STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING ______ B. WING ______	C 09/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was conducted from 9/6/2023 through 9/7/2023. Event ID#4O4Z11. The following intakes were investigated NC00206610, NC00206466, NC00206030, NC00206693, NC00206060. 1 of the 11 allegations resulted in deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, hospice nurse, and facility staff, the facility failed to treat terminal agitation in 1 of 1 (Resident #3) resident reviewed for hospice. The findings included: Resident #3 was admitted to the facility on 1/26/2022 with diagnoses that included late onset Alzheimer's dementia. The resident's medical record included an order for hospice services dated 2/8/2023. Resident #3's discharge Minimum Data Set (MDS) dated 8/19/2023 indicated the resident was severely cognitively impaired and required	F 684	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 is no longer at the facility. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/27/23, an audit was completed on all hospice residents to ensure that any prn medication orders were accurate and that they were being administered as prescribed. Audit was completed on	10/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2023

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

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F 684	Continued From page 1 extensive assistance with activities of daily living and personal hygiene. During the assessment period she received pain medications, both scheduled and as needed. Resident #3 received hospice services during the assessment period. Resident #3's comprehensive care plan was last revised 5/6/2023 and included a focus for hospice services and experiencing a peaceful and dignified death. Interventions included coordinating with the hospice team to ensure residents experienced as little pain as possible. The resident's medical record included the following orders: Give Lorazepam 0.5 MG tablet by mouth twice daily. The order had a start date of 8/7/2023. Give morphine 5 milligram (MG) solution every 4 hours by mouth for pain or shortness of breath. The order had a start date of 8/18/2023. Give morphine 5 MG solution every 2 hours as needed for pain or shortness of breath. The order had a start date of 8/18/2023. A progress noted completed by Hospice Nurse #2 dated 8/18/2023 indicated the resident appeared to be transitioning towards end of life/actively dying and had been moved into a private room per family's request. On 8/18/2023 at 9:21PM Hospice Nurse #2 documented she was in the facility and assessed Resident #3. The Hospice nurse's progress noted indicated Resident #3 had a morphine order scheduled every 4 hours and an "as needed" (prn) dose that could be given every 2 hours.	F 684	9/28/23 by administrative nurses (includes Director of Nursing, Unit Manager and Staff Development Coordinator). No issues were found. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur: Any new hospice orders will now be given directly to an administrative nurse. The orders will be reviewed during the morning clinical meeting the next day, to ensure that they have been initiated, are being followed, and are appropriate for the resident. Staff development Coordinator educated licensed nurses on the importance of ensuring that any prn medications is administered as prescribed and upon request. Education was conducted on 9/27/and completed on 9/30/23. Any licensed nurses not educated prior to 9/30/23 will be educated prior to their next working shift. New hires will be educated during orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: All hospice residents will be assessed by a licensed nurse at least weekly X4, monthly X3, and quarterly thereafter to ensure that any observations of distressed are being properly addressed	

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Additionally, Hospice Nurse #2 instructed Medication Aide (unnamed) to continue Ativan and trained Medication Aide on how to crush and give Ativan.

Give Haloperidol 0.5 MG tablet by mouth every 4 hours for terminal agitation/restlessness. The order had a start date of 8/19/2023.

Resident #3's Medication Administration Record (MAR) for August 2023 revealed the resident was given morphine doses as follows:
8/19/2023 1:00AM 5MG morphine solution given (scheduled every 4 hours).
8/19/2023 1:08 AM 5MG morphine solution given (every 2 hours as needed).
8/19/2023 5:00 AM 5MG morphine solution given (scheduled every 4 hours).
8/19/2023 5:33AM 5MG morphine solution given (every 2 hours as needed).
8/19/2023 8:15 AM 5MG morphine solution given (every 2 hours as needed).
8/19/2023 9:00AM 5MG morphine solution given (scheduled every 4 hours).
8/19/2023 1:00 PM 5MG morphine solution given (scheduled every 4 hours).

The prn morphine was not given again until 3:01 PM just prior to the resident being transported to a hospice house.

On 9/6/2023 at 10:07AM a phone interview was conducted with Resident #3's responsible party (RP). She stated she arrived at the facility the morning of 8/19/2023 prior to 8:00AM. She stated the resident was agitated, restless (pulling at her covers and gown), yelling for help and crying. The RP stated she asked the Medication Aide assigned to her mother if there were any

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and medication is being administered as prescribed. Findings will be documented on Quality-of-Care Audit Tool.

The Director of Nursing will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance.

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F 684	Continued From page 3	F 684		

additional medications to make the resident more comfortable. The Medication Aide told her the resident had received the scheduled dose of morphine at 5:00AM and was not due for another dose until 9:00 AM. The Medication Aide stated she would need to get a nurse to assess and administer the prn dose because she could not. The RP stated she called hospice to make them aware the resident was not comfortable. The RP stated the Director of Nursing (DON) administered the prn dose around 8:15AM. The RP stated hospice called her back around 9:00AM and let her know the nurse would be in the facility at some point that day. Initially, the resident seemed more comfortable after the prn dose of morphine but after an hour became restless and agitated again. The RP stated she wasn't yelling out, but she was restless, crying, and would become more agitated if touched. She did not feel like the resident was comfortable. The RP stated she spoke with the DON and Medication Aide again regarding making the resident more comfortable, but the DON stated she did not feel like the resident needed any additional medication. The RP stated the resident did not receive any medications for comfort between 9:00AM and 1:00PM. During this time, the resident continued to experience restlessness, agitation, and crying. The resident became extremely agitated when the DON and Medication Aide came in the room to perform incontinent care but still was not given any additional medication to make her more comfortable. She did not recall what time incontinence care was provided.

An interview was conducted with the Medication Aide and the DON at 12:47PM on 9/6/2023. The Medication Aide stated she gave the scheduled

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F 684	Continued From page 4	F 684		

morphine solution but did not give the scheduled Ativan or Haloperidol because the resident could not swallow tablets. She further stated she could not give prn doses without a nurse assessing the resident. She stated she did not document assessments on the resident. The Medication Aide described the resident as "fidgeting" by pulling at sheets. She stated when she assisted with incontinence care the resident did begin to kick and resist.

In the same interview the DON stated she did not feel the resident needed additional medications for comfort between 9:00AM and 1:00PM. She did not recall the resident yelling out or crying after the 9:00AM dose of morphine. She stated the resident would kick and become agitated during incontinent care but would stop resisting when not touched. She stated the resident was pulling at her covers and she had one leg thrown off the bed, but she did not believe the resident was in any pain. The DON stated she did call hospice on the morning of 8/19/2023(uncertain of the time) to request a visit from the hospice nurse due to the family's concerns. She was told the family had already called for a visit. The DON stated she did try to provide education to the family regarding end of life and what to expect. She further stated she did not document any assessments of the resident. She only documented that the morphine doses were effective.

On 9/6/2023 at 11:45AM a phone interview was conducted with the Hospice Nurse #1. She stated she was the on-call nurse that weekend and she was not familiar with the resident or the resident's family. The Hospice Nurse stated she arrived at the facility sometime between 1:00PM and

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F 684	Continued From page 5 2:00PM, she was not exactly sure of the exact time. She observed the resident lying on her back and mouth breathing. She stated the resident was restless, picking at her covers, moaning, and became more agitated when touched. She stated the resident's respiratory rate was 24-32 and shallow. The resident did not make eye contact or speak but became agitated (moaning and kicking her legs) when stimulated. She further stated the resident was actively dying and was not comfortable. The Hospice Nurse stated she spoke with the DON regarding the resident's agitation. The DON informed her Medication Aides cannot assess or give prn medication and she had "other stuff going on". The Hospice Nurse called the on-call Hospice provider and got a new order for the morphine to be scheduled instead of prn. However, the family expressed concern about the facility's ability to keep the resident comfortable and the resident was transferred to a hospice house later that afternoon.	F 684		