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 08/04/2022

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
E 000	Initial Comments An unannounced recertification survey was conducted on 08/01/2022 through 08/04/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6BFR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/1/22 through 8/4/22. Event ID# 6BFR11 45 of the 79 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00185342, NC00184946, NC00190703, NC00187140, NC00188716, NC00191593, NC00187685, NC00187796, NC00188340, NC00189914, NC00187695, NC00188348, NC00188422, NC00189340, NC00190993, NC00190930, NC00191237, NC00189739 and NC00191507.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		9/1/22

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

Electronically Signed 08/22/2022

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 08/04/2022

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews, the facility failed to provide privacy to a resident receiving a COVID test in the dining room for 1 of 5 residents reviewed for dignity (Resident #2). Additionally, the facility failed to provide a privacy cover over a urinary catheter drainage bag for 1 of 1 resident reviewed for urinary catheter (Resident #24). The findings included:	F 550	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The staff development coordinator was educated by the Director of Nursing on 8/5/22 on F550 and its content, with emphasis on ensuring that residents are provided privacy when administering	

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 08/04/2022

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 550	Continued From page 2 1. Resident #2 was admitted to the facility on 2/8/22 with diagnoses to include atrial fibrillation and diabetes mellitus. An observation on 8/2/22 at 5:50 PM revealed Resident #2 entered the dining room from the courtyard and was met by the Staff Development Coordinator (SDC) who provided COVID tests to the residents. The SDC proceeded to conduct a COVID test for Resident #2 by swabbing her nostrils in the dining room where other residents were seated as they waited on the dinner trays. After the test was collected, Resident #2 was observed as she left the dining room and walked to her room where her dinner waited. The SDC was not heard to ask Resident #2 to go to her room to conduct a COVID test. On 8/2/22 at 5:53 PM, Resident #2 was interviewed. She stated she "did not like that" when asked how she felt when she received the COVID test in the dining room in front of other residents. Resident #2 added, "that was unprofessional". On 8/3/22 at 10:20 AM, the SDC was interviewed. She stated the COVID tests should be conducted in the resident rooms. She added sometimes residents don't want to go back to their rooms so they collect the COVID tests where they can. She stated she conducted Resident #2's COVID test in the dining room because she was just coming back in from the courtyard. 2. Resident #24 was admitted to the facility on 2/9/22 with diagnoses that included, in part, obstructive uropathy.	F 550	COVID testing. A privacy bag for the catheter was provided to resident #24 on 8/4/22 by his attending certified nursing assistant. All nursing staff was educated by the director of Nursing on 8/4/22 on F550 and its content with emphasis on the importance of ensuring that all catheters are covered with privacy bags to maintain resident dignity. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An observation audit of current residents with catheters was conducted and completed by the Central supply person on 8/4/22, to ensure that all were covered appropriately with privacy bags. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A list of any residents who possess catheters has been placed in a binder at each nursing station for the staff to indicate who has one, and to check to ensure that it is covered by a privacy bag. All covid testing of residents will be conducted in a private setting within the facility by trained staff, to ensure adequate privacy and maintaining of dignity while testing.	

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 08/04/2022

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 550	Continued From page 3 The quarterly Minimum Data Set assessment dated 5/10/22 revealed Resident #24 had moderately impaired cognition and an indwelling urinary catheter. The care plan, updated 6/21/22, included the use of a urinary catheter with an intervention to complete catheter care every shift. On 8/1/22 at 10:35 AM, an observation of Resident #24 revealed he was asleep in bed in his room. The door to the resident's room was opened to the hallway. The resident's urinary catheter drainage bag was uncovered, contained reddish brown colored urine, hung on the side of the bed and was visible from the hallway. Additional observations on 8/2/22 at 1:34 PM, 8/3/22 at 11:44 AM and 8/4/22 at 9:27 AM, revealed Resident #24 was asleep in bed in his room. The door to the resident's room was opened to the hallway. Resident #24's urinary catheter drainage bag was uncovered, contained reddish brown colored urine, hung on the side of the bed and was visible from the hallway. An interview was completed with Nurse Aide (NA) #4 on 8/4/22 at 9:30 AM. She explained she emptied Resident #24's catheter drainage bag in the morning and when she made rounds during the day. She said a privacy cover was supposed to be placed over the drainage bag and located the privacy cover on the couch in Resident #24's room. NA #4 stated she did not know why the bag was uncovered and immediately placed the privacy cover over the catheter drainage bag. On 8/4/22 at 9:55 AM, a telephone interview was	F 550	Staff development Coordinator educated Licensed Nurses, medication aides and certified nursing assistants on F550 and its content with emphasis on ensuring that all residents who possess catheters have them covered with a privacy bag. Additionally, all medication aides and licensed nurses were educated by the Staff Development Coordinator on the importance of ensuring that all residents are tested in a setting where no other resident can observe the test being administered. Education for these areas began on 8/15/22 and was completed on 8/22/22. Newly Hired staff will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled until completion. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: A member of the department manager team (includes social workers, dietary manager, maintenance director, central supply person, medical records, admissions, Scheduler, Human resources, Activities Director, and Admissions, will observe COVID testing for 5 residents weekly X4 and monthly thereafter to ensure that staff is providing privacy when administering COVID tests. Findings will be documented on COVID Testing Observation Tool. Additionally, a member of the department manager's team will observe residents with catheters to ensure they are	

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 08/04/2022

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 550	Continued From page 4 completed with Resident #24's family member. He stated in an ideal situation he thought the drainage bag would be covered to promote Resident #24's dignity. He added when Resident #24 was more alert and cognitively intact prior to his illness, he would not have wanted people to walk by his room and observe a urinary drainage bag uncovered. During an interview with the DON on 8/4/22 at 11:14 AM, she shared all catheter drainage bags should be kept in privacy bags and stated either she or the SDC educated staff on the importance of covering urinary catheter drainage bags.	F 550	equipped with appropriately placed privacy bag, daily X14, weekly X3 and monthly thereafter to ensure dignity is maintained in accordance with F550 and its content. Findings will be documented on the Catheter Observation Tool. The Director of Nursing and/or designee will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, the facility failed to assess the ability of a resident to self-administer medications left on a walker seat for 1 of 2 residents reviewed for self-administration of medications (Resident #64). The findings included: Resident #64 was admitted to the facility on 9/11/19 with diagnoses to include pulmonary embolism. A quarterly Minimum Data Set assessment dated 6/25/22 revealed Resident #64 had intact	F 554	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Medication was removed for Resident#64 room by Director of Nursing on 8/2/22. A self-administration medication assessment was conducted for resident #64 on 8/6/22 by MDS Nurse.. It was determined that she is not able to self-administer her own medications. Medication Aide #1 was educated on	9/1/22

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 08/04/2022

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 554	Continued From page 5 cognition. A review of the care plan included a focus area of short-term memory impairment, difficulty with recall, requires cues and reminders. The care plan did not include a focus area for medication self-administration. A review of the August physician's orders did not include an order for Resident #64 to self-administer her medications. Medications ordered during the hours of 12:00 PM to 2:00 PM were Xarelto 10 milligrams and Neurontin 300 milligrams. A record review did not reveal an assessment for self-administration of medications. On 8/2/22 at 1:20 PM, Resident #64 was sitting in the dining room with her rolling walker in front of her. The walker included a chair seat and on it was a plastic 30 milliliter medicine cup with a small amount of applesauce and two pills. On 8/2/22 at 1:21 PM, Resident #64 stated the plastic cup on her walker seat were her medications and she liked to eat a couple of bites of her lunch before she took them. On 8/2/22 at 1:25 PM, an interview was conducted with Medication Aide #1. She stated she knew she was supposed to stay with residents when she administered their medications and if Resident #64 needed to take her medications with food, she should have waited until the lunch trays were delivered to administer her medications. On 8/4/22 at 4:20 PM, an interview was	F 554	8/6/22 by the Director of Nursing (DON) on F554 and its content with emphasis on the importance of ensuring that residents without an order to self-administer their own medications, be supervised throughout the medication administration process. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/15/2022, a 100% audit of current residents was conducted by MDS nurse to determine which residents were deemed clinically appropriate to self-administer medication. No other residents were found to be clinically appropriate to self administer medications. 3)Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents who have been deemed clinically appropriate to self-administer their own medications will be indicated on resident's individual medication administration record (MAR). All licensed nurses and medication aides were educated by the staff development coordinator (SDC) on 8/16/22, on this new process, as well as on F554 and its content with emphasis on the importance of ensuring that residents without an order to self-administer their own medications,	

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 08/04/2022

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 554	Continued From page 6 conducted with the Director of Nursing. She stated medications were not to be left at the bedside unless the resident had a self-administration assessment completed.	F 554	be supervised throughout the medication administration process. Education was completed on 8/22/22. Newly hired Licensed Nurses and Medication Aides will receive this training during orientation. Anyone that does not receive this training prior to 8/22/22 will not be scheduled until completion. 4)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Director of nursing or designee will observe the medication administration process for 10 residents weekly X4. Monthly X3 and quarterly thereafter to ensure continued compliance with F554. Findings will be documented on the Medication Observation Audit tool. The Director of Nursing or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F554.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		9/1/22

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 08/04/2022

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 561	Continued From page 7 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to honor residents' choice to receive showers (Resident #19 and Resident #85) and to have hair washed (Resident #85) for 2 of 10 residents reviewed for choices. The findings included: 1. Resident #19 was admitted to the facility on 9/23/21 with diagnoses which included hypertension and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated 5/3/22 revealed Resident #19 had intact cognition. She did not have any care	F 561	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/4/22, both NA#7 and NA #2 were educated by the Staff Development coordinator (SDC) on F561 and its content with emphasis on residents right to choose activities and schedules consistent with his or her interests which includes showers On 8/4/22, Resident #85 and Resident #19 were both given showers by certified	

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 08/04/2022

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 561	Continued From page 8	F 561		

refusals documented on the assessment and required extensive assistance with bathing.

A review of the care plan updated on 5/15/22 revealed a focus area of requires assistance with activities of daily living related to impaired mobility. Interventions included assist with activities of daily living as needed.

On 8/1/22 at 10:31 AM, Resident #19 was interviewed. She stated she was supposed to get her showers on Monday and Thursday, but she had not been getting them because there wasn't enough help.

On 8/2/22 at 10:15 AM, Resident #19 stated she did not receive a shower on Monday, 8/1/22.

On 8/3/22 at 11:20 AM, Resident #19 was observed in her bed wearing a blue camouflage shirt.

A continuous observation on 8/4/22 at 2:40 PM to 8/4/22 at 3:20 revealed NA #7 was not on the floor to ask why Resident #19 did not receive her shower.

On 8/4/22 at 3:20 PM, Resident #19 was still wearing the same shirt and stated she did not receive a shower that day.

On 8/4/22 at 4:20 PM, the Director of Nursing was interviewed and stated NA #7 was also assigned to work the 3-11 shift on 8/4/22 so may have been on a break. She stated Resident #19 should have received a shower.

An attempt to interview NA #7 was unsuccessful.
2. Resident #85 admitted to the facility on

nursing assistant.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 8/16/22, 100% of the current resident population was interviewed by a member of the department manager team (includes; Social worker, MDS Nurse, Activity□s Director, Medical Records, Activity□s Director, Admissions, Maintenance Director, Business office manager, Scheduler, Director of Nursing, Staff Development Coordinator, and Dietary Manager) to determine whether they felt they received showers according to their desired schedules. (Resident□s not cognitively intact, BIMS <8, interview was conducted with their responsible party.) Interviews were completed on 8/20/22.

3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Shower Sheet binders have been placed at each nurses station. In addition to placing the sheet to indicate whether the resident received a shower, an additional copy will be given to the director of nursing for review.

All certified nursing assistants (cnas) were educated by Staff Development coordinator on 8/16/22 on F561 and its content with emphasis on resident's right

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 08/04/2022

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 561	Continued From page 9 7/5/2022 with diagnoses of left femur fracture. Resident #85's baseline Care Plan dated 7/5/2022 stated she required the assistance of one staff member for bathing and there were no care plans found for Resident #85 refusing showers or assistance with care. An Admission Minimum Data Set (MDS) assessment dated 7/11/2022 indicated Resident #85 was cognitively intact and she required extensive assistance for bathing. The MDS assessment further indicated Resident #85 had not had any behaviors and had not rejected care. A review of Resident #85's Shower Sheets revealed there was not a shower documented for 7/15/2022, 7/22/2022 and 7/26/2022 on the 3:00 pm to 11:00 pm shift. On 8/1/2022 at 11:32 am an interview was conducted with Resident #85, and she stated she does not receive showers two times a week as scheduled, and she has not refused to take a shower. Resident #85 stated she would like to have two showers a week. Resident #85 stated staff would assist her with a bed bath but she preferred a shower on the two days a week she was scheduled to have a shower. An observation of Resident #85 was conducted on 8/3/2022 at 9:44 am and she was up in her chair in her room. Resident #85 stated she got a shower yesterday, 8/2/2022, on the 3:00 pm to 11:00 pm shift. Resident #85 stated she had asked during her shower if Nurse Aide #2 could wash her hair, but Nurse Aide #2 told her she would have to wait until she had her shower on Friday to have her hair washed. Resident #85	F 561	to choose activities and schedules consistent with his or her interests which includes showers and the importance of documenting refusals as they occur. Education was completed on 8/20/22. Newly Hired cnas will be educated during orientation. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing(DON) or Designee will conduct shower audits at random of 5 residents weekly X4, monthly X3, and quarterly thereafter to ensure adequate compliance with F561. Findings will be documented on Shower Audit tool. The DON and/or Administrative Nurses will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance with F561.	

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 08/04/2022

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 561	Continued From page 10	F 561		

stated she wanted her hair washed.

During an interview with Nurse Aide #2 on 8/3/2022 at 2:58 pm she stated she had showered Resident #85 on the 3:00 pm to 11:00 pm shift on 8/2/2022. Nurse Aide #2 stated Resident #85 had her hearing aides in when she got her to the shower on 8/2/2022 and she had not washed her hair because she did not want to get them wet. Nurse Aide #2 stated she had washed Resident #85's hair on Friday, 7/29/2022. Nurse Aide #2 stated she did not remove Resident #85's hearing aids and wash her hair because Resident #85 told her she was getting cold. Nurse Aide #2 stated she did not remember giving Resident #85's shower to her when she worked on 7/22/2022 but she did remember giving her a bed bath one time because Resident #85 did not feel like getting a shower.

An interview was conducted with the Director of Nursing (DON) on 8/4/2022 at 1:10 pm and she stated she felt Resident #85 had refused her showers on 7/15/2022, 7/22/2022, and 7/26/2022. The DON stated the Nurse Aide should document on a Shower Sheet when a resident refused a shower and then give it to the Nurse. The Nurse should speak with the resident that refused a shower regarding the refusal and then document the refusal on the Shower Sheet. The DON stated they were not able to find a Shower Sheet for 7/15/2022, 7/22/2022, and 7/26/202.

The Administrator was interviewed on 8/4/2022 and stated he was not aware of any issues with Resident #85 not receiving showers when she was scheduled or when she requested a shower. The Administrator stated the DON had been collecting the completed Shower Sheets to

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 08/04/2022

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 561	Continued From page 11 ensure the residents were receiving their showers and it was documented if the resident refused. The Administrator stated he did not know why there was not a Shower Sheet for 7/15/2022, 7/22/2022, and 7/26/2022 for Resident #85.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to post the most recent survey results and ensure the survey results were	F 577	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient	9/1/22

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 08/04/2022

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 577	Continued From page 12 easily accessible to residents in wheelchairs. Findings included: The Aspen Central Office database system revealed the most recent survey at the facility was a complaint investigation survey completed on 6/28/22. During the survey period of 8/1/22 through 8/4/22 observations were made of the facility's survey results located in a notebook on top of the high countertop (approximately 3 feet from the floor) in the facility's reception area. The most recent survey results in the notebook was completed on 6/24/21. In an interview on 8/5/22 at 5:00 p.m., the Administrator revealed only the annual surveys were placed in the survey notebook for viewing by the residents and visitors. He indicated he was unaware the facility was required to post the most recent survey results from any survey including complaint investigation and focused infection control surveys.	F 577	practice: Regional Director of Operations educated facility administrator on F577 and its content with emphasis on the importance of ensuring that residents have the right to most recent survey results upon request, and that it is available to residents in wheelchairs. On 8/16/22, the facility survey binder was updated to include the most recent survey and was lowered to a position accessible to residents in wheelchairs. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No residents were affected by the deficient practice 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/16/22, the facility survey binder was updated to include the most recent survey and was lowered to a position accessible to residents in wheelchairs. Regional Director of Operation educated facility administrator on 8/17/22 on F577 and its content with emphasis on the importance of ensuring that residents have the right to most recent survey results upon request and that it is available to residents in wheelchairs.	

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 08/04/2022

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 577	Continued From page 13	F 577	4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will audit the facility survey binder after every future survey to ensure that it includes the most recent survey findings, and that it remains accessible to residents in wheelchairs. Findings will be documented on Survey Binder Audit tool. The Administrator will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		9/1/22

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 08/04/2022

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 578	Continued From page 14 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately document code status in the electronic health record (EHR) and paper record for 2 of 2 residents (Resident #8 and Resident #58) reviewed for advance directives. Findings included: 1. Resident #8 was re-admitted to the facility on 7/8/22 with diagnoses that included, in part, hypertension, pneumonia and diabetes. The comprehensive Minimum Data Set assessment dated 7/21/22 revealed Resident #8 had severely impaired cognition.	F 578	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The code statuses for both residents #58 and number #8 were not indicated on resident electronic health record (EHR), and did not reflect matching code statuses in both the (EHR), and code status binder located at the nursing station. The code statuses for both resident #58 and resident #8 were both updated in their electronic health record on 8/4/22.	

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 08/04/2022

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 578	Continued From page 15 The physician orders were reviewed in the EHR and an order entered into the computer by the Director of Nursing (DON) on 7/8/22 stated, "Code status: Full Code." Further review of the EHR, on the profile page, indicated Resident #8's code status was Do Not Resuscitate (DNR). On 8/1/22 at 11:57 AM, an observation was made of the code status binder located at the nurse's desk. The binder contained DNR paperwork for Resident #8. During an interview with Medication Aide (MA) #2 on 8/4/22 at 11:05 AM, she explained code status information was located on the computer in the resident's EHR. Resident #8's health record was reviewed with MA#2 and she was unable to locate the resident's code status in the computer. MA#2 then proceeded to the nurse's desk and reviewed the code status binder which indicated Resident #8's code status was DNR. MA#2 said if she needed to find out the code status of a resident, she first looked at the computer and if she was unable to determine the information, she went to the code status binder at the nurse's desk and looked up the information. The DON was interviewed on 8/4/22 at 4:12 PM. She said staff looked at the profile information in the EHR for code status or they looked in the code status binder at the nurse's desk. She explained when a resident came from the hospital, if there was no paperwork for code status then the physician (MD) wrote an order for full code. She stated Resident #8's code status changed to DNR after she was re-admitted to the facility and the MD order should have been updated at the time the code status changed for Resident #8.	F 578	The code status information for both residents was also updated in the Code status binder along with validating paperwork. The updates were completed by medical records person on 8/4/22. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The EHR of 100% of current resident census was audited by Medical Records Person on 8/16/22 to ensure that a CODE status was indicated. The medical records Person also conducted an audit of the CODE status binder(s) at each nursing station to ensure that the code status for each resident had validating paperwork. The audit was completed on 8/22/22. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The morning Clinical meeting has been modified to include a review of new orders from the day before which will consist of any changes in code statuses. Administrative nurses (includes Director of Nursing and Staff Development Coordinator) and medical records clerk were educated on 8/22/22 by regional clinical nurse on the importance of reviewing physician orders when they are received and implementing necessary changes on the MAR with emphasis on	

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 08/04/2022

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 578	Continued From page 16 2. Resident #58 was admitted to the facility on 8/26/20 with diagnoses which included Parkinson's disease. The annual minimum data set dated 6/21/22 indicated Resident #58 was moderately, cognitively impaired. The electronic medical records documented Resident #58's advance directive status as DNR (do not attempt resuscitation) on the face/profile and basic information records. However, the electronic physician's active orders record revealed the resident had a full code advance directive status effective 10/26/20. The residents' portable medical forms, maintained at the nurse's stations in the Emergency Book consisted of Resident #58's face sheet which documented the resident's advance directive status as "Full Code". The book also included a physician signed MOST form (medical order for scope of treatment) documenting Resident #58's advance directive as DNR and no feeding tube with the effective date of 10/26/20. On 8/4/22 at 3:29 p.m., the Director of Nursing acknowledged the discrepancy of the advance directive status between the resident's electronic physician's order and the portable advance directive status, specifically both were effective on the same date.	F 578	code status. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The medical records person will audit code status binder and EHR for accurate code status for each resident, weekly X4, biweekly X3, and monthly thereafter to ensure compliance with F578 and its content. Findings will be documented on code status Audit tool. The Medical Records person will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance with F578.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		9/1/22

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 08/04/2022

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 584	Continued From page 17	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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 08/04/2022

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 584	Continued From page 18 Based on observations, record reviews, resident and staff interviews, the facility failed to maintain a clean living environment for 5 of 12 residents (Resident #35, Resident #58, Resident #86, Resident #17 and Resident #93) and 1 of 6 residents' halls (700 hall) reviewed for environment. Findings included: 1. On 8/1/22 at 10:20 a.m., during an observation of Resident #86's room, there was a miniature trash bin overflowing with trash onto the floor. Also, the bedroom floor was dirty with pieces of paper scattered throughout, dark dirt build-up in the corners of the room and a blue pressure relieving bootie (with a different resident and room number written on it) was lying on the floor. The bathroom floor had dark yellow discolorations on the floor surrounding the toilet. During an observation of Resident #86's room on 8/4/22 at 10:07 a.m. pieces of paper napkins were on the floor, the miniature trash bin had overflowing trash. The blue pressure relieving bootie remained on the floor next to the wall. There was a missing piece of baseboard at the wall near the bathroom. There was a plastic bag of clothes on the bathroom floor which was dirty with yellow stains near and around the toilet. The toilet seat was dirty with brown stains. On 8/4/22 at 10:25 a.m., the surveyor returned to Resident #86's room accompanied by the Housekeeping Director. After observing the conditions of the resident's room, he replaced the miniature trash bin, removed the pressure relieving bootie, and stated the room and	F 584	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/4/22 after observing the conditions of the room for resident #86 the housekeeping director replaced the miniature trash bin, removed the pressure relieving bootie, removed the pieces of paper from the floor, and thoroughly cleaned the bathroom. The baseboard piece for resident #86□s room has been ordered and will be repaired by 9/1/22. On 8/4/22, after being notified about the condition of resident #58□s privacy curtain, The housekeeping director replaced the curtain with one that was clean. The floor was also cleaned and the rid of the dust and pieces of paper. On 8/20/22, an outlet cover was placed on the outlet beside resident #35□s bed. On 8/5/22, the hand sanitizing dispensers located on the walls of the 700 hall were cleaned by housekeeping staff, and rid of all smudges and dried stains. The doorknob of the bathroom for resident #17 was repaired by maintenance director on 8/6/22. The wall paper in resident #17's room has been removed and the walls have been repainted. The gouges behind resident #17□s bed, along with the missing baseboard will be repaired by	

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 08/04/2022

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 584	Continued From page 19 bathroom would be thoroughly cleaned, immediately. An interview on 8/4/22 at 1:31 p.m. with the Housekeeping Director revealed resident rooms were to be cleaned in the mornings including residents' bathrooms then checked two to three times more each day (Sunday through Saturday) during first and second shifts. He stated staff had not made him aware of the soiled/stained condition of the resident's floor which required a deep clean and would be acted on, immediately. 2. During an observation of Resident #58's room on 8/2/22 at 9:25 a.m., a quarter-sized, brown stain was observed on the privacy curtain and the floor was dirty was dust and pieces of paper. On 8/4/22 at 10:15 a.m, a second observation of Resident #58's room revealed the brown stain remained on the privacy curtain and was darker in color. On 8/4/22 at 2:01 p.m., the Housekeeping Director revealed the facility's policy was that privacy curtains were to be changed for a clean set during the deep cleaning of a resident's room and whenever needed. He indicated all dirty/stained curtains were washed by the facility's laundry department. 3. During an observation of Resident #35's room on 8/4/22 at 9:14 a.m., there was no outlet cover on the outlet located on the wall next to the right side of the resident's bed which was against the wall.	F 584	maintenance director by 9/1/22. On 8/6/22, the dust over the overbed light along with the floor was cleaned for resident #93. The floor was cleaned by housekeeping staff. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/9/22, the department managers (includes; social workers, maintenance director, Admissions, Medical Records, Central Supply Person, MDS Nurse, Dietary Manager, Staff Development Nurse, Activity□s Director, Business Office Manager, and Scheduler) completed a 100% observation audit on all skilled nursing rooms. Findings were documented on the Environmental Rounds audit tool. Maintenance Director and Administrator also completed a review of Environmental Round Sheets for the past 90 days in efforts to address any outstanding issues. This was also completed on 8/9/22. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The administrator has implemented weekly meetings with the regional maintenance director as well as with the facility maintenance director to ensure that all maintenance and environmental issues are being addressed in a timely	

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 08/04/2022

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 584	Continued From page 20 4. Throughout the survey period from 8/1/22 through 8/4/22, the hand sanitizing dispensers located on the walls of the 700 hallway were dirty with smudges and dried stains. During an interview on 8/4/22 at 1:31 p.m., the Housekeeping Director revealed the hand sanitizing dispensers were to be wiped and cleaned three times each day. He indicated one staff was assigned to clean the resident's rooms, the biohazard rooms, nourishment room, utility room, hand sanitizing dispensers and the shower room on the 700 hall. He also stated that the housekeeping floor technician was responsible for checking the hand sanitizers on the hall as well as cleaning the handrails and cleaning the floors on the hall and in the common areas. 5. An observation of Resident #17's room on 8/1/22 at 2:40 PM revealed the doorknob was missing from the bathroom door, there were gouges in the wall behind the resident's bed; there was a section of baseboard, 4 inches in length, that had been stripped from the wall next to the bathroom and there was a section of wallpaper border that had peeled away from the wall. During an interview with Resident #17 on 8/1/22 at 2:45 PM, he said the items identified had been there for two months and staff were aware of the environmental issues in his room but had not been repaired or addressed. Observations of Resident #17's room on 8/2/22 at 3:20 PM and 8/3/22 at 8:30 AM revealed the doorknob was missing from the bathroom door, there were gouges in the wall behind the	F 584	manner. On 8/18/22, maintenance director and Environmental service Manager was educated on F584 with emphasis on the importance of maintaining a clean, homelike environment with a sanitary orderly, and comfortable interior. Education was completed on 8/22/22. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Department Managers will complete observation audits for 20 resident rooms daily (M-F)X20, weekly X4, monthly X3 and quarterly thereafter to ensure that any maintenance or environmental issues are being addressed in a timely manner. Findings will be documented on the Ambassador Round Audit tool. The Director or Nursing and/or designee will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance with F584.	

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 08/04/2022

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 584	Continued From page 21	F 584		

resident's bed; there was a section of baseboard, 4 inches in length, that had been stripped from the wall next to the bathroom and there was a section of wallpaper border that had peeled away from the wall.

The Administrator was interviewed on 8/3/22 at 10:05 AM. He shared the facility had ambassadors assigned to each hall who rounded on resident rooms weekly, asked residents if they had any concerns and completed the rounding forms weekly. The Administrator stated the ambassador assigned to Resident #17's hall was out sick. The ambassador forms for Resident #17's hall were requested for the past 30 days but none were provided by the facility.

On 8/4/22 at 10:14 AM, an observation of Resident #17's room was completed with the Maintenance Director. The Maintenance Director measured a nine foot section of wallpaper border that dangled from the wall. He confirmed a four inch section of baseboard had ripped away from the wall beside the bathroom, observed the doorknob missing from the bathroom door and acknowledged the gouges in the wall behind the resident's bed. During an interview with the Maintenance Director on 8/4/22 at 10:20 AM, he said the facility was in the process of removing wallpaper borders from residents' rooms and added there was no formal schedule of when wallpaper was to be removed but stated, "just doing it as we can get it done." He stated the facility had worked on obtaining a contract to have walls repainted, had received bids but the facility had not yet approved the bids. The Maintenance Director said he planned to fix the gouges in the wall behind Resident #17's bed and had placed a wall guard device on the bed to

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 08/04/2022

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 584	Continued From page 22	F 584		

prevent further damage to the wall. He shared there was no set schedule to repair the wall, but "as we can get to it." He explained environmental rounds were completed by administrative staff weekly and any issues identified were reported to the maintenance department. He said there were also work order slips at each nurse's station and at the front desk to report issues, but staff didn't often use the work orders, rather, they told the Maintenance Director as he walked down the hall.

An interview was completed with the Director of Operations on 8/4/22 at 1:39 PM. She said a walk through of the facility was completed in the past week and environmental issues were identified during the tour of the facility. She stated the facility was in the process of obtaining quotes to complete cosmetic updates such as painting and removing wallpaper borders.

6. On 8/1/22 at 10:20 AM, during an observation of Resident #93's room, there was a thick layer of dust on the windowsill and the overbed light. The floor was dirty in the corners with debris and there was debris observed behind the bed and the nightstand.

On 8/4/22 at 10:20 AM, a thick layer of dust remained to Resident #93's windowsill and above the overbed light. The floor remained soiled with debris in the corners and behind the bed and the nightstand.

On 8/4/22 at 10:30 AM, an interview was conducted with Housekeeper #1. He stated he was the housekeeper that cleaned Resident #93's room. He stated for daily room cleaning, he swept the floor, mopped the floor if needed, checked the bathroom, wiped down the bedside

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 08/04/2022

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 584	Continued From page 23 table and made sure things were in order. He stated he did wipe down the windowsill but had not been dusting the overbed lights. On 8/4/22 at 10:30 AM, the Housekeeping Director was interviewed in Resident #93's room. He stated the overbed lights and windowsills were part of daily cleaning. He added floors should be swept and mopped daily as well, to include behind furniture.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for limitations in range of motion (Resident #43) for 1 of 1 resident records reviewed for positioning. The findings included: Resident #43 was admitted to the facility on 3/3/22 with diagnoses that included history of a stroke with hemiplegia/hemiparesis (paralysis/weakness to one side of the body) and contractures to both hips and knees. A nursing progress note from 3/8/22 read that Resident #43 had contractures present to her upper and lower extremities. Review of the Admission MDS assessment dated 3/9/22 revealed Resident #43 had severe	F 641	F641 – Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: MDS Nurse made modifications and completed transmission of Resident #43 ‘s MDS assessment to include resident's bilateral upper and lower extremities. Modifications were completed on 8/8/22. MDS Nurse was educated by Regional MDS consultant on 8/8/22, on F641 and its content and importance of coding assessments accurately to reflect the resident's status.	9/1/22

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 08/04/2022

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 641	Continued From page 24 cognitive impairment and was coded with impairments to her bilateral upper and lower extremities. A quarterly MDS assessment dated 6/8/22 indicated Resident #43 had severe cognitive impairment and required total assistance from staff for all Activities of Daily Living (ADLs). She was not coded with any impairments to the upper or lower extremities. Review of Resident #43's active care plan, last reviewed 6/16/22, revealed a care plan present for assistance required for ADL's, to include eating related to weakness, endurance due to stroke with hemiplegia/hemiparesis, failure to thrive, protein calorie malnutrition, contractures of bilateral knees and hips and dementia. An observation of Resident #43 occurred on 8/2/22 at 3:26 PM while she was lying in bed with visible contractures present to her bilateral upper and lower extremities. On 8/3/22 at 2:30 PM, an interview was conducted with the MDS Nurse who confirmed limitation in range of motion was not coded on the quarterly MDS assessment dated 6/8/22 and should have been. She stated it was an oversight.	F 641	2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/17/22, MDS nurse conducted a MDS review of assessments completed within the past 90 days to ensure accuracy. Review was completed on 8/19 /22. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Interdisciplinary Team (IDT) (consists of Social workers, Activity's Director, MDS Nurse, Rehab Director), Director of Nursing (DON), and/or administrative nurses (includes Staff Development Coordinator and Treatment Nurse) will review a random current resident's MDS assessment daily at the facility Clinical Meeting, to ensure accuracy of MDS. MDS Staff (includes MDS nurses) has been educated by Regional MDS Consultant on F641 and its content, with emphasis on importance of coding assessments accurately to reflect the resident's status. Education was completed on 8/17/22. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The MDS Nurse, director of nursing and/or administrative nurses will review an	

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 08/04/2022

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 641	Continued From page 25	F 641	MDS assessment daily (M-F) X4 weeks, monthly X3 months, and quarterly thereafter to ensure accurate coding. Findings will be documented on MDS audit tool. Facility Administrator and/or DON will create a summary of these audits and present at the facility's monthly QAPI meeting to ensure continued compliance with F641.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to trim a dependent resident's fingernails (Resident #41) for 1 of 8 residents reviewed for Activities of Daily Living (ADL's). The findings included: Resident #41 was originally admitted to the facility on 11/23/21 with diagnoses that included rheumatoid arthritis, history of stroke, muscle weakness and gout. A quarterly Minimum Data Set (MDS) assessment dated 6/6/22 indicated Resident #41 had severely impaired cognition and had no behaviors or refusal of care. He required extensive assistance with personal hygiene and	F 677	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #41 had his nails trimmed on 8/9/22 by certified nursing assistant. NA #6 was educated by Director of Nursing on F677 and its content, with emphasis on the importance of residents maintaining good grooming and hygiene for residents who are unable to carry out their own activities of daily living. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	9/1/22

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 08/04/2022

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 677	Continued From page 26 bathing tasks. A review of Resident #41's active care plan, last reviewed 6/15/22, included a focus area for requiring assistance for Activities of Daily Living (ADL's) related to weakness and endurance. A review of Resident #41's nursing progress notes from 3/3/22 to 8/3/22 revealed no refusals of nail care documented. On 8/1/22 at 11:51 AM, Resident #41 was observed while sitting up in his bed watching TV. He was noted to have long fingernails to both hands. Resident #41 asked how could he get his fingernails trimmed as they were longer than he liked to keep them. An interview occurred with Nurse Aide (NA) #5 on 8/2/22 at 3:30 PM. She stated nail care was completed during personal care and bathing tasks, and she was not assigned to Resident #41. On 8/3/22 at 9:10 AM, Resident #41 was observed sitting up in his bed eating his breakfast. His fingernails remained long. NA #6 was interviewed on 8/3/22 at 10:10 AM and stated she was Resident #41's usual NA during the day shift from 7:00 AM to 3:00 PM. She explained nail care was completed with personal care and bathing tasks to ensure they were clean and short. NA #6 stated she had only cleaned under Resident #41's nail, had not offered to trim them and was unaware nail care was needed. The Director of Nursing (DON) was interviewed on 8/4/22 at 4:21 PM and stated she would	F 677	On 8/18/22, a 100% observation audit of current census was conducted by members of the department manager team (includes; social workers, medical records, business office manager, scheduler, MDS Nurse, Central Supply Person, Director of Nursing, Staff Development Coordinator, Dietary manager, and Maintenance Director,) to determine what residents needed their nails groomed. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility ambassador round sheets conducted by department managers have been modified to include observation of nail care On 8/10/22, All nursing staff were educated by the Administrator and Director of Nursing (DON) on F677 and its content, with emphasis on the importance of residents who maintaining good grooming and hygiene for residents who are unable to carry out their own activities of daily living. Education was completed on 8/22/22. New Hires will be trained during orientation. Anyone not educated prior to 8/22/22 will not be scheduled until completion. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained	

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 08/04/2022

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 677	Continued From page 27 expect nail care, to include trimming fingernails, to be rendered during personal care or shower assistance. The DON was unable to explain why Resident #41's nails were long.	F 677	Department Managers will conduct observation rounds for their assigned residents, daily (M-F) X20, weeklyX4, and monthly thereafter to ensure adequate compliance with F677. Findings will be documented on the Ambassador Rounds audit tool. The DON and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F677.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 6 residents reviewed for pressure ulcers (Resident #41).	F 686	1)Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #41 expired on 8/5/22.	9/1/22

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 08/04/2022

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 686	Continued From page 28 The findings included: Resident #41 was initially admitted to the facility on 11/23/21 with diagnoses that included diabetes type 2, history of pressure injury to the skin, chronic venous insufficiency, and peripheral arterial disease. A review of Resident #41's August 2022 physician orders, revealed an order dated 5/13/22 to check air mattress function every shift. A quarterly Minimum Data Set (MDS) assessment dated 6/6/22, indicated Resident #41 had severe cognitive impairment and was coded with 1 unstageable deep tissue injury, 1 venous/arterial ulcer and had a pressure reducing device to the bed. Resident #41's weight on 7/15/22 was 187.6 pounds (lbs.). On 8/1/22 at 11:51 AM an observation was made of Resident #41's alternating pressure reducing mattress machine set at 350 lbs. The machine had settings from 90 to 750 lbs. and indicated to set according to the resident's weight per pounds. Another observation was made of Resident #41's alternating pressure reducing mattress machine on 8/3/22 at 9:10 AM, which was set at 350 lbs. A phone interview occurred with Nurse #2 on 8/3/22 at 7:45 PM. She stated she checked the functionality of the pressure reducing mattress' making sure the connections were good, the light was on, and the mattress was inflated, but was unaware of a weight setting on the machine.	F 686	Nurse #2 was educated on F686 and its content with emphasis on the importance of Ensuring that residents with alternating pressure mattresses have settings set according to their weight. Education was provided by the Director of Nursing on 8/17/22. 2)Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of 100% of current residents who are currently on alternating pressure mattress was conducted by administrative nurses (includes, MDS nurse, Staff development Nurses, and Director of Nursing) and Central Supply person on 8/18/22, to ensure that all mattresses are set according to resident weight. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur: A list of residents who are currently prescribed to have alternating pressure mattresses have been placed in a binder at all nursing stations with a reminder to check the mattress each shift for proper functioning which includes ensuring that it is set according to resident's weight. All licensed nursing staff will be educated on this new system by staff development Coordinator as well as on the intent of	

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 08/04/2022

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 686	Continued From page 29 On 8/4/22 at 1:30 PM, an observation was made with Nurse #1 of Resident #41's alternating pressure reducing mattress machine and confirmed it was set at 350 lbs. Nurse #1 stated she only checked the functionality of the air mattress on her shift to ensure it was inflated and was unaware of the weight setting. On 8/4/22 at 4:21 PM, an interview was held with the Director of Nursing (DON), who stated the alternating pressure reducing mattress machine should be set according to the resident's weight as stated on the machine. She indicated she was unaware this had not occurred for Resident #41.	F 686	F686, with emphasis on the importance of ensuring that all residents with alternating pressure mattresses, have the setting set according to their weight. Education was conducted on 8/17/22 and was completed on 8/22/22. New hires will be educated during orientation. Any licensed Nurse not educated prior to 8/22/22 will not be scheduled to work until completion of education. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Central Supply person will perform audits of residents with alternating pressure mattress to ensure that they are properly functioning and set according to r resident's weight, daily (M-F) X10, weekly X3, and monthly thereafter to ensure adequate compliance with F686. Findings willl be documented on air mattress audit tool The Director of Nursing (DON) and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
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	F 689		9/1/22

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 08/04/2022

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	Continued From page 30 §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 and resident and staff interviews, the facility failed to provide the assistance of two people and a mechanical lift with transfers which had the potential to cause a fall for 1 of 6 residents reviewed for falls and accident hazards (Resident #93). The findings included: Resident #93 was admitted to the facility on 9/7/13 with diagnoses to include contractures to right and left knees and anxiety. An annual Minimum Data Set assessment dated 7/10/22 revealed Resident #93 had moderately impaired cognition, was not ambulatory and required assistance of two people for transfers. Resident #93 did not have any falls. A review of the care plan dated 7/12/22 revealed a focus area for risk for falls and required assistance with activities of daily living. Interventions included use two people for transfers with mechanical lift. On 8/1/22 at 3:40 PM, an interview was conducted with Resident #93. She stated the staff did not use a mechanical lift to get her up that morning. On 8/1/22 at 3:50 PM, an interview was conducted with Nursing Assistant (NA) #3. She stated she did get Resident #93 up in the morning	F 689	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: NA #3 was educated on F689 and its content with emphasis on the importance of ensuring that residents receive adequate supervision and assistance devices to prevent accidents. Education was conducted by Staff Development Coordinator on 8/5/22. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/9/22, Invacare vendor who services mechanical lifts completed a 100% audit of all facility assistive devices to ensure that they were properly functioning 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has placed binders at each nurse's station to identify residents who require assistive devices when transferring. On 8/10/22, All nursing staff were	

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 08/04/2022

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	Continued From page 31 and did not use a mechanical lift but thought another NA might have helped her. She stated she knew Resident #93 was supposed to be transferred with a mechanical lift because she was a two-person assist. On 8/1/22 at 4:04 PM, an interview was conducted with the Director of Nursing who stated the facility did not use the computerized tablets anymore to follow the care plan. She stated they had an in-service recently regarding transfers and staff should use a mechanical lift for residents that require 2 people for transfers.	F 689	educated by the Administrator and Director of Nursing (DON) on F689 and its content with emphasis on the importance of ensuring that residents receive adequate supervision and assistance devices to prevent accidents. New Hires will be educated during orientation. Education was completed on 8/20/22. Anyone not educated prior to 8/20/22 will not be scheduled to work until completion of education. The facility is NOT currently using any agency or contract staff. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Director of Nursing or Designee will observe 10 resident transfers, weekly X4, monthly X3, and quarterly thereafter to ensure adequate compliance with F689. Findings will be documented on the Resident Transfer audit tool. The DON and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F689.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		9/1/22

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 08/04/2022

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 692	Continued From page 32 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and Registered Dietician (RD) interviews, the facility failed to provide 2 nutritional supplements recommended by the RD for an underweight resident at risk for weight loss for 1 of 7 residents (Resident #93) reviewed for nutrition. The findings included: Resident #93 was admitted to the facility on 9/7/13 with diagnoses which included dysphagia and anemia. An annual Minimum Data Set assessment dated 7/10/22 revealed Resident #93 had moderately impaired cognition. She was able to feed herself after set up, weight was documented as 98 pounds and had no weight loss. The care plan dated 7/12/22 included a focus area of risk for nutritional decline due to medical history and history of significant weight loss. Interventions included provide supplemental	F 692	F692 Nutrition/hydration status maintenance Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A grievance concern was written on behalf of resident #93 to address the him not receiving the health supplements recommended by the Registered Dietician (RD) due to resident being underweight. Dietary manager was educated by the Administrator on 8/5/22 on F692 and its content with emphasis on ensuring that residents receive health supplements as prescribed and that they are provided with meals as ordered. Address how the facility will identify other residents having the potential to be	

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 08/04/2022

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 692	Continued From page 33 nutritional support. Resident #93's weights were documented as 99 pounds on 5/31/22, 99 pounds on 6/3/22 and 97.5 pounds on 7/12/22. A note by the RD dated 7/10/22 included "Health shakes at breakfast. Labs reflect mild protein depletion and anemia. Added magic cup to promote gradual weight gain as current BMI (body mass index) underweight." A review of the August 2022 physician's orders included mechanical soft diet, no added salt, health shake at breakfast, whole milk at lunch and dinner dated 7/6/22. On 8/2/22 at 9:15 AM, an observation of Resident #93's breakfast tray did not include a health shake. On 8/2/22 at 6:10 PM, an observation of Resident #93's dinner tray did not include a magic cup. On 8/4/22 at 10:00 AM, an interview was conducted with the RD. She stated she sees Resident #93 at least monthly and did recommend health shakes at breakfast and a magic cup at dinner. She stated Resident #93 was at risk for weight loss and a 1-2 pound weight loss could be significant for her because she was very thin and underweight. She stated she put nutritional supplement recommendations into the system herself and they were reflected on the tray card so the dietary staff and nursing staff were aware. On 8/4/22 at 11:05 AM, an interview was conducted with the Dietary Manager. She stated	F 692	affected by the same deficient practice: On Tuesday, 8/9/22, a 100% audit of the current census was completed by Dietary Manager to determine which residents were prescribed to receive nutritional supplements. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: During morning clinical meetings, the list of residents with prescribed health supplements will be reviewed with the dietary manager. Kichen staff (aides, cooks,)and nursing staff were educated by dietary manager on 8/18/22 on F692 and its content with emphasis on ensuring that residents receive health supplements as prescribed and that they are provided with meals as ordered. Education was completed on 8/22/22. Anyone not educated prior to 8/22/22 will not be scheduled to work until completion. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 5 resident meal trays will be monitored during various meals (breakfast, lunch, and dinner), to ensure tray accuracy and that health supplements are	

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 08/04/2022

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 692	Continued From page 34 nutritional supplements were located on the tray card under the "notes" section and the dietary staff know to look there. She stated they did have health shakes and magic cups in stock and the dietary staff must have missed them on the tray line. On 8/4/22 at 4:20 PM, the Director of Nursing was interviewed. She stated the nursing assistants were responsible for making sure the residents received what was listed on the tray card to include supplements.	F 692	being provided as indicated weekly X4, monthly X3, and quarterly there after by a member of the department manager team (includes, social workers, business office manager, scheduler, Dietary manager, Activities Director, Medical Records, and Maintenance Director. Findings will be documented on Meal Accuracy Audit tool. The Dietary Manager or Designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		9/1/22

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 08/04/2022

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 693	Continued From page 35 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to ensure 2 of 3 residents, Resident #463 and Resident #40, received enteral feeding tube flushes and free water as ordered by the physician. Findings included: 1. Resident #463 admitted to the facility on 7/25/2022 with diagnoses of failure to thrive. A Minimum Data Set (MDS) assessment had not been completed for Resident #463. During a review of Resident #463's medical record, a physician's order dated 7/28/2022 indicated he should receive 100 milliliters of water before and after each enteral feeding five times daily and an order dated 7/25/2022 indicated he should receive 250 milliliters of feeding five times a day. On 8/2/2022 at 3:59 pm the Staff Development Coordinator (SDC), who was working in a nursing assignment, was observed during an enteral feeding administration for Resident #463. The SDC administers Resident #463's 250 milliliters of enteral feeding per his gastric tube, she flushed the gastric tube with 60 milliliters of water before and 60 milliliters of water after the gastric feeding. An interview was conducted with the SDC on 8/4/2022 at 10:42 am and she stated she did not realize Resident #463's physician's orders indicated he should have a 100 milliliter water	F 693	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1) Staff development coordinator was educated by Director of Nursing on F693 and its content with emphasis on the importance of ensuring that residents who are fed by enteral means receive appropriate treatment as ordered by the physician. This education was completed on 8/17/22 and conducted by the Director of Nursing (DON). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/17/22, 100% audit was conducted by Director of Nursing on residents who are currently receiving enteral feedings to ensure that their orders are entered correctly and being administered as prescribed. Audit was completed on 8/19/22. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Morning clinical meetings will now include review of all current residents who receive enteral feedings to ensure that orders are accurate and that proper interventions are	

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 08/04/2022

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 693	Continued From page 36 flush before and after each gastric feeding and she was following the facility's protocol of giving a 60 milliliter water flush before and after each gastric feeding. During an interview with the Dietician on 8/4/2022 at 10:46 am she stated she recommends the water flushes and free water amounts Resident #463 received and the Physician signs the orders. The Dietician stated she did recommend 100 milliliters of water flush before and after each gastric feeding and the physician did sign the order on 7/28/2022. On 8/4/2022 at 1:10 pm during an interview with the Director of Nursing (DON) she stated Resident #463 should receive the amount of water flush that is recommended by the Dietician and ordered by the Physician. The DON stated she did not know why the SDC did not administer the amount of gastric tube flush that was ordered. The Administrator was interview 8/4/2022 at 1:25 pm and he stated the nursing department should follow the physician orders for gastric tube enteral flushes. 2. Resident #40 admitted to the facility on 5/26/2022 with diagnoses of stroke. A quarterly Minimum Data Set (MDS) assessment dated 7/22/2022 indicated Resident #40 was cognitively impaired and obtained more than 51 % of the calories he needed a day and more than 501 milliliters of fluids a day or more a day from his gastric tube. Review of Resident #40's Physician's Orders revealed he had an order dated 8/2/2022 for	F 693	implemented as any changes occur. All licensed nursing staff were educated by Staff development coordinator on F693 and its content with emphasis on the importance of ensuring that residents who are fed by enteral means receive appropriate treatment as ordered by the physician. This education was completed on 8/22/22. New nursing hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled until completion. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) or designee will observe an enteral feeding of a resident at random daily X10 (M-F), weekly X3, ,and monthly thereafter to ensure adequate compliance with F693 and its content. Findings will be documented on Enteral feeding audit tool. The DON and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F693.	

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 08/04/2022

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 693	Continued From page 37	F 693		

continuous gastric tube feeding at 35 milliliters per hour and 200 milliliter free water flushes every 4 hours.

Resident #40's Medication Administration Record (MAR) for 8/2022 indicated he had a 200 milliliter free water flush via his gastric tube every 4 hours at 1:00 am, 5:00 am, 9:00 am, 1:00 pm, 5:00 pm and 9:00 pm.

An observation was made of the Staff Development Coordinator (SDC), who was working in a nursing assignment, on 8/3/2022 at 9:58 am giving Resident #40 his 9:00 am medications and the scheduled flush of his gastric tube. The SDC administered Resident #40's medications and flushed the gastric tube with 30 milliliters of water before and after the medications. The SDC did not administer Resident #40's 200 milliliter free water flush.

During an interview with the SDC on 8/4/2022 at 9:33 am she stated she gave Resident #40 his medications mixed in 120 milliliters of water and flushed with 60 milliliters before and after the medications.

An interview was conducted with the Dietician on 8/4/2022 at 10:37 am and she stated Resident #40 should receive the free water flushes every 4 hours as ordered and the water used to flush medications would not be included in the amount of the free water flushes. The Dietician stated the free water flush was to ensure Resident #40 received enough fluids.

The Director of Nursing (DON) was interviewed on 8/4/2022 at 1:10 pm and she stated she did not know why the SDC did not give Resident #40

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 08/04/2022

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 693	Continued From page 38 the 200 milliliters free water flush that was ordered on 8/3/2022. The DON stated the 200 milliliter free water flush should be given as ordered by the physician. The Administrator was interviewed 8/4/2022 at 1:25 pm and he stated the nursing department should follow the physician orders for gastric tube enteral flushes.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to provide clean oxygen concentrators for 1 of 2 residents, Resident #463, reviewed for respiratory care. Findings included: Resident #463 admitted to the facility on 7/25/2022 with diagnoses of chronic respiratory failure and pulmonary disease. Resident #463 did not have a completed Minimum Data Set (MDS) assessment. A review of Resident #463's Physician's Orders	F 695	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Once notified, the air intake area of resident #493 was cleaned by a housekeeping worker 8/4/22. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/5/22, a 100% audit of all resident concentrators were audited by	9/1/22

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 08/04/2022

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 695	Continued From page 39 revealed he had an order dated 7/25/2022 for Oxygen at 2 liters per minute via nasal cannula to keep his oxygen saturation above 90%. On 8/1/2022 at 10:42 am an observation of Resident #463 revealed his oxygen concentrator was on and set at 2 liters per minute via nasal cannula and the oxygen concentrator had a thick layer of dust on the air intake area on the oxygen concentrator. During an observation on 8/2/2022 at 1:53 pm, Resident #463's oxygen concentrator continued to have a thick layer of dust on the air intake area and was in use and set at 2 liters per minute via nasal cannula. On 8/4/2022 at 10:42 am an interview and observation of Resident #463's oxygen concentrator was conducted with the Staff Development Coordinator (SDC), and she stated the oxygen concentrator air intake needed to be cleaned and it was covered in dust. The SDC stated she did not know who was responsible for cleaning the oxygen concentrator. During an interview with the Central Supply Aide on 8/4/2022 at 9:53 am, she stated the housekeeping staff clean the oxygen concentrators, but she was not sure about the schedule for cleaning them. An interview was conducted with the Housekeeping Director on 8/4/2022 at 9:56 am and he stated housekeeping cleans the oxygen concentrators when residents are discharged from the facility and then placed the oxygen concentrators back in the central supply after they are cleaned. The Housekeeping Director stated	F 695	housekeeping director to ensure that there was no dust on the air intake area. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The environmental round audits conducted by maintenance director were modified to include inspections of O2 concentrators and indicate whether the air intake filter is dirty or not. The Housekeeping staff was educated on 8/18/22 by Housekeeping Director on F695 and its content with emphasis on the importance of ensuring that the air intake filters remain free from dust. Education was completed on 8/22/22. Anyone not educated prior to 8/22/22 will not be scheduled to work until completion of education. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Housekeeping director or designee will conduct observation audits to ensure that resident Oxygen concentrators are free from dust, daily (M-F) X10, weekly X3, and monthly thereafter to ensure adequate compliance with F695. Findings will be documented on the Oxygen concentrator audit tool. The Administrator will be responsible for	

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 08/04/2022

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 695	Continued From page 40 the housekeeping staff do not clean the oxygen concentrators on a schedule while the resident is using them. On 8/4/2022 at 1:10 pm an interview was conducted with the Director of Nursing (DON), and she stated she did not know who cleaned the oxygen concentrators and nursing did not clean them. During an interview with the Administrator on 8/4/2022 at 1:25 pm he stated the facility was responsible for cleaning the oxygen concentrators and the concentrator air intake should be cleaned weekly with a brush.	F 695	the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance with F695.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		9/1/22

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 08/04/2022

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 756	Continued From page 41 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and Pharmacy Consultant interviews, the facility's Pharmacy Consultant failed to identify the need for an additional Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #20 was admitted to the facility on 2/6/18 with diagnoses which included dementia with behavioral disturbance. A quarterly Minimum Data Set assessment dated 5/4/22 revealed Resident #20 had mild cognitive impairment and had no behaviors. The assessment indicated antipsychotic medications were used daily.	F 756	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An Abnormal Involuntary Movement Scale (AIMS) assessment for Resident #20 was conducted and completed by Director of Nursing and/or administrative nurse (includes Staff Development Nurse and Treatment Nurse) on 8/22/22. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/13/22 the pharmacy consultant completed an audit of all current residents who are due for an AIMS assessment and provided the list to the Director of Nursing	

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 08/04/2022

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 756	Continued From page 42 A review of the August physician's orders included Zyprexa 5 milligrams at bedtime dated to start on 11/12/21. A record review included an (AIMS) assessement was completed on 11/22/21. A comprehensive medical record review revealed no further AIMS assessment were conducted. A review of the monthly pharmacy reviews for May 2022, June 2022 and July 2022 did not include a recommendation to complete another AIMS assessment. On 8/4/22 at 1:53 PM, an interview was consulted with the Pharmacy Consultant. She stated sometimes she had to remind the facility to complete the AIMS assessment and if it was over 6 months since one was completed, she would. She stated Resident #20's AIMS assessment was overdue, but she could not locate where she noted that or recommended the facility complete one. She added that was a part of the monthly pharmacy review and it must have been an oversight.	F 756	(DON) for Review. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The monthly pharmacy reviews will now indicate whether an AIMS assessment is needed for respective resident. The regional MDS nurse educated Administrative Nurses (Director of Nursing, Staff Development nurse, and Treatment Nurse) on 756 and its content and on the importance of ensuring the Abnormal Involuntary Movement Scale (AIMS) assessment is conducted every 3 months or as indicated per company policy. Education was completed on 8/22/22. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained A review of all residents who are receiving antipsychotic medications will be reviewed by Director of Nursing or Designee weekly X4, monthly X3, and quarterly thereafter to ensure that any residents who are due for an AIMS assessment has one completed during recommended time frame. Findings will be documented on AIMS assessment Audit Tool. The DON and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to	

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 08/04/2022

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 756	Continued From page 43	F 756	ensure continued compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		9/1/22

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 08/04/2022

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 758	Continued From page 44 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to identify the need for an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications (Residents #32 and #20). The findings included: 1. Resident #32 was initially admitted to the facility on 4/2/21 with diagnoses which included major depression, anxiety, and dementia with behaviors. A quarterly Minimum Data Set (MDS) assessment dated 5/17/22 indicated Resident #32 had severe cognitive impairment and no behaviors. She was coded as receiving antipsychotic medications daily. A review of the August 2022 physician orders included Seroquel (an antipsychotic medication) 25 milligrams at bedtime that started on 7/12/22.	F 758	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An Abnormal Involuntary Movement Scale (AIMS) assessment for Resident #20 and Resident #31 was conducted and completed by Director of Nursing and/or administrative nurse (includes Staff Development Nurse and Treatment Nurse) on 8/22/22. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/13/22 the pharmacy consultant completed an audit of all current residents who are due for an AIMS assessment and provided the list to the Director of Nursing (DON) for Review. 3) Address what measures will be put into place or systemic changes made to	

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 08/04/2022

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 758	Continued From page 45 A medical record review did not reveal any AIMS assessments that had been completed for Resident #32. On 8/4/22 at 1:00 PM, the Director of Nursing (DON) was interviewed and stated AIMS assessments should be completed when an antipsychotic medication was started and every 6 months afterwards to monitor for side effects. The DON further stated, the Pharmacist usually informed her when an AIMS assessment was due. 2. Resident #20 was admitted to the facility on 2/6/18 with diagnoses which included dementia with behavioral disturbance. A quarterly Minimum Data Set assessment dated 5/4/22 revealed Resident #20 had mild cognitive impairment and had no behaviors. The assessment indicated antipsychotic medications were used daily. A review of the August physician's orders included Zyprexa 5 milligrams at bedtime dated to start on 11/12/21. A record review included an Abnormal Involuntary Movement Scale (AIMS) assessment was completed on 11/22/21. A comprehensive medical record review revealed no further AIMS assessments were conducted. A review of the monthly pharmacy reviews for May 2022, June 2022 and July 2022 did not include a recommendation to complete another AIMS assessment. On 8/4/22 at 1:00 PM, the Director of Nursing (DON) stated AIMS assessments should be	F 758	ensure that the deficient practice will not recur: The monthly pharmacy reviews will now indicate whether an AIMS assessment is needed for respective resident. The pharmacy reviews will be reviewed by the Director of Nursing or designee and AIMS assessment if needed will be conducted by an Administrative Nurse (includes, Director of Nursing, Staff Development Coordinator, MDS Nurse, Treatment Nurse and Unit Manager. New and Readmissions will be also be reviewed on the day of admission by an Administrative Nurse to determine if a AIMS assessment is needed. The regional MDS nurse educated Administrative Nurses (Director of Nursing, Staff Development nurse, and Treatment Nurse) on 758 and its content and on the importance of ensuring the Abnormal Involuntary Movement Scale (AIMS) assessment is conducted every 3 months or as indicated per company policy. Education was completed on 8/22/22. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained A review of all residents who are receiving antipsychotic medications will be reviewed by Director of Nursing or Designee weekly X4, monthly X3, and quarterly thereafter to ensure that any residents who are due for an AIMS assessment has one	

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 08/04/2022

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 758	Continued From page 46 completed when an antipsychotic is started and every 6 months after to monitor for side effects. The DON added the pharmacy typically told them when to do them.	F 758	completed during recommended time frame. Findings will be documented on AIMS assessment Audit Tool. The DON and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		9/1/22

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 08/04/2022

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 761	Continued From page 47 Based on observations and staff interviews, the facility failed to keep unattended medications stored in a locked medication cart for 1 of 6 medication carts (Rehab Hall Medication Cart). The findings included: A continuous observation of an unattended medication cart on the Rehab Hall was made on 8/4/22 from 9:04 AM until 9:08 AM. Then medication cart was noted to be unlocked with the push lock in the out position. The medication cart was outside of room 3225 where other residents, staff and visitors were present. The medication cart was verified to be unlocked by Nurse #3 at 9:08 AM. During an interview on 8/4/22 at 9:08 AM, with Nurse #3, she indicated it was her assigned medication cart and stated she must have forgotten to lock the cart when she stepped away to the nurse's station. She added that all medication carts are to be locked when unattended. An interview with the Director of Nursing on 8/4/22 at 4:21 PM indicated Nurse #3 should not have left the medication cart unlocked while unattended. She stated nursing staff were responsible for securing the contents of the carts they were assigned.	F 761	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Once 8/4/22, once medication cart was observed unlocked, Nurse #3 locked her medication cart On 8/4/22, Nurse #3 was educated by Staff development coordinator (SDC) on F761 and its content with emphasis on the importance of ensuring that the medication remains locked when unattended. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/17/22, a 100% audit of all medication carts was conducted by the maintenance director to ensure that all carts possess proper working locks. Audit was completed on 8/20/22. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Ambassador rounds audit form has been modified to include observations of medication carts and whether they were observed unlocked during administrative rounds. Depart Managers (Includes Social Workers, Medical Records, Business Office Manager, Human Resources, Dietary Manager, Activity's Director,	

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 08/04/2022

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 761	Continued From page 48	F 761	Admissions, Central Supply, and Maintenance Director will conduct these rounds and denote their findings on form. All licensed nurses and medication aides were educated on 8/18/22 by staff development coordinator on F761 and its content with emphasis on the importance of ensuring that all medication carts remain locked when unattended to minimize the risk of any adverse outcomes such as drug diversion or residents consuming medication unsupervised. Education was completed on 8/22/22. New hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled for assigned shift until education is completed. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Director of Nursing or Designee will observe 5 carts at random daily when unattended (M-F)X10, weekly X3, and monthly thereafter to ensure that the carts are locked, and that nurses and medication aides are compliant with F761 and its content. Findings will be documented on medication cart audit tool. The Director of Nursing and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F761.	

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 08/04/2022

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 804	Continued From page 49	F 804		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, test tray evaluation, resident interviews (Resident #52 and #31), and staff interviews, the facility failed to serve palatable foods to residents according to their preference for temperature and taste for 1 of 1 hall observed for breakfast (600 hall). Findings included: Resident #52 was readmitted to the facility 12/9/2017. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/16/2022 assessed Resident #52 to be moderately cognitively impaired. Resident #52 was interviewed on 8/1/2022 at 11:08 AM. Resident #52 reported that the food on all meal trays was cold, and he wanted to eat warm foods. Resident #31 was admitted to the facility 5/17/2021. The most recent annual MDS dated 5/16/2022 assessed Resident #31 to be cognitively intact.	F 804	F804 Nutritive Value/Appear, Palatable Prefer Temp 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/5/22, The dietary manager spoke with residents #31 and #52 to ensure their food preferences were accurate and inquired about preferred temperature of food. Preferences for both resident #31 and #52 were also updated by dietary manager. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/5/22, dietary manager educated dietary cooks on the proper way to cook oatmeal with appropriate consistency through return demonstration method.	9/1/22

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 08/04/2022

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 804	Continued From page 50 Resident #31 was interviewed on 8/1/2022 at 4:17 PM. Resident #31 reported that the food that was delivered for meals was cold when it arrived. Resident #31 reported she wanted to have hot food served at least warm. The kitchen was observed on 8/3/2022 at 8:52 AM. The kitchen staff were preparing the breakfast meal trays for the 600 hall. A test tray was requested, and the tray was placed on the open air cart at 8:58 AM. The cart was followed to the 600 hall with the Dietary Manager (DM) and trays were passed out to the residents of that hall. The test tray was sampled with the DM at 9:17 AM after all residents received their meal. The plate was covered by a dome cover and had a serving of scrambled eggs, a sausage patty, oatmeal, and a piece of French toast. No steam was noted when the dome cover was lifted and the eggs, sausage, and French toast were cold to the touch and taste. The DM agreed that the eggs, sausage, and French toast were cold. Oatmeal was served in a small white plastic bowl and no steam was noted to rise from the oatmeal. The oatmeal was cool to the touch and to taste and the consistency was thin and watery. The DM reported that she felt the oatmeal was warm enough to be palatable. Resident #52 was interviewed on 8/3/2022 at 9:56 AM. Resident #52 reported that his breakfast was cold this morning and he thought the food would taste better if it was warmer. Resident #31 was interviewed on 8/3/2022 at 10:01 AM. Resident #31 reported that her breakfast was cold, and that made it difficult to enjoy the meal.	F 804	On 8/18/22, administrator conducted a survey of 100% of current census that inquired about meal preferences, whether residents felt the meals were palatable, and if the meal temperatures were sufficient. Additionally a meeting with the food committee (consists of 5 appointed residents) was held on 8/22/22 to address any other concerns that the residents may have concerning their meals. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Prior to the meals being sent from the kitchen area to the halls, the temperature of each meal plate will be checked to ensure that it is palatable. The facility has also implemented an “all hands-on deck” program during meals which involves an all-staff approach to distribute meals. In addition to nursing staff, this includes (social workers, housekeeping staff, medical records, Central supply, Business office Manager, Scheduler, Maintenance Director, Activities, Director, Personal Care Assistants, and Medical Records.) This approach will minimize the time that it takes to distribute meals to residents. All dietary staff (includes cooks and	

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 08/04/2022

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 804	Continued From page 51 The DM was interviewed on 8/4/2022 at 1:47 PM. The DM reported that the facility had a monthly food committee that met to discuss the resident choice meal of the month and to discuss likes and dislikes. The DM reported that some residents had reported their food was cold when it was delivered, but she thought nursing staff were reheating foods for the residents that requested. The monthly food committee meeting was conducted on 8/4/2022 at 2:00 PM. During the meeting, residents expressed concerns that the food was cold when it was delivered to their room. A request was made to review the minutes of previous food committee meetings, but none were available. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he expected food to be served at a palatable temperature.	F 804	dietary aides) was in serviced on F804 and its content with emphasis on the importance of residents receiving food that is palatable to taste and their preferred temperature. Education was conducted and completed on 8/22/22 by dietary manager. New hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled for assigned shift until education is completed. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Dietary Manager or designee will observe and consume 2 meal trays daily (M-F) X10, weekly X3, and monthly thereafter to ensure adequate compliance with F804. Findings will be documented on meal tray audit tool. The Dietary Manager will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance with F804.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar	F 806		9/1/22

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 08/04/2022

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 806	Continued From page 52 nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to honor a resident ' s choice for coffee at breakfast for 1 of 2 residents reviewed for choices at meals (Resident #31). Findings included: Resident #31 was admitted to the facility 5/17/2021. The most recent annual Minimum Data Set assessment dated 5/16/2022 assessed Resident #31 to be cognitively intact. A review of Resident #31's medical record revealed a dietary note written by the Dietary Manager (DM) dated 6/20/2022 that documented Resident #31 had been interviewed for meal preferences and her tray card had been updated. Resident #31 was interviewed on 8/1/2022 at 4:17 PM. Resident #31 reported that she wanted a cup of coffee with her breakfast meal, and sometimes the kitchen staff forgot to put a cup of coffee on her tray. Resident #31 reported that other staff would offer to bring her a cup of coffee before or after breakfast, but she preferred to drink coffee with her morning meal. Resident #31 said this was upsetting to her. The kitchen was observed on 8/3/2022 at 8:58 AM. The kitchen staff had prepared the 600 hall resident meal trays. The DM put a cup of coffee on some trays. The DM reported that if a resident wanted coffee with a meal, it would be noted on	F 806	F806 Resident Allergies, preferences, substitutes 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Dietary manager spoke with resident #31 on 8/5/22, about him not receiving his coffee with breakfast and placed the concern on a grievance form. Dietary manager will inspect resident #31’s tray daily for the next 2 weeks to ensure that he is receiving beverage preference during meals. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/18/22, reviewed the meal preferences for 100% of resident’s census to ensure that they were updated and accurate. Audit was completed on 8/19/22, 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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 08/04/2022

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 806	Continued From page 53 their tray card. The delivery of Resident #31's meal tray was observed on 8/3/2022 at 9:05 AM. Resident #31 did not have coffee on her tray. Resident #31's tray card with meal preferences was reviewed and at the top "coffee" was listed. The DM reviewed the tray card and reported that she must have missed that card and she went to get Resident #31 a cup of coffee. An interview was conducted with the DM on 8/4/2022 at 1:47 PM. The DM reported she had interviewed residents in October 2021 and June 2022 for their food preferences. The DM reported the kitchen electronic documentation system did not communicate with the facility electronic documentation system, so the facility system would not show the specific preferences a resident made, but those preferences would be printed on the tray card. The DM explained that when she was putting coffee on the breakfast trays on 8/3/2022 she must have missed her card and Resident #31's preference for coffee. The DM reported they brewed fresh coffee for each hall and distributed cups of coffee to the residents who had a preference. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported they kept fresh coffee at the receptionist desk at the front of the facility and staff or residents were welcome to come to the front desk to get fresh coffee. The Administrator reported all residents should have their beverage choice honored with breakfast.	F 806	recur: Prior to meal trays being transferred to the halls to be distributed to resident, the dietary manager has designated a member of the kitchen staff to inspect meal tray for accuracy.. All dietary staff (includes cooks and dietary aides) was in serviced on F806 and its content with emphasis on the importance of residents having their beverage preferences honored during meals. Education was conducted on 8/18/22 and completed on 8/22/22 by dietary manager. New hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled for assigned shift until education is completed. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained 10 resident meal trays will be monitored during various meals (breakfast, lunch, and dinner), to ensure tray accuracy and that beverage preferences are being provided as indicated weekly X4, monthly X3, and quarterly there after by a member of the department manager team (includes, social workers, business office manager, scheduler, Dietary manager, Activities Director, Medical Records, and Maintenance Director. Findings will be documented on Meal Accuracy Audit tool.	

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 08/04/2022

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 806	Continued From page 54	F 806	The Director of Nursing and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to date an open box of vegetables in the walk-in cooler, an open box of wheat rolls in the walk-in freezer, wet-stacked pans, failed to immerse pans in disinfectant/sanitizing solution for an appropriate length of time, and had stained plastic cups and plastic bowls for 2 of 2 kitchen observations.	F 812	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/1/22, both the open box of red peppers and box of wheat rolls were discarded immediately by the dietary	9/1/22

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 08/04/2022

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 812	Continued From page 55 These practices had the potential to affect food served to the residents (109 out of 116 residents). Findings included: 1. The kitchen was toured on 8/1/2022 at 9:55 AM. The walk-in cooler was observed to have an open box of red peppers. The red peppers were open to air and there was no date on the box indicating the date the box was opened. The dietary manager (DM) was interviewed 8/1/2022 at 10:00 AM. The DM reported the peppers should have been dated when they were opened, and she did not know why the box was not dated. The DM reported the facility used the peppers on 7/29/2022 for the noon meal. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he expected kitchen staff to follow food storage guidelines for the safety of the residents. 2. The walk-in freezer was observed to have an open box of whole wheat rolls. The rolls were in an open plastic bag and there was no date on the box indicating the date opened. The DM was interviewed 8/1/2022 at 10:00 AM. The DM reported the rolls should have been dated when they were opened, and she did not know why the box was not dated. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he expected kitchen staff to follow food storage guidelines for the safety of the residents. 3. The storage rack for pans was observed on	F 812	manager. The dietary manager and dietary aide were both educated on 8/4/22 by facility chemical representative on the preferred time of submersion while sanitizing. On 8/2/22, after being observed stained, both the plastic white bowls and clear plastic drinking glasses were cleaned by dietary aide. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Dietary Manager and Administrator conducted an observation round of the kitchen on 8/18/22 to identify other areas of the kitchen that needed attention to ensure adequate compliance with F812 and its content. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The administrator will be completing weekly observations of the kitchen and has also implemented weekly meetings with the dietary manager to ensure consistent compliance with F812. All dietary staff (including cooks and dietary aides) were in serviced on F812 and its content with emphasis on the importance of residents ensuring the	

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 08/04/2022

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 812	Continued From page 56 8/1/2022 at 10:05 AM. The storage rack had stacks of pans ready for use. Three small metal pans used to hold food in the steam table were stacked together. The pans were observed to have moisture on the inside and outside. Sheet pans were stacked ready for use. The sheet pans were observed stacked wet and moisture was noted inside and outside the pans. The DM was interviewed at the time of the observation, and she reported that all pans should be left to air dry after sanitizing and should not be stacked wet for storage. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he expected dietary staff to follow storage guidelines and not stack wet pans. 4. The kitchen was observed on 8/2/2022 at 12:02 PM. Dietary Aide (DA) #1 was observed washing metal pans in the 3-compartment sink. DA #1 was observed to wash, rinse, and place the pans in the sanitizing sink to soak in a solution of disinfectant. Ten seconds elapsed and DA #1 removed the pans from the sanitizing sink and placed the pans to dry. DA #1 was interviewed at the time of the observation and she reported that she thought that pans had to sit in the disinfecting solution for "just a few seconds." The DM was interviewed at the time of the observation, and she reported that dishes needed to be in the sanitizing solution for 1 minute and then be allowed to air-dry. The DM was not aware DA #1 was uncertain of how long to leave the pans in the sanitizing solution. The bottle of disinfectant/sanitizer was reviewed with the DM on 8/2/2022 at 12:08 PM. The bottle	F 812	importance of; food stored in the walk-in cooler being completely closed and dated to indicate origin of it being opened, not stacking pans that have moisture on the inside and outside of them, immersing pans in disinfectant/sanitizing solution for the appropriate length of time, and making sure that plastic cups and plastic bowls used for meals are not stained before use. Education was conducted on 8/19/22 and completed on 8/20/22 by dietary manager. New hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled to work until completion of education. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Kitchen audit checklist has been implemented to indicate whether meal dishes are clean before use, proper food storage, and proper sanitation practices. Audit checklist will be completed by dietary or designee daily (M-F)X10, weekly X3, and monthly thereafter to ensure adequate compliance with F812 and its content. Findings will be documented on kitchen audit checklist. The Dietary Manager will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance with F812.	

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 08/04/2022

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 812	Continued From page 57	F 812		

directed "To sanitize pre-cleaned ...items ... immerse in (solution) for at least 60 seconds, making sure to immerse completely and air dry."

An interview was conducted with the chemical representative for the facility on 8/4/2022 at 11:50 AM. The chemical representative reported he delivered disinfectant to the facility and provided information on the use of the products. The chemical representative reported that pans and other hand-washed utensils and dishes in the facility kitchen needed to sit, submerged in the disinfectant/sanitizing solution for at least 30 seconds, but preferably 1 full minute and then be allowed to air dry.

The DM was interviewed on 8/4/2022 at 1:47 PM and she reported that she had also talked to the chemical representative to receive additional guidance on the use of the disinfectant/sanitizing solution, and she had instructed DA #1 to allow hand-washed items to sit for 1 minute in the solution.

The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he was not aware of the soak time for the disinfectant/sanitizing solution, and he expected the kitchen staff to follow the manufacturer's guidelines to appropriately use the disinfectant/sanitizer.

5. During the kitchen observation on 8/2/2022 at 12:02 PM, it was observed that clear plastic drinking glasses appeared to have a clear, light brown liquid in them. The plastic glasses were on a tray and waiting to be placed on resident meal trays. When questioned, the DM emptied out the liquid in the drinking glasses and it was observed

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 08/04/2022

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 812	Continued From page 58 to be clear water, and the plastic drinking cups were noted with stains on the inside of the cup. The DM was interviewed during the observation, and she reported that iced tea caused the stains, and the kitchen would bleach the plastic glasses periodically. The DM explained she did not know the last time the plastic glasses had been bleached to remove the stains. After the observation of the stained plastic glasses, the meal service was observed and during the observation, it was noted that the small white plastic bowls were stained. The DM reported that the vegetables served in the small white bowls stained the plastic and like the plastic glasses, the kitchen bleached them periodically, but she did not know the last time the bowls were bleached. The kitchen was observed on 8/4/2022 at 1:46 PM and the clear plastic glasses were observed no longer be stained. The white plastic bowls were not observed. The DM was interviewed on 8/4/2022 at 1:47 PM and she reported the clear plastic glasses and white plastic cups had been bleached to remove staining. The Administrator was interviewed on 8/4/2022 at 3:04 PM. The Administrator reported he was not aware the plastic glasses and small bowls were stained.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		9/1/22

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 08/04/2022

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 842	Continued From page 59	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

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 08/04/2022

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 842	Continued From page 60 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain complete and accurate medical records in the area of isolation precautions for 1 of 34 active resident records reviewed (Resident #43). The findings included: Resident #43 was admitted to the facility on 3/3/22 with diagnoses that included vascular dementia. A review of Resident #43's medical record indicated she was diagnosed with COVID-19 on	F 842	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The order for “Isolation for Enhanced Droplet Precautions” was discontinued on 8/19/22 by the Director of Nursing DON). 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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 08/04/2022

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 842	Continued From page 61 6/2/22 and was relocated to the COVID isolation unit. The medical record also indicated she was removed from isolation for COVID-19 on 6/13/22 and returned to her room. Resident #43's active Physician orders revealed an order dated 6/3/22 that read "Isolation for Enhanced Droplet Precautions". This order did not have a stop date. A quarterly Minimum Data Set (MDS) assessment dated 6/8/22 indicated Resident #43 had severe cognitive impairment and was marked for quarantine. The June 2022 Medication Administration Record (MAR) had an entry for isolation for enhanced droplet precautions that started on 6/3/22. There was no stop date on the entry and was initialed by nursing staff every shift from 6/3/22 to 6/30/22. The July 2022 and August 2022 MARs were reviewed and revealed an order for isolation for enhanced droplet precautions that was being initialed every shift. There was no stop date on the entry. On 8/1/22 at 10:17 AM, an observation was made of Resident #43 while she was lying in bed. There was no signage on the door indicating enhanced droplet isolation precautions. An interview occurred with Nurse #1 on 8/4/22 at 1:30 PM. She reviewed the August 2022 MAR that indicated Resident #43 was on isolation for enhanced droplet precautions. She stated the resident was on the COVID quarantine unit in June when she was diagnosed with COVID-19 but returned to her room on 6/13/22 and the order	F 842	On 8/19/2022, Director of Nursing completed an audit of residents who have had an order for “Isolation for Enhanced Droplet precautions” for the past 90 days to ensure that any inactive orders were discontinued. 3)Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: During morning clinical meetings after a new diagnosis of COVID 19, physician orders will be reviewed to ensure that all physician orders for “Isolation for Enhanced Droplet Precautions” have a stop date. All administrative nurses (includes Director of Nursing, Staff Development Coordinator, and treatment Nurse) were educated on F842 and its content with emphasis on the importance of maintaining complete and accurate medical records in the areas of isolation precautions. Education was conducted and completed on 8/22/22. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained All physician orders for “Isolated Enhanced Droplet Precautions will reviewed weekly X4, monthly X3 and	

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 08/04/2022

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 842	Continued From page 62 should have been resolved. She was unable to state why it was still on the MAR or why staff were still signing off that isolation was in place. The Director of Nursing (DON) was interviewed on 8/4/22 at 4:21 PM and stated the order for isolation for enhanced droplet precautions should have been discontinued when Resident #43 returned to her room on 6/13/22 and felt it was an oversight.	F 842	quarterly thereafter by Director of Nursing or designee to ensure adequate compliance with F842. Findings will be documented on Physician order audit tool. The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F842.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 6/24/21. This was for 11 deficiencies that were cited in the areas of Resident Self-Administer Medications (F554), Formulate Advance Directives (F578), Safe/Clean/Comfortable/Homelike Environment (F584), Accuracy of Assessments (F641), Activities of Daily Living (ADL) Care Provided for Dependent Residents (F677), Treatment/Services to Prevent/Heal Pressure Ulcers (F686), Nutrition/Hydration Status Maintenance (F692), Drug Regimen Review, Report Irregular, Act On	F 867	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All department managers (includes; social worker, director of nursing (DON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, staff development coordinator, medical records, Rehab Director, MDS Nurse, and Central Supply Person) and Administrator, were educated on 8/18/22 on F867 and its content and on the importance of developing and maintaining appropriate plans to correct identified	9/1/22

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 08/04/2022

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 867	Continued From page 63 (F756), Free From Unnecessary Psychotropic Medications (F758), Label/Store Drugs and Biologicals (F761) and Food Procurement, Store/Prepare/Serve-Sanitary (F812) cited on 6/24/21 and recited on the current recertification and complaint survey of 8/4/22. The duplicate citations during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: 1. F554 - Based on observation, record review and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications left on a walker seat for 1 of 2 residents reviewed for self-administration of medications (Resident #64). During the recertification and complaint survey of 6/24/21, the facility failed to determine whether the self-administration of medications was clinically appropriate for 2 of 2 sampled residents who were observed to have medications at bedside. An interview with the Administrator and Director of Nursing (DON) on 8/4/22 at 5:06 PM revealed the Quality Assessment and Assurance (QAA) committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the Staff Development Coordinator (SDC) was new to the facility and	F 867	quality deficiencies. Education was completed on 8/22/22. New hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled to work until completion of education. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 8/18/22, the facility department managers conducted a review of the action plans implemented at the completion of the survey conducted on 6/24/21 to determine the root cause of the repeat deficiencies cited at the completion of the 8/4/22, 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Monthly Quality Assurance Performance Improvement (QAPI) minutes will now include the Regional Director of Operations and the Regional Director of Clinical Services to ensure that all Performance Improvement Plans are effective, attainable, and properly addressing areas of self-identified and cited deficiencies. All department managers (includes; social worker, director of nursing, business	

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 08/04/2022

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 867	Continued From page 64 was "catching up on in-servicing and training staff." The Administrator added the facility had initiated a certified nurse aide class and the first class recently graduated and would be working at the facility which he hoped would help with the staffing challenges. 2. F578- Based on staff interviews and record review, the facility failed to accurately document code status in the electronic health record (EHR) and paper record for 2 of 2 residents (Resident #8 and Resident #58) reviewed for advance directives. During the recertification and complaint survey of 6/24/21, the facility failed to document code status in the EHR for 4 of 7 residents who were newly admitted and reviewed for advance directives. An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff." The Administrator added the facility had initiated a certified nurse aide class and the first class recently graduated and would be working at the facility which he hoped would help with the staffing challenges. 3. F584- Based on observations, record reviews, resident and staff interviews, the facility failed to	F 867	office manager, activities director, housekeeping manager, maintenance director, admissions director, staff development coordinator, medical records, Rehab Director, MDS Nurse, and Central Supply Person) and Administrator, were educated on 8/18/22 on F867 and its content and on the importance of developing and maintaining appropriate plans to correct identified quality deficiencies. Education was completed on new hires will be educated during orientation. Anyone not educated prior to 8/22/22 will not be scheduled to work until completion of education. 4)Indicate how the facility plans to monitor its performance to make sure that solutions are sustained QAPI action plans will be reviewed by the Regional Director of Operations weekly X4, monthly X3, and quarterly thereafter to ensure adequate compliance with F867. Findings will be documented on QAPI Audit tool. The Administrator will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.	

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 08/04/2022

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 867	Continued From page 65	F 867		

maintain a clean living environment for 5 of 12 residents (Resident #35, Resident #58, Resident #86, Resident #17 and Resident #93) and 1 of 6 residents' halls (700 hall) reviewed for environment.

During the recertification and complaint survey of 6/24/21, the facility failed to replace a cracked door guard (in place to protect the doors to the rooms) in a resident room for 1 of 20 resident rooms on the 700 hall.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff."

4. F641- Based on record review, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately for limitations in range of motion (Resident #43) for 1 of 1 resident records reviewed for positioning.

During the recertification and complaint survey of 6/24/21, the facility failed to accurately code the MDS assessment in the areas of: 1) Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR; 2) Vision/use of corrective lenses for 1 of 2 residents reviewed for the self-administration of

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 08/04/2022

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 867	Continued From page 66	F 867		

medications; and 3) Medications and assistance for ADLs for 1 of 5 residents reviewed for unnecessary medications.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff."

5. F677 - Based on observations, record review, resident and staff interviews, the facility failed to trim a dependent resident's fingernails (Resident #41) for 1 of 8 residents reviewed for ADLs.

During the recertification and complaint survey of 6/24/21, the facility failed to assure incontinence care needs were met for three of seven residents reviewed for ADL assistance.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff." The Administrator added the

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 08/04/2022

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 867	Continued From page 67	F 867		

facility had initiated a certified nurse aide class and the first class recently graduated and would be working at the facility which he hoped would help with the staffing challenges.

6. F686- Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 6 residents reviewed for pressure ulcers (Resident #41).

During the recertification and complaint survey of 6/24/21, the facility failed to provide physician recommended repositioning for 1 of 2 residents reviewed for pressure ulcers.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff." The Administrator added the facility had initiated a certified nurse aide class and the first class recently graduated and would be working at the facility which he hoped would help with the staffing challenges.

7. F692 - Based on observations, record review and staff and Registered Dietician (RD) interviews, the facility failed to provide two nutritional supplements recommended by the RD for an underweight resident at risk for weight loss

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 08/04/2022

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 867	Continued From page 68	F 867		

for 1 of 7 residents (Resident #93) reviewed for nutrition.

During the recertification and complaint survey of 6/24/21, the facility failed to provide nutritional supplements as recommended by the RD for 1 of 7 residents reviewed for nutrition.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff." The Administrator added the facility had initiated a certified nurse aide class and the first class recently graduated and would be working at the facility which he hoped would help with the staffing challenges.

8. F756- Based on record review and Pharmacy Consultant interviews, the facility's Pharmacy Consultant failed to identify the need for an additional Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications.

During the recertification and complaint survey of 6/24/21, the facility failed to retain the pharmacy's New Admission Reviews in the resident's medical record or within the facility so the records were readily available for 1 of 5 residents reviewed for unnecessary medications.

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 08/04/2022

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 867	Continued From page 69	F 867		

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff."

9. F758- Based on record review and staff interviews, the facility failed to identify the need for an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications (Residents #32 and #20).

During the recertification and complaint survey of 6/24/21, the facility failed to ensure a physician's order for an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing

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 08/04/2022

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 867	Continued From page 70	F 867		

and training staff."

10. F761- Based on observations and staff interviews, the facility failed to keep unattended medications stored in a locked medication cart for 1 of 6 medication carts (Rehab Hall Medication Cart).

During the recertification and complaint survey of 6/24/21, the facility 1) Failed to store medications in accordance with the manufacturer's storage instructions in 1 of 3 medication carts and 1 of 2 medication store rooms observed; 2) Failed to date a stored medication with a shortened expiration date in 1 of 2 medication store rooms; and 3) Failed to secure prescription topical medications in a locked compartment for 2 of 2 residents who were observed to have medications at bedside.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff."

11. F812 - Based on observations, record reviews and staff interviews, the facility failed to date an open box of vegetables in the walk-in cooler, an open box of wheat rolls in the walk-in freezer, wet-stacked pans, failed to immerse pans in disinfectant/sanitizing solution for an appropriate

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 08/04/2022

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 867	Continued From page 71	F 867		

length of time, and had stained plastic cups and plastic bowls for 2 of 2 kitchen observations.

During the recertification and complaint survey of 6/24/21, the facility failed to label and date resealed food items and failed to ensure dishware were stored/stacked clean and dry.

An interview with the Administrator and DON on 8/4/22 at 5:06 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through ambassador rounds, trends with grievances and quality measures. The Administrator stated the facility had experienced some challenges due to staff and administrative turnover, which he thought contributed to the repeat citation. He added the SDC was new to the facility and was "catching up on in-servicing and training staff."