#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCT 0 7 2013

PRINTED: 09/26/2013 FORM APPROVED

CENTER	S FOR MEDIÇARE &	MEDICAID SERVICES					OM8 NO	O. 0938-0391
STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345006		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		ł		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WNG			C 09/12/2013			
	ROVIDER OR SUPPLIER THAL JEWISH NURSING	& REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	<del></del>	
(X4) IO 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ΒE	(XS) COMPLETION DATE
F 225 SS=D	INVESTIGATE/REPO ALLEGATIONS/INDIV The facility must not a been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misap and report any knowl court of law against a indicate unfitness for other facility staff to the or licensing authorities. The facility must ensuinvolving mistreatment including injuries of unisappropriation of unmediately to the act to other officials in act through established postate survey and cert. The facility must have violations are thorough prevent further potent investigation is in professing at the administrator of the administrator	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or he State nurse aide registry is.  The state nurse aide registry is, and the state nurse aide registry is, and the state nurse aide reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esident property are reported deministrator of the facility and esidence that all alleged ghly investigated, and must difficultion agency).  The evidence that all alleged ghly investigated, and must difficult abuse while the egress.  The state of the state survey and within 5 working days of the eleged violation is verified e action must be taken.		F:	2228	Submission of the response to the Statement of Deficiency by the undersigned does not Constitute as admission that a deficiency exit, were correctly cited and/or require correction.		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	URE			. TITLE		OSH DAY Z

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 plovide 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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation,

, TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345006		NG	·		C	
MANE OF D	ROVIDER OR SUPPLIER				PLOCET APPRECE CITY CYATE TID ACCE		09/12/2013	
	HAL JEWISH NURSING	& REHAB 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)	bt.	ID REFIX FAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	DATE COMPLETICAL (XS)	
F 225	by: Based on record revisinterviews, the facility and a 5 day report to an Injury of unknown (Resident # 2) review origin. Findings include: Resident # 2 was addrollowing diagnoses: primary osteoarthrills moderately/severe os deformity, dementially coordination and must a record review of the dated 6-1-13 revealed interviewable and a Elemental Status) score due to her demential extensive assistance transfers but could predictifity using her feet. A record review of the addressed the potent related to end stage of Further review reveal risk. The resident wall and pivot transfer due Resident # 2 would by	is not met as evidenced lews, staff and physician failed to submit a 24 hour the Health Care Registry for origin for 1 of 3 residents ed for accidents of unknown  mitted on 11-27-13 with the abnormality of gait localized of left leg, steopenia, left knee with behaviors, lack of scle weakness.  Minimum Data Set (MDS) d the resident was not MMS (Brief Interview for was unable to be obtained status. The resident required with bed mobility and opel self throughout the to paddle her wheelchair.  e care plan dated 6-10-13 ial for alteration in comfort osteoarthritis of the left knee, led the resident as a falls is assessed as being a stand		F 225		o nt	9/30/13	
		k of injury. o nurse ' s notes dated resident was found by NA #						

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPRON OMB NO. 0938-0			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	1	(X2) MULTIPLE CONSTRUCTION A BUILDING				
		345006	B. WNG		C 00/40/2049			
	ROVIDER OR SUPPLIER THAL JEWISH NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	09/12/2013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEMCY)	DBE COMPLETS			
F 225	1 attempting to get in resident if she neede NA that her ankle hur assist NA # 1 to stand the bed. The nurse aresident was lying in "movement above the 't be ". Per the recor	her bed and asked the d help. The resident told the t. NA #2 entered the room to d and plyot the resident to esessed the ankle after the the bed and noted there was e ankle where there shouldnud, the physician was notified der was received to obtain a	F 22	Administrator received re- educa Regarding the reporting requiren of injury of unknown origin by the Regional Director of Oper	9/26/1			
	report, dated 8-16-13 fracture to the tibia/fit Further review of the revealed the nurse of the mobile x-ray result received to transport for further treatment.  An interview was constituted the swelling and bruts noted. She stated the attempting to put hers 2 assisted the resident indicated that there will as the resident indicated that there will a stated the resident plvot/transfer due to the lift.  An interview was conpromited the Registere Resident #2 on 8-15-had witnessed the resident table eating her meal	nurses notes dated 8-16-13 intacted the physician with its. At that time an order was the resident to the hospital ducted on 9-10-13 at who was present at the time ring to the left ankle was resident was found self in bed. NA #1 and NA # at to the bed and it was at		Administrator will provide re-educat for the facility staff to include administrative, nursing and ancillary staff related to reporting injury of unknown origin and, reporting an intent F-225.				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROMDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	4	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345008	B. WING	·		1	C /12/2013
NAME OF P	ROVIDER OR SUPPLIER			T-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	112/2013
P. I.				1	3724 WIRELESS DRIVE		
BLOMENT	HAL JEWISH NURSING	& REHAB CENTER			GREENSBORO, NC 27455		
17.0.10	CHRIADVET	ATCHEUT OF GERLOUPLOUP		٠			<del>,</del>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y ALUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD O GROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COVPLETION DATE
F 225	Continued From page	.3		225			
		. The RN reported that she	[	7.ZC	<b>)</b>		
	had taken her evening				Incident / Accidents, concerns and		
	come to Resident #2 room. The nurse stated she assessed the residents' foot and noted the foot was "Obviously broken." The RN reported she notified the physician at that time who ordered a				24 hour hour reporting will be		
					reviewed Monday – Friday daily a		
	mobile x-ray to be dor	te in the facility,			at the facility dally meetings by the		
	During an interview on 9-11-13 at 2:50 pm with NA# 1 who was assigned to Resident #2 on 8-15-13, it was revealed NA# 1 was passing the residents room and noticed the resident attempting to get into bed by herself. NA# 1 stated that she asked the resident if she was ready to go to bed and the rosident replied that she was because her anklo was hurting. At this time, NA# 1 stated that she asked NA# 2 and NA#3 who were passing in the hall to assist her to put Resident #2 to bed. She stated the resident complained of pain and cried out during the stand/pivot transfer. NA# 1 stated she heard no				DON and Administrator to ensure	•	
					that any issues of injury of unknow	'n	
					origin are identified, investigated		
					and reported timely.		
		ting the fracture could have			į.		ĺ
	occurred during the tr	ansfer, it was during the	•				
	time that NA # 1 and NA #2 were putting on the resident's gown that the swelling and bruising						
	was noted.	the swelling and broising					Africa de la delegación delegació
	An interview was cond	ducted with NA#2 on					
	9-11-13 at 3:30 pm, S	he reported that she					
	assisted NA # 1 to pu	t the resident to bed and					}
	that the resident only	complained when they				!	
	attempted to stand her up. NA# 2 denied hearing						
	any popping noises di	uring the transfer, indicating					
	the traceler MA # 0 =	have been injured during				i	
	the transfer. NA # 2 stated that she noticed the				-	İ	
	swelling and bruising to the left ankle when she placed the resident on the bad.						
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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF COMPRECION    A SUMANY SAMELER   A STREET ADDRESS, CITY, STATE, 2P COMPLETED	STATEMENT	OF DEFICIENCIES	(YA) BROMBERICATION	<del></del>			OMB	NO. 0938-039
MANE OF PROVIDER OR SUPPLIER  BLUMENTHAL JEWISH NURSING & REHAB CENTER  CASHD  PREFIX  SUMMARY STATEMENT OF DEFICIENCIES PREFIX  LECAL DEFICENCY ON LIST DEPTICENCY ON LIST DEPTICENCIES PREFIX  F 225  Continued From page 4  On 9-11-13 at 4:10 pm, an interview was conducted with the Administrator. She reported that she did not investigate this fracture as an injury of unknown origin and did not submit a 24 hour or 5 day report to the Health Care Registry because the physician deemed the Incident as a pathological recture related to diffuse, severe to moderate osteopenia. The Administrator followed the facility policy with an in house investigation which involved interviewing all staff involved. Staff to resident #22 physician. The physician came to the facility to explain that the fracture the resident recalved was pathological rollated to her past history of severe osteopenia. He stated the fracture could have possibly occurred while the resident was soft propolling herself using her feat to paddle horself along in the hell. He stated that Injury did not always have to occur to cause a pathological fracture and the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may not have experienced acute pain until she was assisted up and phycloid to the bed by the staff. At this point, the physician stated the resident may have ye	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY	
BLUMENTHAL JEWISH NURSING & REHAB CENTER  SINEST ADDRESS, CITY, STATE, JIP CODE 3724 WIRELESS DRIVE GREENSBORO, NO 27455  SUMMAY STATEMENT OF REFIGIENCIES PREFIX PREFIX PREFIX AND SUMMAY STATEMENT OF REFIGIENCIES PREFIX PREFIX REGULATORY OR LISC IDENTIFIME INFORMATION PREFIX TAG  Continued From page 4  On 9-11-13 at 4:10 pm, an interview was conducted with the Administrator. She reported that she did not investigate this fracture as an injury of unknown origin and did not submit a 24 hour or 5 day report to the Health Care Registry because the physician deemed the Incident as a pathological fracture related to diffuse, sowere to moderate osteopenia. The Administrator followed the facility policy with an in house investigation which involved interviewing all staff involved. Staff to resident abuse was ruled out.  An interview was conducted on 9-12-13 at 8:45 arm with Resident #2 physician. The physician came to the facility to explain that the fracture the resident received was pathological related to her past history of savere osteopenia. He stated the fracture could have possibly occurred while the resident was self propelling horeself using her feet to paddle herself elong in the hall. He stated that Injury did not always have to occur to cause a pathological fracture and the resident may not have experienced ocute pain until she was assisted up and phycled to the bed by the staff. At this point, the physician stated the resident may have yelled out in pain. The physician stated " The nature of a spiral fracture is depending on the movement of the bone when the pathological fracture occurs."  SIMEET ADRESS. CITY, STATE, JPC PROMINERS PLAN OF CORRECTION PREFIX PROMINERS PLAN OF CORRECTION CERCENTOR PROPHATE CORRECTIVE PROMINER PROMINERS PLAN OF CORRECTION CERCENTOR PROMINERS CREENSBORO, NO 27455  PROMINERS Administrator will react consuctive conditions			345008	B. WNG				С
BLUMENTHAL JEWISH NURSING & REHAB CENTER    SUMMAY STATEMENT OF DEFICIENCIES   SUMMAY STATEMENT OF DEFICIENCIES   ID PREFIX   REGULATORY ORLS DEPTICENCY DISTRIPTING INFORMATION)   ID PREFIX   PROMUETS PLANOF CORRECTION CONCERNOR   CARLE CORRECTIVE ACTION SCIOLUD BE CROSS-REFERENCY OF THE APPROPRIATE DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER				IRRET ADDRESS ON STATE TO SOON	0	09/12/2013
GREENBRORO, NC 27455    SUMMARY STATEMENT OF DEFICIENCIES   1D   PROPUER'S PLAN OF CORRECTION   PREFIX   TAG   PROPUER'S PLAN OF CORRECTION   PREFIX   PROPUER'S PLAN OF CORSTITUTE   PROP	BLUMEN	THAL JEWISH NURSING	& DEHAR CENTER					
SUMMARY STATEMENT OF DEFICIENCIES PREPRY TAG  SUMMARY STATEMENT OF DEFICIENCES PREPRY RESULATORY OR USG IDENTIFYING INFORMATION)  FOR TAG  Conditional From page 4  On 9-11-13 at 4:10 pm, an interview was conducted with the Administrator. She reported that she did not investigate this fracture as an injury of unknown origin and did not submit a 24 hour or 5 day report to the Health Care Registry because the physician deemed the Incident as a pathological fracture related to diffuse, sowere to moderate osteopenia. The Administrator followed the facility policy with an in house Investigation which involved interviewing all staff involved. Staff to resident abuse was ruled out.  An interview was conducted on 9-12-13 at 8:45 am with Resident #2 physician. The physician came to the facility to explain that the fracture the resident received was pathological related to her past history of sovere osteopenia. He stated the fracture could have possibly occurred while the resident may not have experienced be presented by the staff. At this point, the physician stated in resident may have yelled out in pain. The physician stated "The nature of a spiral fracture is depending on the movement of the bone when the pathological fracture occurs."  PROVIDERS PLAN OF CORRECTION ADDIO SIGNATION (CANO STREERING) TO HEXAPPROPRIATE OF THE APPROPRIATE OF THE APPROP			WHENWO OFFICE					
On 9-11-13 at 4:10 pm, an interview was conducted with the Administrator. She reported that she did not investigate this fracture as an injury of unknown origin and did not submit a 24 hour or 5 day report to the Health Care Registry because the physician deemed the incident as a pathological fracture related to diffuse, sowere to moderate osteopenia. The Administrator followed the facility policy with an in house investigation which involved interviewing all staff involved. Staff to resident abuse was ruled out.  An interview was conducted on 9-12-13 at 8:45 am with Resident #2 physician. The physician came to the facility to explain that the fracture the resident received was pathological related to her past history of sovere osteopenia. He stated the fracture could have possibly occurred while the resident was soil propelling herself using her feat to peddle herself along in the hall. He stated that injury did not always have to occur to cause a pathological fracture and the resident may not have experienced acute pain until she was assisted up and pivoted to the bed by the staff. At this point, the physician stated the resident may have yelled out in pain. The physician stated " The nature of a spiral fractura is depending on the movement of the bone when the pathological fracture is depending on the movement of the bone when the pathological fracture is depending on the movement of the bone when the pathological fracture occurs."  F 225  Administrator will review weekly results to analyse for any trends  and report findings monthly for  3 months to the facility OA  will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to interventions as needed to ensure continued compliance.  Interventions as needed to ensure continued compliance.  Monitoring will be monthly  Monitoring will be monthly  times 3 months then  quarterly for one year by	PREFIX	I (EACH DEFICIENC)	Y MUST BE PRECEDED BY EACH	PREFE	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI-	e E	COMPLETION
		On 9-11-13 at 4:10 pm conducted with the Ad that she did not invest injury of unknown orig hour or 5 day report to because the physician pathological fracture remoderate osteopenia. The facility policy with a which involved intervie to resident abuse was An interview was cond am with Resident #2 picame to the facility to cresident received was past history of severe of fracture could have porresident was self properto peddle herself along injury did not always he pathological fracture are have experienced acute assisted up and pivoted this point, the physiciar have yelled out in pain. The nature of a spiral fithe movement of the botter injury of the botter of the botter of the power of the power of the point, the physiciar have yelled out in pain.	in, an interview was iministrator. She reported igate this fracture as an in and dld not submit a 24 to the Health Care Registry a deemed the incident as a clated to diffuse, severe to The Administrator followed on in house investigation awing all staff involved. Staff ruled out.  The pathological related to her pathological related the saibly occurred while the stated that in the hall. He stated that have to occur to cause a had the resident may not be pain until she was to to the bed by the staff. At a stated the resident may The physician stated "racture is depending on stated in the pathological related to the pain until she was the total the staff of the bed by the staff. At a stated the resident may The physician stated "racture is depending on the staff of the pathological related to the physician stated "racture is depending on the staff of the pathological related to the physician stated "racture is depending on the staff of the pathological related to the pathological related to the resident may the physician stated "racture is depending on the pathological related to the pathological related to the resident may the physician stated "racture is depending on the pathological related to the pathological rel	F	225	results to analyse for any trends and report findings monthly for 3 months to the facility QA committee. The QA committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance.  Monitoring will be monthly times 3 months then quarterly for one year by		