had been offered to Resident #127 or education had been provided to Resident #127 regarding the benefits and potential side effects of the COVID-19 vaccine.An interview was conducted on 2/12/26 at 11:10 AM with Resident #127. She stated that she did not remember the facility discussing or offering the COVID-19 or providing any education on the benefits and potential side effects of the COVID-19 vaccine with her since her admission to the facility. She reported she wasn't sure if she would take it if they offered it.An interview was conducted with the Infection Preventionist (IP) Nurse on 2/12/26 at 4:45 PM. She reported that the facility did offer the COVID-19 vaccination and she tried to make sure she offered it to all residents every year but she reported she did not keep any formal documentation of consent or declination of the vaccine, only the list she used with the Y and N beside their name indicating if they wanted the vaccine or not. The IP nurse indicated that the Admissions Coordinator was responsible for having any newly admitted residents sign consent forms for the flu and pneumonia vaccinations but not COVID-19. Once the paperwork was signed electronically it was uploaded into the resident's electronic medical record and either the nurse on the floor or the IP nurse reviewed the vaccination status. If it was the nurse on the floor, she writes a note and leaves it for the IP nurse, who then adds the resident to her list of people who need to be vaccinated. The IP nurse reported this process was only for the flu and pneumonia vaccine and she doesn't really have a process for the COVID-19 vaccination for new admissions. The IP nurse reported that if a Resident received the COVID-19 vaccination there should be an order from the Medical Doctor (MD) and it should be recorded in the medical record when it was given. She reported she was not sure if the COVID-19 vaccine was offered to new admissions. The IP indicated she did not offer risk versus benefits education of the vaccine but did offer side effects education of the vaccine to the resident or their responsible party. The Director of Nursing was not available for interview during survey.An interview was conducted with the Assistant Director of Nursing (ADON) on 2/12/25 at 5:00 PM. The ADON reported that she depended on the IP Nurse to offer, educate and vaccinate the residents who agreed to be vaccinated against COVID-19 annually.An interview was conducted with the Regional Nurse Consultant on 2/12/26 at 5:15 PM. The Regional Nurse Consultant reported that upon investigation of the vaccination procedure being used by the IP Nurse, it seems this process was not effective. The Regional Nurse Consultant reported that all residents who wished to have a vaccination should receive it. She reported that education on risk versus benefits should be offered to the resident or responsible party and they should be signing that they received this education and should be documented in the resident's medical record. She stated vaccinations should be offered on admission and annually.An interview was conducted with the Administrator on 2/12/26 at 5:30 PM. The Administrator stated he depended on the IP nurse to educate all residents or their responsible party on vaccinations that were offered in the facility and then to vaccinate all residents who wished to be vaccinated. The Administrator also stated he expected all consents and declinations as well as vaccinations given to be recorded in the Residents' medical record.