PRINTED: 05/29/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GREENDALE FOREST NURSING AND REHABILITATION CENTER SIMMARY STATEMENT OF DEPICIENCES SOUTH STATE, 219 DODE 104 SE SECOND STREET SNOW HILL, NC 28590 FREERY 1/4C FREELENDRY DRY SE PERCEDED BY PULL PRESIDENCY MAYS BE PRECEDED BY PULL PRESIDENCY ON SECOND STREET SNOW HILL, NC 28590 FROM INITIAL COMMENTS A complaint investigation survey was conducted 04/26/24. Event ID# HO.011. The following intake was investigated NC002/15905. 1 of the 1 complaint allegation resulted in deficiency. Past non-compliance began on 04/06/24. The facility came back in compliance effective 04/12/24, F.550 Notify of Changes ([n]ury/Decline/Room, etc.) CFR(s): 483.10(g)(14) (Noffication of Changes (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is. (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident which results in injury and has the potential for requiring physician intervention; (C) A need to after treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment, or (I) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	
INAME OF PROVIDER OR SUPPLIER GREENDALE FOREST NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPICIENCES SOW HILL, NC 28580 PREPIX TAG FOOD INITIAL COMMENTS A complaint investigation survey was conducted od/26/24. Event ID# HC0J11. The following intake was investigated NCJ0215906. 1 of the 1 complaint allegation resulted in deficiency. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G) Non-compliance began on 04/06/24. The facility came back in compliance effective O4/12/44. F 560 Notify of Changes (injury/Decline/Room, etc.) SRB-D CFR(s), 483.10(g)(14)(-(iv)(15)) \$483.10(g)(14)(-(iv)(15)) \$483.10(g)(14)(-(iv)(15)) A consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status, that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a need to discontinue an existing form of treatment displications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment displications); (C) A decision to transfer or discharge the resident from the facility as specified in \$483.15(c)(1)(ii).			345366	B. WING	 		
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		(i) A facility must im consult with the resisconsistent with his corepresentative(s) with (A) An accident involved in the consults in injury and physician intervention (B) A significant characteristic in either life-tollinical complication (C) A need to alter the aneed to discontinuate treatment due to ad commence a new form (D) A decision to train treatment to the consultation (D) A decision to train treatment to the consultation (D) A decision to train treatment to the consultation (D) A decision to train treatment to the consultation (D) A decision to train treatment due to ad commence a new form (D) A decision to train treatment due to ad consultation (D) A decision to train treatment due to ad consultation (D) A decision to train	mediately inform the resident; ident's physician; and notify, or her authority, the resident men there isplying the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial hreatening conditions or ass); reatment significantly (that is, are an existing form of verse consequences, or to orm of treatment); or ansfer or discharge the				
	ABOBATORY		DIGITIDALIED DEDDESCRITATIVES SIGNATUR		TITLE		(Y6) DATE

Electronically Signed 05/14/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345366	B. WING		C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	04/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	(ii) When making not (14)(i) of this section all pertinent informat is available and prove physician. (iii) The facility must resident and the resident as specified in §483. (B) A change in resident (e)(10) of this section (iv) The facility must update the address of the phone number of the representative(s). §483.10(g)(15) Admission to a computation of a computation of a computation of the representative (s). §483.5) must disclosits physical configural locations that compropert, and must specific room changes between the resident specific physician interviews Physician of a resident an injury of unknown resident was observed and swelling under the fracture of the brid occurred for 1 of 1 certain the resident and the resident and the resident was observed and swelling under the fracture of the brid occurred for 1 of 1 certain the resident was observed and swelling under the fracture of the brid occurred for 1 of 1 certain the resident was observed and swelling under the fracture of the brid occurred for 1 of 1 certain the resident was observed and swelling under the fracture of the brid occurred for 1 of 1 certain the resident was observed and the r	tification under paragraph (g) the facility must ensure that the facility must ensure that the facility must ensure that the specified in §483.15(c)(2) wided upon request to the also promptly notify the dent representative, if any, and or roommate assignment (a.10(e)(6); or dent rights under Federal or consument ensurement ensur	F 580	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		345366	B. WING		C 04/26/2024		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	1 04/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 580	Continued From pag	ge 2	F 58	80			
	Findings included.						
	Resident #1 was adı 12/04/20.	mitted to the facility on					
	The Minimum Data Sassessment dated 0 had severely impaire	3/15/24 revealed Resident #1					
	that on 04/06/24 Res swelling and bruising eyes. A full investiga 04/08/24 and it was resident sustained the revealed at approxin Nurse Aide #1 repor Resident #1's nose. x-ray report dated 04	port dated 04/08/24 revealed sident #1 presented with g of her nose and under her ation was conducted on not determined how the ne injury. The investigation nately 11:00 PM on 04/06/24 ted swelling on the bridge of Nurse #2 was notified. An 4/08/24 for Resident #1 or displaced fracture of the					
	04/06/24 through 04	#1's progress notes from /08/24 revealed no evidence as notified when the injury					
	Nurse #2 stated she on 04/06/24 and was Resident #1. She state to go down and look down at that time an swelling underneath although her eye wanot look like a serioudid not notify the Physical	rview on 04/26/24 at 5:20 PM came on shift at 11:00 PM is the assigned nurse for ated Nurse Aide #1 asked her at Resident #1. She went id observed bruising and her left eye. Nurse #2 stated is bruised and swollen it did its injury. She indicated she sysician. She stated it was a open areas, and no bleeding					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _				C 26/2024	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		, , , , , , , , , , , , , , , , , , , ,		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 580	necessary to call the decided she would let the Physician. She sthad received in-servi injuries of unknown s Director of Nursing an During an interview of Nurse #1 stated she nurse on Saturday 04 through 11:00 PM. Shift on 04/06/24 at 1 bruising, swelling, or returned to work the Aide #1 reported to he reported that Resider bruised eye. Nurse # on duty during the niganything to her regar there was no record in	ma, so she didn't think it was Physician. She stated she at the day shift nurse notify ated since the incident she ce training on reporting ource immediately to the nd the Physician. n 04/26/24 at 12:45 PM was Resident #1's assigned 4/06/24 from 7:00 AM he stated when she left her 1:00 PM there was no injury. She stated she next morning and Medication er that Nurse Aide #1 ht #1 had a black and 1 stated Nurse #2 who was	F5					
	Director of Nursing (I injury sometime that it was before 5:00 PN would take care of it. notify the Physician of since the incident she reporting a change in notification of the Phy During an interview of Director of Nursing (I made aware until Mo of unknown source. wasn't notified until (I x-ray which resulted indicated Nurse #2 v	DON) about the unexplained day on 04/07/24 but thought of and the DON stated she She indicated she did not of the injury. Nurse #1 stated the had received training on condition including						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C 04/26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		J4/26/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	condition due to une swelling so that treat initiated. She stated followed the facility punknown source whi and the Physician for not done. During a phone interthe Physician stated injury of unknown so He stated he ordered minimally displaced freported he evaluate 04/09/24. He stated at least by the follow occurred at 11:00 Ph was no delay in treat Monday. He stated Fithe Ear, Nose, & Thr 04/11/24 and from the along with conversat Party it was decided indicated for the nast During an interview of Administrator stated late in the day on 04, #2 should have reported which initiated for the swelling swelling in the day on 04, #2 should have reported which initiated for the swelling	e regarding a change in explained bruising and ment decisions could be Nurse #2 should have rotocol for injuries of ch included to notify the DON of further orders and that was view on 04/26/24 at 4:40 PM he wasn't notified of the urce until Monday 04/08/24. If an x-ray that showed a fracture to the nose. He decided Resident #1 on Tuesday he should have been notified ing day since the injury of at night. He stated there ment by doing the x-ray on Resident #1 was evaluated by oat (ENT) physician on e outcome of that evaluation ions with her Responsible that no treatment would be	F 5	,			
	regarding monitoring condition including in and including notifica stated an ad hoc Qua was held on 04/09/24	hysician. She stated ded to all nursing staff for an acute change in hjuries of unknown source htion of the Physician. She hality Assurance (QA) meeting and the decision was made hance (QA) Committee to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345366	B. WING		C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	1 04/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	regarding this occur of Correction was in	ce Improvement Plan rence. She reported the Plan itiated on 04/08/24 which f an acute change in condition	F 58	80	
	On 04/08/24 Reside Director of Nursing. have bilateral bruisii the bridge of her not On 04/08/24 the phy was ordered which it displaced fracture or	tive action will be ose residents found to have e deficient practice; ent #1 was assessed by the Resident #1 was noted to ng under her eyes and across se. /sician was notified, an x-ray resulted in a minimally			
	were reviewed for the documented acute of new/worsening pain fracture were asses physician, and the Eidentified. On 04/09/24 through conducted with all new facility's abuse and changes in condition.	the last 7 days to ensure change in condition to include thange in condition to include the property of a seed and reported timely to the poon. There were no concerns on 04/10/24 education was the ursing staff regarding the neglect policy and reporting in to the DON and Physician.			
	Physician. There wa implemented.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345366	B. WING		,	C 04/26/2024		
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		3-112-012-01		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 580	Continued From pa	ge 6	F 58	0				
		cility will identify other e potential to be affected by practice;						
	performed skin asset impaired residents to change in condition interventions initiate physician notified for with documentation	ON and Staff Facilitator essments on cognitively to ensure that any concerns or had been assessed, and ed if indicated, and the or further recommendations, in the electronic medical no negative findings.						
	initiated questionna residents regarding not reported to the rafracture. The ques any concerns or cha assessed, and inter and the physician narecommendations, v	ON and Staff Facilitator ires of all alert and oriented new/worsening pain, injuries nurse, and signs/symptoms of stionnaire was to ensure that ange in condition had been ventions initiated if indicated, otified for further with documentation in the ecord. There were no						
		sures will be put into place or nade to ensure that the Il not recur;						
	initiated education v notification of an ac notification of the ph recommendations, a	ON and Staff Facilitator with all nursing staff regarding ute change including nysician for further and to include documentation d. Education was completed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _			1	26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		130	REET ADDRESS, CITY, STATE, ZIP CODE 4 SE SECOND STREET OW HILL, NC 28580	1 0-1	20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	by 04/10/24 . After 04 completed their educ do so prior to the nex would be educated do	1/10/24 any staff who had not ation would be required to t shift. Newly hired staff uring orientation.	F s	580				
		ity plans to monitor its sure that solutions are						
	The decision to monit 04/08/24.	tor and take to QA was						
	times per week for 4	ill review progress notes 5 weeks utilizing the acute The unit manager will s identified.						
	questionaries weekly	Il complete 5 resident for 4 weeks to identify any anagers will address any						
		d DON will review the audits o ensure all areas of concern opriately.						
	QAPI committee for 1	ools/questionaries to the month to review and to ssues, or the need for						
	A QAPI (Quality Assu Improvement) meetii 04/16/24 with the Inte plan of correction was	ng was held again on erdisciplinary team where the						
	The facility alleged co	ompliance with the corrective						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING _			C 04/26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 104 SE SECOND STREET NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 SS=G	on 04/26/24. This incregarding the incident was received to ensure knowledge of the trainaudits were verified. The correct validated to be complete from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriation and exploitation as definitioned includes but is not limic corporal punishment,	ective action was completed luded staff interviews t, and in-service training that re understanding and ning provided. The initial There were no concerns tive action plan was eted as of 04/12/24. Neglect m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This		600			
	physical abuse, corporation involuntary seclusion; This REQUIREMENT by: Based on observatio Physician interviews, the resident's right to unknown source that	y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ns, record review, staff and the facility failed to protect be free from injury of resulted in bruising under re of the bridge of the nasal if for 1 of 1 cognitively iewed for an injury of			Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _				26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1304 SE SECOND STREET SNOW HILL, NC 28580	DE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 600	Continued From pag	e 9	F 6	500				
	12/04/20 with diagno vascular accident (C'dementia. The Minimum Data Sassessment dated 03 had severely impaire physical or verbal be others (e.g. hitting, ki She exhibited no other or scratching herself, dependent care by si (ADLs). She had no anticoagulant (prevenedications. She had An Investigation Repthat on 04/06/24 Resswelling and bruising eyes. A full investigation of 4/08/24 and it was resident sustained the revealed at approxim Nurse Aide #1 report Resident #1's nose. If #2 instructed Nurse Aide #2 Tylenol. Nurse Aide #2 continued to swell an x-ray report dated 04	8/15/24 revealed Resident #1 d cognition. She exhibited no haviors directed toward lcking, grabbing, or yelling). er behaviors such as hitting She required total taff for activities of daily living falls and received						
		#1's progress notes from or to the appearance of						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345366	B. WING		04	C 1/26/2024		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		12012024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 600		ge 10 g under the eyes and the n 04/0624 at 11:00 PM when	F 60	00				
	the injury was identi	fied revealed no n injury that occurred. There						
	(MAR) dated April 2 received scheduled formation) 75 milligr	cation Administration Record 024 revealed Resident #1 Plavix (prevents blood clot ams (mg) every morning for apy. A known side effect of ided bruising.						
	Resident #1 was ob oriented to person of the cause of her inju small yellow discolo suggestive of an old assessment was ob	on on 04/26/24 at 11:30 AM of served lying in bed. She was only. She could not verbalize ary. She was noted to have a red area under her left eye bruise. A full skin served with the assigned to further injuries noted.						
	Resident #1's room oriented reported th under her eyes, but happened. She indic any staff member m stated Resident #1 I resistive to care at ti	on 04/26/24 at 11:45 AM mate who was alert and e bruising suddenly appeared she didn't know what cted she had never witnessed istreating Resident #1. She had dementia and was mes, but she had not g from bed or having any her injury.						
	Nurse #2 stated she on 04/06/24 and wa Resident #1. She st to go down and look	rview on 04/26/24 at 5:20 PM e came on shift at 11:00 PM s the assigned nurse for ated Nurse Aide #1 asked her at Resident #1. She went and observed bruising and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345366	B. WING _		04	C J 26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 600	not able to verbalize stated she did not re shift nurse (Nurse #1 she came on duty re reported that Reside medication, so she with bruising and swelling asked Resident #1 if she said "yes". She regarded an ice pack, her eye was bruised like a serious injury, what happened, and answer. She stated next day, she mention didn't know what couthe injury. She stated and went home. She with no open areas, signs of trauma. She would let the day she stated since the service training on resource, abuse training acute change in conducted. During an interview of Nurse #1 stated she nurse on Saturday of through 11:00 PM. Shift on 04/06/24 at a bruising, swelling, or Aide #1 reported to Medical PM on 04/06/24 on her gown. She as observed blood com	what caused the injury. She ceive any report from the day who reported to her when garding an injury. She nt #1 received anticoagulant wasn't alarmed because the wasn't alarmed because the was a small area. She her face "bothered" her and reported she administered and sonce at that time and Nurse #2 stated although and swollen it did not look She asked Nurse Aide #1 she could not provide an when Nurse #1 came in the and it to her, but Nurse #1 ald have happened to cause and she gave Nurse #1 report a stated it was a small bruise and no bleeding or other a stated she decided she ifft nurse notify the doctor. Incident she had received in eporting injuries of unknowning, and monitoring for an	F	600			

O E I TI E I T	O T OTT INLEDIO THE G	WIEDIO/ WID GENTATION					2. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD			l ,	С
		345366	B. WING			1	26/2024
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2024
					304 SE SECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		s	SNOW HILL, NC 28580		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΑΙΕ	DATE
					,		
F 600	Continued From page	F	600				
		nd held pressure and the					
		rrse #1 reported she left the					
		r medication pass. Before					
		•					
	leaving her shift at 11:00 PM she reported Resident #1 did not have anything wrong with her face and her mouth was not bleeding, and there was no bruising or swelling. She stated she						
	returned to work the						
	Aide #1 reported to h						
	reported that Resider						
	bruised eye. Nurse #						
	on duty during the nig						
		ding the injury. Nurse #1					
		Resident #1 just after 7:00					
		er left eye was bruised and					
		e reviewed her electronic					
		nere was no documentation . She stated she called and					
		of Nursing (DON) about the					
		metime that day on 04/07/24					
		fore 5:00 PM and the DON					
		e care of it. She reported					
	Resident #1 never co	•					
		ted that although Resident					
		was oriented to person and					
	could voice her need	s. She stated Resident #1					
	had been in the facili	ty for years and did not have					
	a history of falls that	she was aware of. She					
	stated Resident #1 w	ould tense up when turning					
		e. She required total care by					
		echanical lift for transfers but					
	-	f the time. She stated					
	· ·	ush staff away at times when					
		minister medications or					
	·	ated Resident #1 was not					
	able to turn or reposit						
	assistance. She state						
		changes in her behavior and					
	remained at baseline. Nurse #1 stated since the						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345366	B. WING		C		
NAME OF PI	ROVIDER OR SUPPLIER	04000		STREET ADDRESS, CITY, STATE, ZIP CODE	•	04/26/2024	
				1304 SE SECOND STREET			
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 13	F 6	00			
	for an acute change i	eived training on monitoring in condition, abuse training, ge in condition, reporting is and symptoms of					
	Nurse Aide #1 stated on 04/06/24 from 3:0 04/07/24 and was as stated when she arrives she provided inconting of blood on her gown called for Nurse #1 to skin tears and at that out a small amount of may be losing a tooth and thought she bit her to get her cleaned up had no complaints of teeth to make sure not seemed okay, and she shift. Later that even in the other to get an ice had bruising under her Nurse #2, the oncominurse. Nurse #2 wen told her to get an ice her face for 1 hour. Noremove the ice pack eye was getting dark eyes. She reported the and the nurse told her for the morning nurse late. She indicated she she provided in the state of the	on 04/26/24 at 1:20 PM she worked a double shift 0 PM through 7:00 AM on signed to Resident #1. She yed for work around 3:30 PM hence care and saw a speck near her neckline. She to look at her. There were no moment she started spitting f blood. She thought she h. The nurse assessed her her tongue and instructed her her tongue and instructed her her stated Resident #1 pain and they checked her her continued on with her high around 11:30 PM she her eyes. She reported this to high 11:00 PM to 7:00 AM hat in around 11:15 PM and hack and put the ice pack on hurse Aide #1 went back to han hour later and noticed her her on both sides under her his to Nurse #2 right away har she was going to leave it her at 7:00 AM since it was her was not given any further					
	Resident #1 required mechanical lift for tra	from Nurse #2. She stated total care and used the nsfers. She indicated she osition herself without staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _				26/ 2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	20/2024	
				1304 SE SECOND STREET				
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	She stated she was of week during the invest Resident #1 had a brown had no idea of how the stated she received in abuse and reporting in a stated after she arrived on her residents and regarding Resident #1 no redness, or bruising around 10:30 AM Sather bed away from the against the wall and rechange or reposition though she doesn't like uses her arms to blood #1 could not turn and assistance. She reporalls on the bed. She her, and sather up in lunch at that time and noticed. She checked nothing was unusual, around 2:30 - 2:45 PM were no signs of bruis around 3:15 PM the reported her mouth wher she had just checked wrong with her mouth.	disoriented most of the time. called in to work the next stigation and was told that oken nose. She stated she ne injury occurred. She n-service training regarding	F6	600				
		at 2:45 PM and she was fine. M she changed assignments						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345366	B. WING _		C 04/26/2024		
	ROVIDER OR SUPPLIER ALE FOREST NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		4/20/2024	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	she returned to work assigned to Residen to see her at the beg two black eyes. She reported it to Nurse assess her and didn's She stated she thougovernight. She stated training since this increpositioning, falls, s in behaviors, and repositioning an interview of Aide #3 stated she with from 7:00 AM until 3 reported injury and with she reported there wobserved during that the injury occurred by broken nose. She stated and required the 2-person assistance cooperative with care to pull on your clother wall when you tried to pull on your clother wall when you tried to pull on your clother wall when you tried to pull on your clother wall when you tried to provide any care for moved her bed slight so she didn't push as always pushed the befollowing care. She stated the provide and the provide	a glance later that day. When Sunday morning, she was the sunday stated she immediately the sunday stated she immediately the sunday su	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345366	B. WING _			C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		04/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	the Physician stated of unknown source of unknown source of unknown source of stated he ordered at minimally displaced reported he evaluate 04/07/24 and interviand asked if she had stated he could not occurred. He reported bedridden for many no delay in treatmer Monday. He stated the Ear, Nose, & The 04/11/24 and from the along with conversa Party it was decided indicated for the nast During an interview Director of Nursing (made aware until Mof unknown source, about Resident #1's from either a nurse of recall exactly. She was and across the started an investigat Responsible Party was allowed to the started and the	riview on 04/26/24 at 4:40 PM I he was notified of the injury on Monday 04/08/24. He in x-ray that showed a fracture to the nose. He ed Resident #1 on Tuesday ewed staff and her roommate dibeen dropped or fallen. He determine how the injury ed Resident #1 had been years. He stated there was not by doing the x-ray on Resident #1 was evaluated by roat (ENT) physician on the outcome of that evaluation tions with her Responsible I that no treatment would be sal fracture. on 04/26/24 at 3:50 PM the (DON) stated she was not conday 04/08/24 of the injury She reported she found out injury on Monday morning or nurse aide but could not went to assess Resident #1's illateral bruising under her to bridge of her nose. She tion at that time and the was notified. She stated the	F6	, , , , , , , , , , , , , , , , , , ,		
	an x-ray which resul Physician evaluated #1 was evaluated by (ENT) physician on Police came on 04/0 Resident #1 and hel	ed on 04/08/24 and ordered ted in a nasal fracture. The her on 04/09/24. Resident y an Ear, Nose, and Throat 04/11/24. She stated the 08/24 and talked with roommate. The Police olay and could not determine ury.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		، ا	С
		345366	B. WING				26/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2024
					304 SE SECOND STREET		
GREENDA	LE FOREST NURSIN	G AND REHABILITATION CENTER			NOW HILL, NC 28580		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 600 Continued From page 17		age 17	F	600			
	During an interviev	v on 04/26/24 at 6:00 PM the					
	_	d she was notified of the injury					
		04/08/24. She stated an					
	,	nitiated at that time related to					
		ed the Physician, and the					
	Responsible Party						
	immediately. She s						
	and showed the na						
		btained during their					
	investigation. Res						
	conducted regarding						
	not been reported						
		ed they could not determine					
		ccurred and thought she could e wall. She stated since the					
		placed a pad between her bed					
		stated education was provided					
		regarding the provision of care					
		ining, and monitoring for an					
	_	ondition including injuries of					
		She stated an ad hoc Quality					
	Assurance (QA) m	eeting was held on 04/09/24					
	and the decision w	as made by the Quality					
	Assurance (QA) Co	ommittee to initiate a					
		ovement Plan regarding this					
		eported the Plan of Correction					
		/08/24 which included					
		cute change in condition to					
		ng, pain, or injury of unknown					
		of an acute change in condition sian, and the Responsible					
		ran, and the Responsible Prough of interventions and					
	monitoring for a ch						
	The Plan of Correct	tion included:					
	Address how corre						
	accomplished for t	nose residents found to have					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	l ^{(X}	(X3) DATE SURVEY COMPLETED		
		345366	B. WING _			C 04/26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	I	04/20/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	been affected by the On 04/08/24 Resider Director of Nursing. If have bilateral bruisin the bridge of her nos On 04/08/24 the phy was ordered which re displaced fracture of Responsible Party w On 04/08/24 Adult Pl enforcement were no On 04/08/24 through conducted with all ale regarding resident al abuse and neglect, a source. There were r On 04/08/24 through were completed on a residents for signs of were no concerns ide On 04/08/24 through were reviewed for the allegations were repo- concerns identified. On 04/08/24 through were reviewed for the documented acute of	and the second s	F	500			
	On 04/08/24 through conducted with all all regarding resident at abuse and neglect, a source. There were no 04/08/24 through were completed on a residents for signs of were no concerns ide. On 04/08/24 through were reviewed for the allegations were reported concerns identified. On 04/08/24 through were reviewed for the allegations were reported concerns identified.	04/09/24 interviews were ert and oriented residents ouse and how to report and injuries of unknown no concerns identified. 04/09/24 skin assessments all non-alert and oriented frabuse and neglect. There entified. 04/09/24 grievance logs are past 30 days to ensure all orted timely. There were no 04/09/24progress notes are last 7 days to ensure hange in condition to include bruising, or signs of a led and reported timely to the Responsible Party. There					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ` ′	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345366	B. WING		04/26/2024			
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 600	of Nursing were eduregarding reportable unknown source or of a crime and it mu Agency within 2 hou. On 04/09/24 through conducted with all n facility's abuse and changes in condition, performing neurolog repositioning resides. On 04/09/24 Reside Physician. There was implemented. On 04/11/24 Reside Ear, Nose, & Throat no new treatment im Address how the fact residents having the the same deficient pure on 04/08/24 the DO performed skin assess impaired residents to change in condition interventions initiate physician notified fo and the Responsible documentation in the	ministrator, and the Director located by the Clinical Director events including injuries of events that were suspicious at be reported to the State ars. In 04/10/24 education was sursing staff regarding the neglect policy, reporting and, interventions for an acute signs/symptoms of fractures, iical checks, and turning and ants. In #1 was evaluated by the last no new treatment Lent #1 was evaluated by the (ENT) physician. There was applemented.	F 600					

_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·			(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 04/26/2024		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1304 SE SECOND STREET SNOW HILL, NC 28580		4/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	initiated questionnair residents regarding r not reported to the notal fracture. The quest any concerns or charassessed, and intervand the physician not recommendations, at had been notified witelectronic medical renegative findings. Address what measures systemic changes madeficient practice will on 04/09/24 the DOI initiated education was abuse, notification of emphasis on assessinew/worsening pain, vital signs, initiating it change, notification of recommendations, at party to include docurecord. Education was signs/symptoms of a and swelling. Complete the standing order for head injuries or unwith completed by 04/10/2 who had not complete required to do so price	N and Staff Facilitator es of all alert and oriented new/worsening pain, injuries urse, and signs/symptoms of ionnaire was to ensure that nge in condition had been entions initiated if indicated, tified for further and the Responsible Party h documentation in the cord. There were no ures will be put into place or ade to ensure that the not recur; N and Staff Facilitator and acute change with ing a change to include signs of a fracture, obtaining interventions for an acute of the physician for further and notifying the responsible mentation in the medical	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING				26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 804 SE SECOND STREET NOW HILL, NC 28580	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 21	F	600			
		ity plans to monitor its sure that solutions are					
	The decision to moni made on 04/09/24.	tor and take to QA was					
	The unit managers will review progress notes 5 times per week for 4 weeks utilizing the acute change auditing tool. The unit manager will address any concerns identified.						
	questionaries weekly	Il complete 5 resident for 4 weeks to identify any anagers will address any					
		d DON will review the audits ensure all areas of concern opriately.					
	QAPI committee for 1	ools/questionaries to the month to review and to ssues, or the need for					
	A QAPI (Quality Assumprovement) meeting 04/16/24 with the Interplan of correction was	ng was held again on erdisciplinary team where the					
	The facility alleged co action plan on 04/12/	ompliance with the corrective 24.					
	on 04/26/24. This inc	ective action was completed luded staff interviews t, and in-service training that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
			, BOILDII			С	
		345366	B. WING _			04/20	6/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 600	audits were verified. dentified.	re understanding and ning provided. The initial There were no concerns	F 6	500			
F 607 SS=D	CFR(s): 483.12(b)(1). §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibineglect, and exploitat misappropriation of re §483.12(b)(2) Establito investigate any suc §483.12(b)(3) Include paragraph §483.95, §483.12(b)(4) Establi QAPI program require §483.12(b)(5) Ensure occurring in federally-facilities in accordance Act. The policies and but are not limited to §483.12(b)(5)(ii) Posemployee rights, as d (3) of the Act.	y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures the allegations, and training as required at sh coordination with the ed under §483.75. The reporting of crimes funded long-term care the with section 1150B of the procedures must include the following elements. Iting a conspicuous notice of lefined at section 1150B(d) Thibiting and preventing at at section 1150B(d)(1) and	F	507			
	§483.12(b)(5)(iii) Proretaliation, as defined (2) of the Act.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345366	B. WING			C 4/26/2024
	ROVIDER OR SUPPLIER ALE FOREST NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		720/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 607	facility failed to implof unknown source immediately report to management. A state unexplained bruising nose to facility management was observed for 1 reviewed for injuries. Findings included. The facility policy date action checklist for infection checklist for infection checklist included Administrator and/offine immediately of an	wiew and staff interviews the ement their policy for injuries that required facility staff to he injury to facility off member failed to report gunder the eyes and over the agement as soon as the injury of 1 residents (Resident #1) of unknown source. Atted 11/28/18 included an injuries of unknown source. Atted 11/28/18 included an injury source. Att	F 60	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C	
NAME OF D		345366	B. WING _	OTDEET ADDRESS SITV STATE 7/D SO		04/	26/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	ΣE		
GREEND/	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET			
		-		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 607	Continued From page	e 24	F 6	507			
	#1 stated Resident # and appeared bruised 04/08/24 for Residen displaced fracture of	stered Tylenol. Nurse Aide 1's nose continued to swell d. An x-ray report dated t #1 revealed a minimally					
	on 04/06/24 and was Resident #1. She sta to go down and look a down at that time and swelling underneath I Resident #1 was not caused the injury. Sh any report from Nurse reported that Resider medication, so she w	came on shift at 11:00 PM the assigned nurse for ted Nurse Aide #1 asked her at Resident #1. She went d observed bruising and her left eye. She stated able to verbalize what e stated she did not receive e #1 regarding an injury. She ht #1 received anticoagulant asn't alarmed because the					
	asked Resident #1 if she said "yes". She re Tylenol 650 milligram applied an ice pack. her eye was bruised a like a serious injury. Swhat happened, and answer. She stated anything else that nig unexplained injury. Scame in the next day. Nurse #1 didn't go int	was a small area. She her face "bothered" her and eported she administered s once at that time and Nurse #2 stated although and swollen it did not look She asked Nurse Aide #1 she could not provide an she didn't think about doing th to address the he stated when Nurse #1 she mentioned it to her, but to any details of what could use the injury. She stated					
	she did not notify the of Nursing regarding source. She stated it open areas, and no b trauma, so she didn't	Administrator or the Director					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343300	D: Willo 	STREET ADDRESS, CITY, STATE, ZIP CO	•	04/26/2024	
TO UNIC OT TH	TO VIDER OR GOL LEEK			1304 SE SECOND STREET	J_		
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COME (CEACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	Continued From page	e 25	F 6	607			
	nurse notify the docto	or. She stated since the lived in service training on					
	Nurse #1 stated she in nurse on Saturday 04 through 11:00 PM. Shift on 04/06/24 at 1 bruising, swelling, or returned to work their Aide #1 reported to he reported that Resider bruised eye. Nurse # on duty during the niganything to her regard stated she assessed AM and noted that he red. She reported she medical record and the as to what happened informed the Director unexplained injury so but thought it was be stated she would take was busy that day an was not notified soon the incident she had reporting a change in should have complete she observed the facilitation that he reporting a change in should have she shift nurse had reported the shift	the stated when she left her 1:00 PM there was no injury. She stated she next morning and Medication er that Nurse Aide #1 at #1 had a black and 1 stated Nurse #2 who was ght shift, did not report ding the injury. Nurse #1 Resident #1 just after 7:00 er left eye was bruised and er reviewed her electronic here was no documentation. She stated she called and of Nursing (DON) about the metime that day on 04/07/24 fore 5:00 PM and the DON er care of it. She stated she d that was why the DON er. Nurse #1 stated since received training on condition. She stated she ed an incident report when its labruising and swelling on 24 and notified the DON was uncertain if the night red it.					
	made aware until Mo	OON) stated she was not nday 04/08/24 of the injury She reported she found out					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345366	B. WING			04/26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		130	REET ADDRESS, CITY, STATE, ZIP CODE 4 SE SECOND STREET OW HILL, NC 28580	, <u> </u>	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU				(X5) COMPLETION DATE
F 607	from either a nurse of recall exactly. She wands and she had bill eyes and across the started an investigatif the Physician was not ordered an x-ray white fracture. The DON stobserved the bruising notified her right awas should have followed injuries of unknown stotify the Administration and that was not don During an interview of Administrator stated late in the day on 04/42 should have reposource to her or the Interview of the night of 04/06/24 provided to all nursing facility management source. She stated enursing staff on reposource immediately and when an injury was investigation was condetermined how the an ad hoc Quality Asheld on 04/09/24 and the Quality Assurance a Performance Improoccurrence. She repositions was condetermined from the Quality Assurance a Performance Improoccurrence. She repositions was condetermined from the Quality Assurance a Performance Improoccurrence. She repositions was condetermined from the Quality Assurance and Performance Improoccurrence. She repositions was condetermined from the Quality Assurance and Performance Improoccurrence. She repositions was condetermined from the Quality Assurance and Performance Improoccurrence. She repositions was condetermined from the Quality Assurance and Performance Improoccurrence. She repositions was condetermined from the Quality Assurance and Performance Improoccurrence.	injury on Monday morning or nurse aide but could not yent to assess Resident #1's lateral bruising under her bridge of her nose. She on at that time. She stated officed on 04/08/24 and ch resulted in a nasal lated Nurse #2 who initially g and swelling should have by. She stated Nurse #2 If the facility protocol for source which included to lot or or the DON immediately lie. In 04/26/24 at 6:00 PM the she was notified of the injury 1/08/24. She indicated Nurse reted the injury of unknow Director of Nursing (DON) on the stated education was g staff regarding notifying of injuries of unknown ducation was provided to reting injuries of unknown and the protocol on what to last identified. She stated a full empleted and it was never injury occurred. She stated is surance (QA) meeting was at the decision was made by the (QA) Committee to initiate overnent Plan regarding this corted the Plan of Correction 18/24 which included reporting source.	F	607			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345366	B. WING		C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	, 0.202021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETION
F 607	Continued From pa	ge 27	F 60	07	
	On 04/08/24 Reside Director of Nursing. have bilateral bruisi the bridge of her no On 04/08/24 the phy was ordered which displaced fracture of Responsible Party v	ose residents found to have e deficient practice. ent #1 was assessed by the Resident #1 was noted to ng under her eyes and across se. ysician was notified, an x-ray resulted in a minimally f the nasal bridge. The was notified.			
	conducted with all a regarding resident a abuse and neglect, source. There were On 04/08/24 throug were reviewed for the allegations were represented to the concerns identified. On 04/08/24 throug	h 04/09/24 interviews were allert and oriented residents abuse and how to report and injuries of unknown no concerns identified. h 04/09/24 grievance logs he past 30 days to ensure all ported timely. There were no h 04/09/24progress notes he last 7 days to ensure			
	documented acute of injuries of unknown reported timely to the Responsible Party. identified. On 04/08/24 the Ad of Nursing were eduregarding reportable unknown source or	change in condition to include source were assessed and le physician, DON, and There were no concerns ministrator, and the Director licated by the Clinical Director le events including injuries of events that were suspicious list be reported to the State			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345366	B. WING		C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 304 SE SECOND STREET SNOW HILL, NC 28580	1 0412012014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 607	Continued From page	-	F 607		
	conducted with all n	n 04/10/24 education was ursing staff regarding the neglect policy, reporting n including injuries of			
	On 04/09/24 Reside Physician. There wa implemented.	ent #1 was evaluated by the as no new treatment			
	I .	cility will identify other potential to be affected by practice.			
	performed skin asse impaired residents t change in condition interventions initiate physician notified fo and the Responsible	on and Staff Facilitator essments on cognitively of ensure that any concerns or had been assessed, and diffindicated, and the refurther recommendations, the Party had been notified with the electronic medical record.			
	initiated questionnal residents regarding not reported to the rafracture. The quesany concerns or chassessed, and interand the physician not recommendations, a had been notified with the process.	oN and Staff Facilitator res of all alert and oriented new/worsening pain, injuries nurse, and signs/symptoms of stionnaire was to ensure that ange in condition had been ventions initiated if indicated, otified for further and the Responsible Party ith documentation in the ecord. There were no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345366	B. WING			C 04/26/2024
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	!	04/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	Continued From page negative findings.	ge 29	F 60	07		
		ures will be put into place or nade to ensure that the Il not recur.				
	initiated education we notification of an accassessing a change pain, signs of a fractinitiating intervention notification of the phrecommendations, aparty to include docrecord. Education we signs/symptoms of a and swelling. Compute standing order for head injuries or unwe completed by 04/10 who had not completed to do so prince assessing a change of the standing order for the standing o	and notifying the responsible umentation in the medical				
		ility plans to monitor its e sure that solutions are				
	times per week for 4	will review progress notes 5 weeks utilizing the acute I. The unit manager will ns identified.				
	questionaries weekl	vill complete 5 resident y for 4 weeks to identify any nanagers will address any				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _			C 04/26/2024		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 104 SE SECOND STREET NOW HILL, NC 28580	1 0-1	20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page concerns identified.	e 30 d DON will review the audits	F	607				
	weekly for 4 weeks to were addressed appr	o ensure all areas of concern opriately.						
		ools/questionaries to the month to review and to ssues, or the need for						
	A QAPI (Quality Assu Improvement) meetin 04/16/24 with the Interplan of correction was	ng was held again on erdisciplinary team where the						
	The facility alleged co action plan on 04/12/	ompliance with the corrective 24.						
F 684 SS=D	on 04/26/24. This income regarding the incident was received to ensu knowledge of the train	t, and in-service training that	F	684				
10 0	§ 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident that residents received accordance with professions.	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345366	B. WING		C 04/26/2024		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	04/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 684	Continued From pag	ge 31	F 68	4			
	care plan, and the real This REQUIREMENT by: Based on record reinterviews the facility following the identification source that resulted the nasal bridge. Neconducted following vital signs were not assessments were refor 1 of 1 cognitively for an injury of unknown Findings included. Resident #1 was ad 12/04/20 with diagnous vascular accident (Codementia). The Minimum Data assessment dated Codementia. The Minimum Data assessment dated Codementia.	esidents' choices. IT is not met as evidenced view, staff and Physician y failed to monitor a resident cation of an injury of unknown in bruising and a fracture of eurological checks were not the unwitnessed head injury, obtained, and pain not conducted. This occurred vimpaired resident reviewed own source. (Resident #1) mitted to the facility on oses including in part cerebral CVA), quadriplegia, and Set (MDS) quarterly 03/15/24 revealed Resident #1 ed cognition. She exhibited no ehaviors directed toward kicking, grabbing, or yelling). her behaviors such as hitting f. She required total staff for activities of daily living falls and received It thinning) medications. She		Past noncompliance: no plan of correction required.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345366	B. WING			C 04/26/2024
	ROVIDER OR SUPPLIER ALE FOREST NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	•	04/20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	revealed at approxim Nurse Aide #1 report Resident #1's nose. #2 instructed Nurse #2 Tylenol. Nurse Aide #3 continued to swell ar x-ray report dated 04 revealed a minimally nasal bridge. Review of Resident # 04/06/24 through 04/ documentation of an documentation of the was observed on 04/ documentation that r conducted for an unv vital signs were obta pain assessments or administered. Review of the Medica (MAR) dated April 20 received scheduled if prevent clot formatio morning for anticoag side effect of this me Review of the Medica (MAR) dated April 20 an order to administe hours as needed for documentation that 1 Resident #1 from 04/ An observation was 11:30 AM of Resident	rately 11:00 PM on 04/06/24 red swelling on the bridge of Nurse #2 was notified. Nurse Aide #1 to apply an ice pack indicated she administered #1 stated Resident #1's nose ad appeared bruised. An #/08/24 for Resident #1 displaced fracture of the #1's progress notes from #08/24 revealed no injury. There was no e swelling and bruising that #06/24. There was no neurological checks were witnessed head injury, or that ined. There was no record of that as needed Tylenol was ation Administration Record #124 revealed Resident #1 Plavix (a medication to n) 75 milligrams (mg) every ulation therapy. A known dication included bruising. ation Administration Record #124 revealed Resident #1 plavix (a medication to n) 75 milligrams (mg) every ulation therapy. A known dication included bruising.	F	584		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF DEFICIENCIES (X3) DATE STATEMENT OF DEFICIES (X3) DATE STATEMENT OF DEFICIENCIES (X3) DATE STATEMENT OF D		SURVEY				
		345366	B. WING			C	
NAME OF D		345366	B. WING _	OTDEE	TARRESO OITY OTATE 7/R CORE	04/	26/2024
NAME OF P	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	ALE FOREST NURSIN	G AND REHABILITATION CENTER			SE SECOND STREET		
				SNOV	V HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	age 33	F 6	884			
	1	the cause of her injury. She					
		a small yellow area under her					
		of an old bruise. A full skin					
		bserved with the assigned					
		no further injuries noted.					
	During a phone int	erview on 04/26/24 at 5:20 PM					
	Nurse #2 stated sh	ne came on shift at 11:00 PM					
	on 04/06/24 and w	as the assigned nurse for					
		stated Nurse Aide #1 asked her					
	-	ok at Resident #1. She went					
		and observed bruising and					
	_	th her left eye. She stated					
		ot able to verbalize what					
		She stated she did not receive					
		urse #1 regarding an injury. She					
	· ·	dent #1 received anticoagulant					
		e wasn't alarmed because the ng was a small area. She					
		if her face "bothered" her and					
		e reported she administered					
	I	once at that time and applied an					
		2 stated although her eye was					
		en it did not look like a serious					
		Nurse Aide #1 what happened,					
		provide an answer. She stated					
	she didn't think abo	out doing anything else that					
	night to address th	e unexplained injury. She					
	indicated she did r	not complete neurological					
		ne any concerns such as					
		, dizziness, or difficulty					
		ed Nurse Aide #1 to obtain vital					
		he did not know if the vital					
	-	otained, and she did not follow					
	·	aide. She stated she did not					
	_	reports during the shift that					
		ngoing pain but indicated she					
	did not provide fur	ther monitoring to address her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345366	B. WING _			04/26/2024	
	ROVIDER OR SUPPLIER ALE FOREST NURSIN	G AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	#1 who worked on observed anything came in the next of Nurse #1 didn't go have happened to she gave Nurse #1 stated outside of the instructed to fill our regarding the injurt do any paperwork area was first observed in the day shift nurse so she didn't think physician. She stated it was a areas, and no blees on she didn't think physician. She stated it was a areas, and no blees on she didn't think physician. She stated it was a areas, and no blees on the incident training on reporting monitoring for an a including conduction obtaining vital sign assessments. During an interview Nurse #1 stated shourse on Saturday through 11:00 PM. shift on 04/06/24 abruising, swelling, Aide #1 reported to 4:00 PM on 04/06/00 on her gown. She observed blood condetermined she had several should be shoul	age 34 I she wanted to speak to Nurse 04/06/24 to find out if she had I. She stated when Nurse #1 ay, she mentioned it to her, but into any details of what could cause the injury. She stated I report and went home. She he paperwork she was ton Monday 04/08/24 yof unknown source, she didn't or notification on the night the erved. She stated she did not of Nursing regarding the injury e and did not notify the lent #1's Responsible Party. It is a small bruise with no open eding or other signs of trauma, it was necessary to call the ted she decided she would let enotify the doctor. She stated she had received in service ing injuries of unknown source, acute change in condition ing neurological checks, is, and conducting pain I w on 04/26/24 at 12:45 PM he was Resident #1's assigned 104/06/24 from 7:00 AM She stated when she left her it 11:00 PM there was no or injury. She stated Nurse on her earlier that day around 124 that Resident #1 had blood assessed Resident #1 and ming from her mouth and and bitten her tongue. They in and held pressure and the	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD			,	c
		345366	B. WING			04/26/2024	
NAME OF PROVIDER OR S	UPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ODEENDALE FOREST	MIDONO	AND DELIABILITATION OF NEED		1:	304 SE SECOND STREET		
GREENDALE FOREST	NURSING A	AND REHABILITATION CENTER		S	NOW HILL, NC 28580		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
room and fileaving her Resident # face and his no bruising to work the reported to Resident # #1 stated high reported to Resident # left eye was reviewed his was no do stated she hursing (Disometime reported to She stated years and was aware tense up with She stated required the stayed in bith Resident # they attern provide cal Resident #	topped. Nutrinished her shift at 11 and do not her that Nutrinished and her that Nurse #2 will did not replay a shift at 3 and her that day or cumentation called and ON) about that day or commentation called and ON) about that day or commentation called and of pain or commentation of the she reported dof pain or commentation of She states why the person and Resident and her turning she require mechanical would pupted to address the states and no commentation of the states and the she require mechanical would pupted to address the states and no commentation of the states and no	e 35 Irse #1 reported she left the reported she reported save anything wrong with her was not bleeding. There was g. She stated she returned hing and Medication Aide #1 lurse Aide #1 reported that ack and bruised eye. Nurse who was on duty during the cort anything to her regarding stated she assessed to 7:00 AM and noted that her and red. She reported she hic medical record and there who as to what happened. She informed the Director of the unexplained injury to 04/07/24 but thought it was the DON stated she would stated she was busy that day to DON was not notified the Resident #1 never to 04/07/24. She indicated that #1 had dementia she was add could voice her needs. #1 had been in the facility for we a history of falls that she ated Resident #1 would g her and providing care. The total care by staff and scal lift for transfers but if the time. She stated sush staff away at times when minister medications or sted since the incident shanges in her behavior and to Nurse #1 stated since the	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245200	P WING	R WWW			С	
		345366	B. WING _			04/	26/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
GREENDA	ALE FOREST NURSIN	G AND REHABILITATION CENTER		1304 SE SECOND STREET				
OI (LLIID)				SNOW HILL, NC 28580				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 684	Continued From pa	age 36 le in condition, and reporting a	F 6	684				
	signs and symptor hindsight she shou report when she of	n, reporting skin issues, and ns of fractures. She stated in ild have completed an incident oserved the facial bruising and						
	the DON right awa	•						
	Nurse Aide #1 state on 04/06/24 from 3 04/07/24 and was stated when she a she provided incor of blood on her go	w on 04/26/24 at 1:20 PM ed she worked a double shift 8:00 PM through 7:00 AM on assigned to Resident #1. She rrived for work around 3:30 PM attinence care and saw a speck wn near her neckline. She						
	skin tears and at the out a small amoun may be losing a to and thought she bit to get her cleaned	nat moment she started spitting t of blood. She thought she oth. The nurse assessed her t her tongue and instructed her up. She stated Resident #1 of pain and they checked her						
	seemed okay, and shift. Later that eve noticed Resident # had bruising under	e none were loose. Resident #1 she continued on with her ening around 11:30 PM she t1's face was turning red and ther eyes. She reported this to oming 11:00 PM to 7:00 AM						
	nurse. Nurse #2 w told her to get an id her face for 1 hour remove the ice paceye was getting dayeyes. She reported and the nurse told	ent in around 11:15 PM and ce pack and put the ice pack on . Nurse Aide #1 went back to ck an hour later and noticed her arker on both sides under her d this to Nurse #2 right away her she was going to leave it						
	late. She indicated	rse at 7:00 AM since it was she was not given any further ht from Nurse #2. She stated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _				26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	•	1304 \$	ET ADDRESS, CITY, STATE, ZIP CODE SE SECOND STREET W HILL, NC 28580	, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	∋ 37	F	684				
	the investigation and had a broken nose. S of how the injury occureceived in-service tr injuries such as a chareporting bruising and	aining regarding reporting ange in behavior and						
	Director of Nursing (I made aware until Mo of unknown source. S about Resident #1's i from either a nurse o recall exactly. She w nose and she had bil eyes and across the started an investigating Responsible Party was Physician was notifie an x-ray which result physician evaluated if	DON) stated she was not enday 04/08/24 of the injury of the reported she found out enjury on Monday morning or nurse aide but could not ent to assess Resident #1's eateral bruising under her bridge of her nose. She con at that time and the eas notified. She stated the don 04/08/24 and ordered ed in a nasal fracture. The ener on 04/09/24. Resident an Ear, Nose, and Throat						
	(ENT) physician on 0 Nurse #2 who initially swelling should have stated Nurse #2 shouprotocol for injuries o included to notify the further orders and that there was no record monitoring on the nigidentified. She stated checks, and no recornurses must initiate resident with a known when the resident was their head per the face	4/11/24. The DON stated of observed the bruising and notified her right away. She all have followed the facility of unknown source which DON, and the Physician for at was not done. She stated that Nurse #2 provided that Nurse #2 provided that shift after the injury was there were no neurological dof vital signs. She stated the eurological checks for any or suspected head injury as unable to report hitting standing order. She is no order for neurological						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345366	B. WING			1	C 26/2024
	NAME OF PROVIDER OR SUPPLIER GREENDALE FOREST NURSING AND REHABILITATION CENTER				ADDRESS, CITY, STATE, ZIP CODE SECOND STREET HILL, NC 28580	<u> 04/</u>	20/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	the injury to obtain or to include frequency, for notifying the phys neurological checks of the residents progress during the investigation. Nurse #2 did not compassessments, obtain no documentation that to Resident #1. She so 04/08/24 and talked or roommate. The Polica and could not determ. During a phone intensificated of unknown source of stated he ordered and minimally displaced for reported he evaluate 04/07/24 and interview and asked if she had stated he could not doccurred. He reported bedridden for many yhave been notified at since the injury occur stated there was no othe x-ray on Monday evaluated by the ENfrom the outcome of conversations with he decided that no treating the resident in the state of the treating the nasal fracture.	sto notify the physician of ders for neurological checks duration, and parameters ician. She indicated were to be documented in its notes. She indicated that on it was determined that inplete neurological vitals signs, and there was at Tylenol was administered stated the Police came on with Resident #1 and her it determined no foul play inne what caused the injury. In Monday 04/08/24 at 4:40 PM he was notified of the injury in Monday 04/08/24. He in it is a vicinity in the was notified of the injury in Monday 04/08/24. He is a vicinity in Tuesday in the weed staff and her roommate in been dropped or fallen. He is etermine how the injury in desident #1 non Tuesday in the stated he should in least by the following day in the stated Resident #1 was in physician on 04/11/24 and that evaluation along with the reresponsible Party it was ment would be indicated for	F	584			
	Administrator stated	on 04/26/24 at 6:00 PM the she was notified of the injury 08/24. She stated Nurse #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C 4/26/2024	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 1304 SE SECOND STREET SNOW HILL, NC 28580	•	7/20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	on the night of 04/06 was provided to all monitoring for an actincluding injuries of Nurse #2 should harmonitoring for a chanight and indicated education was provided to all monitoring for a chanight and indicated education was provided in the education was injury occurred. She assurance (QA) meand the decision was and the decision was assurance (QA) Concurrence. She reput was initiated on 04/06 monitoring for an actinclude new bruising source. Reporting of the DON, physicial Party, and follow the monitoring for a chance accomplished for the been affected by the On 04/08/24 Resided Director of Nursing. have bilateral bruising the bridge of her not the product of the produc	d the injury of unknow source 6/24. She stated education nursing staff regarding that change in condition unknown source. She stated we conducted ongoing ange in condition during the that was not done. She stated ded to nursing staff on unknown source and the do when an injury was d a full investigation was as never determined how the estated an ad hoc Quality eting was held on 04/09/24 s made by the Quality mmittee to initiate a vernent Plan regarding this ported the Plan of Correction 08/24 which included and change in condition to g, pain, or injury of unknown of an acute change in condition and, and the Responsible ough of interventions and ange in condition. It is action will be one residents found to have deficient practice; Ent #1 was assessed by the Resident #1 was noted to angunder her eyes and across	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 04/26/2024		
	NAME OF PROVIDER OR SUPPLIER GREENDALE FOREST NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580		04/26/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 40 esulted in a minimally	F 68	84			
		the nasal bridge. The					
	On 04/08/24 Adult Plenforcement were no	rotective Services and law otified.					
	conducted with all all regarding resident all abuse and neglect, a	04/09/24 interviews were ert and oriented residents ouse and how to report and injuries of unknown no concerns identified.					
	were completed on a	04/09/24 skin assessments ill non-alert and oriented f abuse and neglect. There entified.					
	were reviewed for the	04/09/24 grievance logs e past 30 days to ensure all orted timely. There were no					
	were reviewed for the documented acute of new/worsening pain, fracture were assess	04/09/24progress notes e last 7 days to ensure hange in condition to include bruising, or signs of a sed and reported timely to the Responsible Party. There entified.					
	of Nursing were educ regarding reportable unknown source or e	ninistrator, and the Director cated by the Clinical Director events including injuries of events that were suspicious at be reported to the State rs.					
	On 04/09/24 through	04/10/24 education was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345366	B. WING _			C 04/26/2024	
	ROVIDER OR SUPPLIER ALE FOREST NURSING	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	•	- · · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	facility's abuse and a changes in condition, performing neurolog repositioning resider. On 04/09/24 Reside Physician. There was implemented. On 04/11/24 Reside Ear, Nose, & Throat no new treatment im Address how correct accomplished for the been affected by the On 04/08/24 the DO performed skin asses impaired residents to change in condition interventions initiate physician notified for and the Responsible documentation in the There were no negative findings. On 04/08/24 the DO initiated questionnai residents regarding not reported to the rea fracture. The questions or characteristics and the residents of the real fracture. The question of the residents of the real fracture. The question of the real fracture.	ursing staff regarding the neglect policy, reporting in, interventions for an acute signs/symptoms of fractures, ical checks, and turning and ints. Int #1 was evaluated by the is no new treatment Ent #1 was evaluated by the (ENT) physician. There was inplemented. Itive action will be ose residents found to have	F6	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345366		B. WING		C 04/26/2024			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1120/2024	
GREENDA	J F FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET			
OKELNDA	REE I GREGI HOROING	NEIASIENATION GENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 42	F 68	84			
	recommendations, ar	nd the Responsible Party n documentation in the					
	Address what measur systemic changes ma deficient practice will						
	abuse, notification of emphasis on assessin new/worsening pain, vital signs, initiating ir change, notification or recommendations, ar party to include docur record. Education was igns/symptoms of a and swelling. Complethe standing order for head injuries or unwit completed by 04/10/2 who had not complete required to do so prior	th all nursing staff regarding an acute change with ng a change to include signs of a fracture, obtaining nterventions for an acute f the physician for further and notifying the responsible mentation in the medical					
		ity plans to monitor its sure that solutions are					
	The decision to monit made on 04/09/24.	or and take to QA was					
	The unit managers w	ill review progress notes 5					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345366			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING _			C 04/26/2024	
NAME OF PROVIDER OR SUPPLIER GREENDALE FOREST NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580			7/20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	change auditing tool address any concern The Social Worker was questionaries weekly concerns. The unit management of the concerns identified.	weeks utilizing the acute The unit manager will	F 6	84			
	weekly for 4 weeks to were addressed app The Administrator or findings of the audit QAPI committee for determine trends or continued monitoring A QAPI (Quality Assumprovement) meet 04/16/24 with the Intiplan of correction was action plan on 04/12 Validation of the corron 04/26/24. This incregarding the incider was received to ensuknowledge of the tra	DON will present the tools/questionaries to the 1 month to review and to ssues, or the need for 1. Jurance Performance and was held again on erdisciplinary team where the 1st discussed.					