PRINTED: 08/20/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCT	ION	COM	E SURVEY PLETED
		345006	B. WING _				C / 17/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER	1	3724 WIRELES	ess, city, state, zip code es drive ro, nc 27455	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(E/	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprel §483.21(b)(1) The faimplement a comprecare plan for each resident rights set fo §483.10(c)(3), that i objectives and timef medical, nursing, an needs that are ident assessment. The codescribe the followir (i) The services that or maintain the residency of the services that or maintain the residency of the services that under §483.24, §483.10, inclustreatment under §484 (iii) Any specialized rehabilitative services provide as a result of recommendations. I findings of the PASA rationale in the resident's represent (A) The resident's general desired outcomes. (B) The resident's purpose for this purpose for	hensive Care Plans acility must develop and chensive person-centered chesident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's ad mental and psychosocial ified in the comprehensive comprehensive care plan must ag - are to be furnished to attain dent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights ading the right to refuse 3.10(c)(6). services or specialized ces the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record. ith the resident and the ative(s)- coals for admission and reference and potential for cilities must document t's desire to return to the essed and any referrals to es and/or other appropriate	F	556	TITLE		8/13/18 (X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/06/2018

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.

Electronically Signed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUCTION		TE SURVEY MPLETED
		345006	B. WING			C 7/17/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7771772010
				3724 WIRELESS DRIVE		
BLUMENT	THAL NURSING & REHA	BILITATION CENTER		GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 1	F 65	6		
		in accordance with the				
		h in paragraph (c) of this				
	section.	,				
	This REQUIREMENT	is not met as evidenced				
	by:					
		iew, observation and staff		This plan of correction constitute	s a	
	interview, the facility	•		written allegation of compliance.	is also of	
	comprehensive meas Resident #7 that add	•		Preparation and submission of the correction does not constitute an	•	
		residents reviewed for		admission or agreement by the p		
	contractures.	coldents reviewed for		the truth of the facts or alleged or		
				correctness of the conclusions se		
	Findings included:			on the statement of deficiencies.		
				of correction is prepared and sub	•	
	I .	nitted to the facility on 9/8/17		solely because of the requiremer		
	with numerous diagn			state and federal law, and to den		
	dementia, coronary a			the good faith attempts by the pr		
	contracture of the rigi	ht hand.		improve the quality of life of each F656	resident.	
		Minimum Data Set (MDS)		ROOT CAUSE		
		16/18 coded the Brief		The alleged noncompliance resu	ited from,	
		Status (BIMS) a score of 3		the facility failed to develop a		
		cognitive impairment) with		comprehensive measurable for re	esident	
		ation on one side of the er Section (O) the MDS		#7 that addressed a right hand contracture. MDS coordinator #2	indicated	
	''	days Resident #7 received		during an interview on 7/17/2018		
	I .	ion and splint assistance		was an oversight on her part.	triatrit	
	was zero (O).	ion and opinit addictance		IMMEDIATE ACTION		
				On 7/17/2017 comprehensive ca	re plan	
	Review of the Care A	rea Assessment (CAA)		for right hand contracture was de	-	
	·	esident #7 had a right-hand		for resident #7 by MDS Coordina	tor #2	
	I .	acility would proceed with		IDENTIFICATION OF OTHERS		
	developing a care pla	an to monitor skin integrity.		On 7/18/18 MDS coordinator #1,		
	Daview of the committee	an dated 5/22/40		coordinator #2 and/or MDS coord		
	1	an dated 5/23/18 revealed		completed an audit of 100 percel		
	hand contracture.	o address the resident's right		current residents in the facility to any other resident with a contrac	-	
		at 4:20 PM with MDS		without a comprehensive care plant		
		tated the facility currently		place. Six other residents were id		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				C 17/2018
	ROVIDER OR SUPPLIER THAL NURSING & REHA	BILITATION CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE REENSBORO, NC 27455	1 011	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 656	does not have a restriplan was not the best needs regarding splir interview on 7/17/18 coordinator #2 who sa mistake for failure that address the right-hard Interview on 7/17/18 Development Coordination should have been with resident's right hand Interview on 7/17/18 Administrator and the was held. The administrator	orative program and the care t to meet the individual ints or contracture. A second at 9:50 AM with MDS stated it was it oversight and to develop a care plan to and contracture. at 11:48 AM with the Staff mator who stated a care plan itten to address the contracture.	F	356	with contractures without care plan in place. On 7/18/2018 comprehensive caplan was developed for each of the six identified residents and filled in individuresident's medical records. Findings of this audit was documented on contract audit tool maintained in the facility compliance binder. SYSTEMIC CHANGES Effective 8/13/2018, MDS coordinator #MDS coordinator #2 and/or MDS coordinator #3 who complete MDS 3.0 assessment for any active resident in the facility is required to assess resident's extremities (both arms & both legs) to determine if a resident has any contracture. MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator will then develop a comprehensive person-centered care plan with measurable objectives and timeline that address identified contracture(s). On 8/6/2018 Regional reimbursement consultant from the management and consulting company that oversee the facility re-educated MDS coordinator # MDS coordinator #2, MDS coordinator # MDS coordinator #2, MDS coordinator Director of Social services #1 , Action Director and Dietary Manager. This education emphasized on the important of developing care plan that reflect resident's medical and clinical condition as indicated on the Care Area Assessment (CAA). Effective 8/13/201 this education is added to new hires orientation education for MDS nurses, Director of Social Services, Activities Director, and Dietary Manager (DM) and the contracture of the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director, and Dietary Manager (DM) and the care Activities Director and Dietary Manager (DM) and the care Activities Director and Dietary Manager (DM) and the care Activities Director and Dietary Manager (DM) and the care Activities	ure #1, he 1, #3, vity ce n 8;	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
			5 14/110			С
		345006	B. WING _			07/17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
RILIMENT	THAI NIIDSING & DEL	ABILITATION CENTER		3724 WIRELESS DRIVE		
DECIMIEN	THAL NORSING & INLI	IABILITATION CENTER		GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	
F 656	Continued From pa	age 3	F	will be provided annually. MONITORING PROCESS Effective 8/13/2018, MDS O will review section V of MDS completed by the MDS coor MDS coordinator #3 or vice ensure that any triggered Coordinate indicated of the recotherwise if the care plan of rationale indicated of the recotherwise if the care plan is developed. Any issues ide this monitoring process will promptly. Findings from this process will be documented plan development monitorin filed in the facility compliance proper follow up is done. The process will take place daily Friday) for two weeks, week weeks, then monthly x 3 mc completed assessments or pattern of compliance is ma Effective 8/13/2018, MDS of MDS coordinator #2 and/or coordinator #3 will monitor of reviewing all new contracture clinical stand up meeting to new identified contracture h developed person-centered measurable objectives and contracture identified withou will be addressed promptly, this monitoring process will documented on a "Stand up form" and filed in the facility binder after proper follow up monitoring process will take	S 3.0 rdinator #2 of versa to are area tracture Cardeveloped or ason of not entified during be addresses monitoring don a "Care ing tool" and ce binder after is monitoring (Monday tookly x 2 more onthis for the until the aintained. Coordinator # MDS compliance be res in the date ensure any mas a locare plan witimelines. And the aintained is compliance by compliance or is done. The coordinator witimelines and the care plan witimelines. And the care plan witimelines are plan witimelines are plan witimelines. The compliance of t	er ng ed 1, by illy nh ny n

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 07/17/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	07/17/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 656	Continued From page	4	F 656	(Monday to Friday) for two weeks, wee x 2 more weeks, then monthly x 3 months, or until the pattern of compliant is maintained. Effective 8/13/2018, MDS coordinator # MDS coordinator #2 and/or MDS coordinator #3 will report findings of thi monitoring process to the facility Qualit Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Execution Director and the Director of Nursing an MDS coordinators (#1, #2, & #3) will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	ce £1, s y e e e e e e e e e e e e e e e e e e
F 677 SS=D	l <u></u>	or Dependent Residents	F 677	Compliance date 8/13/2018	8/13/18
	out activities of daily I services to maintain of personal and oral hyg	ent who is unable to carry iving receives the necessary good nutrition, grooming, and iene; is not met as evidenced			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C 7/47/2049	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		7/17/2018	
TVAIVIL OF T	TO VIDER OR OUT FILE				<i>,</i> _		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		3724 WIRELESS DRIVE			
				GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From page	e 5	F 67	77			
		on, record review and staff alled to cut the fingernails on		F677			
		s dependent on staff for care.		ROOT CAUSE			
		of 1 resident reviewed for		Director of Nursing, and the fa	acility		
	activities of daily livin			Executive Director discussed			
	donvince of daily livin	g (/ 152).		to identify the root cause of the			
	Findings included:			noncompliance. Root cause a	•		
	i manigo moladoa.			conducted revealed, the alleg			
	Resident #7 was adn	nitted to the facility on 9/8/17		non-compliance resulted from			
	with numerous diagn	<u>-</u>		an employee to provide nail of	•		
	dementia, coronary a			identified residents; resident			
	contracture of the rig			#7 is dependent on staff to ca			
		Minimum Data Set (MDS)		activities of Daily living, speci			
		16/18 coded the Brief		care. The root cause analysis			
	Interview for Mental S	Status (BIMS) with a score of		the alleged noncompliance w	as caused by		
	3 (which represented	severe cognitive		the employees' culture within	the facility		
	impairment).			that include, but not limited to), lack of		
	Under Section (G) the	e MDS coded extensive		residents' centered care deliv	ery culture,		
	assistance of one sta	iff for personal hygiene and		lack of good customer service	e, and lack of		
	extensive assistance	of 2 staff for bathing.		consistent staffing who provide	de care for		
	Review of the care pl	an dated 5/23/18 revealed a		residents in the facility to ass	ure care is		
	problem for Resident	#7 which required		delivered to residents in the f	acility at all		
		lated to decreased mobility.		times.			
	_	e Resident #7's needs met					
		es included the assistance of		IMMEDIATE ACTION			
		oming and other ADLS.					
		17 at 11:05 AM revealed		On 07/17/2018, Unit Coordinate			
		ails on his left hand were		provided nail care by trimmin	g and filling		
	0	ended approximately 1/16		resident's #7 nails.			
	inches from his finger			IDENTIFICATION OF OTHER	₹S		
		18 at 11:45 AM revealed					
	Resident #7's fingern			100% audit of all current resid			
	remained unchanged			facility was completed by the			
	Interview on 7/16/18			Coordinator #1, #2 and #3. D			
	Treatment Nurse who			Nursing, Assistant Director of			
		d picks at his skin. The		and/or Unit Manager on 8/02/			
		ted Resident #7 will get skin		to identify any other resident			
	tears when he scratc	hes himself. Observation		care needs to include nails ca	are. Two		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345006	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343006	B. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	07/	17/2018
TO THIS COLUMN	NOVIDEN ON OUT FEEL				724 WIRELESS DRIVE		
BLUMEN1	THAL NURSING & REHA	ABILITATION CENTER			REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	UMMARY STATEMENT OF DEFICIENCIES ID ID DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From pag	e 6	F	677			
F 6//	now revealed Reside hand remained long. Observation on 7/16 Resident #7's finger remained long. Observation on 7/16 Resident #7's finger remained long. Observation on 7/17 Resident #7's finger remained long. Interview on 7/17/18 Assistant (NA) #3 re his fingernails but the told Nurse #1. On 7 interviewed. Interview on 7/17/18 Administrator and the	ent #7's fingernails on his left /18 at 3 PM revealed hails on his left hand /18 at 3:43 PM revealed hails on his left hand /18 at 9:45 AM revealed hails on his left hand /18 at 9:45 AM revealed hails on his left hand at 10:50 AM with Nursing wealed tried in the past to cut bey were too hard to cut and /17/18 Nurse #1 could not be at 12 noon with the le Regional Clinical Director nistrator stated she expected		677	other residents were identified with need for nail care. Nail care for identified residents provided by Unit Coordinator and Unit Coordinator #3 on 8/3/2018. Findings of this audit is documented on the "ADL care audit tool" maintained in facility compliance binder. SYSTEMATIC CHANGES Effective 8/13/18; all residents will receive necessary services and care to maintain good grooming that includes, not limited to, nail care during daily ADI care. The ADL care to include nail care will be provided by certified nursing assistance with an oversite of the licenturses, based on each resident's plan care, effective 8/13/18. Effective 8/13/2018, facility will establist consistent assignment for licensed nursing nursing aides. This will aide on improving residents' centered care delivery and customer centered approast aff members will be familiar with the residents under their care as the result each resident needs will be anticipated include ADLs care specifically nail care Effective 8/13/18 the facility will conduct an interdisciplinary monthly team building meeting that with include the departme supervisors to discuss culture change initiatives to be implemented in the facility resident care activities. These meetings are intended to improve employee culture in the facility and hen improve quality of care to all our reside On 8/06/2018; Chief Clinical officer from the consulting and Management Company contracted by the facility revi	#2 In the eive but Lessed of the ses ach. to to the set of the ses ach. to the set of the ses ach.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
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		345006	B. WING _			7/17/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DΕ	
RIUMENT	THAI NURSING & RE	HABILITATION CENTER		3724 WIRELESS DRIVE		
DECIMIEN	THAL NOROING & RE	INABIENATION GENTER		GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From p	page 7	F 6	a "bath/shower form" to include documentation for nail care. Inursing staff will utilize the resheet effective 8/13/2018; certified on duty will notify a licensed of any refusal of care specific to nail care promptly when it Licensed nurse will discuss we resident to validate the refusal document actions taken as a Completed bath/shower form maintained in the residents' semaintained at each nursing seffective 8/13/2018. Director of Nursing, Assistant Nursing and/or Staff develop coordinator will complete 100 re-education to all current nutinclude full time, part time an nursing staffs. This education an emphasis on the important providing ADLs care for deperesidents. Nursing staff were re-educated on how to access resident plan of care to deter assistance/services needed Nurses on duty were re-educated Nurses on duty were re-educated by 08/13/2018 will allowed to work until educate education will also be added process for all new nursing effective 08/13/2018 and will annually. MONITORING PROCESS:	Facility vised shower nursing aide nurse on duty cally related occurs. vith the al and ppropriate. is will be shower books station It Director of ment 0% rising staff, to d as needed in will provide ince to endent also is each mine the for ADL's. cated to follow days to make ded. This by f not not be ed. This to new hire imployees	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345006	B. WING			l	7/2048
NAME OF P	ROVIDER OR SUPPLIER	343000	1 3	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	07/	17/2018
					WIRELESS DRIVE		
BLUMENT	THAL NURSING & REHA	ABILITATION CENTER	GREENSBORO, NO		ENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 677	Continued From pag	e 8	F	Ni arriving real	ffective 08/13/2018, the Director of ursing, Assistant Director of Nursing and/or Unit Coordinator #1, #2, and/or ill complete the random audit of ten esidents to ensure nail care is provide my negative finding will be corrected romptly. Any issues identified during the ionitoring process will be addressed romptly. Findings from this monitoring rocess will be documented on an "AD are monitoring tool "and filed in the incility compliance binder after proper allow up is done. This monitoring process will take place daily (Monday through riday) for two weeks, weekly x 2 more reeks, then monthly x 3 months or until the pattern of compliance is maintained ffective 8/13/2018, Director of Nursing and/or Strevelopment Coordinator will report andings of this monitoring process to the incility Quality Assurance and erformance Improvement Committee my additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained the QAPI committee can modify this plan of compliance. ESPONSIBLE PARTY Iffective 8/13/2018, the center Executive in the plan of correction of this plan of correction of this alleged noncompliance to ensure and the Director of Nursing will be ultimately responsible to ensure and the plan of correction of this alleged noncompliance to ensure a facility remains in substantial	d. his L ess il d. aff ne for l d. lan	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345006	B. WING		C 07/17/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 677	Continued From page	e 9	F 67	compliance. Compliance date 8/13/2018	
F 686 SS=D	Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ		F 68	1	8/13/18
	§483.25(b)(1) Pressul Based on the compreseight, the facility in (i) A resident receives professional standard pressure ulcers and dulcers unless the indidemonstrates that the (ii) A resident with prenecessary treatment with professional star promote healing, previous received the received the promote healing, previous received the received	the ulcers. Schensive assessment of a must ensure that- scare, consistent with a soft practice, to prevent does not develop pressure vidual's clinical condition beywere unavoidable; and assure ulcers receives and services, consistent and ards of practice, to went infection and prevent eloping.			
	interview the facility for assessments for Rest the left thumb. This was residents reviewed for Findings included: Resident #5 was read 9/18/13 with cumulativascular dementia with Review of the wound on 3/5/18 an unstagativas identified. Continuan ulcer wound asses 4/10/18. Further reviews	dmitted to the facility on ve diagnoses which included		F686 ROOT CAUSE Director of Nursing, and the facility Executive Director discussed on 8/ to identify the root cause of this alle noncompliance for resident #5. Root-cause analysis conducted rev the alleged non-compliance resulte failure by the facility to maintain a sustainable systemic process that a n ongoing assessment for resider pressure ulcers. The root cause an added that the alleged noncomplia was also caused by the employees culture within the facility that includ not limited to, lack of residents' cer	oo6/18 eged vealed, ed from assure hts with halysis nce s' e, but

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION		(X3) DATE S COMPL	
		345006	B. WING			O7/4	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, 2		07/1	7/2018
				3724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REH	ABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	TO THE APPROPRIA		(X5) COMPLETION DATE
				DEFIC	IENCY)		
F 686	the Nurse Practition "left thumb pressure measured 3 centime om in width (W) and due to yellow slough record review revea 4/28/18. On 5/17/1 completed 21 days from 4/28/18. Record review reve assessment was co from 5/17/18. Observation of the v 12:35 PM performe assisted by Nursing wound measured 0 D. The previous Treatr for interview during Interview on 7/17/18 Treatment Nurse st for her within the las about the missing w Interview on 7/17/18 Administrator and th was held. The Adm	A/26/18 (16 days later) when her's progress notes indicated e injury with yellow slough that eters (cm) in length (L) X 2.1 d depth (D) was undetermined h in wound bed. Continued aled a wound assessment on 8 an assessment was from 4/26/18 and 19 days aled on 6/9/18 another wound empleted which was 23 days wound care on 7/16/18 at d by the Treatment Nurse and p Assistant #4 revealed the .5 cm L X 1.0 cm W X 0.1 cm ment Nurse was not available the survey. 8 at 9:41 AM with the current ated this was a recent position est month and was not sure yound assessments. 8 at 12 noon with the ne Regional Clinical Director inistrator stated she expected onduct weekly assessments	F6	care delivery culture, la customer service, and I staffing who provide can the facility to assure respressure ulcers receive services to include ongoing and appropriate interversion of Resident was completed by the facility and the facility and the facility and the facility and the facility binder. Systemic delivery culture, la customer service, and I service, an	lack of consistent re for residents is sidents with a necessary oing assessment and care at #5 pressure ulcar of pressure ulcar on in facility by Unit pordinator #2, Unit product of the pressure ulcar of this audit is re ulcar audit to be a compliance of the facility has a licensed wour facility. This groukly and conduct conjunction with	cer re re t nit se ure	
				the facility assessments Effective 8/13/2018; the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				GREENSBORO, NC 27455				
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F 686	Continued From page	e 11	F6	skin assessment schedule re-implemented to be used s 8/13/2018;, the skin assessmevised by the Chief Clinical 8/6/2018. Resident's weekly assessments schedule show assessment due between da and Thursday, every week. The monitoring of completion of sussessments by members of administration between week Monday through Friday. Effective 8/13/2017, the Directive 8/13/2018, assessments as take place at all times. 100% in service education where completed by the Director of Assistant Director of nursing Development Coordinator to nurses by 8/13/2018, among was the emphasis on completed by 8/13/2018, among was the emphasis on completed by 8/13/2018, assessment of resid pressure ulcers. Any License staff not educated by 8/13/20 allowed to work until educate education will also be added process for all new licensed effective 8/13/18 and also will annually. MONITORING PROCESS Effective 8/13/2018, Director Assistant Director Of Nursing coordinators (#1, #2, and #3) the completion of the prior daskin assessment on daily clir to ensure its completion and	nent schedulofficer on skin on resident's ays of Sunda This will allow scheduled for nursing addys of Sunda This will allow scheduled for the sessments of the topics of t	s ay bow		

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F 686	Continued From page	e 12	F 68	through. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a "Skin Assessment monitoring tool "and filed in the facility compliance binder after properfollow up is done. This monitoring proces will take place daily (Monday through Friday) for two weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is maintained. Effective 8/13/2018, Director of Nursing Assistant Director of Nursing and/or State Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee from any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plate to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 8/13/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	n er ess	
F 688	Increase/Prevent Dec CFR(s): 483.25(c)(1)-	crease in ROM/Mobility -(3)	F 68	Compliance date 8/13/2018	8/13/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 688	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				,			
	occupational therapis residents reviewed w #7) Findings included: Resident #7 was adm with numerous diagnorm dementia, coronary a contracture of the right Review of the occupation 5/3/18 to the encrevealed the right har fingers contracted. A (splint)was tried and of	rtery disease and It hand. Itional therapy plan of care If of service on 5/16/18 If was initially fisted with			Director of Nursing, and the facility Executive Director discussed on 8/06/1 to identify the root cause of this alleged noncompliance for resident #7. The alleged noncompliance resulted from the facility failure to apply a soft splint devi or rolled gauze as recommended by the Occupational Therapist on Resident #7 Root-cause analysis conducted reveale the alleged non-compliance resulted from communication failure between therapy department and nursing department. IMMEDIATE ACTION On 7/17/2018, Rolled gauze was applied to palm of Resident #7 by the facility	ne ce e 7. ed, om		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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revealed education on 5/16/18 to allow therapy to nursing. Review of the annuassessment dated Interview for Menta 3 (represented sevrange of motion limupper extremity. U coded the number passive range of mwas zero (O). Rev Assessment (CAA #7 had a right-handwould proceed with monitor skin integr Review of the care no care plan to add contracture. Interview on 7/16/1 Medication Aide #1 a restorative progradministrator this platerview on 7/16/1 revealed previously went in between hiwound and needed not sure why the good Observation at the there was no soft sapplied to the right Observation on 7/1 soft splint device night hand. Observation on 7/1 soft splint device night hand.	e used. Further record review to nursing staff was provided of for a smooth transition from sual Minimum Data Set (MDS) 5/16/18 coded the Brief al Status (BIMS) with a score of the recognitive impairment) with nitation on one side of the nuder Section (O) the MDS of days resident received notion and splint assistance view of the Care Area summary revealed Resident dontracture and the facility in developing a care plan to ity. In plan dated 5/23/18 revealed dress the resident's right hand as the facility did not have am but was told by the program would be restarted. If at 11:05 AM with Nurse #1 y Resident #7 had a splint that is fingers and developed a did a softer splin. Nurse #1 was auze was not in his right hand.	F		designated licensed nurse. IDENTIFICATION OF OTHERS On 8/06/18, Director of Rehabilitation Services, Director of Nursing and/or Un Coordinators (#1, #2, #3) completed 100% audit of current residents in the facility to identify any other resident with contracture without proper intervention place such as range of motion exercise splint or brace device in place. No othe resident identified without proper intervention in place. Findings of this at was documented on contracture audit to maintained in the facility compliance binder. SYSTEMIC CHANGES Effective 8/13/2018; the resident with devices necessary to manage contract will be applied by a Restorative aide or nursing assistant on duty per resident's individual care plan. Effective 8/13/2017, the Director of Nursing appointed a Unit Coordinator # to oversee the restorative and contract management program in the facility to ensure proper coordination and communication between therapy department and nursing department. U Coordinator #1 will ensure that any resident with ordered splint is transcribe and communicated to nursing team timely. 100% in service education will be completed by the Director of Nursing, Director of Rehabilitation services, Assistant Director of nursing and/or Sta Development Coordinator to all nursing staff and rehabilitation department by	h a in cor r udit ool ure in aff		

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F 688	Continued From page	e 15	F 6	88			
F 088	Observation on 7/16/soft splint device nor right hand. Observation on 7/17/soft splint device nor right hand. Interview on 7/17/18 Development Coording was expected to place #7 contracted right has Interview on 7/16/18 Administrator reveale additional information Resident #7 had a special was applied as reconducted to Cocupational Therape Interview on 7/16/18 Clinical Director (RCI locate additional information Resident #7 had a special point of the recommental points of the recomm	18 at 3:43 PM revealed no roll gauze was applied to the 18 at 9:45 AM revealed no roll gauze was applied to the at 11:48 AM with the Staff nator stated nursing staff e a roll gauze into Resident and. at 5:30 PM with the ed she was unable to locate in to clarify and validate olint device or rolled gauze nmended by the list (OT). at 5:36 PM with the Regional D) stated he was unable to rmation to clarify that olint device or rolled gauze inded by OT. at 12 noon with the	F 6	emphasis on contract communication between nursing and the role Coordinator #1, to end intervention related to implemented appropsite staff and/or therapy 8/13/2016 will not be educated. This educated to new hire properties of Nursing staff & thera 8/13/18 and also will MONITORING PROTHE Director of Nursing Coordinators will mone reviewing all resident ensure they are properties will take planthen weekly for 2 were 3 months or until a pais maintained. Any note in identified will be add audit will be reviewed clinical stand up meet the properties of Nursing report the finding to and Performance Important to any and the properties of the months or until a pat maintained. The QAI modify this plan to end remains in substantia RESPONSIBLE PAFE	reen therapy and of the Unit insure each resider to contracture is priately. Any nursing staff not educated allowed to work unation will also be rocess for all new py staff effective in the provided annurate of the provided per resolution of the provided per resolution of the provided per resolution of the provided per research provided per resolution of the provided per resolution of the provided per provided p	nt's g by nntil ally. y ss, for ce This I in nce g 3 e is	

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F 688	Continued From pag	e 16	F 68	implementation of this plan of corre for this alleged noncompliance to et the facility remains in substantial compliance.	
F 865 SS=D	QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2	sclosure/Good Faith Attmpt)(h)(i)	F 86	Compliance date 8/13/2018	8/13/18
	§483.75(a) Quality a improvement (QAPI)	ssurance and performance program.			
		nt its QAPI plan to the State ter than 1 year after the regulation;			
	except in so far as s	tary may not require ords of such committee uch disclosure is related to uch committee with the			
	and correct quality d a basis for sanctions	by the committee to identify eficiencies will not be used as			
	Based on observation interview the facility's Assurance Committed implemented procedd interventions that the following the annual survey of 3/15/2018. deficiency which was	ons, record reviews, and staff is Quality Assessment and see failed to maintain ures and monitor these is committee put into place recertification and complaint. This was for one (1) recited is originally cited during the in and complaint of 3/15/2018,		ROOT CAUSE Repeated citation caused by the factorial failure to follow through with plan of set forth on the previous surveys. The alleged noncompliance resulted from facility failed to develop a comprehence measurable for resident #7 that addressed a right hand contracture coordinator #2 indicated during an	action he m, the ensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 865	Continued From page	e 17	F 8	365				
	deficiency was F656 continued failure of the	ted again during the /17/2018. The repeat (develop care plans). The the facility during two federal the same pattern of the facility's			interview on 7/17/2018 that it was an oversight on her part. IMMEDIATE ACTION On 7/17/2017 comprehensive core place.	2		
	inability to sustain an program. Findings included:	effective Quality Assurance			On 7/17/2017 comprehensive care plat for right hand contracture was develop for resident #7 by MDS Coordinator #2	ed		
		d review, observation and cility failed to develop a surable care plan for			IDENTIFICATION OF OTHERS On 7/18/18 MDS coordinator #1, MDS coordinator #2 and/or MDS coordinator completed an audit of 100 percent of current residents in the facility to identify			
	contracture in 1 of 2 r contractures. During the recertificat	esidents reviewed for tion and complaint survey			any other resident with a contracture without a comprehensive care plan in place. Six other residents were identified			
	the facility failed to de care plan that identifie	acility was cited for F656, evelop a resident centered ed the primary language for panish. This was evident for			with contractures without care plan in place. On 7/18/2018 comprehensive caplan was developed for each of the six identified residents and filled in individu			
	1 of 1 resident that was communication.	·			resident's medical records. Findings of this audit was documented on contract audit tool maintained in the facility			
	7/17/2018 at 1:15pm	who stated an expectation ies with the regulation as it			compliance binder. SYSTEMIC CHANGES			
	Improvement (QAPI),	that the facility does not get y issues and monitor the			On 8/13/2018, Chief Clinical Officer completed re-training with the facility Administrator and the Director of Nursi regarding the quality assurance	ng,		
					performance improvement program (QAPI) process. This education will include how to identify quality deficience as well as ways to establish a system the will ensure consistent and measurable			
					outcomes. The education will also cover methods on how to track and trend dat as well as best practices on root cause analysis.	a,		

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F 865	Continued From page	÷ 19	F8	365	Director of Social Services, Activities Director, and Dietary Manager (DM) ar will be provided annually. MONITORING PROCESS Effective 8/13/2018 the facility will cond a directed performance improvement poverseen by the Contracted and management company, to ensure the facility systematically creates sustainat systemic process to avoid repeat regulatory deficiencies. This will be accomplished through monthly visit by member of the management and consulting company for 3 months or un the pattern of compliance is maintained F656: Effective 8/13/2018, MDS Coordinator #1 will review section V of MDS 3.0 completed by the MDS coordinator #2 or MDS coordinator #3 vice versa to ensure that any triggered Care area Assessment to include Contracture Care Area (CA) has a care plan developed or rationale indicated of the reason of otherwise if the care plan not developed. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented a "Care plan development monitoring to and filed in the facility compliance bind after proper follow up is done. This monitoring process will take place daily (Monday to Friday) for two weeks, week x 2 more weeks, then monthly x 3 mon for the completed assessments or until the pattern of compliance is maintained	duct plan ble the til d. or f f on ool" er / kly ths		

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F 865	Continued From page	÷ 20	F8	Effective 8/13/2018, MDS coor MDS coordinator #2 and/or ME coordinator #3 will monitor com reviewing all new contractures clinical stand up meeting to ensure identified contracture has developed person-centered cameasurable objectives and time contracture identified without a will be addressed promptly. Fir this monitoring process will be documented on a "Stand up meform" and filed in the facility cobinder after proper follow up is monitoring process will take play (Monday to Friday) for two weeks 2 more weeks, then monthly months, or until the pattern of cois maintained. Effective 8/13/2018, MDS coor MDS coordinator #2 and/or ME coordinator #3 will report finding monitoring process to the facility Assurance and Performance Improvement Committee for an additional monitoring or modificational monitoring or modificati	onpliance by in the daily sure any a prepared in the daily are plan with relines. Any a care plan andings from the dings of this graph of the dings of this graph of the dings of		

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F 865 Continued From page 21 F 865 implementation of this plan of correct for this alleged noncompliance to ens the facility remains in substantial compliance. Compliance date 8/13/2018		