STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 09/12/2024

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LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/09/24 through 09/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # AY3S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/09/24 through 09/12/24. Event ID# AY3S11. The following intakes were investigated NC00221902, NC00220925, NC00220045, NC00218886, NC00218899, NC00219155, NC00219859, NC00219879, NC00221252, NC00220047, NC00220586, and NC00221400. 2 of the 30 complaint allegations resulted in deficiency.	F 000		
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. §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.	F 561		10/2/24

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

Electronically Signed | 10/01/2024

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F 561	Continued From page 1 §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 record review, observation, and resident and staff interviews, the facility failed to honor a residents' request to have medications administered at a time that was desired for 1 of 4 residents (Resident #64) reviewed for choices. The findings included: Resident # 64 admitted to facility on 7/16/24 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 08/23/24 indicated Resident #64 was cognitively intact. On 09/10/24 at 12:51 PM an interview was conducted with Resident #64 and he indicated he was concerned with the time he was getting his medications. He indicated he would sometimes receive his morning medications close to lunch time. Resident #64 stated, "I have talked numerous times to someone here about my medications and getting them on time, and nothing has changed" A review of Resident#64's September electronic	F 561	Resident #64 continues to reside in the facility and remains in stable condition. The Director of Nursing (DON) spoke with Resident #64 regarding his medication administration times. Resident #64's medication administration times were changed to his preferred times, allowing for 1 hour before and 1 hour after. The resident agreed with medication administration times and variance. On 9/30/2024, the DON completed an audit of current residents' medication administration times for the prior 24 hours to ensure medication is being administered timely to include documenting in the electronic health record once administered to the resident. Any areas of concern were addressed by the DON at the time of the audit. On 9/30/2024, the DON/Staff Development Coordinator (SDC) initiated education with licensed nurses and certified medication aides (CMA) regarding the timely administration of residents' medications to include	

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F 561	Continued From page 2 medication administration record revealed morning medication times scheduled for 7:00 AM, 8:00 AM, and 9:00 AM. On 09/11/24 at 9:46 AM an interview was conducted with Resident #64 and he stated he had not received his medications yet. An interview was conducted with Nurse #4 on 09/11/24 at 11:46 AM and she indicated, Resident #64 went to the medication cart around 10:30 am and requested his medications. The Nurse indicated she was working her way to Resident #64's room, however she was running behind on the medication pass. She stated, "I came in to help out and got here about 8:00 or 8:30 AM, so I'm running behind." Nurse #4 acknowledged Resident # 64's morning medications were administered late. At 11:57 AM on 09/11/24 another Interview was conducted with Resident #64 and he stated, "they were making me late for bible study, so I went to ask for my medicines." He indicated he just wanted to get his medications a certain time every day without having to ask for them. On 09/11/24 at 12:00 pm and interview was conducted with the Director of Nursing (DON) and she indicated she would change Resident #64's medication times so he would get them as he preferred. An interview was conducted on 09/12/24 at 10:54 AM with the Administrator and he stated, "he expected the Resident to get his medications timely." He indicated it was the Residents' right to get his medications when he wanted them, and we should honor his request.	F 561	documenting in the electronic health record once administered. Education was completed on 10/1/2024. Any licensed nurse or CMA who did not complete education, will be in serviced by the DON/SDC prior to beginning their next scheduled shift. Newly hired licensed nurses or CMAs will be in serviced by SDC during orientation. The DON/SDC/Unit Managers (UM) will conduct a random audit of five (5) residents weekly for four (4) weeks and Monthly for two (2) months to ensure residents' medication is being administered timely and documented in the electronic health record once administered. The DON/SDC/UM will address all concerns identified during the audit to include staff re-training. The DON/SDC will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification 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's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter 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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		10/2/24

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F 580	Continued From page 4 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews of the staff, physician, and nurse practitioner, the facility failed to notify the on-call nurse practitioner when a resident had a change in condition (Resident #95). This deficient practice affected 1 of 2 residents reviewed for hospitalization. Findings included: Resident #95 was admitted to the facility on 5/9/23 with diagnoses of diabetes, atrial fibrillation on anticoagulant, and end stage renal disease dependent on renal dialysis. On 6/12/24 at 7:30 pm Nurse #1 documented in the neurological assessment form Resident #95 had blood pressure (BP) 135/95, pulse (P) 91, respirations (R) 13, and temperature (T) 97.0. The resident was lethargic with both pupils reactive but sluggish. The resident had no motor function of all extremities and hand grasp. There was no headache, seizure, drainage from the ear or nose, or vomiting. On 9/11/24 at 2:49 pm Nurse #1 was interviewed. Nurse #1 stated she had not informed the on-call nurse practitioner (NP) on 6/12/24 at 11:30 pm	F 580	Resident #95 no longer resides in the facility discharging 6/13/2024. On 9/13/2024 Nurse #1 was educated individually by Staff Development Coordinator (SDC) regarding identifying a resident's change of condition and notifying the physician/NP immediately. On 9/13/2024, the Director of Nursing (DON)/ SDC/Unit Manager (UM) completed a 100% audit of incident reports for prior 30 days to ensure the physician/nurse practitioner (NP) was immediately notified of any resultant change of condition. No other areas of concern identified. On 9/13/2024, the SDC initiated an in-service with licensed nursing staff regarding notification of the physician/NP when a resident has a change in condition. Inservice was completed by 9/17/2024. After 9/17/2024, any nursing staff that were not in serviced by the SDC, will complete in servicing before working their next scheduled shift. Any newly hired nurses will be educated by the SDC	

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F 580	Continued From page 5 when the resident had a change in her neurological status starting at 7:30 pm. Nurse #1 stated "I do not think I included the pupils and lethargy information when I contacted the NP about the resident's sleepiness. The NP was informed the resident was too drowsy and sleepy to wake up for medication at 7:30 pm and 11:30 pm." Nurse #1 stated she had not thought to notify the NP about the sluggishness of the eyes, lethargy, diaphoresis, and that she had not moved her extremities. The NP directed Nurse #1 to hold the resident's evening medications. On 9/12/24 at 12:35 pm an interview was conducted with the day-shift Nurse Practitioner. The Nurse Practitioner stated she was not on call on 6/12/24. There was a high risk for bleeding when a resident was receiving anti-coagulant. The Nurse Practitioner stated she would want to be called at the time when there was a change in the resident's neurological status. The Nurse Practitioner stated the on-call service for after hours (after 5:00 pm and before 7:00 am) do not know the residents and would be solely reliant on what the nurse reported. The on-call service providers do not have access to the facility's records. On 9/12/24 at 11:30 am an interview was conducted with the Physician. The Physician stated any change in a resident's neurological status needs to be reported immediately to medical staff.	F 580	during orientation. The Interdisciplinary team (IDT) will review documentation to include incidents 5x/week x4 weeks then 1x/week x4 weeks then monthly for one month to ensure the physician/NP and/or on-call physician/NP is immediately notified of any change in resident condition. The MDS Nurse, SDC, QA Nurse, and DON will address all concerns identified during the audit to include notification of the physician/NP and/or staff re-training. The Administrator and/or DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		10/2/24

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F 684	Continued From page 6 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews of the staff, physician, and nurse practitioner, the facility failed to identify a resident's change in condition (Resident #95). This deficient practice affected 1 of 2 residents reviewed for hospitalization. Findings included: The resident had medical orders for scope of treatment (MOST) form dated 3/21/22 signed by a representative. Section A was for do not resuscitate. Section B was limited additional interventions: Do not intubate or mechanical ventilate but may consider less invasive airway support such as BiPAP or CPAP (oxygen mask with positive pressure), transfer to hospital if indicated, and avoid intensive care. Sections C and D were to provide antibiotics and intravenous fluids. Resident #95 was admitted to the facility on 5/9/23 with diagnoses of diabetes, atrial fibrillation on anticoagulant, and end stage renal disease dependent on renal dialysis. Resident #95's care plan dated 5/23/24 documented she had an impaired cognitive function and thought process, was at risk for falls, required hemodialysis, and was receiving anticoagulant for atrial fibrillation (dysrhythmia of	F 684	Resident #95 no longer resides in the facility discharging 6/13/2024. On 9/13/2024 Nurse #1 was educated individually by Staff Development Coordinator (SDC) regarding identifying a resident's change of condition and notifying the physician/NP immediately. On 9/13/2024, the Director of Nursing (DON)/ SDC/Unit Manager (UM) completed a 100% audit of incident reports for prior 30 days to ensure the physician/nurse practitioner (NP) was immediately notified of any resultant change of condition. No other areas of concern identified. On 9/13/2024, the SDC initiated an in-service with nursing staff regarding identification of a change in a resident's condition to include, but not limited to, change in mentation, neurological status, and/or functional status. Inservice includes identifying a change in the resident's condition, accurate documentation of the change, and notification of the physician/NP. Inservice was completed by 9/17/2024. After 9/17/2024, any nursing staff that were not in serviced by the SDC, will complete in	

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F 684	Continued From page 7 the heart). Anticoagulant interventions were to monitor for changes in mental status, changes in vital signs, and lethargy. Resident #95 had an order dated 2/11/24 for Eliquis (anticoagulant) 2.5 mg twice a day. On 9/12/24 at 10:38 am an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #95 on 6/12/24 from 7:00 am to 7:00 pm. The resident was assessed by the Director of Nursing (DON) and me up to 5:00 pm. The resident was at her mentation baseline. The resident went to dialysis at approximately 10:30 am to 4:00 pm on 6/12/24. The resident had her dialysis as scheduled. Nurse #2 stated at dialysis the resident would have had heparin anticoagulant in the dialysis solution in addition to her twice a day facility provided anticoagulant. Resident #95 had no change on my shift 6/12/24 before dialysis. "I last saw the resident about 5:30 pm sitting up in her bed with her meal." On 6/12/24 at 7:30 pm Nurse #1 documented in the neurological assessment form Resident #95 had blood pressure (BP) 135/95, pulse (P) 91, respirations (R) 13, and temperature (T) 97.0. The resident was lethargic with both pupils reactive but sluggish. The resident had no motor function of all extremities and hand grasp. There was no headache, seizure, drainage from the ear or nose, or vomiting. On 6/12/24 at 11:40 pm Nurse #1 documented in the neurological assessment form Resident #95 had BP 144/105, P 93, R 14, and T not documented. The resident was lethargic with both pupils reactive but sluggish. The resident	F 684	servicing before working their next scheduled shift. Any newly hired nurses will be educated by the SDC during orientation. The Interdisciplinary team (IDT) will review documentation to include incidents 5x/week x4 weeks then 1x/week x4 weeks then monthly for one month to ensure a resident's change of condition was identified, documented accurately, and the the physician/NP and/or on-call physician/NP is immediately notified. The DON/SDC/Unit Managers (UM) will address all concerns identified during the audit to include notification of the physician/NP and/or staff re-training. The DON/SDC will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	

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had no motor function of all extremities and hand grasp. Nurse #1 was unable to assess headache, seizure, drainage from the ear or nose, or vomiting.

Nurse #1's nurses' note dated 6/13/24 at 12:20 am of Resident #95. The resident was lying in bed, unlabored breathing, diaphoretic, lethargic, and unarousable. The resident's evening medications were placed on hold due to resident acute changes and inability to arouse to swallow. The nurse practitioner was notified (of the inability to arouse and swallow medication).

On 6/13/24 at 3:20 am Nurse #1 documented in the neurological assessment form. Resident #95 was unresponsive with both pupils fixed. The resident had no motor function of all extremities and hand grasp. Nurse #1 was unable to assess whether the resident had a headache, seizure, drainage from the ear or nose, or vomiting.

On 9/11/24 at 2:48 pm an interview was conducted with Nurse #1. Nurse #1 stated on 6/12/24 at 7:00 pm Resident #95 had a neurological assessment every 4 hours. The resident was barely responding with labored breathing and was diaphoretic. Nurse #1 stated she could not tell if the change was neurological because the resident had received dialysis earlier that day. Residents were usually worn out after dialysis. Nurse #1 stated she passed the medication to other residents and returned to Resident #95 to administer medications at 11:00 pm. The resident was too "sleepy" to wake up and swallow her evening medications. The resident's pupils were responsive but slow and she would only moan when attempted to wake. The resident was not moving her extremities and

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was diaphoretic. Nurse #1 decided she would wait for the resident to wake up and tried again at 11:30 pm. Nurse #1 assessed Resident #95, she was still "very tired," not waking up and not moving. Nurse #1 believed the resident was tired from dialysis and had not refused medication before. The resident was not talking, just moaning at 7:30 pm and 11:30 pm assessments. Nurse #1 stated she called the on-call nurse practitioner and informed her the resident was very sleepy and could not swallow evening medication. The nurse practitioner directed Nurse #1 to hold the resident's evening medications.

Interview continued: Nurse #1 stated she came back at approximately 3:20 am on 6/13/24 and Resident #95 was unable to wake up and was not moving. The resident had a large amount of saliva in her mouth and her tongue was stuck on the left side and she had extreme diaphoresis. Nurse #1 tried sternal rub and was unable to wake the resident. Nurse #1 called NA #1 into the resident's room and they both could not wake the resident. Nurse #1 stated she called another nurse into the resident's room and this nurse could not wake the resident. The resident was noted to not react to sternal rub, saliva was coming out of her mouth, and her pupils were not reactive and fixed. The resident was not responding at all, she had a weird gurgling noise in her mouth. Nurse #1 stated she called the DON to inform her of the resident's status and was directed to send the resident out. Nurse #1 stated she called 911 around 3:45 am on 6/13/24. Nurse #1 further stated that something was not right with the resident, she was very diaphoretic and needing her clothes changed, and her blood glucose check was 147, but the resident was not

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responding to anything. She had no muscle control and fixed pupils. Nurse #1 went on to state she thought the resident was sleepy from dialysis. Nurse #1 had not suspected a neurological change because "I was not at the facility all day to see the resident." Nurse #1 was aware the prior shift nurse had not observed the resident's lethargy. Nurse #1 stated she received in report the resident was at neurological baseline when she came back from dialysis at 4:30 pm on 6/12/24. The resident's mental status was normal prior to the 7:00 pm to 7:00 am shift on 6/12/24. "Everything changed on my shift." Nurse #1 stated the resident's blood pressure was elevated which was not normal for her.

On 9/12/24 at 10:30 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated she was assigned to Resident #95 on 6/12/24 from 7:00 pm to 7:00 am. NA #1 stated the resident was talking to her but drowsy at 7:00 pm. NA #1 thought the resident was tired from dialysis. The resident was more quiet than normal and remained that way until the next check at 11:00 pm when the resident was not talking, and the NA thought the resident was sleeping and had not tried to wake her. NA #1 stated sometime after midnight the resident could not wake up, not sure the exact time. Around 3:00 am on 6/13/24 Nurse #1 called me into the resident's room to observe the resident. The resident was not able to wake up and not moving. Nurse #1 stated another nurse attempted to wake the resident unsuccessfully. The resident was sent out by EMS to the hospital.