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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/08/23 through 05/12/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # S04C11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 5/8/23 to conduct a recertification and complaint investigation survey and exited on 5/12/23. Additional information was obtained up to and including 5/26/23. Therefore, the exit date was changed to 6/1/23. Event ID # S04C11. The following intakes were investigated NC00192625, NC00192955, NC00192611, NC00201146, NC00193864, NC00197683, NC00199936, NC00199920, NC00196963, NC00195557, NC00201938, NC00193654, NC00195963, and NC00193687. 7 of the 40 complaint allegations resulted in deficiencies.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family	F 565		6/13/23

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

Electronically Signed | 06/13/2023

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 1 group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and review of the Resident Council Minutes, the facility failed to record and/or respond to concerns voiced by residents during Resident Council meetings for 9 of 10 months (July 2022, August 2022, October through, December 2022, and January, February, March, and April 2023). Findings included: The Resident Council meeting minutes for July, August, October, November, and December 2022 revealed no concerns or grievances were documented from residents. The minutes indicated Resident #38, Resident #29, Resident	F 565	1. Resident Council Meeting was held on 6/8/2023 with the Administrator and Regional Nurse Consultant invited. 2. Current residents are potentially affected by this deficiency. 3. On 6/2/2023 Regional Nurse Consultant educated Administrator and Activities Director on recording concerns of the residents during the resident council meeting and giving the concerns to the appropriate department head for resolution. Once the department head resolves the concerns it is to be given to the Administrator and Activities Director in writing and presented in the next council	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 2 #2, and Resident #55 attended these meetings. During an interview with the current Activities Director on 05/12/23 at 12:00pm, she stated she began working at the facility in April 2023. She indicated she oversaw the Resident Council meetings and documented the minutes, but no concerns or grievances were brought up in the April 2023 Resident Council meeting. The Activities Director was not able to locate resident council minutes from January 2023 to present. A telephone interview was attempted on 05/12/23 at 12:32pm with the previous Activities Director, but she was not available for interview. On 05/10/23 at 2:03pm a Resident Council meeting was held and attended by 10 alert and oriented members of the resident council (Resident #38, Resident #29, Resident #2, Resident #55, Resident #41, Resident #76, Resident #78, Resident #10, Resident #34, and Resident #70). During the meeting the residents were notified that based on review of the Resident Council minutes for July, August, October, November, and December 2022 no concerns were voiced by the residents and minutes from January 2023 through April 2023 were requested for review but were not able to be located by the facility. The residents in attendance reported that concerns had been reported at each meeting for the last year as well as each meeting of 2023. Residents #38, #29 and #2 stated that concerns with food, pests, cleanliness of rooms were ongoing concerns that had been reported for months. The residents stated that their concerns had not been resolved and they were unaware of efforts to resolve their concerns as they remained ongoing, and the	F 565	meeting. The Regional Nurse Consultant educated the department heads on resolving concerns with written resolutions and to be given to the Administrator and Activities Director. 4. The administrator will review resident council meeting minutes for concerns and writing resolutions from the appropriate department monthly x 3 months. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 3 issues had not improved. The Administrator was interviewed on 05/11/23 at 2:59pm. He spoke about the process for concerns/grievances reported during the Resident Council minutes. He explained that the Resident Council minutes were to include any concerns/grievances reported during the meetings and the Activities Director was to put all of these concerns/grievances on a grievance form and submit them to him for follow-up. Resident Council members would be updated on the status of the previous month's complaints at the next Resident Council meeting. He revealed that he was not aware that the former Activities Director had not been recording concerns/grievances on the Resident Council minutes or putting group grievances on the facility grievance form so the facility could provide the Resident Council members a response to their concerns.	F 565		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with residents and staff, the facility failed to protect a resident's right to be free from employee to resident physical abuse for 1 of 1 resident investigated for abuse (Resident #13). Resident #13 had reported to the facility Nurse Aide (NA)#1 needed to feed her roommate correctly. Resident #13 alleged later the same evening NA #1 grabbed Resident #13's face very hard, squeezed her face, in a manner which scared the resident and after the incident the resident was found to have bruising on her right jawline and right cheek. The findings included: Resident #13 was admitted to the facility on 1/16/19 with diagnoses that included hemiplegia/hemiparesis following cerebrovascular accident (stroke), contracture of right hand and forearm, and anxiety disorder. The Minimum Data Set (MDS) dated 2/16/23, indicated Resident #13's cognition was intact for daily decision making and she required total assistance with activities of daily living. The assessment indicated the resident did not receive anticoagulants during the 7 days look back period. Review of the 24-hour initial report dated 8/15/22 revealed on 8/15/22 at 12:44 PM, the facility was made aware of the resident to employee abuse. The law enforcement was notified on 8/15/22 at 1:00 PM. Review of the working 5-day report dated 8/22/22	F 600	Past noncompliance: no plan of correction required.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

revealed the incident occurred on 8/14/22 at 10:30 PM. Resident #13 alleged she was physically abused when NA #1 grabbed and squeezed her face. The resident had bruising on her right jawline and right cheek. The report documented on 8/15/22 the administrator received the allegation that NA #1 physically abused Resident #13 when she grabbed and squeezed her face which resulted in bruising to the right side of her face. The resident was assessed by the Director of Nursing (DON) and the assessment indicated the resident had light pink bruising to the right side of her face. The physician was notified of the abuse. The local law enforcement was notified. Resident #13 had also notified the police of this allegation. NA #1 was suspended pending investigation. NA #1 denied the accusation and was unavailable for further interviews during the time of investigation. The report further indicated, after the initial investigation, the administrator and DON wrote an action plan that was reviewed by the Quality Assurance and Performance Improvement (QAPI) committee, which included the facility's medical director. The plan was implemented with the goal to prevent resident abuse.

The Administrator provided the following timeline and investigation regarding the incident between NA #1 and Resident #13 on 8/15/22.

" On 8/14/22 at approximately 6:40 PM. Resident #13 reported to staff NA #1 did not feed her roommate.
" On 8/14/22 at approximately 6:45 PM the Director of Nursing (DON) investigated the grievance with no concerns noted.
" On 8/14/22 at some time between

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

approximately 10:45 PM - 11:00 PM, Resident #13 contacted the police and reported abuse. Resident #13 alleged to the police while she was assisted to bed by NA #1, the NA had placed one hand over her mouth and another hand over her throat (in the area where her (surgical) mask was hanging off both ears below her chin) and squeezed her face.

" On 8/14/22 Resident #13's skin assessment was completed by Nurse #1 with no new findings.

" NA #1 left the facility; Nurse # 4 asked her to leave at 10:46 PM on 08/14/22.

" The resident was monitored for any changes by Nurse #4. throughout the duration of the shift (8/14/22, 7:00 PM to 8/15/22, 7:00 AM). No changes were noted.

" On 8/15/22 at approximately 11:30 AM, Resident #13 reported the allegation to the Administrator. At 11:45 AM, the administrator notified DON about the allegation.

" On 08/15/22 at approximately 12:00 - 12:30 PM, the DON performed a skin assessment on Resident #13. Assessment revealed discoloration to the right side of face. Assessment indicated an approximately 1-inch light pink straight-line bruise to right jawline and approximately 1/8-inch darker pink dot shaped bruise on right side of face close to the chin.

" The Administrator notified the Police and Medical Director of this allegation on 8/15/22 at 1:00 PM.

" On 8/15/23 all staff re-education was initiated on Abuse Reporting, Zero tolerance for Retaliation, Engaging with a Behavioral Resident, Signs of Staff Burnout, Honoring Resident Preferences, (specifically honor what time the resident chooses to go to bed) and Notifying the supervisor when conflicts occur with a resident.

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

Review of the full plan of correction was done on site on 5/11/2023 given by the Administrator and DON.

Review of Resident #13's chart revealed a progress note by Nurse #4 dated 8/14/22 when Resident #13 alleged physical abuse by NA #1. Resident #13 alleged NA #1 grabbed her face and neck leaving bruising on her right jaw line and right cheek.

An interview was conducted on 5/11/23 at 1:50 PM and Resident # 13 stated she had made an abuse allegation regarding NA #1 sometime last summer. She recalled she had reported NA #1 for not feeding her roommate correctly. Resident #13 further stated NA #1 came to her bed and grabbed and squeezed her face so hard it scared her. She indicated she began screaming for NA #1 to leave her room. She indicated the assigned nurse came to her room when they heard her scream, and then NA #1 left the room.

An attempt was made to contact NA #1 on 5/11/23 at 11:30 AM by telephone was unsuccessful, and a voice message was left for NA #1 to return a call. No return call was received.

An attempt was made to contact Nurse #1 on 5/11/23 at 11:40 AM by telephone, was unsuccessful, and a voice message was left for Nurse #1 to return a call. No return call was received.

During an interview with the DON on 5/11/23 at 2:30 PM, she indicated Resident #13 had a 1-inch light pink straight-line bruise to her right jawline and approximately 1/8-inch darker pink

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

dot shaped bruise on the right side of her face close to the chin. The DON stated NA #1 was suspended at the time of investigation. The NA initially denied the incident and later was unavailable for any interviews.

During an interview on 5/11/2023 at 2:30 PM, the Administrator stated the facility has a zero tolerance of abuse. The Administrator further stated NA #1 was terminated from the facility. He expected all residents to be free from abuse and neglect and free from any retaliation. The Administrator indicated that the abuse allegation was substantiated.

Plan of Correction from the facility received on 5/26/23:

Interventions for affected resident:
On 8/14/22 Resident #1 had a skin assessment completed by Licensed Nurse #1 with no findings. The nurse aide left the facility at 10:46 P.M. Licensed Nurse #1 monitored Resident #1 throughout the duration of the shift for any changes with no changes noted on 8/15/22. Resident #1 reported the allegation to the administrator. Administrator notified the Director of Nursing performed skin assessment on Resident #1 with discoloration to right side of face noted. The administrator submitted the facility report intake and nurse aide #1 was suspended pending outcome of investigation. Investigation initiated. Director of Nursing notified the Medical Director and psychiatry. The Director of Nursing obtained a new order for x-ray of Resident #1 right jaw due to bruising Resident #1 educated about risks of sleeping with personal belongings in bed. The administrator reviewed the personnel file for nurse aide #1 to validate background,

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9	F 600		

certifications, and reference checks were performed on hire. Director of Nursing completed an additional certification check on nurse aide #1 to validate no substantiated findings of resident abuse, neglect, or misappropriation in a nursing Facility. Director of Nursing provided one to one education on abuse reporting to Licensed Nurse #1 and nurse aide #2 who were working on the North Hall.

Interventions for residents identified as having the potential to be affected:
Residents residing on North Hall with a brief interview for mental status of 8 or greater were interviewed by the Social Services Dept. to determine if they had any concerns of abuse.
Residents residing on North Hall with a brief interview for mental status of 7 or below had a skin assessment completed to observe for any injury of unknown origin. The Administrator and Director of Nursing were educated by the Corporate Nurse Consultant on abuse reporting per Federal Regulations. The administrator reviewed Grievance Log for the last 90 days to validate any alleged abuse or neglect was properly reported and investigated. The administrator reviewed facility report intakes for the last 12 months to determine if there were other allegations against nurse aide #1. The administrator reviewed Risk Events for the last 90 days to validate any alleged abuse or neglect was properly reported and investigated. The administrator reviewed staffing for 8/14/22.
Residents residing in the facility, with a brief interview for mental status of eight or higher, have been educated about the risks of sleeping with personal belongings in bed. Observational Angel Rounds performed for any items in the residents' bed that could be a hazard to sleep

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

with / beside. If any items are noted, the Director of Nursing and Administrator will be notified.

Systematic Change:
The administrator and Director of Nursing re-educated current staff on Abuse Reporting, zero tolerance for Retaliation, engaging with a Behavioral Resident, Signs of Staff Burnout, and notifying the supervisor if conflicts with a resident occur initiated on 8/15/22. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Newly hired staff received an in-service packet prior to working and this was verified by the facility trainers and orientation form. The Administrator and Director of Nursing were educated by the Corporate Nurse Consultant on abuse reporting per Federal Regulations.
Social Services Director will interview five staff members per week for twelve weeks to validate staff knowledge of abuse reporting, zero tolerance for retaliation, engaging with a behavioral resident, signs of staff burnout, and notifying the supervisor if conflicts with a resident occur Director of Nursing or Nurse Supervisor will randomly review five skin assessments weekly for twelve weeks to validate there are no unexplained skin conditions are noted. The administrator will review grievances and risk events five times weekly for twelve weeks to validate any allegation of abuse or neglect is reported and investigated timely. The administrator will interview five residents with a brief interview of mental status of eight or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse. During angel rounds once per week for twelve weeks the assigned Department Managers will observe any items in

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

the residents' bed that could be a hazard to sleep. If any items are noted, the Director of Nursing and administrator will be notified. Weekly for twelve weeks the Director of Nursing or social worker will perform observations of staff interactions with three behavioral residents to validate interaction is appropriate. Weekly for twelve weeks the administrator and/or social worker will follow-up with three residents who made grievance reports to validate there was no staff retaliation in response to the grievance.

Monitoring of the change to sustain system compliance ongoing:
In the monthly Quality Assurance and Performance Improvement Meeting, the Social Worker, Director of Nursing, Department Managers, and administrator will present the findings of the interview audits. The QAPI Committee will review interview audits and make recommendations to assure compliance is maintained ongoing. QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing.

Compliance date: 8/22/2022

The Allegation of Compliance was validated on 5/11/23 when staff interviews revealed they received education on the Abuse policy and procedures, residents' rights to be free from physical abuse and neglect. The education included documentation and reporting to management immediately when they become aware of reported, suspected abuse, and/or injury. Staff were also educated on the assessment and daily checks of residents' skin impairments during personal care, using the body

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 audit form. The body audit form would provide the location of the skin impairment with staff to circle the area on the diagram. The body audits would include measurements and description of the noted area. Nurse's Aides must submit the reports about skin and/or abuse issues daily to the Nurse/Unit Manager immediately. The Nurse would review the body audit daily to be placed in the physician and wound care notebook for further evaluation. The Unit Manager would review the body audit forms weekly to ensure all skin impairments and/or injuries were reviewed by the physician and/or wound care nurse. The report would be submitted to the Director of Nursing and the Administrator. Facility documentation revealed staff were trained on the following topics and additional training: abuse policy and procedures, residents' rights education and interviewing for abuse, nurse notification and assessment, body audit forms and physician notification of injury unknown origin. Attestations related to the abuse training were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working their next shifts. Newly hired staff received an in-service prior to working and this was verified by the facility trainers and orientation form. The facility alleged compliance as of 8/22/22.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 13 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the staff failed to report an allegation of employee to resident abuse to the Administrator immediately. This was evident for 1 of 3 residents reviewed for allegations of abuse. (Resident #13). Findings included: The facility's Abuse, Neglect and Exploitation Policy dated 11/1/22 read in part: "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect,	F 607	1. When the Administration was informed of the allegation on 8/15/2022 the investigation was initiated and the Initial Report for alleged abuse was submitted immediately upon notification. 2. On 6/2/2023 the Administrator audited reported allegations of abuse and/or neglect from the last 60 days to verify 24 hour and 5-day reports were completed and submitted timely as required by the regulation and Elder Justice Act. 3. On 8/22/2022 the Director of Nursing did one on one education with the licensed practical on he abuse policy	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 14 exploitation and misappropriation of resident property. The components of the facility abuse prohibition plan included: The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." A review of a progress note dated 8/14/22 at 11:00 pm read in part, Resident #13 alleged Nursing Assistant (NA #1) grabbed her face and neck. A further review of the progress note read in part "on 08/14/22 Resident #13 was heard cursing very loud from her room. Writer was on the hallway passing medicine and heard the resident. The Nursing Assistant (NA #1) stepped out of the room and said, "I am trying to help her, but she is cursing me" Another NA was sent in the room to help with putting Resident to bed. That was after 10:30 pm. At 11:00 pm the police rang the bell and indicated they had received a call from Resident #13. The police went into the room and came back 10 minutes later and stated he could not find any injury or abuse by looking at the resident. The writer did not find physical injury at the time of assessment. The police left the building and called back to the facility at 12:00 am for information about NA #1 and the witness." Attempts to contact Nurse #1 by telephone were unsuccessful, and a voice message was left for	F 607	which states, Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. immediately, but not later than 2 hours after the allegation is made if the event that cause the allegation involved abuse or result in serious bodily injury., or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury&. On 6/2/2023 Regional Nurse Consultant educated the leadership team, including the Administrator and Director of Nursing on the abuse policy which states, Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. immediately, but not later than 2 hours after the allegation is made if the event that cause the allegation involved abuse or result in serious bodily injury., or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury&. Effective 6/2/2023, the Administrator and designee educated current staff members on reporting all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property, are reported immediately to the Administrator and/or Director of Nursing. Education will continue in orientation with new hires.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 15 Nurse #1 to return call. No return call was received. During an interview with the Administrator on 5/11/2023 at 1:30pm, he indicated he was notified of the alleged allegation of abuse to Resident #13 on 08/15/22 at 11:44 am. The Administrator indicated he reported the initial allegation to the state on 08/15/22 at 1:00pm. During an interview with the Administrator on 5/11/23 at 3:55 pm, he indicated it was his expectation to follow the abuse policies of the facility. He indicated he expected staff to call him and or the DON immediately with a report of abuse.	F 607	In-person and/or via phone. 4. Regional Director of Operations or designee will monitor 24 hour and 5-day reports to ensure reports are sent in according to the regulations weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 16	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 17 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of discharge to the ombudsman for 1 of 1 resident (Resident	F 623	1. Resident #246 no longer resides in the facility. 2. On 6/13/2023 the Regional Nurse	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 18 #246) reviewed for discharge to the hospital. This practice had the potential to impact other residents. The findings included: Resident #246 was admitted on 3/22/22. Review of nursing note dated 12/8/22, revealed Resident #246 was sent to the hospital on 12/8/22 and did not return to facility. During an interview with the Social Worker on 5/12/23 at 12:32 pm it was revealed she was responsible for sending the notification to the ombudsman of discharges. The Social Worker stated she notified the ombudsman of discharges that facility initiated but was not aware that she was supposed to send notification for residents that were transferred to the hospital. An interview was conducted on 5/12/23 at 1:22 pm with the Regional Nurse Consultant (who was covering for the Administrator), and she indicated the facility was expected to send facility-initiated discharges and hospital transfers to the ombudsman.	F 623	Consultant notified the ombudsman of the discharges dated 11/1/2023 □ 5/31/2023. 3. On 6/13/2023 the regional nurse consultant educated the Minimum Data Set Nurse, Administrator, and Business office manager on notifying the Ombudsman monthly of any dischargers from the facility. 4. The administrator will audit notification to the ombudsman monthly x 3 months to ensure that notification was sent. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 19 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the bed hold policy to 1 of 1 residents discharged to the hospital (Resident #246). This practice had the potential to impact other residents. The findings included: Resident #246 was admitted to the facility on 3/22/22 and discharged to the hospital on 12/8/22. Resident #246 had a diagnosis including Alzheimer's disease. The significant change in status Minimum Data Set (MDS) dated 11/17/22, indicated Resident #246 cognition was impaired.	F 625	1. Resident #246 no longer resides in the facility. 2. On 6/2/2023 a bed hold was sent to the residents that were discharged to the hospital on the dates of 5/21/2023 to 6/2/2023. 3. On 6/2/2023 the Regional nurse consultant educated the admissions director on calling the resident or family members to ask if they would like to hold the bed for residents that are discharged to the hospital. On 6/2/2023 the Director of Nursing educated the license nurses on sending a bed hold with the resident when they are sent to the hospital and to document that bed hold was sent. Any new hires will be educated in orientation.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 20 A review of nursing note written by Nurse # 9 dated 12/8/22 at 12:58 pm revealed Resident #246 was sent out to the emergency department (ED) per hospice. The family was made aware. Attempts to contact Nurse #9 for an interview were unsuccessful. An interview was conducted on 5/12/23 at 12:32 pm with the Social Worker (SW) and she indicated she was not aware that she was responsible for follow up on of the bed hold policy and had not done so. During an interview on 5/12/23 at 1:22 pm with the Regional Nurse Consultant, and she indicated it was the expectation that the bed hold policy would be sent with the resident by Nursing when a resident was transferred to the hospital and the SW would follow up with the resident representative and/or the resident the next day after transport to the hospital.	F 625	4. The administrator will review residents sent to the hospital Monday through Friday x 8 weeks to ensure a bed hold was sent with the resident to the hospital. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan with measurable goals and objectives to address nutrition for 1 of 25 residents (Resident # 24). Findings included:	F 656	1. Resident #24 care plan was updated to reflect nutritional status on 5/10/2023. 2. On 6/2/2023 the Minimum Data Set Nurse reviewed current residents care plans to ensure nutritional status was reflected. Corrections completed on 6/8/2023.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 22 Resident #24 was readmitted on 5/5/23 with diagnoses that included end stage renal disease, and dependence on Hemodialysis. A review of the admission Minimum Data Set (MDS) assessment dated 1/9/23 revealed the resident was admitted to the facility on 1/2/23. Resident was assessed as cognitively intact and needed extensive assistance with one-person physical assistance for activities of daily living (ADL). Assessment indicated Resident #24 was receiving dialysis. Review of the Care Area Assessment (CAA) revealed the resident was triggered for Nutrition and Nutrition status to be addressed in care plan. Review of Resident #24's care plan revealed the resident was not care planned for nutrition. During an interview on 5/10/23 at 11:28 AM, the Dietitian (RD) stated the resident was on renal diet and was on supplements to meet protein needs. The RD indicated the resident's care plan related to nutrition must have been missed. The resident needed a care plan as Resident #24 was a dialysis resident, on a special diet and was prone to nutrition related issues. During an interview on 5/11/23 at 8:03 AM, The MDS coordinator stated she was hired at the end of January and did not complete the resident's admission assessment. The MDS coordinator further stated that when the CAA's were triggered, a care plan for the triggered area was completed. The MDS coordinator indicated she reviews the CAA section on the MDS assessment and ensures the triggered areas had care plans completed by the respective departments. She stated Resident #24 was assessed as needing a	F 656	3. On 6/2/2023 the Regional Nurse Consultant educated the Minimum Data Set Nurse on ensure residents care plans include nutrition status. 4. The Administrator or designee will monitor 6 care plans weekly x 8 weeks to ensure residents care plans reflect nutrition status. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 therapeutic/ special diet and assessment indicated the resident was on Dialysis. She added the resident needed to be care planned for nutrition. MDS coordinator stated as she had not completed the assessment, she was unsure why the care plan was not completed. On 5/11/23 at 3:38 PM, the facility Administrator was interviewed. He indicated it was the expectation that the residents be care planned in detail when CAAs were triggered for continuation of care.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to involve residents and/or resident's representatives in the care planning process for 1 of 1 sampled resident reviewed for care plan participation (Residents # 2). The findings included: Resident #2 was readmitted on 2/21/23 with diagnoses in part, paraplegia, liver carcinoma and heart failure. A record review of the most recent admission Minimum Data Set (MDS) dated 2/28/23 revealed Resident #2 was admitted to the facility on 2/15/10. The resident was assessed as cognitively intact and was dependent on staff for most of the activity of daily living. Review of the resident's care plan revealed it was reviewed by staff on 3/9/23, but there was no indication that the resident or resident's family participated in the care plan meeting or in the development of Resident #2's plan of care. During an interview on 5/8/23 at 12:39 PM, Resident #2 stated the facility had not invited the resident to any care plan meeting or to participate in developing the resident's plan of care. Resident #2 indicated she did not participate in her care plan meeting. During an interview on 5/11/23 at 8:15 AM, Social Worker (SW) indicated she reviewed the	F 657	1. Resident #2 attended a care plan meeting on 6/9/2023. 2. Current residents reviewed to ensure the Representative Party was involved in the care planning process. Care plans were scheduled. Completed 6/6/2023. 3. On 6/2/2023 the Regional Nurse Consultant educated the Minimal Data Set Nurse on inviting the resident and/or the Representative Party to the care plan meeting. 4. The administrator will attend 4 care plan meetings to ensure the resident and/or the Representative Party was invited in the care planning process weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25	F 657		

Assessment Review Date (ARD) for MDS that was given by the MDS coordinator at the beginning of the month. The resident's family/ representatives were contacted and asked if they would like to participate in the care plan meeting via phone or in person. A date was scheduled for the meeting based on their convenience. The SW stated if the resident was their own responsible party, then they were contacted to see if there was anyone, they would like to invite to their care plan meeting. Resident #2 was her own responsible party and care plan meetings were usually conducted in the resident's room. SW was unsure when the previous care plan meeting was conducted for the resident. SW stated there was no documentation to prove the care plan meeting was conducted and who attended the meeting. SW also indicated there was no written information available to indicate the care plan meeting was completed for the resident.

During an interview on 5/11/23 at 8:08 AM, the MDS coordinator indicated she sends out a calendar to the SW, indicating all the residents whose ARD's were up for the month. The MDS coordinator stated the SW sets up the care plan meeting dates with residents and resident's family members based on this calendar. The MDS coordinator further stated she was hired in January 2023 and was unable to confirm or deny if any care plan meeting was conducted. The MDS Coordinator stated there was no documentation to prove if a care plan meeting was conducted for Resident # 2 and there was no documentation to indicate who attended the meeting and what was discussed.

During an interview on 5 /11/23 at 3:39 PM, The

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26 Administrator stated the expectation was that care plan meetings and notifications were per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. He further stated residents and/or resident's representatives should be involved in the care plan meeting and make decisions about their care. The Administrator indicated documentation related to the care plan attendance and meeting should be completed in a timely manner.	F 657		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 27 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on facility staff, Nurse Practitioner (NP) interviews, Pharmacist, and record reviews, the facility failed to administer a sedative medication to a resident 6 of 6 nights during the stay in the facility. This occurred for 1 of 22 residents (Resident # 245) whose medications were reviewed. The findings included: Resident # 245 was admitted to the facility on 9/23/22 with diagnoses that included aftercare following total knee replacement and insomnia. She had a resident-initiated discharge home on 9/30/22. The Minimum Data Set 5-day assessment revealed Ms. Bell was cognitively intact. The care plan dated 9/26/22 revealed Resident # 245 had ADL self-care performance deficit related to generalized weakness and pain due to recent surgery. Review of admission orders dated 9/23/22 revealed Zolpidem Tartrate (Ambien) Tablet 10 milligrams (mg); Give 1 tablet by mouth at bedtime for difficulty sleeping Take 5 to10 mg by	F 755	1. Resident #245 no longer resides in the facility. 2. On 6/2/2023 the Director of Nursing and nurse management audited the medication carts by using the medication administration record to ensure current residents medication was available to administer as ordered. The medical physician and Representative Party was called and informed if medication was not available. Medication was immediately ordered. Completed 6/3/2023. 3. On 6/2/2023, the Regional Nurse Consultant educated the Director of Nursing and nurse managers on when a new admission arrives at the facility it is their responsibility to ensure medications arrive in a timely manner to administer as ordered. If medications are available in the emergency kit, they are to pull the medication until it arrives from pharmacy. The Director of Nursing and/or designee educated the licensed nurses regarding the process of ensuring medications are given as ordered by the medical physician. The Director of Nursing and/or designee educated licensed nurses on using the emergency kit if the medication	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 28	F 755		

mouth at bedtime. It was due to be administered at 9:00 PM.

The Electronic Medication Administration Record (EMAR) for Resident # 245 revealed Ambien did not have administration documented on 9/23/22, 9/24/22, 9/26/22, 9/27/22, 9/28/22, and 9/29/22. There were chart codes on the EMAR with the number '9' that indicated 'see nurse note' for 9/23/22, 9/24/22, 9/26/22, 9/27/22, and 9/28/22. On 9/29/22 there was blank medication administration on the EMAR indicating Ambien was not given. Ambien was documented as given on 9/25/22.

The Nurse Practitioner (NP) seen Resident # 245 on 9/26/22 and her progress note revealed insomnia was a diagnosis and Ambien 10 mg tablet; 5 to 10 mg to be administered at bedtime.

An interview on 05/09/23 at 11:25 AM with Regional Nurse Consultant # 1 revealed she was unable to provide the nurses ' notes documentation for the dates with the number ' 9 ' chart code on the EMAR for 9/23/22, 9/24/22, 9/26/22, 9/27/22, and 9/28/22. She was unable to verify how the Ambien was documented as given on 9/25/22.

An interview on 5/11/23 at 8:05 AM was conducted with the Director of Nursing (DON). She indicated she was unaware that Resident # 245 did not receive Ambien during her stay and unaware the Ambien was not delivered from the pharmacy when the admission orders were faxed to them upon admission on 9/23/22. She indicated a provider ' s prescription for the Ambien was required to be faxed to the pharmacy. The DON revealed Ambien was not

is not available. If the medication is not in the emergency kit the nurse will call the pharmacy to receive it from the backup pharmacy. New licensed nurses will receive this education in orientation.
4. The Director of Nursing or designee will review new admission orders on the next business day to ensure medications are available to administer. Director of Nursing or designee will review 8 residents to ensure they are receiving their medications as ordered weekly x 8 weeks. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 29	F 755		

available in the in-house medication dispense (PYXIS) machine. The DON revealed that the nighttime nurses should have contacted the pharmacy, the provider, and herself when they could not locate the Ambien during their medication pass. She further revealed she did not know why the nurse documented the Ambien was given on 9/25/22 because it was not delivered or available in the facility.

An interview was conducted on 5/11/23 at 11:58 AM with the NP. She indicated not being able to have scheduled Ambien was not good for Resident # 245 due to her diagnosis of insomnia. The NP explained the nursing staff should have contacted the nighttime on call provider to see if there was an alternative in stock medication such as melatonin if the Ambien was not available during medication pass. She revealed the normal process for obtaining Ambien, which is a controlled substance, was the requirement of a provider ' s prescription to be sent in with the admission orders so it will be delivered upon admission to the facility. The NP stated she was not aware the Ambien was not administered to Resident # 245 and the nursing staff should have addressed the availability of the medication early in her stay at the facility.

On 5/12/23 at 8:25 AM during a telephone interview with night nurse # 1 he indicated he did not locate the Ambien during his medication pass to Resident # 245 and did not notify the pharmacy, provider, or the DON.

A telephone interview was conducted on 5/12/23 at 10:15 AM with the facility ' s Pharmacist. She revealed the Ambien for Resident # 245 was not delivered to the facility because they did not

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 30	F 755		

receive a prescription when the admission orders were faxed in on 9/23/22. The Pharmacist indicated Ambien was a controlled drug that required a prescription to be faxed in so it may be delivered. The Pharmacist also indicated the nursing staff should have contacted the pharmacy when they noticed the medication was not able to be located during medication administration on nights.

An interview on 5/12/23 at 11:15 AM with Nurse # 4 who placed the admission orders in the computer for Resident # 245. Nurse # 4 indicated she placed the admission orders in the computer on 9/23/22 and was waiting on resident to arrive to the facility to receive the prescription so she could fax it to the pharmacy. Nurse # 4 revealed the prescription for the Ambien was not in the admission packet when Resident # 245 arrived at the facility from the hospital. Nurse # 4 further revealed that it was the responsibility of the admitting nurse of Resident # 245 to obtain the prescription from the facility ' s provider if it was not included in the admission packet.

On 5/12/23 at 11:20 AM during an interview with Regional Nurse Consultant #2, she stated she expected prescriptions for all controlled substances to be obtained by the nursing department and faxed to the pharmacy so the medication could be delivered on the night of admission to the facility.

Telephone interviews with the two other night nurses that provided care for Resident # 245 during her stay were unsuccessful.

The Medical Director was out of the country and not available for telephone interview.

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Director interview the facility failed to follow physician orders to obtain a hemoglobin A1c (HbA1c) every three months as ordered for Resident #33 for 1 of 24 residents reviewed. Findings included: Resident #33 was admitted to facility 3/11/22 and had a diagnosis of type 2 diabetes. Annual Minimum Data Set (MDS) dated 3/15/23 revealed Resident #33 was cognitively intact.	F 757	1. Resident #33 labs were drawn and resulted on 5/18/2023. 2. On 6/2/2023 the Regional Nurse Consultant and Director of Nursing reviewed current residents orders from 1/1/2023 through 6/2/2023 to ensure labs were drawn as ordered by the medical physician. Medical physician were called if labs were not drawn to obtain new orders. Completed 6/2/2023. 3. On 6/2/2023 the Regional Nurse Consultant educated the Director of Nursing and Nurse Managers on	6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 32 A review of Resident #33's care plan dated 3/14/22 revealed Resident had diabetes. Goal was Resident would have no complications related to diabetes. A review of Resident #33's physician orders revealed the following: order dated 9/28/22 Trulicity Solution Pen-injector 0.75 MG/0.5ML (Dulaglutide) Inject 0.75 milligram subcutaneously one time a day every Thursday. order dated 10/10/22 Lantus SoloStar 100 UNIT/ML Solution pen-injector Inject 30 units subcutaneously every morning and at bedtime. order dated 12/21/22 Humalog KwikPen 100 UNIT/ML Solution pen-injector Inject subcutaneously after meals. A review of physician orders for the month of September 2022 revealed an order to obtain HbA1c (a blood test that measures your average blood sugar levels over the past three months) every three months. A review of lab dated 9/30/22 resulted in HbA1c result of 14.3 and normal range 4.0-6.0. During an interview with the Director of Nursing (DON) on 5/10/23 at 5:35 pm it was indicated there were no other HbA1c lab results for Resident #33. The DON stated she contacted the lab company on 5/10/23 and they informed her there had not been a HbA1c for Resident #33 in December. She indicated the facility had changed lab companies in February and was unable to get information from the company. The DON verified she could only locate the 9/30/22 HbA1c lab	F 757	reviewing orders during business hours to ensure labs were drawn as ordered by medical physician. If labs are not drawn as ordered the Director of Nursing will call the ordering physician to obtain new orders. 4. Director of Nursing or designee will review orders to ensure labs were drawn as ordered Monday through Friday x 8 weeks. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 33 result. The DON stated it was her expectation to follow the physician orders for labs as ordered. On 5/11/23 at 10:00 am an interview was conducted with the Medical Director. He indicated he had been working in the facility for little over 2 months. He stated he would expect labs to be conducted as ordered, which included the order for the HbA1c for Resident # 33 to be checked every 3 months as ordered. An interview was conducted on 5/11/23 at 11:48 am with the Nurse Practitioner (NP) and she stated a HbA1c lab was ordered for every 3 months for Resident #33. She indicated the facility had been through several lab companies, and it was difficult to get labs. She stated she expected the HbA1c to be drawn every 3 months as ordered.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34	F 842		

(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on facility staff and record reviews, the facility failed to accurately document a sedative medication for a resident 1 of 6 nights during the stay in the facility. This occurred for 1 of 22 residents (Resident # 245) whose medications were reviewed. The findings included: Review of admission orders dated 9/23/22 revealed Zolpidem Tartrate (Ambien) Tablet 10 milligrams (mg); Give 1 tablet by mouth at bedtime for difficulty sleeping Take 5 to10 mg by mouth at bedtime. It was due to be administered at 9:00 PM. The Electronic Medication Administration Record (EMAR) for Resident # 245 revealed Ambien did not have administration documented on 9/23/22, 9/24/22, 9/26/22, 9/27/22, 9/28/22, and 9/29/22. There were chart codes on the EMAR with the number '9' that indicated 'see nurse note' for 9/23/22, 9/24/22, 9/26/22, 9/27/22, and 9/28/22. On 9/29/22 there was blank medication administration on the EMAR indicating Ambien was not given. Ambien was documented as given on 9/25/22.	F 842	1. Resident #245 no longer resides in the facility. 2. On 6/2/2023 the Regional Nurse Consultant and Director of Nursing reviewed current residents Medication Administration Record to ensure accurate documentation. The Medical physician was called to review the results. Completed 6/8/2023. 3. On 6/2/2023 Director of Nursing educated the licensed nurses and medication aides on accurately documenting in the resident's medication administration recorded. Education included if the medication is not available the licensed nurses and medication aides will retrieve the medication from the emergency backup system. If the medication is not available from the emergency backup system, the licensed nurses will call the medical doctor to obtain a new order if needed and the pharmacy to see when the medication is to arrive. The license nurses and medication aides will notify the nurse managers regarding if the medication is not available for guidance if needed. 4. Director of Nursing or designee will	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 36 An interview on 05/09/23 at 11:25 AM with Regional Nurse Consultant # 1 revealed she was unable to verify how the Ambien was documented as given on 9/25/22 since the medication was not delivered to the facility or available in the facility. During an interview on 5/11/23 at 8:05 AM with the Director of Nursing (DON) she indicated she was unaware the Ambien was not delivered from the pharmacy when the admission orders were faxed to them upon admission on 9/23/22. She indicated a provider's prescription for the Ambien was required to be faxed to the pharmacy. The DON revealed Ambien was not available in the in-house medication dispense (PYXIS) machine, therefore it was not available to the nurses for emergency backup. She indicated she did not know why the nurse documented the Ambien was given on 9/25/22 at 9:00 PM because it was not delivered or available in the facility. The DON further indicated nurses should not document medications as administered in the EMAR if the medication was not given or available. During an interview on 5/12/23 at 11:20 AM with Regional Nurse Consultant #2 she stated she was unaware of how the Ambien could be administered if the medication was not delivered or available in the facility.	F 842	review 8 residents medication administration record to ensure accuracy of documentation weekly x 8 weeks. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867		6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 37	F 867		

procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 38	F 867		

and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 39 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 5/12/23. This was for a deficiency that was cited in the area of Development/implement a Comprehensive Care plan on 5/28/21 and recited on the current recertification and complaint survey on 5/12/23. The QAA committee additionally failed to maintain	F 867	1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F656 and F925 on 6/8/2023. 2. Current residents are potentially affected by this deficiency. 3. The Regional Nurse Consultant educated the Administrator and Director of Nursing on the appropriate functioning on	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 40 implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 6/16/22. This was evident by the deficiency in the areas of maintain an effective pest control program originally cited on the recertification and recited on the current recertification and complaint survey of 5/12/23. The repeated citations during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included The tags were cross referenced to: F 656 Based on record review and staff interview, the facility failed to develop a care plan with measurable goals and objectives to address nutrition for 1 of 25 residents (Resident # 24). During the previous survey on 5/28/21, the facility failed to develop a comprehensive person-centered plan of care that included the daily use of an antipsychotic and antianxiety medication. This was evident for 1 of 5 residents reviewed for unnecessary medications. F 925 Based on observations, record review, resident and staff interview the facility failed to provide a pest free living environment for 4 of 4 residents residing in the facility. (Resident #243, Resident #38, Resident #2, and Resident #18). During the previous survey on 6/16/22, the facility	F 867	the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F565 and F925 on 6/2/2023. On 6/2/2023, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Unit Support Nurse, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. 4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility□s progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.	

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 41 failed to provide a pest free living environment for 8 of 91 residents residing in the facility. On 5/12/23 at 3:50 pm, during interview with the Corporate Consultant Nurse, her expectation for the facility do not have repeat tags. She indicated that the facility to have monthly quality assurance meetings with team. She added that the Administrator to had received the corporate quality assurance forms and she would be reviewing them.	F 867		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide a pest free living environment for 4 of 4 residents residing in the facility. (Resident #243, Resident #38, Resident #2, and Resident #18). Findings Included: a. During the facility tour on 5/8/23 at 10:00 AM, an observation was made of a roach crawling on the 100 hallway. b. During a Resident Council meeting on 5/10/23 at 10:00 AM, residents who attended the meeting (Residents #38, Resident #18, and Resident #2) reported that the facility had issues with pests in their room. There were roaches in their rooms and in the hallways.	F 925	1. Residents #243, #38, #2, and #18 rooms were inspected, cleaned, and treated for pests. 2. The facility was inspected by the administrator and designees for pest sightings on 6/2/2023. No pest was seen at the time. The Pest control company was issued a notice of termination. A new contract was signed 6/8/2023. Pest control services will treat weekly and as needed. 3. The Administrator and designee educated staff to place work order in if pest were sighted timely. The department heads received education from the Regional Nurse Consultant during the angel rounds they are question the alert and oriented residents if they have seen pests. The department heads will do	6/13/23

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 42	F 925		

Resident #38 (President of Resident Council) was interviewed on 5/10/23, at 4:00 PM. The resident indicated that the facility had issues with pests. Resident #38 stated she saw a roach crawling on the wall beside the bathroom door in her room last night (on 5/9/23). Resident #38 indicated she had been complaining in the Resident Council meeting for months and that concerns had not been addressed.

c. On 5/8/23 at 11:39 AM, Resident #243 was interviewed, and the resident reported that roaches were crawling on the light fixture and on the ceiling in his room. He indicated a roach had fallen on him. The resident stated the roach was crawling on him, and he had a fall trying to get away from it. Resident #243 indicated he reported it to the nurse on duty. Review of the admission Minimum Date Set Date May 203 indicated Resident #243 was assessed as cognitively intact.

During a second interview with Resident #243 on 5/10/23 at 2:00 PM, the resident stated he had observed roaches again last night (5/9/23). The resident indicated he was upset with roaches in his room.

During an interview on 05/12/23 at 8:00 AM, Nurse #10 indicated she was assigned to the resident during the night of 5/8/23. Nurse #10 stated she did not see roaches in Resident #243's room on the day of his fall. She, however, stated she had seen roaches occasionally during the night in the hallways. Nurse #10 indicated she had reported these issues with the roaches to the Director of Nursing (DON) and the Administrator.

d. Resident #2 was interviewed on 05/12/23 at

observations during their angel rounds. If a pest was sighted, they are to report it immediately to the administrator. The administrator will call the pest control company and have maintenance to treat the room as well. New hires will be educated on to place work order in if pest were sighted timely in orientation.
4. The administrator and designee will audit 5 rooms per hall to ensure no pests are sighted weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed.
Administrator will review the results of weekly audits to ensure any issues identified are corrected.

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 43	F 925		

11:30 AM and indicated that the facility had issues with roaches for a year. She indicated that the roaches crawled on her bed, side table and privacy curtain during the late evening on 5/11/23 and early morning on 5/12/23. Resident #2 also indicated that this information had been discussed in Resident Council, however nothing was done. Resident #2 also indicated she reported this information to staff assigned to her regularly. She added the cockroaches appeared during the evening and early morning "most of the time".

Interview on 5/11/2023 at 10:30 AM, Nurse Aide (NA)# 10 indicated she had observed roaches on the hallway. NA #10 added she had reported the sightings to the Administrator and Director of Nursing.

Interview was conducted with Nurse #10 and Nurse #11 together on o 5/12/23 at 11:30 PM. Both nurses indicated they were assigned to 100-hall indicated and worked during the night shift. Nurses stated the facility had issues with roaches for years. Both nurses indicated they avoid putting anything on the floor because of these roaches crawling on them. Nurse #10 and Nurse #11 indicated they had reported this issue and both DON and Administrator were aware of this. Nurses reiterated that the roach issues were bad.

Review of the pest control contract dated from July 2022 to May 2023, revealed in part, "service would be provided monthly for roach and rodent elimination. Insecticide could be used in vacant resident rooms upon request." Review of the pest control contract for the month of April 2023 revealed weekly visits to the facility.

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 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDEN PLACE CENTER FOR NURSING AND REHABILITATION	1201 CAROLINA STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 44 Review of a pest control service report from July 2022 to May 2023 revealed insecticide was applied to target roaches. This was applied to fire door introduction point, front door introduction point, interior hallways, interior kitchen area, interior laundry / housekeeping areas, and some vacant rooms. Review of the pest control service did not include treatment of Resident #243's, Resident #38's, or Resident #2's rooms during the month of May 2023. During an interview on 5/12/23 at 1:00 PM, the Pest Control Technician stated he had been providing pest control services at the facility for seven months. He stated he treated the facility on 5/5/23 and had not seen any signs of living roaches. He explained he saw dead roaches in the common area and vacant rooms. He explained he sprayed insecticide on interior areas the best he could. The technician added he could only treat a resident room if it was vacant. He stated the facility did not routinely request him to treat specific resident rooms. He indicated he would work with the facility to come up with a plan to eliminate pests and this plan would need to be weekly treatments if not several days during the week. During an interview on 5/12/23 at 3:54 PM, the Corporate Consultant Nurse revealed the Administrator was aware of the pest issues in the facility. The Corporate Consultant Nurse also indicated that the expectation was when any resident complains of pests, the Pest Control company would service their room and surrounding areas. Administrator was not available for interview.	F 925		