STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING ______ B. WING ______	C 10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE** **GREENSBORO, NC 27455**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, family interview and staff interview the facility failed to provide the assistance of two-person staff when providing incontinence care which resulted in a fall with minor injury for 1 of 3 residents reviewed for falls (Resident #1). Findings included: Resident #1 was admitted to the facility on 2-16-17 with multiple diagnoses which included atrial fibrillation, muscle weakness, hemiplegia affecting the left side, dysphagia. A review of the quarterly Minimum Data Set (MDS) dated 7-27-18 revealed Resident #1 was moderately cognitively impaired and needed extensive assistance with 2 people for bed mobility, transfers, dressing, toileting and personal hygiene. The care plan dated 8-3-18 revealed a goal that Resident #1 would not have any significant injury from a fall. The interventions for that goal were as followed; therapy screen as needed, fall assessment, place items within reach, place call light within reach, anticipate and meet resident	F 689	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. F689 Free from Accidents and Hazards/Supervision/Devices ROOT CAUSE The alleged noncompliance resulted from CNA # 1 failed on 9/8/2018 to provide Resident #1 supervision of 2 people while providing incontinent care in bed and failed to follow the residents care plan and care guide. CNA # 1 stated she was not informed that the resident was a 2 person assist with incontinent care in bed and properly educated on the process for determining the resident□s level of assistance status in the smart charting	10/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/23/2018

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.

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F 689	Continued From page 1 needs and extensive assistance with 2 staff members for incontinence care and toileting. During an interview with Resident #1's family on 10-8-18 at 9:20 am she stated Resident #1 fell out of the bed during incontinence care because there was only one nursing assistant and when she rolled the resident on his side he fell out of the bed. Resident #1 was interviewed on 10-8-18 at 9:30 am. The resident was noted to not be able to answer questions regarding his fall in September. He was noted to be combining information from a fall he had several months ago with information from his recent fall in September. Resident #1 did state his left arm and shoulder were hurting but would state it was from his fall several months ago not his recent fall. He also denied any back pain and was observed moving his left arm slightly without any complaints or signs/symptoms of pain. During an interview with the nursing assistant (NA) #1 on 10-8-18 at 1:20 pm she stated she was the nursing assistant that provided care to Resident #1 on 9-12-18. She stated she was a restorative aide and had not worked the hall but was asked by the nurse to help on hall 500 by providing incontinence care to Resident #1. NA #1 stated she was not informed that Resident #1 was a 2 person assist during care and since she did not work on the halls she was not aware on how to access the kiosk (a portable computer system with the needs of the residents) system to see what assistance was needed. She also stated she had not asked because she felt if the resident had special care she would have been informed. She stated she was providing	F 689	Kiosk. IMMEDIATE ACTION Resident # 1 was assessed by nursing staff on 9/8/2018 and identified a small laceration above his eye. Resident # 1s responsible party and medical provider were notified and the resident was sent the Emergency Department for further evaluation. The resident returned to the facility after evaluation and all tests were negative for injury. On 9/8/2018 CNA # 1 was reeducated regarding the level of assistance status of resident # 1 and the use of the resident care guide in the smart charting kiosk to determine this level of assistance. IDENTIFICATION OF OTHERS Starting 10/19/2018 - 10/22/2018 the Director of Nursing Services, Staff Development Coordinator and Unit Coordinators observed 100% of all resident with a incontinence assistance level of 2 persons or greater and all residents were transferred according to their care plan and care guide. SYSTEMIC CHANGES Effective 10/18/2018 10/22/2018 the Director of Nursing Services and or Staff Development Coordinator will complete 100% education for all nursing staff. This education will include utilizing the care plans and resident care guide in the smart charting kiosk to ensure proper level of assistance for each resident. This education will be completed by 10/22/2018. Any nursing staff not educated prior to 10/22/2018 will not be allowed to work until educated. Effective 10/22/2018 all new nursing	

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F 689	Continued From page 2 incontinence care and Resident #1 was on his left side when he started "reaching for something" and when he did he rolled off the bed. NA #1 stated she checked the resident and pushed the call light for help. She denied that Resident #1 ever lost consciousness and stated he spoke with her until help arrived. She also denied the resident ever complained of pain during that time but that he did have a "small" cut above his eye. A review of the incident report from 9-12-18 revealed the nursing assistant was performing incontinence care on Resident #1 by herself and the resident reached for something and rolled out of the bed. The report also revealed the resident was sent to the emergency room and had a computed tomography (CT) scan completed of his head with no issues found and returned to the facility. An interview with the Director of Nursing occurred on 10-8-18 at 6:05 pm who stated he would be surprised if the nursing assistant did not receive training on their computer system or how to locate information in the kiosk. He stated that information was part of their basic training during orientation. He stated he expected any nursing assistant asked to help on a unit would receive report about the residents and be able to access the kiosk system. During an interview with the nurse #2 for Resident #1 on 10-9-18 at 10:33 am she stated she was the agency nurse on 9-12-18 caring for Resident #1. She stated she responded to the nursing assistant needing help and assessed the resident and obtained vital signs. The nurse stated after the assessment and the vital signs were within normal limits she assisted the resident into his	F 689	employees as part of their orientation process will receive in-servicing on the utilization of care plans and care guides to determine a resident□s level of assistance. MONITORING PROCESS Effective 10/23/2018 The Director of Nursing, Staff Development Coordinator and Unit Coordinators will monitor compliance by a random observation of 10 resident incontinence care daily to ensure the resident is receiving the level of assistance required, Monday □ Friday for 2 weeks, then weekly for 2 weeks, then monthly for 3 months or until a pattern of compliance is maintained. Any negative finding identified will be addressed promptly. This audit will be reviewed and documented in clinical stand up meeting. Effective 10/23/2018, the Director of Nursing Services will report the finding to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance. RESPONSIBLE PARTY Effective 10/23/2018 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	

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F 689	Continued From page 3 chair. She stated Resident #1 complained of his head hurting but denied pain anywhere else and that the cut above his eye was the size of a rice grain and was not actively bleeding. Nurse #2 stated she contacted the doctor and the resident representative and received orders to send him to the emergency room for further evaluation. She denied the residents speech was slurred or that he ever lost consciousness "no he was sitting up in his chair watching TV till the ambulance came to take him to the emergency room." The nurse stated she did not inform the nursing assistant the resident was a 2 person assist because she was unaware the nursing assistant did not know.	F 689		