| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 05/06/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Blumenthal Health and Rehabilitation Center** | **3724 Wireless Drive , Greensboro, North Carolina, 27455** |

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| F0000 | INITIAL COMMENTS<br><br>A complaint investigation was conducted from 5/5/2026 to 5/6/2026. Event ID #230E4F-H1. The following intakes were investigated 3005890, 3001050, 3000478, 2976767, 2974769, and 2808629.<br><br>One of the twenty-four allegations resulted in a deficiency. | F0000 | | 05/13/2026 |
| F0684<br>SS = E | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and resident, staff, and Nurse Practitioner interviews, the facility failed to ensure physician orders for daily weights were implemented as prescribed for 3 of 3 residents reviewed with orders for daily weights (Residents #9, #11, and #12).<br><br>Findings included:<br><br>1. Record review revealed Resident #12 was originally admitted to the facility on 2/19/2026, with diagnoses of Type 2 diabetes mellitus and congestive heart failure.<br><br>A discharge Minimum Data Set assessment dated 3/23/2026, documented Resident #12 as cognitively intact.<br><br>Resident #12 was readmitted to the facility on 3/27/2026. | F0684 | The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F684 – Quality of Care<br><br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>The Director of Nursing reviewed the daily weights orders for residents # 9, # 11 and # 12 to ensure that the orders were accurately placed into the electronic health record and populate properly onto the eMAR.<br><br>The medical provider was notified of the missing weights, and the medical provider conducted a clinical reassessment of the residents. The care plans for each resident were updated to reflect the correct status of the residents. Residents were offered alternative weighing measures to include the mechanical lift. Any refusals were communicated to the medical provider.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br><br>All residents are at risk for this deficient practice. On | 05/22/2026 |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0684 SS = E | Continued from page 1<br>Record review revealed Resident #12 had a physician's order initiated on 3/28/2026, directing staff to obtain a daily weight at 7:00 AM and to report to the physician if the resident experienced more than a two-pound weight increase for monitoring congestive heart failure.<br><br>Resident #12 had an additional physician's order initiated 3/28/2026 for 20 milligrams of furosemide (diuretic) to be administered as two tablets by mouth one time a day for fluid retention.<br><br>A care plan focus area initiated on 3/30/2026, identified Resident #12 as being at risk for nutritional decline related to congestive heart failure and diabetes mellitus, with an intervention directing staff to obtain weights as ordered.<br><br>During an interview conducted on 5/6/2026 at 12:05 PM, Resident #12 stated he had a history of congestive heart failure since 2020 and denied current shortness of breath. Resident #12 reported it had been approximately one month since his weight had last been taken at the facility and that he had only been weighed monthly since admission.<br><br>Review of the March, April, and May 2026 electronic Medication Administration Records revealed no documentation that daily weights were obtained for Resident #12.<br><br>Additional record review showed that Resident #12 had a recorded weight of 191.6 pounds on 3/28/2026. The next documented weight was 217.9 pounds on 4/2/2026. There was no further documentation of any weights obtained after 4/2/2026 for Resident #12.<br><br>An interview with the previous interim Director of Nursing on 5/6/2026 at 3:33 PM, revealed that when the physician's order for daily weights for Resident #12 was entered into the electronic record, a required selection box was not activated, resulting in the order not populating onto the electronic Medication Administration Record (MAR). The interim Director of Nursing confirmed the nurse who entered the verbal order into the electronic medical record should have selected the box to have the order populate into the electronic MAR. The interim Director of Nursing stated that if the order had appeared on the MAR, nursing staff would have known to complete the daily weights on Resident #12.<br><br>During an interview on 5/6/2026, at 12:26 PM, Nurse Practitioner (NP) #1 stated it was clinically indicated | F0684 | Continued from page 1<br>5/7/26 a functional wheelchair scale was placed on the unit to obtain daily weights.<br><br>The Director of Nursing completed a 100% audit of all residents on daily weights to ensure that the physician orders were fulfilled and populated accurately to the eMAR.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br><br>On 05/09/2026, the Staff Development Coordinator initiated education with current licensed nurses including agency nurses. Education included: .1. How to accurately enter daily weight orders into the electronic medical record in Point Click Care to ensure that it populates into the eMAR. 2. Offering of alternative ways to obtain weights including mechanical lift when wheelchair scale not available. 3. Notification to the medical provider when daily weights are not obtained as ordered. 4. This education will be completed by 05/21/2026. Any license nurses that did not receive this education by 05/21/2026 will not be allowed to take an assignment until the training has been completed. Education will continue with new hire orientation.<br><br>On 05/09/2026 the Staff Development Coordinator initiated education with current licensed nurses including agency nurses, certified nurse aides, and maintenance staff on the Medical Equipment Response Protocol. This education will be completed by 05/12/2026. Any license nurses, certified nurse aide and maintenance staff that did not receive this education by 05/21/2026 will not be allowed to take an assignment until the training has been completed. Education will continue with new hire orientation<br><br>On 5/20/2026 medical providers received education from the Director of Nursing regarding placing orders on hold or evaluating residents as appropriate whenever daily weights not obtained as ordered.<br><br>On 05/07/2026, the facility established a Medical Equipment Response Protocol. Upon identification of any inoperable weight scale (or other equipment essential to carrying out physician orders, the employee will (1) document the equipment failure in the maintenance log program (TELS) (2) notify the DON and Administrator; (3) identify available alternative equipment (e.g., mechanical lift scale, bariatric scale, personal scale) and implement | 05/22/2026 |

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| F0684 SS = E | Continued from page 2<br>for Resident #12 to have daily weights obtained due to congestive heart failure. NP #1 acknowledged it was a problem that the daily weights were not completed and that the physician's order was not followed, as the absence of weight data made it impossible to determine whether the resident experienced fluid-related weight gain.<br><br>2. Resident #11 was originally admitted to the facility on 1/25/2022 with a diagnosis of congestive heart failure.<br><br>A care plan focus area revised on 12/11/2025, identified Resident #11 as having an increased nutritional and hydration risk related to congestive heart failure and diuretic use, which could promote significant weight fluctuations. The care plan included an intervention directing staff to monitor weights as ordered.<br><br>An annual Minimum Data Set Assessment dated 4/3/2026, coded Resident #11 as cognitively intact and able to independently stand from a seated position and transfer to and from a chair or the side of the bed.<br><br>Resident #11 had a physician's order dated 4/14/2026 for 20 milligrams of torsemide (diuretic) to be administered as one tablet by mouth every 24 hours as needed for a weight gain of 3 to 5 pounds for congestive heart failure.<br><br>Resident #11 had an additional physician's order dated 4/14/2026 for 60 milligrams of torsemide to be administered as three 20 milligrams tablets by mouth two times a day for fluid retention.<br><br>Resident #11 had a physician's order dated 4/16/2026 that directed staff to obtain a daily weight at 6:00 AM and to notify the physician of a three-pound weight gain in a 24-hour period as an indicator of fluid retention.<br><br>During an interview on 5/6/2026 at 8:25 AM, Resident #11 reported that the facility's floor weight scale had been broken for approximately a month. Resident #11 stated she had an active physician's order for daily weights due to congestive heart failure and fluid retention. Resident #11 denied shortness of breath but reported feeling as though she was retaining fluid. Resident #11 stated she had been offered the option of being weighed using a mechanical lift but declined because the lift caused shoulder pain due to an injury she sustained. Resident #11 reported she was able to stand on a floor scale but had been told her weight could not | F0684 | Continued from page 2<br>immediately; (4) notify the attending physician/NP for each resident with an active order dependent on the unavailable equipment; and (5) obtain a physician/NP order to either place the weight order on hold or modify the method/frequency of weighing, with clinical rationale documented. A backup floor scale was procured and placed in service on 05/07/2026. The facility will maintain a minimum of two (2) operational weight measurement options at all times (e.g., floor scale and mechanical lift scale).<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.<br><br>The Director of Nursing and/or designee will complete a 100% audit of residents with daily weight orders; review MAR compliance, equipment status logs, and order-hold documentation on going monthly one (1) time daily for four (4) weeks and then two (2) times weekly for eight (8) weeks. The Maintenance Director will complete daily inspection of scale equipment operability one (1) time daily for two (2) weeks, then weekly for four (4) weeks.<br><br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Compliance date 05/22/2026 | 05/22/2026 |

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| F0684 SS = E | Continued from page 3<br>be obtained until the scale was repaired.<br><br>Review of the April 2026 Medication Administration Record (MAR) for Resident #11 revealed multiple dates on which daily weights were not obtained, including April 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 28, and 30, with entries marked as blank, not applicable, or coded as “9 – other/see progress notes.” Corresponding medication administration progress notes documented repeated statements that the scale was broken or unavailable, including entries on April 18 (“unable to weigh. Scale is waiting to be fixed”), April 19 (“weigh scale waiting to be fixed”), April 24 (“resident refused to be weighed by mechanical lift”), April 25 (“unable to assess weight due to inoperable scale”), April 26 (“scale unavailable”), April 27 (“unable to obtain scale unavailable”), and April 30 (“unable to obtain weight scale inoperable”). No explanatory comment was documented for April 28.<br><br>Review of the May 2026 MAR for Resident #11 showed additional missed weights on May 1, 2, 3, 4, and 6, with medication administration progress notes stating on May 1 that the “scale [was] broken” and on May 6 that the “scale [was] broken [and the resident] did not want a lift weight due to shoulder pain.”<br><br>During an interview on 5/6/2026, at 11:19 AM, Unit Supervisor #2 reported the floor scale had been broken for several weeks, though she was unsure of the exact duration. She stated the mechanical lift scale was operational, but Resident #11 declined its use. Unit Supervisor #2 confirmed that the Medical Director and Nurse Practitioner (NP) #1 were aware that the scale was non-operational and that daily weights for Resident #11 were not being recorded. She also confirmed the physician’s order for daily weights had not been placed on hold despite the inability to obtain weights.<br><br>During an interview on 5/6/2026 at 3:33 PM, the previous interim Director of Nursing (DON) stated she had been informed during a risk-management meeting the prior week that the scale had been broken for approximately one month. She stated the physician’s order for daily weights should have been placed on hold for residents unwilling to be weighed on the mechanical lift scale while the floor scale was being repaired.<br><br>In an interview on 5/6/2026, at 12:26 PM, Nurse Practitioner (NP) #1 confirmed he had been made aware that daily weights were not being completed for residents with physician orders requiring them | F0684 | | 05/22/2026 |

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| F0684 SS = E | Continued from page 4<br>due to the floor scale being non-operational. He stated it was a significant problem that daily weights were not obtained for Resident #11, as they were clinically indicated for monitoring congestive heart failure. Although the resident was not experiencing shortness of breath, NP #1 stated the failure to follow physician orders created a potentially unknown problem regarding whether the resident was experiencing fluid-related weight gain.<br><br>3. Resident #9 was admitted to the facility on 6/14/2024 with a diagnosis of congestive heart failure.<br><br>A care plan focus area initiated on 7/5/2024 identified Resident #9 as being at risk for complications secondary to diuretic use related to congestive heart failure, with an intervention directing staff to monitor for weight loss and weight gain.<br><br>Resident #9 had a physician order initiated 11/27/2025, which directed staff to obtain a daily weight on every day shift.<br><br>A quarterly Minimum Data Set assessment dated 3/18/2026, coded Resident #9 as cognitively intact and able to independently stand from a seated position and transfer to and from a chair or the side of the bed.<br><br>During an interview on 5/6/2026, at 12:15 AM, Resident #9 stated he had congestive heart failure and shortness of breath and therefore had a physician's order for daily weights. The resident reported the scale had been broken and believed he had been weighed four or five days prior, though he was unsure of the exact date.<br><br>Review of Resident #9's April 2026 Medication Administration Record (MAR) revealed multiple dates on which daily weights were not obtained, including April 18, 19, 21, 22, 23, 25, 28, and 30, with entries coded as "9 – other/see progress notes." The medication administration progress notes documented repeated statements that the scale was broken or not working, including entries on April 21 ("scales for repair all parties"), April 22 ("scale not working"), April 23 ("scale broken"), April 28 ("scale not working"), and April 30 ("scale broke"). No explanatory comment was documented for April 25.<br><br>Review of Resident #9's May 2026 MAR revealed additional missed weights on May 1 and May 3, with administration progress notes stating on both dates that the "scale [was] not working." | F0684 | | 05/22/2026 |

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| F0684 SS = E | Continued from page 5<br><br>During an interview on 5/6/2026 at 11:19 AM, Unit Supervisor #2 reported the floor scale had been broken for several weeks, though she did not know the exact duration. Unit Supervisor #2 reported that the mechanical lift scale was operational, and Resident #9 was willing to be weighed on that scale sometimes. Unit Supervisor #2 stated that, in addition, there was a resident who had a personal scale in her room that was used to weigh other residents, and this might be how weights in the electronic record were obtained for Resident #9, after the floor scale became non-operational. Unit Supervisor #2 stated that the Medical Director and Nurse Practitioner (NP) #1 were aware that the floor scale was non-operational and that daily weights for Resident #9 had not been consistently completed. Unit Supervisor #2 confirmed that the order for daily weights for Resident #9 was not put on hold when the weight scale was identified as broken.<br><br>During an interview on 5/6/2026, at 3:33 PM, the previous interim Director of Nursing (DON) stated she had been informed during a risk-management meeting the prior week that the scale had been broken for approximately one month. The interim DON stated the physician's order for daily weights should have been placed on hold while the scale was being repaired, or that the mechanical lift scale should have been offered as an alternative.<br><br>In an interview on 5/6/2026, at 12:26 PM, Nurse Practitioner (NP) #1 confirmed he had been made aware that daily weights were not being completed for residents with physician orders requiring them. He stated it was a significant problem that daily weights were not obtained for Resident #9, as they were clinically indicated for monitoring congestive heart failure. Although the resident was not experiencing shortness of breath, NP #1 stated that the failure to follow physician orders created an issue in determining whether the resident was experiencing fluid-related weight gain. | F0684 | | 05/22/2026 |