STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/25/25 - 03/27/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#3) including failing to take the resident to a follow-up visit with an orthopedic provider for hip pain; failing to notify the provider of the resident's non-compliance with oxygen administration; and failing to notify the provider the resident was not wearing compression stockings as ordered due to the compression stockings being unavailable. The findings are: Review of Resident #3's current FL-2 dated 07/24/24 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, heart disease, vascular disease, chronic obstructive pulmonary disease, anemia, and malignant neoplasm of unspecified bronchus (lung cancer). -The resident was ambulatory. -The resident required assistance with bathing, feeding, and dressing. Review of Resident #3's Resident Register	D 273	10A NCAC 13F.0902b The facility shall assure referal and follow-up to meet the routine and acute care needs of residents. 1. The facility shall ensure all future and ongoing appointments are meet according to the resident's needs. 2. Transportation Coordinator was in serviced on timeliness and proper notification of cancellation, rescheduled and/or refusals 3. ED, RCC, or designee will review all discharge summaries within 24 hours of admission or return to ensure all areas requiring clarification or follow-up are addressed. 4. A referral and follow-up tracker has been created and initiated to follow all future appointments. RCC or Designee will initiate the start of the tracker. RCC and Transportation Coordinator will track each appointment until the appointment is complete. ED will do weekly audit of appointment tracker to ensure all referral and follow-up has been initiated/completed.	3/28/2025 3/28/2025 3/28/2025 4/21/2025

Reviewed and Acknowledged - WW 05/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 1 revealed: -The resident was admitted to the facility on 07/24/24. -The resident required assistance for dressing, bathing, ambulation, hair/grooming, and scheduling appointments. -The resident's memory was documented as adequate. -The resident used a wheelchair. Review of Resident #3's current assessment and care plan dated 08/08/24 revealed: -The resident was documented as being ambulatory with the use of a wheelchair. -The resident limited range of motion and limited strength in her upper extremities. -The resident had shortness of breath and used oxygen. -The resident was documented as being oriented and having adequate memory. -The resident used eyeglasses and had limited vision. -The resident required supervision by staff with eating, toileting, and transferring. -The resident required limited assistance by staff with ambulation and grooming. -The resident required extensive assistance by staff with bathing and dressing. a. Review of Resident #3's podiatry visit note dated 11/12/24 revealed: -The resident was being seen for routine podiatry care. -The resident had diabetic neuropathy (nerve pain) and lower extremity edema (swelling in lower legs). -The resident complained of lower leg edema; onset unknown. -The resident had bilateral edema from midfoot to calf.	D 273	Continued 5. Medication Aide will notify RCC of any and all refusals, non-compliance, or change of condition in all residents. RCC will notify provider of any and all changes, refusals, non-compliance.	5/6/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 2 -The resident reported the swelling was better in the morning and worse by the end of the day. -The resident reported the swelling made her legs feel tight and sometimes achy. -The resident was taking a diuretic (used to decrease fluid build-up and swelling). -There was an order for open-toed compression stockings, staff to apply in the morning and remove at night before bed. (Compression stockings are used to improve blood flow and reduce pain and swelling in the legs.) Review of Resident #3's hospital emergency room (ER) after visit summary dated 12/19/24 revealed: -The resident was seen for lower extremity issue. -The resident was diagnosed with cellulitis (skin infection) of the foot. Review of Resident #3's ER provider notes dated 12/22/24 revealed: -The resident was seen for shortness of breath and right-sided abdominal pain. -The resident was diagnosed with right lower lobe pneumonia and pedal (foot) edema. Review of Resident #3's hospital ER after visit summary dated 12/24/24 revealed: -The resident also continued to have cellulitis of the left foot. -The resident was prescribed a new antibiotic for infection. Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry to apply compression stockings every morning and remove at night. -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 3 -Compression stockings were documented as unavailable on 16 occasions including: 01/02/25, 01/06/25, 01/09/25 - 01/11/25, 01/14/25 - 01/16/25, 01/18/25 - 01/21/25, 01/23/25 - 01/25/25, and 01/28/25. -Compression stockings were documented as being refused on 01/29/25. -Compression stockings were documented as not being applied on 01/07/25 due to the resident being unavailable. -Compression stockings were documented as being "on" for 3 days including 01/12/25, 01/26/25, and 01/30/25. -Compressions stockings were documented as being "off" on all other occasions. Review of Resident #3's February 2025 eMAR revealed: -There was an entry to apply compression stockings every morning and remove at night. -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm. -Compression stockings were documented as unavailable on 14 occasions including: 02/02/25, 02/03/25, 02/05/25 - 02/08/25, 02/12/25, 02/13/25, 02/15/25, 02/16/25, 02/20/25 - 02/22/25, and 02/26/25. -Compression stockings were documented as being refused on 02/19/25 and 02/27/25. -Compression stockings were documented as not being applied on 02/17/25 due to the resident being unavailable. -Compression stockings were documented as being "on" for 2 days including 02/09/25 and 02/17/25. -Compressions stockings were documented as being "off" on all other occasions. Review of Resident #3's March 2025 eMAR dated 03/01/25 - 03/25/25 revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 4 -There was an entry to apply compression stockings every morning and remove at night. -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm. -Compression stockings were documented as unavailable on 13 occasions including: 03/01/25, 03/03/25, 03/05/25, 03/07/25, 03/08/25, 03/11/25 - 03/13/25, 03/15/25 - 03/17/25, 03/22/25, and 03/25/25. -Compression stockings were documented as being refused on 03/02/25. -Compression stockings were documented as not being applied on 3/18/25 due to the resident being unavailable. Observation of Resident #3 on 03/26/25 at 3:00pm revealed: -The top of the resident's left foot was slightly swollen. -The top of the resident's right foot was swollen more than the left foot. -The resident's left ankle was swollen. -The resident was not wearing compression stockings. Interview with Resident #3 on 03/26/25 at 3:00pm revealed: -She was supposed to have compression stockings, but the facility never got any for her. -She did not know why she never got any compression stockings to wear. -She usually had a little swelling in her feet. -Her right foot and ankle were always swollen more than the left foot. Interview with a medication aide (MA) on 03/26/25 at 3:00pm revealed: -She did not remember Resident #3 ever having any compression stockings. -A couple of months ago, the resident's legs were	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 5	D 273		

red, purple, and painful.
-She had no explanation for why compression stockings were sometimes documented as being applied on the eMARs when the resident had no compression stockings available to wear.
-She did not recall if she reported the resident not having compression stockings available to wear.

Interviews with the Resident Care Coordinator (RCC) on 03/26/25 at 4:17pm and 03/27/25 at 9:25am revealed:
-He just started as the RCC in February 2025.
-He just received a list of residents who needed compression stockings from a third shift MA that morning, 03/26/25.
-Resident #3 was included on that list.
-He was not aware until today, 03/26/25, that Resident #3 did not have any compression stockings.
-The MAs should have notified him sooner that the resident did not have any compression stockings.
-He would be responsible for notifying the provider that the resident was not wearing compression stockings as ordered due to the stockings being unavailable.

Interview with the Administrator on 03/26/25 at 4:17pm revealed:
-She was not aware Resident #3 did not have any compression stockings until today, 03/26/25.
-A third shift MA provided a list of residents who needed compression stockings today, 03/26/25.
-The MAs should have notified the RCC or her soon about Resident #3's compression stockings being unavailable.

Interview with the facility's contracted podiatry provider on 03/27/25 at 12:58pm revealed:
-She was not aware the facility did not get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 6	D 273		

compression stockings for Resident #3 when she ordered them in November 2024.
-The facility staff had not notified her that the resident was not wearing compression stockings as ordered.
-The resident had a chronic problem with swelling in her lower extremities.
-She ordered compression stockings to help maintain and prevent swelling in the resident's legs from getting worse.
-She had not observed the resident's legs since November 2024 because the resident had refused podiatry visits in January 2025 and today, 03/27/25.
-The facility should have notified her about the resident not having compression stocking to wear as ordered.

b. Review of Resident #3's current FL-2 dated 07/24/24 revealed an order for oxygen apply 2 liters via nasal cannula continuously. (Oxygen therapy is a treatment that delivers extra oxygen to the lungs for those with breathing problems.)

Review of Resident #3's hospital discharge summary dated 03/21/25 revealed:
-The resident was admitted to the hospital on 03/18/25 with shortness of breath due to pneumonia and respiratory failure.
-The resident was diagnosed with sepsis (serious condition in which the body responds improperly to an infection) due to pneumonia.
-New pulmonary nodules were identified on scans of the lungs.
-The resident was to continue oxygen at 2 liters per minute (LPM) upon discharge on 03/21/25.

Observation of Resident #3 on 03/25/25 at 9:56am revealed:
-The resident was lying in bed wearing oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7	D 273		

tubing.
-The resident's oxygen concentrator was set on 2.5 LPM.

Interview with Resident #3 on 03/25/25 at 9:56am revealed:
-She just returned to the facility from the hospital last Thursday (03/20/25).
-She was in the hospital for pneumonia and sepsis, and they found more lesions in her lungs, so she thought her lung cancer was back.
-She thought her oxygen was increased to 3 LPM while she was in the hospital.
-She felt like 3 LPM of oxygen was too much so she adjusted the setting on her oxygen concentrator to 2.5 LPM.
-She thought 2.5 LPM of oxygen would be better for her, especially if she was up and walking around.

Review of Resident #3's March 2025 electronic medication administration record (eMAR) dated 03/01/25 - 03/25/25 revealed:
-There was an entry for oxygen 2 LPM via nasal cannula continuously.
-The scheduled times for documentation of Oxygen was "day shift", "evening shift", and "night shift".
-Oxygen use at 2 LPM was documented for all 3 shifts from 03/01/25 - 03/25/25 (day shift) except for 03/19/25 (day shift) - 03/21/25 (day shift).
-There was no documentation to indicate the resident was non-compliant with the correct setting for the oxygen administration.

Observation of Resident #3 on 03/26/25 at 3:00pm revealed:
-The resident was sitting on the side of the bed wearing oxygen tubing.
-The resident's oxygen concentrator was set on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 8 2.5 LPM. Interview with a medication aide (MA) on 03/26/25 at 3:00pm revealed: -When she initialed the eMAR for Resident #3's oxygen administration, she was checking to see if the resident was wearing the oxygen. -She did not usually check the setting on the oxygen concentrator to make sure it matched the amount instructed on the eMAR. -She had not noticed the resident's oxygen concentrator was set on 2.5 LPM instead of 2 LPM as ordered. Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 1:05pm revealed: -When the MAs documented oxygen administration on eMARs, the MAs were supposed to make sure the oxygen was being used and was set on the amount ordered by the provider. -If the oxygen was not on the correct setting, the MAs were supposed to adjust it to the correct setting as ordered. -The MAs should document the non-compliance on the eMARs and report it to him. -The MAs should notify him of any non-compliance with the oxygen administration. -He would be responsible for notifying the resident's primary care provider (PCP) of the non-compliance. Interview with the Administrator on 03/26/25 at 4:17pm revealed: -She was not aware Resident #3 was non-compliant and used the wrong amount of oxygen. -The MAs should report any non-compliance to the RCC or her. -The RCC would then report the non-compliance	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9 to the PCP. Interview with Resident #3's PCP on 03/27/25 at 9:45am revealed: -No one at the facility had notified her that Resident #3's oxygen was on 2.5 LPM instead of 2 LPM as ordered. -If she had known about the oxygen being on the wrong setting, she would have documented it and educated the resident and staff. -The resident's oxygen level was usually around 97% on 2 LPM of oxygen. c. Review of Resident #3's orthopedic provider visit note dated 01/02/25 revealed: -The resident was seen for left hip AVN (avascular necrosis). (Avascular necrosis is death of bone tissue due to lack of blood supply.) -Treatments were discussed with the resident. -The resident was to follow-up in 3 to 4 weeks for left hip pain. -There was an appointment scheduled for 01/30/25 at 1:50pm for a visit with imaging. Review of Resident #3's provider visit notes and facility progress notes revealed no documentation the resident was seen by the orthopedic provider for a follow-up visit on 01/30/25. Review of Resident #3's facility progress note dated 03/12/25 at 9:24pm revealed the resident said her hips were bothering her when she tried to walk. Interview with Resident #3 on 03/27/25 at 12:35pm revealed: -She saw an orthopedic provider for her hip a while back (could not recall when). -The orthopedic provider wanted her to go to a clinic for pain management for her hip pain.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10 -She did not recall having a follow-up appointment with the orthopedic provider for her hip pain. Interviews with the facility's Transporter on 03/27/25 at 10:09am and 1:37pm revealed: -She did not recall Resident #3 having a follow-up appointment with an orthopedic provider. -She did not see any appointments on the calendar for Resident #3 to see an orthopedic provider. Interviews with the Resident Care Coordinator (RCC) on 03/27/25 at 9:25am and 1:05pm revealed: -He just started as the RCC in February 2025. -He was not aware Resident #3 had missed a follow-up appointment with an orthopedic provider in January 2025. -The facility's Transporter was responsible for setting up any follow-up appointments and taking the residents to their appointments. -If an appointment for a resident had to be cancelled, the Transporter was responsible for calling to cancel and reschedule the appointment. -There was currently no system to check behind the Transporter to make sure residents were taken to their appointments. Interview with the Administrator on 03/27/25 at 2:13pm revealed: -Referrals and follow-up appointments were usually put in the Transporter's box to set up the appointments. -The RCC was responsible for following up with the Transporter to ensure referrals and follow-ups were being done. -There was no process to check behind the RCC. Telephone interview with a patient representative	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11 at Resident #3's orthopedic provider's office on 03/27/25 at 10:47am revealed: -Resident #3 had an appointment on 01/30/25 but was a "no show, no call". -The resident did not show up for the appointment and no one called to cancel or reschedule the appointment. -Their office left a message at the facility for the RCC on 01/30/25 at 12:58pm to reschedule the appointment for 01/30/25 at 9:50am. -They did not hear back from the facility and the resident was again a "no call, no show" on 01/31/25. -They called the facility again on 01/31/25 at 11:29am and left voicemail for the RCC. -They had not heard back from the facility and the appointment had not been rescheduled. Telephone interview with a medical assistant at Resident #3's orthopedic provider's office on 03/27/25 at 3:58pm revealed: -The resident was seen by the orthopedic provider on 01/07/25 and received an injection in her knee. -The resident was also seen by the orthopedic provider on 01/02/25 related to avascular necrosis (a condition where bone tissue dies due to a loss of blood supply) of the hip. -The appointment for 01/30/25 was for x-rays of the resident's hips. -She spoke with the orthopedic provider today, 03/27/25, and he did not have major concerns about the missed appointment since the resident had been referred to a pain clinic.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 12 following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation and implementation for 1 of 5 sampled residents (#3) related to not ordering and having compression stockings available for a resident to wear as ordered for leg swelling. The findings are: Review of Resident #3's current FL-2 dated 07/24/24 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, heart disease, vascular disease, chronic obstructive pulmonary disease, anemia, and malignant neoplasm of unspecified bronchus (lung cancer). -The resident was ambulatory. -The resident required assistance with bathing, feeding, and dressing. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on 07/24/24. -The resident required assistance for dressing, bathing, ambulation, hair/grooming, and scheduling appointments. -The resident's memory was documented as adequate. -The resident used a wheelchair.	D 276	10 A NCAC 13F.0902c Health Care The facility shall assure documentation of the following in the residents record. Written procedures, treatments or orders from a physician or other licensed health professional; and implementation of procedures, treatments, or order specified in Subparagraph (c)(3) of this rule. 1. The facility shall insure all orders are implemented in a timely manner. 2. Med Techs were in serviced on Compression Stocking application, The 6 Medication rights, and Medication not on cart. 3. A medication tracker has been implemented to track all orders. RCC or Designee will review all new orders and initiate the medication tracker. Orders will be faxed to pharmacy then placed on the EMAR t reflect on the MAR. RCC or Designee will track new order to ensure implementation and proper notification if medication is not available. 4. ED will review new order tracker twice weekly to ensure orders are placed on residents EMAR, medication is in facility, new orders have been implemented, if medication is not proper notification is in place	3/28/2025 3/26/2025 4/21/2025 4/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 13 Review of Resident #3's current assessment and care plan dated 08/08/24 revealed: -The resident was documented as being ambulatory with the use of a wheelchair. -The resident limited range of motion and limited strength in her upper extremities. -The resident had shortness of breath and used oxygen. -The resident was documented as being oriented and having adequate memory. -The resident used eyeglasses and had limited vision. -The resident required supervision by staff with eating, toileting, and transferring. -The resident required limited assistance by staff with ambulation and grooming. -The resident required extensive assistance by staff with bathing and dressing. Review of Resident #3's podiatry visit note dated 11/12/24 revealed: -The resident was being seen for routine podiatry care. -The resident had diabetic neuropathy (nerve pain) and lower extremity edema (swelling in lower legs). -The resident complained of lower leg edema; onset unknown. -The resident had bilateral edema from midfoot to calf. -The resident reported the swelling was better in the morning and worse by the end of the day. -The resident reported the swelling made her legs feel tight and sometimes achy. -The resident was taking a diuretic (used to decrease fluid build-up and swelling). -There was an order for open-toed compression stockings, staff to apply in the morning and remove at night before bed. (Compression stockings are used to improve blood flow and	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 14	D 276		

reduce pain and swelling in the legs.)

Review of Resident #3's hospital emergency room (ER) after visit summary dated 12/19/24 revealed:
-The resident was seen for lower extremity issue.
-The resident was diagnosed with cellulitis (skin infection) of the foot.

Review of Resident #3's ER provider notes dated 12/22/24 revealed:
-The resident was seen for shortness of breath and right-sided abdominal pain.
-The resident was diagnosed with right lower lobe pneumonia and pedal (foot) edema.

Review of Resident #3's hospital ER after visit summary dated 12/24/24 revealed:
-The resident was diagnosed with a fracture of the little toe on the right foot.
-The resident also continued to have cellulitis of the left foot.
-The resident was prescribed a new antibiotic for infection.

Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to apply compression stockings every morning and remove at night.
-Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm.
-Compression stockings were documented as unavailable on 16 occasions including: 01/02/25, 01/06/25, 01/09/25 - 01/11/25, 01/14/25 - 01/16/25, 01/18/25 - 01/21/25, 01/23/25 - 01/25/25, and 01/28/25.
-Compression stockings were documented as being refused on 01/29/25.
-Compression stockings were documented as not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 15	D 276		

being applied on 01/07/25 due to the resident being unavailable.
-Compression stockings were documented as being "on" for 3 days including 01/12/25, 01/26/25, and 01/30/25.
-Compressions stockings were documented as being "off" on all other occasions.

Review of Resident #3's February 2025 eMAR revealed:
-There was an entry to apply compression stockings every morning and remove at night.
-Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm.
-Compression stockings were documented as unavailable on 14 occasions including: 02/02/25, 02/03/25, 02/05/25 - 02/08/25, 02/12/25, 02/13/25, 02/15/25, 02/16/25, 02/20/25 - 02/22/25, and 02/26/25.
-Compression stockings were documented as being refused on 02/19/25 and 02/27/25.
-Compression stockings were documented as not being applied on 02/17/25 due to the resident being unavailable.
-Compression stockings were documented as being "on" for 2 days including 02/09/25 and 02/17/25.
-Compressions stockings were documented as being "off" on all other occasions.

Review of Resident #3's March 2025 eMAR dated 03/01/25 - 03/25/25 revealed:
-There was an entry to apply compression stockings every morning and remove at night.
-Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm.
-Compression stockings were documented as unavailable on 13 occasions including: 03/01/25, 03/03/25, 03/05/25, 03/07/25, 03/08/25, 03/11/25 - 03/13/25, 03/15/25 - 03/17/25, 03/22/25, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 16 03/25/25. -Compression stockings were documented as being refused on 03/02/25. -Compression stockings were documented as not being applied on 3/18/25 due to the resident being unavailable. Observation of Resident #3 on 03/26/25 at 3:00pm revealed: -The top of the resident's left foot was slightly swollen. -The top of the resident's right foot was swollen more than the left foot. -The resident's left ankle was swollen. -The resident was not wearing compression stockings. Interview with Resident #3 on 03/26/25 at 3:00pm revealed: -She was supposed to have compression stockings, but the facility never got any for her. -She did not know why she never got any compression stockings to wear. -She usually had a little swelling in her feet. -Her right foot and ankle were always swollen more than the left foot. Interview with a medication aide (MA) on 03/26/25 at 3:00pm revealed: -She did not remember Resident #3 ever having any compression stockings. -A couple of months ago, the resident's legs were red, purple, and painful. -She had no explanation for why compression stockings were sometimes documented as being applied on the eMARs when the resident had no compression stockings available to wear. Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 4:17pm revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 17 -He just started as the RCC in February 2025. -The former RCC would have been responsible for making sure Resident #3's order dated 11/15/24 for compression stockings was sent to the pharmacy. -The former RCC was responsible for measuring the resident's legs and getting those measurements to the pharmacy so the compression stockings could be ordered. -He just received a list of residents who needed compression stockings from a third shift MA that morning, 03/26/25. -Resident #3 was included on that list. -He was not aware until today, 03/26/25, that Resident #3 did not have any compression stockings. -He tried to check the eMARs for accuracy monthly for all residents. -He did not notice the discrepancies with the documentation for Resident #3's compression stockings when he reviewed the eMARs. Interview with the Administrator on 03/26/25 at 4:17pm revealed: -She was not aware Resident #3 did not have any compression stockings until today, 03/26/25. -A third shift MA provided a list of residents who needed compression stockings today, 03/26/25. -The RCC was responsible for monitoring the eMARs once a month. -There was no process to check behind the RCC. Interview with the facility's contracted podiatry provider on 03/27/25 at 12:58pm revealed: -She was not aware the facility did not get compression stockings for Resident #3 when she ordered them in November 2024. -The facility staff had not notified her that the resident was not wearing compression stockings as ordered.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 18 -The resident had a chronic problem with swelling in her lower extremities. -She ordered compression stockings to help maintain and prevent swelling in the resident's legs from getting worse. -She had not observed the resident's legs since November 2024 because the resident had refused podiatry visits in January 2025 and today, 03/27/25. Interview with Resident #3's primary care provider (PCP) on 03/27/25 at 9:45am revealed: -The resident had ongoing leg swelling that caused worsening pain and making it difficult to walk. -The resident had redness and pitting edema in her legs at times. -The resident had a history of cellulitis and wounds related to swelling in her legs and peripheral vascular disease. -The resident should be wearing compression stockings for 12 hours on and then 12 hours off. -The compression stockings would keep the fluid from pooling (build-up of excess fluid). -If the resident had worn compression stockings as ordered in November 2024, it may have improved and decreased the swelling in her legs.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30	D 280	10A NCAC 13F.0903 (C) Licensed Health Professional Support The facility shall assure that by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents health status, care plan and care provided, as required in Paragraph (a) of this rule, is completed within the first 3o days of admission or within	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 19 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 1 of 5 sampled residents (#3) with LHPS tasks included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for applying and removing compression stockings, oxygen administration and monitoring, and inhalation medication by machine. The findings are: Review of Resident #3's current FL-2 dated 07/24/24 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, heart disease, vascular disease, chronic obstructive pulmonary disease, anemia, and malignant neoplasm of unspecified bronchus (lung cancer).	D 280	Continued 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following 1. performing a physical assessment of the resident as related to the residents diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this rule 2. evaluating the residents progress to care being provided; 3. recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and 4. documenting the activities in Subparagraphs (1) through (3) of this Paragraph 1. It is the facilities responsibility to assure all LHPS are completed accurately 2. RCC or Designee will accompany LHPS nurse while they do physical assessment. RCC and or designee will co-sign LHPS to verify physical assessment was completed.	3/28/2025 4/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 20 -The resident was ambulatory. -The resident required assistance with bathing, feeding, and dressing. -There was an order for oxygen, apply 2 liters via nasal cannula continuously. (Oxygen therapy is a treatment that delivers extra oxygen to the lungs for those with breathing problems.) -There was an order for Albuterol solution 0.63mg/3ml use 1 vial via nebulizer every 6 hours as needed for shortness of breath and wheezing. (Albuterol nebulizer solution is used to treat breathing problems associated with chronic obstructive pulmonary disease.) Review of Resident #3's podiatry visit note dated 11/12/24 revealed: -The resident was being seen for routine podiatry care. -The resident had diabetic neuropathy (nerve pain) and lower extremity edema (swelling in lower legs). -The resident complained of lower leg edema; onset unknown. -The resident had bilateral edema from midfoot to calf. -The resident reported the swelling was better in the morning and worse by the end of the day. -The resident reported the swelling made her legs feel tight and sometimes achy. -The resident was taking a diuretic (used to decrease fluid build-up and swelling). -There was an order for open-toed compression stockings, staff to apply in the morning and remove at night before bed. (Compression stockings are used to improve blood flow and reduce pain and swelling in the legs.) Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on	D 280	Continued 3. ED will verify physical assessment was completed at the end of each LHPS visit. 4.RCC will complete an audit on all LHPS to ensure physical assessment has been completed.	4/24/2025 5/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 21	D 280		

07/24/24.
-The resident required assistance for dressing, bathing, ambulation, hair/grooming, and scheduling appointments.
-The resident's memory was documented as adequate.
-The resident used a wheelchair.

Review of Resident #3's current assessment and care plan dated 08/08/24 revealed:
-The resident was documented as being ambulatory with the use of a wheelchair.
-The resident limited range of motion and limited strength in her upper extremities.
-The resident had shortness of breath and used oxygen.
-The resident was documented as being oriented and having adequate memory.
-The resident used eyeglasses and had limited vision.
-The resident required supervision by staff with eating, toileting, and transferring.
-The resident required limited assistance by staff with ambulation and grooming.
-The resident required extensive assistance by staff with bathing and dressing.

Observation of Resident #3 on 03/25/25 at 9:56am revealed:
-The resident was lying in bed wearing oxygen tubing.
-The resident's oxygen concentrator was set on 2.5 liters per minute (LPM).

Interview with Resident #3 on 03/25/25 at 9:56am revealed:
-She just returned to the facility from the hospital last Thursday (03/20/25).
-She was in the hospital for pneumonia and sepsis (serious condition in which the body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 22	D 280		

responds improperly to an infection) and they found more lesions in her lungs, so she thought her lung cancer was back.
-She thought her oxygen was increased to 3 LPM while she was in the hospital.
-She felt like 3 LPM of oxygen was too much so she thought 2.5 LPM of oxygen would be better for her.

Second observation of Resident #3 on 03/26/25 at 3:00pm revealed:
-The top of the resident's left foot was slightly swollen.
-The top of the resident's right foot was swollen more than the left foot.
-The resident's left ankle was swollen.
-The resident was not wearing compression stockings.

Second interview with Resident #3 on 03/26/25 at 3:00pm revealed:
-She was supposed to have compression stockings, but the facility never got any for her.
-She did not know why she never got any compression stockings to wear.
-She usually had a little swelling in her feet.
-Her right foot and ankle were always swollen more than the left foot.

Review of Resident #3's current licensed health professional support (LHPS) review dated 02/21/25 revealed:
-The nurse documented the resident's LHPS tasks were applying and removing TED hose (compression stockings), inhalation medication by machine, and oxygen administration and monitoring.
-The nurse documented the resident was in her room.
-The resident used a walker to ambulate and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 23	D 280		

could transfer on her own.
-The resident had orders for oxygen 2 liters continuously.
-The resident had orders for nebulizer 4 times a day.
-The resident had an order for compression stockings.
-The resident needed supervision for activities of daily living.
-The nurse documented no concerns were noted.
-The nurse recommended to continue to plan of care.
-There was no physical assessment related to any of the resident's LHPS tasks.
-There was no physical assessment related to the resident's medication for inhalation or oxygen administration including no documentation of the resident's lung sounds or noting if the resident was having any shortness of breath, coughing, or wheezing.
-There was no documentation to indicate if the resident was receiving 2 liters of oxygen continuously as ordered at the correct setting or if the resident was wearing the oxygen.
-There was no physical assessment of the resident's legs to indicate if there was any swelling or to indicate if the resident was wearing the compression stockings as ordered.

Telephone interview with the facility's contracted LHPS nurse on 03/27/25 at 3:27pm revealed:
-She usually reviewed residents' electronic medication administration records (eMARs) to identify LHPS tasks when she did the quarterly reviews.
-She usually went to a resident's room and did an assessment of a resident depending on the LHPS tasks.
-If there was an order for compression stockings, she usually looked at a resident's feet for swelling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 24	D 280		

or wounds.
-If there was an order for oxygen, she usually listened to lung sounds and checked oxygen saturation levels.
-If she observed the oxygen on the wrong setting, she would report it to staff but not document it.
-If there was an order for nebulizer treatments, she usually listened to lung sounds.
-If there was an order for fingerstick blood sugars and insulin, she checked to make sure they were rotating sites.
-If a diabetic resident saw podiatry, the podiatry notes should be in the resident's record with documentation of the condition of their feet.
-She tried to observe residents walk throughout the day while she was in the facility.
-She did not always get an opportunity to observe resident's transferring.
-If there was an order for a urinary catheter, she usually checked the urine.
-If there was a pressure wound, she would check to see it was still listed on the eMAR and looked at home health notes about the wound.
-She did not usually take dressings off to observe a wound.
-She usually only documented the physical assessment if there was a concern and she would discuss it with facility staff.
-She did not recall any concerns with Resident #3's LHPS tasks during the February 2025 review.
-She was not aware Resident #3 was not wearing compression stockings and none were available for the resident to wear.
-She was not aware Resident #3 was not using oxygen at 2 LPM as ordered.

Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 1:05pm revealed:
-The LHPS nurse usually gave the LHPS reviews

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 25 to him. -He was responsible for making sure the LHPS reviews were done quarterly, and any recommendations were followed up. -The LHPS nurse usually reviewed the residents' records for the LHPS reviews. -He thought the LHPS nurse did physical assessments of the residents, but he was not sure. -The LHPS nurse usually discussed any concerns or changes in tasks with him. -He had not noticed Resident #3's LHPS review was incomplete and did not include a physical assessment of her LHPS tasks. Interview with the Administrator on 03/27/25 at 2:13pm revealed: -The RCC was responsible for the LHPS reviews and making sure the reviews were complete. -There was no process to check behind the RCC.	D 280		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367	10 A NCAC 13F.1004(J) Medication Administration (j) the residents medication administration record (MAR) shall be accurate and include the following 1. residents name 2. name of medication or treatment orders; 3.strength and dosage or quantity of medication administered. 4. instructions for administering the medication or treatment; 5. reasons or justification for the administration of medications or treatment as needed (PRN) and documenting the results effect on the residents;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 26 medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 5 sampled residents (#3, #5) for medications used to treat and prevent acid reflux (#5) and documentation for the use of oxygen (#3), and the application and removal of compression stockings (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 07/24/24 revealed diagnoses included type 2 diabetes mellitus, hypertension, heart disease, vascular disease, chronic obstructive pulmonary disease, anemia, and malignant neoplasm of unspecified bronchus (lung cancer). a. Review of Resident #3's podiatry visit note dated 11/12/24 revealed: -The resident was being seen for routine podiatry care. -The resident had diabetic neuropathy (nerve pain) and lower extremity edema (swelling in lower legs). -The resident complained of lower leg edema; onset unknown. -The resident had bilateral edema from midfoot to	D 367	continued 6. date and time of administration; 7. documenting of any omission of medications or treatments and the reason for the omission, including refusals; and 8. name or treatment of the person administering the medication treatment , if initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR) 1. It is the facilities responsibility to assure accurate medication administration 2. Med Techs were in serviced on Compression stocking application, the 5 medication rights, and medication not on cart 3. A medication tracker has been implemented to track all orders. RCC or designee will receive all new orders and initiate the medication tracker. Orders will be faxed to the pharmacy the placed on the EMAR. RCC or designee will track new order to insure implementation and proper notification if medication is not available.	3/28/2025 3/28/2025 4/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 27 calf. -The resident reported the swelling was better in the morning and worse by the end of the day. -The resident reported the swelling made her legs feel tight and sometimes achy. -The resident was taking a diuretic (used to decrease fluid build-up and swelling). -There was an order for open-toed compression stockings, staff to apply in the morning and remove at night before bed. (Compression stockings are used to improve blood flow and reduce pain and swelling in the legs.) Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry to apply compression stockings every morning and remove at night. -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm. -Compression stockings were documented as unavailable on 16 occasions including: 01/02/25, 01/06/25, 01/09/25 - 01/11/25, 01/14/25 - 01/16/25, 01/18/25 - 01/21/25, 01/23/25 - 01/25/25, and 01/28/25. -Compression stockings were documented as being refused on 01/29/25. -Compression stockings were documented as not being applied on 01/07/25 due to the resident being unavailable. -Compression stockings were documented as being "on" for 3 days including 01/12/25, 01/26/25, and 01/30/25. -Compressions stockings were documented as being "off" on all other occasions. Review of Resident #3's February 2025 eMAR revealed: -There was an entry to apply compression stockings every morning and remove at night.	D 367	Continued 4. ED will review new order tracker twice weekly to insure orders are placed on residents MAR, and is in the facility and all new orders have been implemented, if medication is not proper notification is in place. 5. RCC or Designee will run facility report on new orders and D/C orders, that will be compared to the MAR and cart for MAR accuracy and pharmacy delivery daily for 2 weeks, then weekly thereafter. 6. RCC will in service all Med Techs on O2 compliance, O2 monitoring, Compression stocking compliance and any other non-compliant concern. RCC will in service on proper notification of any refusal, or non-compliant concern	4/21/2025 4/21/2025 5/7/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 28 -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm. -Compression stockings were documented as unavailable on 14 occasions including: 02/02/25, 02/03/25, 02/05/25 - 02/08/25, 02/12/25, 02/13/25, 02/15/25, 02/16/25, 02/20/25 - 02/22/25, and 02/26/25. -Compression stockings were documented as being refused on 02/19/25 and 02/27/25. -Compression stockings were documented as not being applied on 02/17/25 due to the resident being unavailable. -Compression stockings were documented as being "on" for 2 days including 02/09/25 and 02/17/25. -Compressions stockings were documented as being "off" on all other occasions. Review of Resident #3's March 2025 eMAR dated 03/01/25 - 03/25/25 revealed: -There was an entry to apply compression stockings every morning and remove at night. -Compression stockings were scheduled to be applied at 6:00am and removed at 8:00pm. -Compression stockings were documented as unavailable on 13 occasions including: 03/01/25, 03/03/25, 03/05/25, 03/07/25, 03/08/25, 03/11/25 - 03/13/25, 03/15/25 - 03/17/25, 03/22/25, and 03/25/25. -Compression stockings were documented as being refused on 03/02/25. -Compression stockings were documented as not being applied on 3/18/25 due to the resident being unavailable. Observation of Resident #3 on 03/26/25 at 3:00pm revealed: -The top of the resident's left foot was slightly swollen. -The top of the resident's right foot was swollen	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 29	D 367		

more than the left foot.
-The resident's left ankle was swollen.
-The resident was not wearing compression stockings.

Interview with Resident #3 on 03/26/25 at 3:00pm revealed:
-She was supposed to have compression stockings, but the facility never got any for her.
-She did not know why she never got any compression stockings to wear.
-She usually had a little swelling in her feet.
-Her right foot and ankle were always swollen more than the left foot.

Interview with a medication aide (MA) on 03/26/25 at 3:00pm revealed:
-She did not remember Resident #3 ever having any compression stockings.
-A couple of months ago, the resident's legs were red, purple, and painful.
-She had no explanation for why compression stockings were sometimes documented as being applied on the eMARs when the resident had no compression stockings available to wear.

Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 4:17pm revealed:
-He just started as the RCC in February 2025.
-He was not aware until today, 03/26/25, that Resident #3 did not have any compression stockings.
-The MAs should not document Resident #3 was wearing compression stockings on the eMARs when there were no compression stockings available in the facility for the resident to wear.
-The MAs should not document Resident #3 refused to wear compression stockings on the eMARs when there were no compression stockings available in the facility for the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 30	D 367		

to wear.
-He tried to check the eMARs for accuracy monthly for all residents.
-He did not notice the discrepancies with the documentation for Resident #3's compression stockings on the eMARs.

Refer to interview with the Administrator on 03/27/25 at 2:13pm.

b. Review of Resident #3's current FL-2 dated 07/24/24 revealed an order for oxygen apply 2 liters via nasal cannula continuously. (Oxygen therapy is a treatment that delivers extra oxygen to the lungs for those with breathing problems.)

Review of Resident #3's hospital discharge summary dated 03/21/25 revealed:
-The resident was admitted to the hospital on 03/18/25 with shortness of breath due to pneumonia and respiratory failure.
-The resident was diagnosed with sepsis (serious condition in which the body responds improperly to an infection) due to pneumonia.
-New pulmonary nodules were identified on scans of the lungs.
-The resident was to continue oxygen at 2 liters per minute (LPM) upon discharge on 03/21/25.

Observation of Resident #3 on 03/25/25 at 9:56am revealed:
-The resident was lying in bed wearing oxygen tubing.
-The resident's oxygen concentrator was set on 2.5 LPM.

Interview with Resident #3 on 03/25/25 at 9:56am revealed:
-She just returned to the facility from the hospital last Thursday (03/20/25).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 31 -She was in the hospital for pneumonia and sepsis, and they found more lesions in her lungs, so she thought her lung cancer was back. -She thought her oxygen was increased to 3 LPM while she was in the hospital. -She felt like 3 LPM of oxygen was too much so she adjusted the setting on her oxygen concentrator to 2.5 LPM. -She thought 2.5 LPM of oxygen would be better for her, especially if she was up and walking around. Review of Resident #3's March 2025 electronic medication administration record (eMAR) dated 03/01/25 - 03/25/25 revealed: -There was an entry for oxygen 2 LPM via nasal cannula continuously. -The scheduled times for documentation of Oxygen was "day shift", "evening shift", and "night shift". -Oxygen use at 2 LPM was documented for all 3 shifts from 03/01/25 - 03/25/25 (day shift) except for 03/19/25 (day shift) - 03/21/25 (day shift). -There was no documentation to indicate the resident's oxygen was set on 2.5 LPM on any occasion in March 2025. -There was no documentation to indicate the resident was non-compliant with the correct setting for the oxygen administration. Observation of Resident #3 on 03/26/25 at 3:00pm revealed: -The resident was sitting on the side of the bed wearing oxygen tubing. -The resident's oxygen concentrator was set on 2.5 LPM. Interview with a medication aide (MA) on 03/26/25 at 3:00pm revealed: -When she initialed the eMAR for Resident #3's	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 32	D 367		

oxygen administration, she was checking to see if the resident was wearing the oxygen.
-She did not usually check the setting on the oxygen concentrator to make sure it matched the amount instructed on the eMAR.
-She had not noticed the resident's oxygen concentrator was set on 2.5 LPM instead of 2 LPM as ordered.

Interview with the Resident Care Coordinator (RCC) on 03/27/25 at 1:05pm revealed:
-When the MAs documented oxygen administration on eMARs, the MAs were supposed to make sure the oxygen was being used and was set on the amount ordered by the provider.
-If the oxygen was not on the correct setting, the MAs were supposed to adjust it to the correct setting as ordered.
-The MAs should document the non-compliance on the eMARs and report it to him.
-He tried to check the eMARs for accuracy monthly for all residents.

Refer to interview with the Administrator on 03/27/25 at 2:13pm.

2. Review of Resident #5's current FL-2 dated 10/28/24 revealed diagnoses included type 2 diabetes, asthma, dysphasia, anxiety, and insomnia.

Review of Resident #5's physician's orders dated 03/21/25 revealed there was an order for Pantoprazole (Protonix) 40mg tablet, 1 tablet daily before breakfast. (Pantoprazole is used to treat and prevent acid reflux.)

Review Resident #5's March 2025 electronic medication administration records (eMAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 33 revealed: -There was an entry for Pantoprazole 40mg tablet, 1 tablet daily before breakfast scheduled for 7:00am and 8:00pm daily. -There was documentation Pantoprazole 40mg tablet was administered at 7:00am from 03/22/25 to 03/26/25. Interview with a medication aide (MA) on 03/27/25 at 8:53am revealed she documented the Pantoprazole 40mg tablet was administered because she thought it was the medication in the purple and white bottle. Observation of Resident #5's medications on hand on 03/26/25 at 3:29pm revealed: -There was no Pantoprazole 40mg tablet in the medication cart. -The medication in a purple and white bottle was Nexium. (Nexium is used to treat and prevent acid reflux. Nexium and Pantoprazole are not the same medication.) Interview with a medication aide (MA) on 03/27/25 at 8:53am revealed she documented the Pantoprazole 40mg tablet was administered because she thought it was the medication in the purple and white bottle. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/26/25 at 3:43pm revealed: -They received the order for Pantoprazole 40mg tablet but Resident #5 had an active order for Nexium. -The Pantoprazole and Nexium were duplicate orders therefore, the pharmacy would not dispense the Pantoprazole. -She called the provider to get the order clarified but had not heard back from the provider's office.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043027	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEAF CARE CENTER	2041 NC 210 NORTH LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 34 Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 3:49pm revealed: -He placed the Pantoprazole 40mg tablet in the eMAR system. -The MAs should have checked the order three times and notified him the medication was not in the facility. -He would have called the provider to inform them there was a duplicate order for Resident #5. Interview with the Administrator on 03/26/25 at 4:06pm revealed: -The MAs should have completed the medication omission report provided by the facility if the Pantoprazole for Resident #5 was not in the facility. -They should have given the medication omission report to the RCC. -The RCC would have investigated and called the provider and/ or pharmacy to determine why the Pantoprazole was not available. - She expected the MAs to check the eMAR and the medication to ensure accuracy. Refer to interview with the Administrator on 03/27/25 at 2:13pm. Interview with the Administrator on 03/27/25 at 2:13pm revealed: -The RCC was responsible for monitoring the eMARs once a month. -There was no process to check behind the RCC.	D 367		