	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345366	B. WING		05	C 5/20/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000		8.73, Emergency ID I91611	F 000			
	complaint investigatio through 5/20/21. The compliance with the r	ertification survey and in was conducted on 5/17/20 facility was found out of equirements of 42 CFR Part ng Term Care Facilities.				
F 561	2 of 5 complaint alleg resulting in deficiencie Self-Determination	ations were substantiated es.	F 561			6/29/21
SS=D	CFR(s): 483.10(f)(1)-	(3)(8)				
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
	§483.10(f)(3) The res	ident has a right to interact				
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 06/11/2021

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.

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/24/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345366 B. WING		B. WING		C 05/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORREC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO	
F 561	Continued From pag	e 1	F 56 ⁻			
	with members of the	community and participate in both inside and outside the				
		sident has a right to ctivities, including social, unity activities that do not				
	facility.	nts of other residents in the Γ is not met as evidenced				
	Based on observation interviews, the facility	ons, record review and staff / failed to allow lokers to smoke without		Greendale Forest Nursing and Rehabilitation Center acknowledg receipt of the Statement of Deficie		
		never they wanted for 2 of 2		and proposes this Plan of Correct		
	-	or choices. (Resident #23		the extent that the summary of fin factually correct and in order to m	dings is aintain	
	Findings included:			compliance with applicable rules a provisions of quality of care of res The Plan of Correction is submitte	idents.	
	times revealed the fo			written allegation of compliance.		
	· 10:00 AM, 1 6:00 PM and 8PM.	1:30 AM, 2:00 PM, 4:00 PM,		Greendale Forest Nursing and Rehabilitation Center response to Statement of Deficiencies does no		
	Resident #23 was ad 03/18/2021.	lmitted to the facility on		denote agreement with the Stater Deficiencies nor does it constitute admission that any deficiency is a	ment of e an	
		on Minimum Data Set (MDS) Resident #23 revealed the rely intact		Further, Greendale Forest Nursin Rehabilitation Center reserves the refute any of the deficiencies on t	e right to	
	A review of Resident	#23 ' s safe smoking 21/2021 revealed the facility		Statement of Deficiencies through Informal Dispute Resolution, form	ו	
	had assessed the res could smoke indeper	sident as a safe smoker that ndently.		appeal procedure and/or any othe administrative or legal proceeding		
		# 23 ' s care plan dated the resident was care		On 6/9/21, the Social Worker (SW initiated interviews and education	-	
	planned to smoke inc	dependently per his smoking		residents who smoke to include re	esident	

Facility ID: 923035

If continuation sheet Page 2 of 25

	STOR MEDICARE &	MEDICAID SERVICES				IO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
		345366	B. WING		0	C 05/20/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				1304 SE SECOND STREET			
GREEND/	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE	
F 561	Continued From page	a 2	F 56	51			
1 001			F 30		arda ta		
		al was for the resident to lays. The interventions		#23 and resident #32 in rega Smoking with emphasis on s			
		moking materials are placed		for supervised and independ			
		rea. 2. Assist resident in		The Social Worker and/or U			
	obtaining smoking m			will address any concerns id			
	• •	quest. 3. Educate resident		the interviews. Interviews wi	-		
	on the facility 's smo			completed by 6/29/21.			
	Resident #32 was ad	mitted to the facility on		On 6/10/21, the Quality Ass	urance Nurse		
	11/09/2020.			(QA) amended the signage	posted at		
				entrance of the smoking are			
		VDS dated 01/21/2021 for		signage identified scheduled			
		ed the resident had mild		for supervised smokers and			
	cognitive impairment			safe smokers will be allowed			
				smoke area per resident pre			
	A review of Resident			will continue to monitor smo			
		25/2021 revealed the facility		ensure residents who smoke			
		sident as a safe smoker that		social distancing per facility	protocol.		
	could smoke indeper	idently.			tou initiatod		
	A review of Decident	# 22 La sara plan datad		On 6/11/21, the Staff Facilita			
		# 32 ' s care plan dated		an in-service for all staff to in			
		the resident was care dependently per his smoking		Administrator, nurses, nursi dietary staff, housekeeping			
		al was for the resident to		staff, maintenance staff, Acc			
		afely in designated areas thru		Payable, Accounts Receival			
		erventions included: 1.		Worker, Admissions, recepti			
		ontinued ability to smoke		laundry staff, activity staff ar			
		t and regular basis. 2.		Records in regards to Resid			
		at times of own choice in		Preferences/Smoking. Emp			
		areas. 3. Resident may		smoke times for supervised			
	smoke independently			choices on smoking time pre			
	. ,			independent and safe smok			
	Observations made of	on 05/17/2021 at 11:16 am		will be completed by 6/29/21			
	and 05/18/2021 at 4:	04 pm revealed Resident		hired Administrator, nurses,	nursing		
		esignated smoking area with		assistants, dietary staff, hou	sekeeping		
		eing supervised by Nurse #2.		staff, therapy staff, maintena			
	Resident #23 and #3	2 were observed lighting		Accounts Payable, Accounts			
	their own cigarette.			Social Worker, Admissions,			
				laundry staff, activity staff ar	nd Medical		

Facility ID: 923035

If continuation sheet Page 3 of 25

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345366	B. WING		C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2021
	COMBER OR OUT LIER			1304 SE SECOND STREET	
GREENDA	LE FOREST NURSIN	G AND REHABILITATION CENTER		SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIC
F 561	entrance to the our posted sign, red in residents are to be smoking." The obs door was locked w to be entered by st smoking area. An interview with N revealed all smokin supervised by facil An interview with t 05/19/2021 at 10:4	05/17/2021 at 11:31 am, of the tdoor smoking area revealed a color, that stated in part, "All supervised by staff while servation also revealed the rith a keypad requiring a "code" taff to open the door to the Nurse #2 on 05/19/21 10:03 am ng sessions for residents were	F 561		ds to , counts a 10 y x 1 ation dent #32 The dical rector king n and onthly he ne nance nthly thly x hd
F 656	Develop/Implemer	nt Comprehensive Care Plan	F 656	frequency of monitoring.	r 6/29/21

CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	0: 06/24/2021 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE COMPI	LETED
		345366	B. WING		_		20/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER		304 SE SECOND STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The corr describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.24 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive hprehensive care plan must g- the to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and efference and potential for ilities must document is desire to return to the ssed and any referrals to s and/or other appropriate	F 656		DEFICIENCY)		

If continuation sheet Page 5 of 25

		MEDICAID SERVICES					
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
D FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG			
			5.14/11/0			С	
		345366	B. WING			5/20/2021	
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET			
				SNOW HILL, NC 28580			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETIC DATE	
F 656	Continued From pag	e 5	F6	556			
		in the comprehensive care					
		in accordance with the					
	-	h in paragraph (c) of this					
	section.	T :					
		T is not met as evidenced					
	by: Based on observation, record review and			On 6/2/21, therapy staff as	sossod		
		r failed to provide splint		resident # 62 for changes in			
		to the care plan for 1 of 2		motion (ROM) to left wrist w	•		
		#62) reviewed for limited		concerns identified. The spl			
	range of motion.	· · ·)		applied to left wrist per resid			
	The findings included	d:			•		
	Resident #62 was ac	lmitted to the facility on		On 6/11/21, the Nurse Mana	agers initiated		
		osis of hemiplegia following		an audit of all residents care			
		fecting the left side and		use of splint to include resid			
	dementia.			audit is to ensure that splint			
		Data Set (MDS) dated		per resident plan of care to			
		ident #62's cognition was		decrease in ROM. The there Administrative Nurses and/o			
		She required total assistance I toilet use. She needed		hall nurse will address all ar	0		
	-	with eating and transfers did		concern identified during the			
		revealed she had functional		to be completed by 6/29/21.			
	limitation in range of						
	extremity on one side			On 6/11/21, the QA nurse in	itiated an		
				audit of all residents care pl			
	The current care plai	n identified Resident #62		of splints. This audit is to en	isure splint		
		potential to restore or		application was identified or			
		self-sufficiency for mobility as		Care (POC) Task Listing for			
	characterized by the	-		assistant to document appli			
	-	notion/ambulation related to		when indicated. Audit will be	e completed by		
		of further contractures. able to tolerate (left wrist		6/29/21.			
		parator every day for 4 hours)		On 6/11/21, the Staff Facilita	ator initiated		
		ort/skin breakdown. Resident		an in-service with all nurses			
	-	k up with digit separator		nurse #6 and nursing assist			
		s. Perform stretch to left		nursing assistant (NA) #2 in			
		pefore splint application.		Range of Motion/Splints wit			
	-	ing to be done after AM		applying splints per residen	•		
	activities of daily livin	ng (ADL) and monitor skin		to prevent a decrease in RC	Mahility		

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
		345366	B. WING		C 05/20/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/20/2021
				1304 SE SECOND STREET		
SREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 6	F 656			
	integrity under applie	d splint/brace daily.		In-service to be completed by newly hired nurses and nursing		
		AM, Resident #62 was g her splint on her left hand.		will be in-serviced by the Staff during orientation in regards to Motion/Splints.		
	On 5/19/21 at 3:00 PM, Resident #62 was observed not wearing her splint on her left hand.			10% of all residents care plann of splints, to include resident #		
		AM, Resident #62 was g her splint on her left hand.		audited by the Minimum Data S (MDS) utilizing Splints Audit To	Set Nurse ool two	
	on 5/20/21 at 11:45 A #62 should be wearir	erapy Staff #1 was conducted AM and she stated Resident ng her splint as instructed arged from therapy on		times a week x 2 weeks then w weeks then monthly x 1 month that splint is applied per the pla prevent a decrease ROM abilit documentation in POC. The M will address all areas of concer	to ensure an of care to y with DS nurse	
	with Resident # 62 or stated she had never splint and never knew	e Aide (NA) #2 who worked n a regular basis and she r seen Resident #62 with a w she needed to have a confirmed that a splint was		during the audit to include appl splint per plan of care and re-e staff. The Director of Nursing (I review and initial the Splints Au times a week x 2 weeks then w weeks then monthly x 1 month completion and that all areas o were addressed.	ducation of DON) will idit Tool two /eekly x 2 to ensure	
	Resident #62 needed An interview was cor Nursing on 5/20/21 a current care plan was	stated she never knew d to have a splint placed. nducted with the Director of t 5:05 PM and she stated the s not followed for Resident		The DON will forward the result Splints Audit Tool to the Execut Assurance Performance Impro (QAPI) Committee monthly x 2 The Executive QAPI Committee monthly x 2 months to review to Audit Tool to determine trende	tive Quality vement months. e will meet he Splints	
E 600	#62 and it should hav	ve been. crease in ROM/Mobility	F 688	Audit Tool to determine trends issues that may need further in put into place and to determine for further and/or frequency of	terventions the need	6/29/21

Facility ID: 923035

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/24/202 MAPPROVE 0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		05	C 5/20/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 688	Continued From page	e 7	F 688	3		
	resident who enters t range of motion does range of motion unles condition demonstration of motion is unavoidal §483.25(c)(2) A resid motion receives appro- services to increase r prevent further decrea §483.25(c)(3) A resid receives appropriate assistance to maintai the maximum practical reduction in mobility i This REQUIREMENT by: Based on observation review the facility fails application for 1 of 1 #62) reviewed for ran The findings included Resident #62 was ad 12/5/17 with a diagno- cerebral infarction aff dementia. The annual Minimum 4/9/21 revealed Resid cognitively. She required bed mobility and toile extensive assistance	ent with limited range of opriate treatment and range of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. T is not met as evidenced in, interviews and record ed to provide splint sample resident (Resident age of motion/contractures. I: mitted to the facility on osis of hemiplegia following fecting the left side and Data Set (MDS) dated dent #62 was impaired uired total assistance with t use. She needed with eating and transfers did revealed she had functional		On 6/2/21, therapy staff assessed resident # 62 for changes in range motion (ROM) to left wrist with no concerns identified. The splint wa applied to left wrist per resident ca On 6/11/21, the Nurse Managers an audit of all residents care planu use of splint to include resident # audit is to ensure that splint was a per resident plan of care to preven decrease in ROM. The therapy st Administrative Nurses and/or assi hall nurse will address all areas of concern identified during the audit to be completed by 6/29/21. On 6/11/21, the QA nurse initiated	e of s are plan. initiated ned for 62. This applied nt aff, igned f t. Audit	

Facility ID: 923035

If continuation sheet Page 8 of 25

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE 0. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · · ·	E SURVEY IPLETED
		345366	B. WING		C 05/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0.	0/20/2021
				1304 SE SECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 688	Continued From page	<u>- 8</u>	E 68	8		
F 688	 The current care plan identified Resident #62 required assistance/potential to restore or maintain function of self-sufficiency for mobility as characterized by the following functions: positioning and locomotion/ambulation related to risk for development of further contractures. Resident #62 will be able to tolerate left wrist cock up splint with digit separator every day for 4 hours, without pain/discomfort/skin breakdown. Resident to wear left wrist cock up splint with digit separator every day for 4 hours. Perform stretch to left wrist and all fingers before splint application. Stretching and splinting to be done after AM activities of daily living (ADL) and monitor skin integrity under applied splint/brace daily. A Nursing Training Sheet from therapy was reviewed and showed 3 staff members were trained in September 2020: Please put patient's left wrist cock up splint with digit separators on patients left hand every day for 4 hours each day to prevent further contractures and to maintain skin integrity. Please stretch patient's left wrist 		F 68	 audit of all residents care planner of splints. This audit is to ensure application was identified on the Care (POC) Task Listing for nurs assistant to document application when indicated. Audit will be com 6/29/21. On 6/11/21, the Staff Facilitator in an in-service with all nurses to in nurse #6 and nursing assistants in nursing assistant (NA) #2 in regar Range of Motion/Splints with emplaplying splints per resident plant to prevent a decrease in ROM at In-service to be completed by 6/2 newly hired nurses and nursing a will be in-serviced by the Staff Faculation in regards to R Motion/Splints. 10% of all residents care planner of splints, to include resident # 62 	splint Point of ing n of splint npleted by nitiated clude to include to include to include to include to include to sistants acilitator ange of d for use 2 will be	
	and all fingers of left splinting to increase j	hand in preparation for oint mobility.		audited by the Minimum Data Se (MDS) utilizing Splints Audit Too times a week x 2 weeks then we weeks then monthly x 1 month to	l two ekly x 2 o ensure	
		AM, Resident #62 was g her splint on her left hand.		that splint is applied per the plan prevent a decrease ROM ability documentation in POC. The MDS	with	
	On 5/19/21 at 3:00 Pl observed not wearing	M, Resident #62 was g her splint on her left hand.		will address all areas of concern during the audit to include applica splint per plan of care and re-edu	ation of	
	observed not wearing	AM, Resident #62 was g her splint on her left hand.		staff. The Director of Nursing (DC review and initial the Splints Audi times a week x 2 weeks then we	DN) will it Tool two ekly x 2	
	on 5/20/21 at 11:45 A	erapy Staff #1 was conducted M and she stated Resident scontinued on 10/15/20 and		weeks then monthly x 1 month to completion and that all areas of o were addressed.		

Facility ID: 923035

If continuation sheet Page 9 of 25

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
ORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
				С	
	345366	B. WING		05/20/2021	
WIDER OR SUPPLIER					
E FOREST NURSING A	ND REHABILITATION CENTER		SNOW HILL, NC 28580		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE COMPLE	
she was to wear a spl brevent further contra vere trained on placir day and Resident #62 splint as instructed. An interview with NA is 5/20/21 at 11:55 AM a rained in September Resident #62, but she esident any longer. So o locate in the reside t62 a splint was requind 20n 5/20/21 at 12:00 F who works with reside conducted and she st Resident #62 with a so needed to have a spli esident task list. 20n 5/20/21 at 12:01 F with the resident on a interviewed, and she st Resident #62 needed 20n 5/20/21 at 12:30 N ocating Resident #62 able. The facility consultant at 3:24 PM and she si ocate documentation Resident #62. She w	int on her left hand to cture. She reported staff og the splint for 4 hours a 2 should be wearing her #3 was conducted on and she stated she was 2020 to place the splint on a doesn't work with that She stated she was unable nt care task list for Resident ired. PM an interview with NA #2, ent on a regular basis, was ated she had never seen plint and never knew she nt placed. It was not on the PM Nurse #6, who worked regular basis, was stated she never knew to have a splint placed. Jurse # 10 was observed 's splint in her bedside	F 68	8 The DON will forward the result Splints Audit Tool to the Executi Assurance Performance Improv (QAPI) Committee monthly x 2 I The Executive QAPI Committee monthly x 2 months to review th Audit Tool to determine trends a issues that may need further int put into place and to determine	ve Quality ement months. will meet e Splints nd/or erventions the need	
	DEFICIENCIES ORRECTION WIDER OR SUPPLIER E FOREST NURSING A SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page the was to wear a spl prevent further contra vere trained on placir lay and Resident #62 splint as instructed. An interview with NA si 5/20/21 at 11:55 AM a rained in September Resident #62, but she esident any longer. So to locate in the reside t62 a splint was required 20n 5/20/21 at 12:00 F who works with reside conducted and she st Resident task list. 20n 5/20/21 at 12:01 F with the resident on a interviewed, and she st Resident #62 needed 20n 5/20/21 at 12:30 N tocating Resident #62 able. The facility consultant at 3:24 PM and she si Resident #62. She w VA task record it was	DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345366 WIDER OR SUPPLIER E FOREST NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 she was to wear a splint on her left hand to orevent further contracture. She reported staff were trained on placing the splint for 4 hours a lay and Resident #62 should be wearing her uplint as instructed. An interview with NA #3 was conducted on 5/20/21 at 11:55 AM and she stated she was rained in September 2020 to place the splint on Resident #62, but she doesn't work with that esident any longer. She stated she was unable to locate in the resident care task list for Resident #62 a splint was required. On 5/20/21 at 12:00 PM an interview with NA #2, who works with resident on a regular basis, was conducted and she stated she had never seen Resident #62 with a splint and never knew she needed to have a splint placed. It was not on the esident task list. On 5/20/21 at 12:01 PM Nurse #6, who worked with the resident on a regular basis, was conducted and she stated she never knew Resident #62 needed to have a splint placed. On 5/20/21 at 12:30 Nurse # 10 was observed ocating Resident #62's splint in her bedside able. The facility consultant was interviewed on 5/20/21 at 3:24 PM and she stated she was unable to ocate documentation the splint was placed on Resident #62. She was able to show me in the VA task record it was there, but 2 other NA's	ORRECTION IDENTIFICATION NUMBER: A. BUILDING 345366 B. WING	DEFICIENCIES ORRECTION (X1) PROVIDERSUPPLENCLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 345366 5. WING VIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE Continued From page 9 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS FLAN OF CORE (EACH DEFICIENCY) Continued From page 9 F 688 F 688 F 688 Interview with NA #3 was conducted on rained in September 2020 to place the splint for 4 hours a lay and Resident #62 should be wearing her pipint as instructed. F 688 The DON will forward the result Splints Audit Tool to the Executiv Assurance Performance Improv (QAPI) Committee monthly x 2 The Executive QAPI Committee monthly x 2 months to review th Audit Tool to determine trends a issues that may need further into put into place and to determine for further and/or frequency of n of submet add she stated she had never seen Resident #62 with a splint and never knew Resident #62 needed to have a splint placed. Dn 5/20/21 at 12:00 PM an interview with NA #2, who works with resident on a regular basis, was neterviewed, and she stated she had never seen Resident #62 needed to have a splint placed. Dn 5/20/21 at 12:30 Nurse #10 was observed ocating Resident #62's splint in her bedside able. F f f f f f f f f f f f f f f f f f f f	

TATEMENT C	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
			A. BUILDIN B. WING	G	С
		345366	B. WING		05/20/2021
NAME OF Pr	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1304 SE SECOND STREET	CODE
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 688	Continued From page	<u>-</u> 10	F 6	88	
		ce it. She stated it was a	10		
	computer problem.				
F 693 SS=D	Tube Feeding Mgmt/ CFR(s): 483.25(g)(4)		F 6	93	6/29/21
	both percutaneous er percutaneous endosc enteral fluids). Based	c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's ssment, the facility must			
	eat enough alone or v enteral methods unle condition demonstrat	ent who has been able to with assistance is not fed by ss the resident's clinical es that enteral feeding was d consented to by the			
	means receives the a services to restore, if and to prevent compl including but not limit diarrhea, vomiting, de abnormalities, and na	ent who is fed by enteral ppropriate treatment and possible, oral eating skills ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic asal-pharyngeal ulcers. is not met as evidenced			
	by: Based on staff interv facility failed to admir	iew and record review, the nister an enteral flush for one ved for enteral feeding		On 6/11/21, the assigned provided resident flush pe order and assessed resid signs/symptoms of dehyd concerns identified.	er physician lent #79 for
	Findings included:				
	A review of the medic #79 was admitted 11/	al record revealed Resident		On 6/11/21, the Administr initiated an audit of medic administration records (M	cation

Event ID: I91611

Facility ID: 923035

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		0.00		OMB NO. 0938-03	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	345366	B WING		С	
	343300			05/20/2021	
ONDER OR SOLT EIER					
LE FOREST NURSING	AND REHABILITATION CENTER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	
Continued From page	e 11	F 693			
including Dysphagia, enabling nutrition and administered for som anything by mouth), a The Admission Minim 12/5/2020 noted Resi impaired for cognition assistance for all daily person. A review of the Medic (MAR) for March 202 11/30/2020 for Entera hours for hydration flum illiliters (ml) of wate was scheduled for mi and 6:00 PM. On Mar flush was not docume On 5/20/2021 at 3:45 was interviewed and have called her and s	Gastrostomy tube (a tube a medication to be eone who cannot take and Dementia. hum Data Set (MDS) dated ident #79 was severely a and needed total y care with the help of one cation Administration Record 1 revealed an order dated al Feed Order every six ush peg tube with 150 r every six hours. The flush dnight, 6:00 AM, 12 noon rch 14,2021 the 6:00 PM ented as administered. PM the Director of Nursing stated the facility should she would have come to the		 residents with gastrostomy feeding include resident #79 from 6/1/21-6/ This audit is to ensure that resident received flushes via gastrostomy tu physician orders. The assigned hall will address all areas of concern ide during the audit to include assessm the resident and notification of the physician. Audit will be completed to 6/29/21. On 5/20/21, 100% Med Pass Audits initiated by the Director of Nursing a Staff Facilitator with all nurses to innurse #15 to ensure all residents wigastrostomy feeding tubes were proflushes per physician orders. The D of Nursing and Staff Facilitator will address all areas of concern identified uring the audit. Audit will be completed by 6/29/21. On 6/11/21, the Staff Facilitator initian in-service with all nurses in regars Rights of Medication Administration include but not limited to flushes via tube. In-service will be completed by 6/29/21. All newly hired nurses will in-serviced by the Staff Facilitator in regards to Rights of Medication Administration. The QA nurse, staff facilitator and N Managers will review MARs for all residents with gastrostomy feeding 	10/21. s be per I nurse entified ent of Dy s were and clude ith ovided Director ied leted ated urds to to a PEG y be n Murse tube to	
	F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER LE FOREST NURSING / SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page including Dysphagia, enabling nutrition and administered for som anything by mouth), a The Admission Minim 12/5/2020 noted Res impaired for cognitior assistance for all dail person. A review of the Medic (MAR) for March 202 11/30/2020 for Entera hours for hydration flu milliliters (mI) of wate was scheduled for mi and 6:00 PM. On Mar flush was not docume On 5/20/2021 at 3:45 was interviewed and have called her and s	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345366 ROVIDER OR SUPPLIER LE FOREST NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 including Dysphagia, Gastrostomy tube (a tube enabling nutrition and medication to be administered for someone who cannot take anything by mouth), and Dementia. The Admission Minimum Data Set (MDS) dated 12/5/2020 noted Resident #79 was severely impaired for cognition and needed total assistance for all daily care with the help of one	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A. BUILDING 345366 B. WING B. WING	F DEFICIENCIES CORRECTION (X1) FROVIDER/SUPPLIERCLIA JEENTIFICATION NUMBER: (X2) MULTIFIE CONSTRUCTION A BUILDING 345366 STREET ADDRESS, CITY, STATE, ZIP CODE 1394 SE SECOND STREET SNOW HILL, NC 28550 STREET ADDRESS, CITY, STATE, ZIP CODE 1394 SE SECOND STREET SNOW HILL, NC 28550 SUMMARY STATEMENT OF DEFICIENCES (EACH OPENCIENCY WARTS THE PRECEDED FOR FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 F 693 residents with gastrostomy feeding including Dysphagia, Gastrostomy tube (a tube enabling nutrition and medication to be administered for someone who cannot take anything by mouth), and Dementia. The Administration Record (MAR) for March 2021 revealed an order dated 11/30/2020 for Enteral Feed Order every six hours of hydration flush pe tube with 150 milliliters (mil) of water every six hours. The flush was scheduled for midnight, 6:00 AM, 12 noon and 6:00 PM. ON March 14:2021 the 6:00 PM flush was not documented as administered. On 6/1/121, the Staff Facilitator will address all areas of concern identif during the audit. Audit will be completed to 6/29/21. ON 5/20/2021 at 3:45 PM the Director of Nursing was interviewed and stated the facility should have called her and she would have come to the facility and passed the medications. On 6/1/121, the Staff Facilitator will address all areas of concern identif during the audit. Audit will be completed to 6/29/21. On 6/1/1/21, the Staff Facilitator will adress will arevie	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	06/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
		345366	B. WING			C 05/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00-	
GREEND	ALE FOREST NURSING A	AND REHABILITATION CENTER		13	304 SE SECOND STREET		
				S	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From page	≥ 12	F	693	 physician orders. The QA nurse, staff facilitator and Nurse Managers will address all concerns identified during the audit to include assessment of residen providing flushes per physician order, a re-education of staff. The DON will rever the MARs three times a week x 2 week weekly x 2 weeks and then monthly x month to ensure audit was complete at all concerns addressed. The QA nurse, staff facilitator and Nurse Managers will complete med pass aud with 5 nurses to include nurse #15 utilit the Med Pass Audit Tool weekly x 4 we then monthly x 1 month to ensure residents with gastrostomy feeding tub were provided flushes per physician orders. The QA nurse, staff facilitator and Nurse Managers will address all concerns addressed. Nurse Managers will address all concerns identified during the audit to include assessment of resident, providing flush per physician order, notification of the physician and re-education of staff. The DON will review Med Pass Audit Tool weekly x 4 weeks then monthly x 1 mot to ensure audit was complete and all concerns addressed. The DON will forward the results of the Med Pass Audit Tool and MAR Audit to Executive Quality Assurance Performat Improvement (QAPI) Committee month x 2 months. The Executive QAPI Committee will meet monthly x 2 month to review the Med Pass Audit Tool and MAR Audit to determine trends and/or issues that may need further interventi put into place and to determine the need to the provision of the physic of the Med Pass Audit Tool and MAR Audit to determine the need to the place and to determine the place and to determine the need to the place and to determine the need to the place and to determine the place and to deter	t, and iew (s, 1 nd se it zing beks es and frms hes e nth e nth s the nce nly hs	

Event ID: I91611

Facility ID: 923035

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			()(0)			O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		345366	B. WING			C 5/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/20/2021	
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 693	Continued From page	e 13	F 69	3 for further and/or frequency of mo	nitoring		
SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)		F 72		nitoring.	6/29/21	
	CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.						
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on staff interv	section, the facility must nurse to serve as a charge		On 6/10/21, the Administrator rev the daily staff sheet and determine			
	halls reviewed for sta	ffing on March 14, 2021 PM, when no nurse was		was sufficient staffing to meet resi needs and to administer resident medications/gastrostomy feedings	dent		

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STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		0	C 5/20/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		0/20/2021
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	e 14	F 72	25		
				flushes per physician⊡s orde		
	Findings included:			resident # 6, #35, #28, #33 a	nd # 79.	
		oss referenced to F760:		On 6/11/21, the Administrator		
		ews and record review, the		of Nursing (DON) reviewed the		
	•	nister scheduled medications		staffing schedule for the next		
		nts reviewed for medication		review is to ensure daily staff	•	
	•	lent #6, Resident #35,		sufficient based on the staff	•	
	Resident #28, and Re	esident #33).		provide needed care to resid include administering resider		
	h This citation is cros	ss referenced to F693:		medications/gastrostomy fee		
		ew and record review, the		flushes per physician s orde		
		hister an enteral flush for one		enable them to reach their hi		
		wed for enteral feeding		practicable physical, mental,	•	
	(Resident #79).			psychosocial well-being. The concerns identified.	re were no	
	A review of records re					
	0	March 14, 2021, which		On 6/11/21, the Administrator		
		as assigned to work from nad called out. A second		facility contracts with staffing	agencies.	
		duled to work 3:00 PM to		The facility will utilize on-call Administrative nurses and ag	ency staffing	
		out. The sheet listed the		to ensure daily staffing is suff		
		se #10 and Nurse #10 was		on the staff s ability to provide		
		nurse from 7:00 PM to 11:00		care to residents to include a		
	PM.			resident medications/gastros	0	
				feedings and flushes per phy	-	
		6 PM, in an interview, Nurse		order and to enable them to r		
		in at 7:00 PM on 3/14/2021.		highest practicable physical,	mental, and	
	Nurse #10 stated she			psychosocial well-being.		
		0 PM until 11:00 PM and			or initiated	
	checked all blood sug	jais.		On 6/11/21, the Staff Facilitat an in-service with all nurses,		
	In an interview on 5/2	20/2021 at 3:12 PM Nurse		Administrator, and Scheduler	to include	
		ed the 300 - 400 halls on		nurse #10, #14 and #15 in re		
		AM until 3:00 PM. Nurse #14		Sufficient Staff with emphasis		
		d off to Nurse #15 and gave		expectations, ensuring the so	-	
	the keys to the medic	-		reviewed daily for adequate s		
				patterns and notification of O	n-Call nurse,	
	Nurse #15 was interv	riewed on 5/20/2021 at 3:17		DON and/or Administrator wh	nen sufficient	

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						B NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		· · · ·	DATE SURVEY COMPLETED
			A. BOILDING	·		С
		345366	B. WING			05/20/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
		AND REHABILITATION CENTER		1304 SE SECOND STREET		
GREENDA	REF TOREST NORSING /			SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 725	Continued From page	e 15	F 72	25		
		jot report, counted the		staff is not available. The	All newly hired	
		ication cart, and took the		Administrators, DON, nur	•	
		#14 on 3/14/2021. Nurse		schedulers will be in-serv		
		he keys and report because neone was coming to work		Facilitator during orientati Sufficient Staff.	on in regards to	
	In an interview with th	ne Director of Nursing (DON)		The Director of Nursing, A Nurse and/or Administrate		
		PM, the DON stated she		staffing schedule 5 x a we	ek x 4 weeks	
		nat both nurses scheduled		then monthly x 1 month to		
		for evening shift (one for		weekends utilizing the Su		
		and one for 3:00 PM to 11:00 nd the on call nurse would		Audit Tool. This audit is to staffing is sufficient based	•	
		DN indicated she spoke with		ability to provide needed		
	-	on call, and who told the		to include administering re		
		got her car, she would be		medications/gastrostomy		
		ed she did not realize Nurse		flushes per physician⊡s c		
		ere until 7:00 PM. The DON e gone to the facility and		enable them to reach thei	•	
		until Nurse #10 arrived.		practicable physical, men psychosocial well-being.		
				nursing, Administrative N		
				Administrative staff on Du		
				all concerns identified dur		
				include but not limited to r		
				Administrator/DON and of nursing coverage. The Administrator/DON and of nursing coverage.	0	
				review the Sufficient Staff		
				weekly x 4 weeks then me		
				to ensure all areas of con addressed.	cern were	
				The DON will forward the	results of	
				Sufficient Staff Audit Tool		
				Quality Assurance Perform		
				Improvement Committee x 2 months. The Executiv		
				Committee will meet mon		
				and review the Sufficient	•	
				to determine trends and /	or iccurce that	1

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345366	B. WING		С
	ROVIDER OR SUPPLIER	343300		STREET ADDRESS, CITY, STATE, ZIP CODE	05/20/2021
	ROVIDER OR SOFFLIER			304 SE SECOND STREET	
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
F 725	Continued From pag	e 16	F 725		
				may need further interventions put int	o
				place and to determine the need for	
				further and / or frequency of monitorir	ng.
		of Significant Med Errors	F 760		6/29/21
SS=E	CFR(s): 483.45(f)(2)				
	The facility must ens				
r - t	,	nts are free of any significant			
	medication errors.	T is not mat as suideneed			
		T is not met as evidenced			
	by: Based on staff and r	esident interviews and		On 6/11/21, the Director of Nursing	
		cility failed to administer		assessed resident #6 finger stick bloc	bd
		ns for four of five residents		sugar and ensured medications were	
		tion administration (Resident		administered per physician⊡s order.	
	#6, Resident #35, Re	esident #28, and Resident			
	#33).			On 6/11/21, the Director of Nursing	
				assessed resident #35 finger stick blo	bod
	Findings included:			sugar and ensured medications to	
				include Haldol were administered per	
		dical record revealed		physician⊡s order.	
	Resident #6 was adr			On 6/11/21, the Director of Nursing	
	Asthma.	Diabetes Mellitus, and		assessed resident #28 and ensured	
	Astrina.			medications to include Eliquis were	
	The Quarterly Minim	um Data Set (MDS) dated		administered per physician s order.	
		sident #6 was cognitively			
		tensive assistance for all		On 6/11/21, the Director of Nursing	
	daily care with the he	elp of one person.		assessed resident #33 and ensured	
				medications to include Hydralazine w	ere
		oted on 12/2/2020 there was		administered per physician⊡s order.	
		cale insulin with blood sugar			
	checks at meals and	0		On 5/21/21, the Medical Director was	
		er sliding scale: if $200 - 250 =$		notified of medication omissions for	
		6 units; 301 - 350 = 9 units;		resident #6, #35, #28 and #33 with no new orders.	ע
		Call MD if Finger Stick is over 400, subcutaneously			
	four times a day for I			On 6/11/21, the Director of Nursing	

Facility ID: 923035

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/24/202
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRU		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345366	B. WING _				C)5/20/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CODE		
				1304 SE SE	ECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HIL	LL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	e 17	F7	60			
	10				ed an audit of all MARS fr	om 6/1/21-	
	A review of the Medic	cation Administration Record			21. This audit is to ensure		
		2021 indicated on March 14,			ations were administered		
		ocumented reading for the			cian⊡s order. The assigne		
		nented amount of insulin			, unit manager and staff fa		
	administered for the t	time of 4:30 PM. The next			dress all concerns identi		
	scheduled time for a	FSBS was 8:30 PM and the		the au	udit. Audit will be complete	ed by	
	FSBS was document were 9 units of insulir	ed at 312, also documented n administered.		6/29/2		·	
					20/21, 100% Med pass a		
		PM, Resident #6 was			ed by the Director of Nurs	•	
		ed she did not remember			Facilitator with all nurses		
	getting checked that	day or receiving insulin.			#15 to ensure all residen ations were administered		
	On 5/20/2021 at 3:45	PM, the Director of Nursing			cian orders. The Director		
		e given the medications on			taff Facilitator will addres	-	
	the hall if she had be	•			ncern identified during the will be completed by 6/29		
	2. A review of the me	dical record revealed					
		mitted 12/3/2020 with		On 6/1	11/21, the Staff Facilitator	⁻ initiated	
	diagnoses including	•			service with all nurses an		
		order, Major Depressive			ation aides in regards to	•	
	Disorder, Diabetes M	lellitus, and other impulse			ation Administration. Em	•	
	disorders.				ministering medications p		
					cian order and notifying th		
		um Data Set (MDS) dated			rsing if at any time a nurs		
		lent #35 was severely			ilable or unable to admin		
		n and needed extensive to			ations per physician⊡s o		
		Il care with the help of one			vice will be completed by		
	person.				wly hired nurses will be in		
	Posidont #25 was	ro planned on 6/25/2020 for		-	e Staff Facilitator in regard	•	
		re planned on 6/25/2020 for d interventions included			dication Administration du	unig	
				orienta	auon.		
		ugar (FSBS) as ordered by blan for use of psychotropic			A nurse, staff facilitator a	nd Nurso	
		20 included intervention of			gers will review MARs for		
		ns per physician orders.			ents to include Resident #		
		na per priyaiciari orders.			Resident #28, and Reside		
	A review of orders for	r Resident #35 revealed an			times a week x 2 weeks,		
					unies a week x Z weeks,	WEERIY X Z	

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	· · · ·	TE SURVEY
						С
		345366	B. WING)5/20/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		AND REHABILITATION CENTER		1304 SE SECOND STREET		
GREENDA	ALE FOREST NORSING A	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From page	e 18	F 7	60		
		1, for Haloperidol tablet 5		weeks then monthly x 1 mor	th to ensure	
		tablet by mouth two times a		medications were administer		
	day related to Schizo	phrenia, unspecified.		physician⊡s order. The QA i		
				facilitator and Nurse Manage		
	An order dated 12/3/2	-		address all concerns identifi	-	
		liter (ml) (Insulin Lispro)		audit to include assessment		
		cale: if 150 - 200 = 1 unit; 51 - 300 = 3 units; 301 - 350		notification of the physician t instructions and re-education		
		er = 5 units and call MD,		DON will review the MARs th		
	subcutaneously four t			week x 2 weeks, weekly x 2		
	Diabetes Mellitus.			then monthly x 1 month to e		
				was complete and all concer		
	a. A review of the Me	dication Administration		addressed.		
		rch 14, 2021 for Resident				
		r for Haldol 5 mg give one		The QA nurse, staff facilitato		
		mes a day. The scheduled		Managers will complete med	•	
		and 4:00 PM. There was no		with 5 nurses to include nurs		
		ark (denoted given) and no		medication aides utilizing the		
	documented signatur	e for the 4:00 PM dose.		Audit Tool weekly x 4 weeks x 1 month to ensure all resid		
	b. Further review of th	A = MAR for $3/14/2021$		gastrostomy feeding tubes w		
		Humalog solution 100		flushes per physician orders		
		o) Inject as per sliding scale.		nurse, staff facilitator and Nu		
	, , ,	cation was scheduled at 6:30		Managers will address all co		
	AM, 11:30 AM, 4:30 F	PM and 9:00 PM. In the		identified during the audit to	include	
	column for the FSBS			assessment of resident, prov		
		olumn for amount of insulin		per physician order, notificat	ion of the	
	given, there was none			physician and re-education		
		9:00 PM column the FSBS		DON will review Med Pass A		
		247 and Resident #35 was		weekly x 4 weeks then mont		
	administered 2 units of	bi insulin.		to ensure audit was complet concerns addressed.	e and all	
	On 5/20/2021 at 3.45	PM, the Director of Nursing				
		cility had called, she could		The DON will forward the rea	sults of the	
	have gone to the facil	-		Med Pass Audit Tool and MA		
	-	ning. The DON said she felt		Executive Quality Assurance		
	it was a communication	-		Improvement (QAPI) Comm		
	anything.			x 2 months. The Executive C	-	
				Committee will meet monthly	/ x 2 months	

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		MEDICAID SERVICES		LE CONSTRUCTION		(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· · ·	LETED
							С
		345366	B. WING			05/	20/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	,	DER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CO	DRRECTIVE ACTION SHOULD FERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETIO
F 760	Continued From page	e 19	F 76	0			
	-	d review revealed Resident		to review the M	led Pass Audit Tool and	b	
		/27/2020 with diagnoses of			determine trends and/or		
	Atrial Fibrillation and	nypertension.			ly need further intervent and to determine the ne		
	The Quarterly Minimu	um Data Set (MDS) dated			or frequency of monito		
		ident #28 to be cognitively					
		tensive assistance only for al hygiene, all other daily					
		at hygiene, an other daily nt of help or supervision only.					
	potential for bleeding	3/26/2021 noted a focus for related to anticoagulant llation. Interventions included n as ordered by the					
		vealed an order on s tablet (Apixaban) give 2.5 outh two times a day for					
	(MAR) for 3/14/2021 (Apixaban). Give 2.5 day for anticoagulant	mg by mouth two times a . The scheduled times for 8:00 AM and 4:00 PM. The					
	(DON) stated if the fa have gone to the faci	ning. The DON said she felt					
	Resident #33 was ad	dical record indicated mitted 12/3/2020 with nypertension, Diabetes					

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D PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345366	B. WING		05	C / 20/2021	
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		20/2021	
REENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE	
F 760	Continued From page Mellitus and peripher		F 76	0			
	(MDS) dated 3/26/20 moderately impaired	ge Minimum Data Set 21 noted Resident #33 was for cognition and needed istance for all daily care with n.					
	for Hydralazine Hydro	d an order dated 12/15/2020 ochloride tablet 50 milligram y mouth three times a day					
	(MAR) for March 202 50 mg 1.5 tablet by m	cation Administration Record 1 revealed the Hydralazine nouth was scheduled for d 4:00 PM. On 3/14/2021 s not documented as					
F 880 SS=D	(DON) stated if the face have gone to the face	ning. The DON said she felt on issue as much as & Control	F 88	10		6/29/21	
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345366	B. WING			OF CORRECTION (X5) CTION SHOULD BE COMPLE D THE APPROPRIATE DATE	
NAME OF P	ROVIDER OR SUPPLIER	DICAID SERVICES) PROVIDER/SUPPLIE/CLAI IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING 345366 B. WING 345366 B. WING PREHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580 WENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) PREVIDENT PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLD CROSS-REFERCED TO THE APPR DEFICIENCY) I F 880 th an infection prevention CP that must include, at g elements: F 880 for preventing, identifying, and controlling infections sees for all residents, , and other individuals a contractual n the facility assessment \$483.70(e) and following ards; F 880 andards, policies, and am, which must include, cce designed to identify diseases or n spread to other F spread for infections; to should be used for a to timited to: n of the isolation, ctious agent or organism e isolation should be the for the resident under the meder which the facility with a communicable lesions from direct I					
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER				CTION (X5) OULD BE (X3) DATE SURVEY COMPLETED C 05/20/2021 (X5) COMPLET	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trar to be followed to prev (iv)When and how iscor resident; including bu (A) The type and durated depending upon the in involved, and (B) A requirement that least restrictive possill circumstances. (v) The circumstances must prohibit employed disease or infected sh	blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; e standards, policies, and ogram, which must include, llance designed to identify ble diseases or r can spread to other ; m possible incidents of se or infections should be ensmission-based precautions rent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/24/2021 MAPPROVED O. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345366	B. WING			05	C 5/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER			1304 SE SECOND STREET			
					SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	by staff involved in dia §483.80(a)(4) A syster identified under the facorrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update their This REQUIREMENT by: Based on observation record review, the fac state surveyors who achours for signs and sy This failure occurred Findings included: The Center for Medic Memorandum on Gui Control, revised 4/27/ the frequency of testin facility 's COVID-19 si continue to screen all persons entering the volunteers, and visito of COVID-19". In an interview on 5/1	he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. Ide, store, process, and to prevent the spread of view. ct an annual review of its ir program, as necessary. is not met as evidenced n and staff interview and cility failed to screen two entered the building after ymptoms of COVID - 19. during a global pandemic. are Services (CMS) dance under Infection (2021, stated "Regardless of ng being performed or the status, the facility should I staff (each shift), and all facility such as vendors, rs, for signs and symptoms 7/2021 at 9:15 AM, the	F	880	On 6/11/21, the Infection Preventionis and Administrator under the oversight the Facility Consultant initiated an aud all assigned screeners. This audit is to ensure that all staff and/or visitors we screened per facility protocol to includ but not limited to instructing staff/ visit to sanitized hands prior to screening process, review of Covid screening questions, temperature monitoring ar completion of the screening log with staff/visitor signature. The Administrat and/or Staff Facilitator will address all areas of concern identified during the audit to include re-training of staff. Th audit will be completed by 6/29/21. Th Infection Preventionist and DON addressed all concerns identified durint the audit.	of dit of re e ors nd or e e		
	of COVID-19". In an interview on 5/1 facility Director of Nur visitors, vendors and				Infection Preventionist and DON addressed all concerns identified duri			

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
							C
		345366	B. WING				20/2021
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER			04 SE SECOND STREET		
				SN	NOW HILL, NC 28580		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 880	Continued From pag	e 23	F 88	30			
		screened for temperature,			Preventionist/Staff Facilitator initiated a	an	
		to COVID -19 signs and			in-service with all assigned staff in		
		and recorded. The DON			regards to Screening Process with		
		f have been trained to			emphasis on instructing staff/ visitors t	0	
	-	e leaves the parking lot and			sanitized hands prior to screening process, review of Covid screening		
	returns, they are scre	eried again.			questions, temperature monitoring an	Ч	
	NA #3 came to the d	oor and the surveyors			completion of the screening log with	u	
	entered. NA #3 left in				staff/visitor signature. In-service to be		
					completed by 6/29/21. All newly hired		
	The surveyors stood	in the lobby at the screening			screeners will be in-serviced by the St	aff	
	station. No one came	e to screen them. Nurse #11			Facilitator during orientation in regards	s to	
	-	edication cart, facing the			Screening Process		
	-	t come toward them. The					
		ed Nurse #11 who stated he			Facility leadership staff to include the		
		as soon as he called his One surveyor asked what			Infection Preventionist, Medical Record		
		Nurse #11 again stated he			Director, Social Worker and/or Minimu Data Set Nurse (MDS) will observe the		
		as soon as he called his			screening process 10 times weekly x 4		
		Surveyors began their			weeks then monthly x 1 month to inclu		
	observations and inte				all shifts and weekends utilizing the		
		ompanied to the door by			Screening Audit Tool. The Infection		
	Nurse #11.				Preventionist, Medical Records Director	or,	
					Social Worker and/or MDS nurse will		
) AM the Director of Nursing			address all areas of concern identified		
		/ Nurse #11 should have			during the audit. The Director of Nursin	-	
		ors, and Nurse #11 had been			will review and initial the Screening Au Tool weekly x 4 weeks then monthly x		
	trained in the screeni	ing process.			month to ensure all areas of concern v		
					identified.		
					The Administrator will forward the resu	llts	
					of the Screening Audit Tool the Execut	ive	
					Quality Assurance Performance		
					Improvement (QAPI) Committee month	hly	
					x 2 months. The Executive QAPI		
					committee will meet monthly x 2 month and review the Screening Audit Tool to		
					determine trends and / or issues that n		

Event ID: I91611

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/24/2021 1 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	05/20/2021		
GREENDALE FOREST NURSING AND REHABILITATION CENTER				1304 SE SECOND STREET				
				SNOW HILL, NC 28580				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	IX (EACH CORRECTIVE ACTION SI		D BE	(X5) COMPLETION DATE	
F 880	Continued From page	≥ 24	F		need further interventions put into p and to determine the need for further / or frequency of monitoring.			
	7(02-99) Previous Versions Obs	olete Event ID: 1916			tv ID [.] 923035 If co.			

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