PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345006	B. WING				C / 30/2017	
NAME OF PI	ROVIDER OR SUPPLIER		'	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				3724 WIRELESS DRIVE				
BLUMENI	HAL NURSING & REHA	BILITATION CENTER		GREENSBORO, NC 27455				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
IAG	REGENION ON	EGG IDENTIL PINO IN GRAMMITORY	IAG		DEFICIENCY)			
F 400	66 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS			400			4/07/47	
	l - _ - - - -		F	166			4/27/17	
SS=C	TO RESOLVE GRIEV	ANCES						
	(j)(2) The resident has	s the right to and the facility						
		forts by the facility to resolve						
	grievances the reside	ent may have, in accordance						
	with this paragraph.							
	(i)(3) The facility must	t make information on how						
	, •, ,	complaint available to the						
	resident.	•						
	(i)(4) The facility mus	t establish a grievance policy						
		resolution of all grievances						
		ts' rights contained in this						
	paragraph. Upon requ	uest, the provider must give						
	a copy of the grievand	ce policy to the resident. The						
	grievance policy mus	t include:						
		ndividually or through						
		t locations throughout the						
	facility of the right to f	-						
	,	in writing; the right to file						
		usly; the contact information all with whom a grievance						
		is or her name, business						
		email) and business phone						
	, ,	e expected time frame for						
		v of the grievance; the right						
		cision regarding his or her						
	grievance; and the co							
	independent entities v	with whom grievances may						
		ertinent State agency,						
		Organization, State Survey						
		ng-Term Care Ombudsman						
	program or protection	and advocacy system;						
	(ii) Identifying a Griev							
		eeing the grievance process,						
	receiving and tracking	g grievances through to their						
ABOBATORY	DIDECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE	

04/21/2017

Electronically Signed

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

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F 166	by the facility; maintal information associate example, the identity grievances submitted written grievance decoordinating with start necessary in light of start necessary, talk prevent further potent right while the alleger investigated; (iv) Consistent with § reporting all alleged values, including injurtant anyone furnishing se provider, to the admit as required by State (v) Ensuring that all valued include the date the grammary statement of the steps taken to invisummary of the pertinger as to whether the grieconfirmed, any correct taken by the facility and the date the writted (vi) Taking appropriated accordance with State of the residents' right or if an outside entity	any necessary investigations ining the confidentiality of all ad with grievances, for of the resident for those I anonymously, issuing sisions to the resident; and the and federal agencies as specific allegations; using immediate action to tial violations of any resident diviolations involving neglect, ries of unknown source, ion of resident property, by rivices on behalf of the inistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, a ment findings or conclusions it's concerns(s), a statement evance was confirmed or not citive action taken or to be a result of the grievance, and cent findings or soulcasions it's concerns (s), a statement evance was confirmed or not citive action taken or to be a result of the grievance, and cent findings or soulcasions it's concerns (s), a statement evance was confirmed or not citive action taken or to be a result of the grievance, and cent findings or soulcasions it's concerns (s), a statement evance was confirmed or not cettive action taken or to be a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcasions is a result of the grievance, and cent findings or soulcast	F1	66				

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F 166	Organization, or local confirms a violation rights within its area (vii) Maintaining evid result of all grievand 3 years from the issubscission. This REQUIREMENT by: Based on record refacility's grievance presidents' rights: the anonymously, the rigresponse to grievan information of the gritheir name, physical address, and busine frame of how long a Findings Included: A review of the facility Grievance Policy' die Administrator on 3/2 will investigate all grievances and comprievances and comprievance and compried and comprievance and compried and comprievance and comprievance and comprievance and compried and comprievance and comprievance and comprievance and compried and comprievance and com	al law enforcement agency for any of these residents' of responsibility; and dence demonstrating the es for a period of no less than uance of the grievance T is not met as evidenced view and staff interviews the olicy failed to include the right to file grievances ght to obtain a written ces submitted, the contact ievance official including: and e-mail business ess phone number and the grievance is kept. ty policy titled "Investigation implaints Grievance Procedure ated 7/2016, provided by the 18/17, revealed "Our facility ievances and complaints filed administrator is assigned the rseeing investigation of iplaints. Upon receipt of a	F	166	The creation and submission of this plof correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for a our residents. Immediate Action No Residents named were sited to be affected by alleged deficient practice Notification to residents were posted in prominent locations throughout the fact of the right to file grievances orally or in writing along with contact information of the grievance officer by the Administration 4/06/2017. A new Policy and procedure with the data	all ility n of tor	
	A review of the facili Grievance Procedur the Administrator on Grievance must be	ty policy titled "Section 1557 e" dated 7/2016, provided by 3/29/17, revealed "1. submitted to the Section 1557			of revision march 2017 was initiated or 4/6/2017 and implemented in the facilit by the Regional Clinical Consultant #2; this policy and procedures contains the revised regulatory components implemented on phase one as of November 2016	n Yy	

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F 166	F 166 Continued From page 3		F ·	166				
	filing the grievance becomes aware of the alleged discriminatory. 2. A complaint must be in writing, containing the name and address off the person filing it. The complaint must state the problem or				Identification of Others All resident in the facility have the			
	Section 1557 coordin	ninatory action. 3. The ator or his/her designees			potential to be affected by the alleged deficient practice.			
		stigation of the complaint.			Social Worker #1 and Social Worker #			
		y be informal, but will be			informed all active residents on the nev	N		
		Il interested persons an evidence to the complaint			grievance policy and procedure by 4/27/2017.			
	An interview with the Administrator on 3/29/17 at 2:45 PM revealed he had given us the wrong				Systemic Changes			
		3/28/2017 and replaced that			Effective 4/27/2017 the new grievance			
		57 Grievance Procedure"			policy and procedure has been added	to		
		. During this interview with also revealed that he was			the admission packet for all new	4		
		Regulation for the grievance			admissions to the facility. New admitter resident(s) and/or responsible party wi			
		hat the facility did not have			informed about their rights to file	100		
	I -	e policy with the required			grievance or concerns orally or in writte	∍n,		
	components effective	November 2016.			as well as steps facility will take to			
					address such grievances.			
					Effective 4/27/2017 the new grievance policy and procedure will be discussed			
					quarterly during resident's council mee	ting		
					by Activity Coordinator #1 or Activity			
					Coordinator #2 or Administrator.			
					Effective 4/27/2017, Regional nurse			
					consultant will review to ensure the fac	ility		
					receive and implement any updated policies and procedures put forth base	d		
					on regulatory changes, industry best	J.		
					practices or for any other reasons. This	3		
					review will take place no later than a w			
					from the date if and when a policy and			
					procedure is put forth.			

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F 166 Continued From page 4		F 1		100% of active facility employees will be educated on the new Grievance Policy	e			
					and Procedure by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Development Coordina (SDC). This educated was initiated on 4-6-2017 for all active employees to include full time, part time, and as need employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allow to work until educated. This education was also added to new hire process for new employees effective 4/27/17 and a will be provided annually.	ded ved		
					Monitoring Process Effective 4/27/17 weekly audits will be conducted by Social Services #1 or So Services #2 and or the Administrator to ensure new grievance policy and procedure have been discussed for new admissions during new admission process, and during quarterly resident's council meetings.	N S		
					Effective 4/27/2017 a weekly audit will conducted by DON, ADON or Facility payroll and human resources personne for all new hires to ensure new Grievan policy and procedure has been discuss during orientation. These audits will be conducted weekly times 4 weeks then monthly times 4 months. Results of the audits mentioned above	el, ace ed		

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F 166	Continued From page		F 16	be reported to the facility Quality Assurance, Performance Improvement committee by Social Worker #1 or Social Worker #2, monthly x 6 months. The QAPI committee will recommend any additional monitoring needs or modification of these plans as the committee deems appropriate.	cial	
F 253 SS=E	SERVICES (i)(2) Housekeeping a necessary to maintair comfortable interior;	maintenance services a sanitary, orderly, and	F 25	3	4/27/17	
	Based on observation facility staff interviews and disinfect a reside observation was mad spots on the floor for (for Resident #40) ob substance in the bath maintain housekeepin services to provide cliclean toilets in reside maintained, safe and 7 residents halls. (Haland Hall 700) The findings included 1) An observation marevealed a towel was of Resident #40 's baland the wall. The who with many large red sides.	ean resident's rooms and nt's bathroom and proved a comfortable interior on 4 of all 200, Hall 500, Hall 600		F253 The white towel that appears to be saturated with red spots removed from resident #40 room by Housekeeping/Laundry supervisor on 3/28/2017 and discarded in biohazard Resident #40s bathroom has been cleaned and disinfected by the House keeping supervisor on 3/28/17, red/br spots removed from bathroom floor. 200 Hall Room 213 Blinds replaced by the maintenance supervisor and or assist maintenance supervisor on 3/31/2017 500 Hall Room 502 Wall Paper removed by the maintenance supervisor and or assist maintenance supervisor on 3/31/2017 Room 503 White patch painted, back bathroom door repaired and dripping	d bin. erown tant 7	

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NAME OF D		343006	B. WING _		TREET ARRESTO CITY OTATE ZIR CORE	03/	30/2017
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F 253	Continued From p	age 6	F 2	253			
	pattern (approxima	ately 18" long) starting			faucet repaired by the maintenance		
		inches directly in front of the			supervisor and or assistant maintenand	ce	
		where the towel laid in the			supervisor on 3/31/2017.		
	_	room. In addition, there were			•		
		spots observed on the			Room 504 Wall Paper removed, corne	r	
	bathroom floor in t	the same general area as the			behind bed A painted and door has bee	en	
	streak marks.				cleaned by maintenance supervisor an	d	
					or assistant maintenance supervisor or	า	
		conducted on 3/28/17 at 8:25			3/31/2017.		
		1 was in Resident #40 's room					
		observation and had been			Room 506 Bathroom and bathroom do		
		nmate with the breakfast meal.			frame has been repainted, Drawer und	er	
		#1 stated Resident #40 had			TV has been properly repaired, Wall		
		the staff was aware she would oor at times. When asked what			Paper has been removed and door sanded and re-stained by the		
		d to do, the NA stated she			maintenance supervisor and or assista	nt	
		g the towel in a red bag since it			maintenance supervisor on 3/31/2017	111	
	_	d would tell the hall nurse so			mamenance supervisor on 6/6 1/2017		
		e housekeeping staff about the			Room 600 Hall		
	blood on the floor.	· ·			Room 601 Wall Paper removed and flo	or	
					molding in bathroom repaired by		
	An observation ma	ade on 3/28/17 at 9:00 AM			maintenance supervisor and or assista	nt	
	revealed the towe	I was no longer in Resident #40			maintenance supervisor on 04/04/2017	7	
	's bathroom. Hov	vever, the red/brown streaks					
	and drops remaine	ed on the floor.			Room 603 Wall by drawers have been		
					painted, door frame near bathroom has	3	
		ade at 9:30 AM revealed the			been painted and faucet has been		
		treaks remained on the			repaired (tighten and dripping fixed) by		
	bathroom floor.				maintenance supervisor and or assista		
	A = i=t== ::=:				maintenance supervisor on 04/06/2017	,	
		conducted on 3/28/17 at 9:35 Nurse #1 was the nurse			Room 604 Bathroom door frame		
					repainted, Drawer handle under TV		
	_	ent #40 ' s hall. Upon inquiry, ne NA had reported the bloody			repairted, Drawer handle under TV		
		sident #40 's bathroom. The			closet cleaned by the maintenance		
		would pass this on in report to			supervisor and or assistant maintenance	ce	
		/hen asked if she had notified			supervisor on 04/04/2017.		
		department of the red/brown					
		bathroom floor, Nurse #1 stated			Hall 700		

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F 253	Continued From page	e 7	F 253	3			
	the NA had already done so.			Room 720 Night stand replaced and 6 holes in bathroom repaired by			
	An interview was con	ducted on 3/28/17 at 9:40		maintenance supervisor and or assista	ant		
		ng the interview, the NA ne Housekeeping Supervisor		maintenance supervisor on 04/06/201			
		esident #40 ' s bathroom		Room 716 Room wall has been repair	od l		
	floor.	esident #40 's battiloom		and painted by maintenance supervisor			
	noor.			and or assistant maintenance supervise			
	An interview was con	ducted on 3/28/17 at 9:45		on 04/06/2017.			
	AM with Housekeeper #1. Housekeeper #1 was			011 04700720 17 .			
	T			Room 709 Bathroom floor around toile	.+		
	mopping the floor in the room next to Resident #40's room at the time of the interview. When			cleaned and stains removed by			
		e was going to mop next,		Housekeeping and Laundry superviso	r on		
		ted across the hallway to		04/06/2017.			
		Resident #40 's). The		04/00/2017.			
	T	when she was finished with		Room 711 Hole in bathroom wall repair	ired		
	those rooms, she wo			and painted by maintenance supervisor			
	direction down the ha			and or assistant maintenance supervise			
		vould mop Resident #40 's		on 04/06/2017			
		keeper stated she usually		S. 6 6 6			
		Housekeeper #1 stated she		Room 702 Door sanded and repaired	bv		
		oor got "messy" and she		maintenance supervisor and/or assista			
		sident a chance to get up		maintenance supervisor on 04/06/201			
		oing there because the floor		maintenance capenness on a need 201			
		o" again. Upon further		Room 708 Residents bathroom walls a	and		
		per stated she would mop		floor cleaned by Housekeeping and			
		room floor after lunch so she		Laundry supervisor on 04/06/2017			
	would not have to go			, , , , , , , , , , , , , , , , , , , ,			
	3 .			Room 706 Door sanded and repaired	bv		
	An interview was con	ducted on 3/28/17 at 9:47		maintenance supervisor and or assista			
	AM with the Houseke	eping/Laundry Supervisor.		maintenance supervisor on 04/06/201			
		owledged NA #1 had told her		·			
		room floor needed cleaning		Identification of Others:			
		ood on the floor. The					
		she had asked Housekeeper		100% audit of all resident rooms audit	ed		
	#1 to take care of it. \	When asked how soon she		to identify any other room with			
		this to be done, she stated		housekeeping needs to include any ble	ood		
	the floor should have			or body fluids. This audit was complete	ed		
	"Immediately." Acco	mpanied by the		by housekeeping and laundry supervis	sor		

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F 253	3 Continued From page 8		F 2	253				
F 253	Housekeeping / Laun observation was mad Resident #40 's bath floor, the Supervisor sthis right now." An interview was con AM with the facility 's Improvement/Quality and Staff Developme QI/QA nurse was reprontrol responsibilities SDC shared some retraining) with her. Dusituation encountered bathroom was discust control perspective. forward, staff will be rurse stated, "The blobeen cleaned up imm." An interview was con AM with the facility 's During the interview, Resident #40 's bath DON stated, "My exp staff to get the room spossible."	dry Supervisor, an le on 3/28/17 at 9:50 AM of room floor. Upon viewing the stated, "We're going to get ducted on 3/30/17 at 10:31 a Quality Assurance (QI/QA) Nurse int Coordinator (SDC). The orted to assume Infection resident for the facility; and, the sponsibilities (such as staff uring the interview, the din Resident #40's sed from the infection The SDC stated, "Going re-educated." The QI/QA rood on the floor should have nediately." ducted on 3/30/17 at 11:29 a Director of Nursing (DON). The situation encountered in room was discussed. The rectation would be for the sanitized as soon as	F 2	253	on 3/28/17. No other rooms noted with house keeping needs such as cleaning blood or body fluids. 100% audits of all resident rooms in the facility conducted by the Maintenance supervisor and/or assistant maintenance supervisor on 4/6/2017, 4/7/2017 and 4/21/2017 to identify any other resident room with the following areas of concerns with blinds not in good repair identified. Maintenance supervisor and assistant maintenance supervisor replaced the blinds on the 15 other identified rooms on 4/6/2017, 4/7/2017 and 4/21/2017. 2. Missing Wall paper, torn wall paper, and/or not in a good repair; 58 other rooms identified not to be in a good repair identified rooms on 4/6/2017, 4/7/2017 and 4/21/2017. 2. Missing Wall paper, torn wall paper, and/or not in a good repair; 58 other rooms identified not to be in a good repair identified rooms started on 4/6/2018 and to be completed by 4/27/2017. Any room not repaired by 4/27/2017 will be removed out of service until repaired.	eece trns; /or pair. nt on 017		
	at 3:11 PM with the H Supervisor. Upon inc reported Resident #4 cleaned on 3/28/17 u	0 's bathroom floor was sing a disinfectant product. loor was cleaned, the water			3. Wall Repair, Door Repair, Floor molding, Door frames painting; 36 other rooms identified to be in need of one or more repair of identified areas mention above. Maintenance supervisor and/or assistant maintenance supervisor repaired and/or removed all identified areas in 36 noted rooms started on 4/6/2017 and to be completed by	r ed		

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F 253	AM. The slats in the lower end and one so other slats. 500 Hall Room 502 was obs AM. The room had border above the do Room 503 was obs AM. The wall had we the door in the bathrouse in the bathrouse in the bathrouse the door. In the missing paint. The cobe dirty. Room 506 was obs 11:28PM. The bathrouse other was obs 11:28PM. The bathrouse of the door in the bathrouse in the door in the door. In the door in the door in the door in the door in the door. In the door in the door in the door in the door. The door bathrouse door the door in the door. In the door in the door. In the door in t	erved on 3/28/2017 at 10:14 e window blinds are bent at the slat was broken and tied to the erved on 3/28/2917 at 10:04 a missing section of wallpaper borway in room. erved on 3/28/2017 at 10:15 white patch on it, the back of room needs painting. The	F2	253	4/27/2017. Any room not repaired by 4/27/2017 will be removed out of servicuntil repaired. 4.Resident□ Bathrooms Repair; to incl leaking faucet(s), bathroom floor, walls and paints.26 other residents'□ bathrooms noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired, all identified areas in 26 note rooms started on 4/6/2017 and to be completed by 4/27/2017. Any resident bathroom not repaired by 4/27/2017 wibe removed out of service until repaire 5. Condition of residents□' furniture; 9 other furniture noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired all identified furniture in 9 note rooms on 4/6/2017, 4/7/2017 & 4/8/2019.	ude , d d.		
	the TV appears to h drawer. The wall pa hanging down, the d appeared banged u Hall 600 Room 601 was obs AM. The wallpaper	om the bottom drawer under had a wrong-sized face on aper border above bed A was door on side near hinges up and needing staining. erved on 3/28/2017 at 11:23 border was loose above the floor molding was warped in 2			Effective 4/27/2017 House Keeping/Laundry Supervisor re-established a cleaning assignment of housekeeping staff on duty to ensure each resident room is cleaned and sanitized in a daily basis. Effective 4/27/2017, revised deep cleaning schedule put forth by the housekeeping/Laundry supervisor for each re to be deep cleaned once monthly, By the	se oom		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 253	253 Continued From page 10		F 2	253				
	AM. The wall by draw door frame near bath faucet was dripping a loosed. Room 604 was obse AM. The door frame	rved on 3/28/2017 at 11:09 vers had missing paint. The proom had missing paint. The pand the entire fixture was rved on 3/28/2017 at 11:15 going into the bathroom had pandle on drawer under the			Effective 4/27/2017 a maintenance wo book will be placed at each nursing stawhere any maintenance issue(s) can be recorded by any staff member. Maintenance supervisor or assistant maintenance supervisor will check these books daily (Monday to Friday). Any maintenance needs on the week-end to requires immediate attention, a	tion e se		
	missing paint. The handle on drawer under the TV was attached on one side and not the other. Black/gray matter was observed under the dresser and closet it appeared to be dirty.				maintenance supervisor or assistant maintenance supervisor will be contact by staff on duty.	ed		
	PM. The resident's non the front part and resident's bathroom need of repairs. Room 716 was obse PM. The resident roopainted white patche	rved on 3/27/2017 at 12:08 ight stand was missing wood it was rough to touch. In the had 6(six) holes in wall in rved on 3/27/2017 at 12:53 om wall had multiple areas of s on the wall which did not this room was missing paint.			100% of active facility House Keeping laundry employees received additional training on cleaning and disinfecting of floors and surfaces after blood or body fluid spills and contamination. This education was completed by Housekeeping/Laundry Supervisor and Quality assurance nurse. This educatio was initiated on 4-6-2017 for all active housekeeping and laundry employees, include full time, part time, and as need employees. This education will be completed by 4/27/2017, any house	d/or on to		
	PM. The bathroom's substance around th stained. Room 711 was obse PM. The resident's wobserved with a large an apple in need of resident Room 702 was obse	rved on 3/28/2017 at 8:44 room had jagged edges that			keeping/Laundry staff not educated by 4/27/2017 will not be allowed to work useducated. This education was also add to new hire process for all new house keeping/laundry employees effective 4/27/17 and also will be provided annual 100% of active facility employees will be educated on the new maintenance request log and Procedure to request a maintenance needs by Director of Nursing or Staff Development Coordinates.	antil ded ally. de any sing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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				3724 WIRELESS DRIVE			
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F 253	Continued From pag	e 11	F 25				
	AM. The resident's be smeared substance, dirty laundry on the base PM. The door to the were rough to touch. During an interview of 3/29/2017 at 2:30 PM room are clean every deep clean once a reanother room and/or She stated we had a used in the bathroom to remove the stains are check daily. During an interview of (MD) on 3/30/2017 at that he had only bee weeks of March 2011 list of room that are in the wall, doors in reacility had ordered rooms and that each	rved on 3/28/2017 at 12:23 room had jagged edges that with Housekeeper # 2 on M. She stated that resident's day and that rooms are esident were moved to discharge out of the facility. special substances that we as to clean around the toilets. She also stated that rooms with the Maintenance Director to 4:00 PM. The MD revealed in at this facility since the first model of repairs from holes are do frepairs and that the lew blinds for some of the resident was going new		(SDC). This education was initial 4-6-2017 for all active employees include full time, part time, and a employees. This education will completed by 4/27/2017, any streducated by 4/27/2017 will not be to work until educated. This edwas also added to new hire provinew employees effective 4/27/1 be provided annually. Monitoring Process: Effective 4/27/17 Director of nur Assistant Director of Nursing, and Maintenance supervisor will revimaintenance request books were weeks, then monthly x 3 months halls to assure service requests followed up appropriately. Effective 4/27/17 Housekeeping supervisor will complete environ Infection control audits weekly x then monthly x 3 months on all hassure floors and surfaces are coproperly.	es to as needed be aff not oe allowed ducation cess for all 7 and will rsing, ad/or iew the ekly x 4 s on all had been mental a 4 weeks, halls to		
	facility. He also indic cleans up resident's remained on residen report to maintenance The Maintenance dir some of the issues ir was not aware of bed	ated he still learning the ated housekeeping staff room daily and if stains t's floor this needed to be e to deep clean the floors. ector also indicated that a the resident's rooms he cause he hadn't done a full only been here less than 30		Results of audits will be reported Quality assurance performance improvement committee meeting x 4 months by the Housekeepin supervisor, or until pattern of co is achieved. QAPI committee wi modify this plan as deemed appensure continuous compliance. Maintenance supervisor and/or	g monthly g/laundry mpliance Il		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 253	3/30/2017 at 4:40 PM that Director of Nursir this month and are sti Administrator indicate resident's rooms and and items that need to a timely manner.	with the Administrator on I. The Administrator revealed and and MD all of us came in ill identifying issues. and expectation would be that the facility are kept clean to be repaired be repaired in		2253	Administrator will review maintenance work books to ensure compliance with work orders. This review will be completed weekly x 4 weeks, then monthly x 3 months or until the pattern compliance is maintained. Findings of t monitoring process will be reported to facility quality assurance and performal improvement committee monthly x 3 months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee.	his nce	
F 278 SS=D	ACCURACY/COORD (g) Accuracy of Asses	SMENT DINATION/CERTIFIED ssments. The assessment of the resident's status.	F2	278			4/27/17
	(h) Coordination A registered nurse mu each assessment with participation of health						
	the assessment is co	e must sign and certify that mpleted.					
	• •	n and certify the accuracy of					
	(j) Penalty for Falsification(1) Under Medicare a who willfully and known	nd Medicaid, an individual					
	(i) Certifies a material	and false statement in a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION IG	COME	(X3) DATE SURVEY COMPLETED	
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F 278	penalty of not more assessment; or (ii) Causes another is and false statement subject to a civil more \$5,000 for each assess. (2) Clinical disagree material and false statement and false statement and false statement. Based on record refacility failed to accurdiagnosis of myoclor (MDS) assessmant (MDS) asses	t is subject to a civil money than \$1,000 for each Individual to certify a material in a resident assessment is ney penalty or not more than essment. In ment does not constitute a atement. It is not met as evidenced view and staff interview the rately code the active nic jerk on the Minimum Data ent for 1 of 2 residents who rvices within the facility.	F 2		#1 on of MDS a nosis. smitted		
	included Depakote fi jerks. Record review of the revealed myoclonic active diagnoses list Interview on 03/30/2 coordinator #1 who soverlooked coding the	ne diagnoses." 017 at 6:27 PM with the		100% audit completed on 4/21/17 4/22/2017 of all active residents for most recent MDS assessment was conducted by Regional MDS consultant #2, I Nurse #1, MDS Nurse #2 and/or Nurse #3 to ensure all active diagramere coded appropriately in section MDS. 19 Other residents noted winaccurate coding in section I. Modifications/corrections were dor Minimum Data Set as indicated per Resident Assessment Instrument guidelines on 4/22/2017 to 4/27/20	or the s ultant MDS MDS noses on I of with ne to er (RAI)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(>	X3) DATE SURVEY COMPLETED
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BI LIMEN	THAL NURSING & REI	HABILITATION CENTER		3724 WIRELESS DRIVE		
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F 278		age 14 sheld. The expectation stated or was the MDS must be	F2	MDS Nurse #1, MDS N MDS Nurse #3. Systemic Changes Effective 4/27/2017, MI nurse #2 and/or MDS reach resident's physicidiagnosis, completed be nurse practitioner, or plin the last 60 days of the reference date (ARD). review include each resprogress notes, the moderation and/or treat with a date falls in the I ARD. Once a diagnosis documented in the last Nurse #1, MDS nurse #1 nurse #3 will determine active. (Active diagnosis affect the resident's fur care during the last 7 diagnosis except, Item Infection (UTI), which heriteria and does not us look back period). MDS code the diagnosis in serident's MDS assess criterion above are met by MDS nurse #1, #2, and determined to be active guidelines for UTI assection. Effective 4/27/17 prior MDS Nurse #1, #2, and Effective 4/27/17 prior MDS Nurse #1	DS nurse #1, MDS nurse #3 will review an-documented by Medical Doctor, hysician assistant, he assessment The source of this sident's physician ost recent history e summaries, and ach resident's tment signed and last 60 days of is is identified as 60 days, MDS #2 and/or MDS is are those that notioning or plan or lays, for all 12300 Urinary Tranas specific coding se the active 7-day is nurse will then section I of that sment when the transfer UTI will be coderand/or #3 when is based on RAI essment and	w a , s t t d d

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 278	Continued From page				Nurse #2 (Whomever is not signing off section I, on the assessment) will revie completed MDS assessment to ensure accurate coding of diagnosis in Section per RAI guidelines. Any assessment noted with inaccurate coding in Section Modifications/corrections will be done to Minimum Data Set as indicated per RAI guidelines promptly by MDS Nurse #1, and or #3. MDS nurse #1, MDS 2 and/or MDS #3 re-educated by MDS Consultant #1 on proper ways of coding MDS assessment specifically section I on 4/6/2017 This education is also added to new hire process for all MDS nurses 4/27/17 and also will be provided annually. Monitoring Process: Effective 4/17/17 MDS Section I review will take place Monday through Friday 4 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS assessments weekly for 4 weeks, then 25% of all completed MDS nurse #1, MDS nurse #2, and/or MDS nurse #1, MDS nurse #2, and/or MDS nurse #3 will present the findings this audit to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months of until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined to QAPI committee.	w il, ol, ol, the state of the	
F 280	483.10(c)(2)(i-ii,iv,v)(3	3),483.21(b)(2) RIGHT TO	F 2	280			4/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 280 SS=D	483.10 (c)(2) The right to part and implementation of plan of care, including (i) The right to participal including the right to be included in the plan request meetings and revisions to the personal camount, frequency, and other factors related to plan of care. (iv) The right to receivance of the plan of care. (v) The right to see the right to sign after sign of care. (c)(3) The facility shall	ticipate in the development of his or her person-centered ground but not limited to: pate in the planning process, dentify individuals or roles to nning process, the right to at the right to request on-centered plan of care. pate in establishing the nutcomes of care, the type, and duration of care, and any to the effectiveness of the we the services and/or items of care. The care plan, including the difficant changes to the plan.	F2	80			
	shall support the resignanning process mu						
	resident representation (ii) Include an assess strengths and needs.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 280	483.21 (b) Comprehensive C (2) A comprehensive C (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not limit (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food the resident and the resident and the resident repident repident repident repident's care plan. (F) Other appropriate disciplines as determined or as requested by the ciii) Reviewed and reviewed.	are Plans care plan must be- ' days after completion of ssessment. terdisciplinary team, that sited to 'sician. e with responsibility for the I and nutrition services staff. eticable, the participation of esident's representative(s). be included in a resident's participation of the resentative is determined endevelopment of the staff or professionals in fined by the resident's needs the resident. eticable the participation of the resident resentative is determined to development of the	F	280			
	comprehensive and q	ssment, including both the juarterly review					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(2	(X3) DATE SURVEY COMPLETED	
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by: Based on record revie interviews, the facility for Responsible Party (RP Plan meetings for 1 of reviewed for notification Plan meetings. Findings included: Resident #71 was admit 8/11/2015 and re-admit cumulative diagnoses wand Respiratory failure Data Set (MDS) dated Resident #71 required with Activities of Daily Lintact. Medical Records review until March 29, 2017 resorted for the serion of RP being invited to the any documentation of Emeeting. On 3/28/17 at 12:30 Plattempted with Resider respond to any question A telephone interview was Resident # 71's Responsat 2PM. The RP stated notification of Care platindicated that she had the care of Resident # 7	is not met as evidenced w and staff and family failed to invite the to participate in Care 3 residents (resident #71) In of participation in Care witted to the facility on tted again on 3/10/17 with which included Diabetes The Quarterly Minimum 1/17/17 indicated that 1 person for assistance Living and was cognitively w from August 16, 2016 evealed no documentation the care plan meeting nor RP participating in the M an interview was ant #71 and he would not ons. was conducted with ansible Party on 3/29/2017 I she never received any	F2	Immediate Action Resident #71 -care plan me was sent to family by Social but resident was discharged from facility prior to an actual meeting. Identification of others 100% audit by Regional nur #1 on 4/24/17, 4/25/17, 4/26 residents and or responsible invited to participate in their meeting. No documented e identified that any invitation sent/made to either the resid responsible party, as the pro invitation could not be retrie computer that had crush wit as reported by Social worke Social Worker #1 and Social mailed or delivered Care Pla for a Care plan (CP) meetin Responsible Party or reside building on 3/31/2017 Systemic Changes Effective 4/27/2017 a care p schedule will be adhered to Minimum Data Set (MDS) a schedule for each resident of Budget Reconciliation Act (C assessments. Effective 4/27/2017 Social V social worker #2 and or Acti Coordinator #1, and or #2 w the invitation in the resident'	I Service #1 I on 4/9/17 al care plan I see Consultar 6/17 to valida I e party were I care plan I vidence I had been I dent or I oof of such I ved from the I such proof I suc	ate of	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345006	B. WING _			03/	30/2017
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F 280	that family members a plan meetings. She so documentation that Rebeen invited or had a meetings since August facility sent out invitated members, however the letters were stored or that the facility had not family members received they didn't have any of the facility was unab documentation that Rever been invited to hear at 4 PM revealed that went out to each family resident's care plan in that the letters were stored to a Administrator stated to the facility would inviting residents to all Care Residents and that the letters were stored to all Care Residents and the facility would inviting the stored to the stored the stor	MDS Coordinator on vealed that she was aware should be invited to care tated that she had no resident #71's family had ttended any of his care plan at 2016. She stated that the cion letters to the family he computer that these in had crashed. She reported to way of knowing if the rived the invitation because way to track this. The to provide any resident #71's family had his care plan meeting. Administrator on 3/30/2017 at the facility had a letter that filly inviting them to the meeting, but the computer stored in had crashed and	F2	280	record. Social Worker #1 and or #2 will also document in resident's medical record if the attendance by the resident and or their responsible party is not practical. Social worker #1 and #2, Activity Coordinator #1, and Activity Coordinator #2 were re-educated on 4/18/2017 by Regional Clinical Director #2 on systematic changes pertaining to Interdisciplinary Care Plan invitations process. Monitoring Process: Effective 4/27/17 MDS coordinators #1 #2, and or #3, will audit, that the Care Plan meeting is scheduled and Resider and or Responsible Party have been notified with response charted in medic record by following the MDS schedule (OBRA) assessments. They will also assure that notification, attendance and response is documented on each resid clinical record by Social Worker #1, soc worker #2 and/or Activity Coordinator # and or #2. The audits of Care Plan Invitations will be completed weekly x 4 weeks, then monthly x 3 months by MD coordinators #1, #2, and or #3. Effective 4/27/2017 MDS coordinators #2, and or #3 will report findings to facili Quality Assurance Performance Improvement Committee, monthly for s months, for any additional monitoring needs or modifications of this	nt cal of ent cial £1, £1 SS #1, lity	
F 282 SS=D	483.21(b)(3)(ii) SERV PERSONS/PER CAR	/ICES BY QUALIFIED RE PLAN	F 2	282	requirement.		4/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From pag	ge 20	F 28	32	
		ve Care Plans ed or arranged by the facility, omprehensive care plan,			
	care. This REQUIREMENT by: Based on observation record review the fainterventions for 2 or reviewed for care plan was not followed staff needed during Resident #263's car related to implement Findings Included: 1. Resident #185 was diagnoses of muscle infection, and gait all the Cognitively impaired extensive assistance locomotion off the curtoilet support. The reassist with toilet use incontinent of bowel urine. The resident had a compare the cognitively impaired extensive assistance locomotion off the curtoilet support. The reassist with toilet use incontinent of bowel urine.	ch resident's written plan of T is not met as evidenced ons, staff interviews and cility failed to follow care plan f 31 sampled residents ans. Resident #185's care and related to the number of a sit to stand lift transfer. be plan was not followed tation of fall interventions. as admitted on 4/4/16 with the be weakness, urinary tract conormality. aum Data Set (MDS) dated aresident was severely be with bed mobility, transfers anit, dressing, hygiene, and besident required 2 person besident required 3 person besident required 3 person besident required 4 person besident required 5 person besident required 6 person besident required 7 person besident required 8 person besident required 9 person besident required 9 person		Immediate Action Resident #185 -Lift pad used on resident #263 fall mat was placed the bed, a bed and chair alarm was put in place per resident care plant quality assurance nurse on 3/31/20 Resident's care card was updated to reflect the use of floor mat, bed and alarm by the Quality Assurance on 3/31/2017 as well. Identification of Others 32 other facility lift pads currently in were inspected by the Assistant Administrator on 3/29/2017. One other pad was removed and discarded by Assistant Administrator due to its unfavorable condition caused by we tear. 100% audit of all fall care plans for a residents completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Region Nurse consultant #1 to determine if intervention put in place was implentication.	9/17 Deside also by the 17. Do chair use the lift of the ear and eactive onal any mented
	3/13/17. Fall Interve	care plan for falls updated on ntions included to use the sit fers with assistance with 2			nented es

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0-10000		STREET ADDRESS, CITY, STA	ATE ZIR CODE	03/30/2017	
NAME OF FI	NOVIDER OR SUFFLIER				ATE, ZIF CODE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		3724 WIRELESS DRIVE			
				GREENSBORO, NC 274	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page	e 21	F 2	32			
	people.			documented on "fal	Il intervention audit		
	рсоріс.				documented process		
	Nursing Assistant #1	was interviewed on 3/29/17			dentified to be in place	I I	
	_	ted Resident #185 used the			to nurse's aides, thus	I I	
		e changed the resident. She			dents with intervention		
	-	ange the resident in bed or			by nurse's aide had a	I I	
		tance from another staff		potential to affect b			
	member.	tarios irom another otali		noncompliance.	y and anogoa		
				Systemic Changes			
	Nursing Assistant (N	A) #1 was observed taking			, nursing assistants		
	,	bathroom on 3/29/17 at			ppropriate number of		
	11:02 AM. The reside	ent was taken to the		staff during transfer			
	bathroom on 600 hal	l via wheelchair. Nursing		individual care plan			
	Assistant #1 asked N	lursing Assistant #2 to come			, applies such pads		
	help her with Resider	nt #185 when she was		appropriately per m	nanufacturer		
	finished with helping	another resident. Nursing		recommendation fo	r transfer of residents		
	Assistant #2 never re	eturned to assist NA #1 to		When using mecha	nical lift, at least 2		
	care for Resident #18	35. The sit to stand lift was in		person will assists	each resident, unless		
	the bathroom. NA #1	was observed to place the		resident's evaluatio	n by healthcare		
	sit to stand lift pad wa	as placed behind Resident		professional docum	nented on resident pla	n	
		air. The lift was placed in		of care indicate res			
		and the lift pad went under		transferred by one	person assist with		
		nd was connected via loops		mechanical lift, per	manufacturer		
		oand that went around the		guidelines.			
		not connected and the waist		Effectively 4/27/201			
		ling beside the resident. The			d as a communication		
		lly from under her arms from			aides of appropriate		
		a standing position with			each resident togethe		
	_	1 staff member (Nursing			ber of staff required fo	or	
	T	ent's #185 brief was changed		the Activity of daily			
	and the resident was				to take place. Care		
		stance of only 1 person		Cards also include			
	(Nursing Assistant #7	1).		about each residen			
	Niconaima A = -:-44 !/4	was interviewed == 0/00/47		necessary for indivi			
		was interviewed on 3/29/17			s aides. This include	_	
		ed the resident was not really			Il interventions such a	I I	
	-	with the transfer. She stated			fall mat on floor and/	I I	
		ift, she would put the sit to			hree ring binders titled	¹	
	stand litt pad under ti	he resident's her arms and		"Care Cards" place	s at each nurse's	1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING _			1	C 30/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	00/2011
				37	724 WIRELESS DRIVE		
BLUMENT	THAL NURSING & REHA	BILITATION CENTER		G	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
					DEFICIENCY)		
F 282	Continued From pag	F	282				
	lock the resident's wh	neelchair then lift the resident			station for easy access by the nurse's		
	up. She stated that to	echnically they used 2 people			aides. This process was put in place w	ith	
	with the lift but that N	IA #2 never came back to			the collaboration among the Regional		
	help her by the time t	the resident was lifted. NA#1			Clinical Consultant #2, Director of		
	stated NA #2 must ha	ave been busy. She stated			Nursing, Assistant Director of Nursing,		
	the resident was mos	stly an easy transfer. She			Quality Assurance nurse, MDS		
	stated the waist belt	on the lift pad was broken,			Coordinator #1, MDS Coordinator #2,		
	which was why it was	s not snapped this morning.			MDS coordinator #3 and the Staff		
		d she used only had 2 plastic			Development Coordinator		
	prongs on the belt and would slip out. She stated				100% active residents in facility were		
	the other sit to stand	lift pads were being used.			re-assessed for individualized care nee		
					This re-assessment was completed on		
		ewed on 3/30/17 on 6:07			4/25/2017, 4/26/2017 & 4/27/2017 by t		
		she would expect that the			Regional Nurse consultant #1, Director	of	
		anned for the appropriate lift			nursing and/or Assistant Director of		
		n was followed correctly for			nursing. Appropriate intervention was p	out	
	each resident requiri	ng assistance with transfers.			in place and added to each resident's		
					care card.		
		as admitted to the facility on			Effective 4/27/2017 Care cards will be		
	3/20/17 and his diagi	noses included Alzheimer 's			initiated on admission by the admitting		
	disease.				nurse and updated at least quarterly a		
					with any change in treatment plan, rela		
		um data set (MDS) had not			to resident's direct care and safety, by		
	been completed for F	Resident #263.			hall nurses and/or interdisciplinary care		
					plan team. Interventions to be carried of		
		dated 3/20/17 for Resident			by nursing aides will be added to be pa	ırt	
		s at risk for injury from falls			of each resident care cards.		
	related to history of fa				100% of nursing staff, to include licens		
	I .	d for staff to frequently check			nurses and nurse's aides ware in-servi	ced	
		te to his care plan was made			on proper use of mechanical lifts,		
	I .	a fall and a therapy screen			attaching the appropriate lift pads to th		
	I .	ervention. An update was			lift and ensuring that the minimum of 2		
		n on 3/24/17 related to			persons are present during a mechanic		
		nats, bed alarm, chair alarm			lift transfer, unless the plan of care state		
		est position were added as			otherwise, removing any pads that wer		
	interventions.				broken, frayed or in poor condition out	of	
					circulation and notifying central supply		
		nt report for Resident #263			and/or nurse administrative staff (DON		
	provided by the Direct	ctor of Nursing (DON)			ADON, QA nurse, supervisor, and/or S	taff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251	_		Ι,	С
		345006	B. WING				30/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
				37	724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		G	REENSBORO, NC 27455		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 282	Continued From page	e 23	F:	282			
	revealed he had a fal	I on 3/20/17 at 8:02 pm. He			development coordinator) so that		
		in a chair and fell. He had			replacements could be ordered. This		
	no injuries and action	is to be taken included his			education also covered the use of care		
	bed was to be in low	position.			cards as the communication tool.		
					Licensed nurses ware educated on the		
		nt report for Resident #263			use of such cards and how to initiate a		
	·	revealed on 3/23/17 at 5:45			new card on admission and how to rev	se	
		as found on the floor in front			the care card with any changes in		
		ent stated he hit his right arm			treatment plan. Nursing aides ware		
		nish area was noted to his			educated on how to access, the care cards and how to obtain information from	m	
		a skin tear was noted to his stions taken included active			such.	/III	
	_	oper and lower extremities,			This education provided by Director of		
		al signs and that his bed was			Nursing (DON), Assistant Director		
	to be in a low position	_			(ADON) of Nursing or Staff Developme	nt	
	'				Coordinator (SDC). This educated was		
	A review of an incide	nt report for Resident #263			initiated on 4-6-2017 for all nursing sta		
	provided by the DON	revealed on 3/24/17 at 5:30			include full time, part time, and as need	led	
	am Resident #263 wa	as found lying on the floor in			employees. This education will be		
	_	side. He had some redness			completed by 4/27/2017, any staff not		
	to the right side of his				educated by 4/27/2017 will not be allow		
	_	checks, ice applied to the			to work until educated. This education	=	
		, observations and bed in			was also added to new hire process for		
	low position.				new employees effective 4/27/17 and a	ilso	
	An absorbation on 2/	27/17 at 2:21 pm of Resident			will be provided annually.		
		s sitting in a chair in his			Monitoring Process:		
		ot in a low position. There			Monitoring 1 100033.		
		air alarm or bed alarm in			Effective 4/27/2017, resident care card	s	
	place.				will be reviewed by the clinical	-	
	•				interdisciplinary team daily (Monday the	ru	
	A nursing note dated	3/28/17 for Resident #263			Friday), and by the week-end supervisor		
	revealed that he had	an order on 3/24/17 for his			or nurse in-charge on (Saturday &		
		tion, fall mat beside bed, bed			Sundays), to ensure its presence and		
	alarm and chair alarn	n.			accuracy as appropriate. This team wil	J	
					consist of but not limited to the DON,		
	An observation on 3/2				ADON, QA Nurse, SDC, MDS#1, MDS		
		led he was sitting in a chair			and/or MDS#3., this review will take pl		
	i in his room. His bed v	was not in a low position.	1		daily (Monday thru Friday) for 4 weeks		1

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		(
		345006	B. WING _				30/2017
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DITIMENT	HAL NURSING & REHA	BII ITATION CENTER		37	724 WIRELESS DRIVE		
BLUWENT	HAL NUNSING & KEHA	BILITATION CENTER		G	REENSBORO, NC 27455		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	in place. An observation on 3/3 #263 revealed he wa exit his room. He sat surveyor entered his to be in a low position chair alarm or bed ala An interview on 3/30/Assistant (NA) #2 reveor for Resident #263. Sl walk on his own because and needed to use a was confused. She salarm because he was checked his room anno bed or chair alarm they should have been to aware that he was mats. An interview on 3/30/revealed that Reside have a bed and chair March 2017 medicati (MAR) for Resident # alarms had been sign stated that she was resupposed to have fallisted on his MAR. An interview on 3/30/Director of Nursing (Examples)	ats, chair alarm or bed alarm 30/17 at 1:45 pm of Resident s standing up and starting to down in his chair when this room. His bed was observed h. There were no fall mats, arm in place. 177 at 1:53 pm with Nursing wealed that she was the NA he stated that he should not ause he was not that stable walker. She stated that he tated he had a bed and chair as at risk for falls. She d confirmed that there were his in place. She stated that en there. She stated she was s supposed to have fall 177 at 2:02 pm with Nurse #4 and #263 was supposed to have fall 178 at 2:02 pm with Nurse #4 and #263 and the bed and chair ned off as being present. She not aware that he was I mats and they were not 179 at 1:36 pm with the DON) revealed it was her interventions were in place	F	282	then weekly x 4 weeks, then monthly x months. Any negative findings noted w be addressed by the member of the interdisciplinary team promptly. Quality Assurance nurse will report findings to facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effectively 4/27/2017; Director of nursing Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all new admission for previous day, daily (Monthru Friday) and the week-end supervisior nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review witake place daily (Monday thru Friday) five weeks then weekly x 4 weeks, then monthly x 3 months. Any negative findinated will be addressed promptly QAP nurse will report findings to facility Qualessurance Performance Improvement Committee for any additional monitorin needs or modifications of this requirem Effective 4/27/2017, central supplies clor Quality Assurance nurse will inspect condition of slings in the facility to determine functionality. Any sling noted unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance or Central supplies Clerk will report finding of this audit to facility Quality Assurance Performance Improvement Committee	ill / ng, y day or 4 ngs lity gent erk the d in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING				C / 30/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	130/2017
DILIMENT	THAI MUDRING & DEH	ADII ITATION CENTED		37	724 WIRELESS DRIVE		
BLUMENI	THAL NURSING & REH	ABILITATION CENTER		G	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314 SS=D	PREVENT/HEAL PI		F3	314			4/27/17
	(b) Skin Integrity -						
	facility must ensure (i) A resident receive	essment of a resident, the that- es care, consistent with					
	pressure ulcers and ulcers unless the inc	rds of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and					
	necessary treatmen professional standa healing, prevent infe from developing.	ressure ulcers receives t and services, consistent with rds of practice, to promote ection and prevent new ulcers IT is not met as evidenced					
	Based on observat interviews and staff provide wound care for 1 of 2 residents (Resident #22).	ions, record review, resident interviews the facility failed to as ordered by the physician reviewed for pressure ulcers			Resident #22: Treatment rendered per physician order by a treatment nurse of 3/29/2017. Wound was assessed by the Regional Nurse Consultant #2 and	n	
	10/20/15 and his dia stasis insufficiency, and coronary artery A quarterly minimum 3/14/17 for Residen pressure ulcer with worsened since the	dmitted to the facility on agnosis included venous protein calorie malnutrition disease. In data set (MDS) dated t #22 revealed a stage 2 onset date of 3/14/17 that had last assessment. It also lent #22 was cognitively intact.			treatment nurse on 3/30/2017. No deterioration in the wound was noted for treatment nurse assessment on 3/27/2017. Treatment was deemed appropriate for wounds and wounds showed improvement from prior assessments. Performance improvement action were implemented for weekend licensed nur who was responsible for resident care treatment on 3/25/2017 & 3/26/2017 during day shift (7AM-7PM). This action	e rse and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
							С	
		345006	B. WING _			03	/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				37	724 WIRELESS DRIVE			
BLUMEN	HAL NURSING & RE	EHABILITATION CENTER		G	REENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
Г 244	O-ations d Farms	00						
F 314	Continued From p	page 26	F3	314				
					was put forth by the Director of Nursing	g on		
		3/23/17 for Resident #22			4/6/2017.			
		had pressure ulcers to his right						
		erventions included treatment as			11 (55 (5 (5))			
		and right heels and nutritional			Identification of Others			
	supplements to p	romote wound healing.			100% audit of all active regident's with	_		
	A ravious of the ph	nysician 's orders for Resident			100% audit of all active resident's with wound care orders completed by the	1		
		order on 3/23/17 to cleanse the			Regional nurse Consultant #2, and the	۷		
right heel with normal saline, apply santyl, cover with a 4x4 gauze and wrap with kerlix daily. An right heel with normal saline, apply santyl, cover orders matched the treatment								
		4110						
	_	on 3/23/17 to cleanse the left			administration records record on 4/12	/17.		
		saline, apply medihoney, cover			as well as the documentation for	,		
		and wrap with kerlix daily.			completion of such orders are noted in	ı		
					resident's record per order and to inclu			
	A wound assessn	nent dated 3/27/17 for Resident			Saturdays and Sundays			
	#22 revealed he h	nad a stage 3 pressure ulcer on						
	his left heel that h	ad been identified on 3/23/17.			100% of all active residents with press	ure		
		r this ulcer were documented as			ulcers were assessed by Treatment nu			
		cm) length by 0.40cm width by			and by Certified wound nurse from sis			
		ot care assessment indicated			facility on 4/27/2017. No pressure ulce			
		pulses non-palpable, peripheral			were noted to have deteriorated from t	heir		
		(PVD) present and no signs or			previous documented assessment.			
	symptoms of infe	ction.			Systemic Changes:			
	A wound assess	nent dated 3/27/17 for Resident			Systemic Ghanges.			
		nad an unstageable pressure			Effective 4/27/2017, each resident			
		neel that had been identified on			treatment is rendered per physician or	der.		
	_	ments for this ulcer were			On- coming nurse will check treatment			
	documented as 0	.80cm length by 0.70cm width.			records for omissions prior to acceptin			
		ment indicated the pressure			cart form previous shift nurse. On- con	-		
		eable due to slough at the			Nurse will not accept cart until treatme			
	wound bed, there	were no signs or symptoms of			are completed or reconciled.			
		al or pedal pulses present and						
	PVD present.				100% of licensed nurses employed by	the		
		n 3/27/17 at 12:00 pm revealed			facility ware re-educated on ensuring	<u> </u>		
		s sitting up in his wheelchair.			treatment orders are rendered per			
		had dressings on them that			physician order, completed on the			
	were dated 3/24/	Resident #22 stated the			frequency ordered and documented or	1		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345006	B. WING _			l	30/2017
	ROVIDER OR SUPPLIER HAL NURSING & REHA	ABILITATION CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE REENSBORO, NC 27455	1 00/	55/2517
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	(3/24/17), but had not weekend. An observation on 3/Resident #22 was sithe had socks on both stated that the dress changed today and stomorrow, "but you hare actually changed. An observation of wowas conducted on 3/wound nurse. Resided dressings on both of 3/28/17. The wound orders for both of his surveyor the wound: She removed the drescheel appeared smallicircular in shape with cleaned the wound wantyl, 4x4 gauze, a wrapped it in gauze. 3/29/17. She remove heel appeared smallicircular in shape with his left heel with norm medihoney, 4x4 gaux wrapped it in gauze. 3/29/17. She was ob	thad been done on Friday of been changed over the 27/17 at 4:30 pm revealed ting up in his wheelchair and hof his feet. Resident #22 ings on his feet were should be changed again never know for sure until they d." Dound care for Resident #22 /29/17 at 10:00 am with the ent #22 was lying in bed with his feet that were dated nurse reviewed the treatment heels and showed this supplies she would be using. Easing from his right foot and all amount of light yellow sing. The area on his right er than the size of a dime, in a small red center. She with normal saline, applied the foam heel cushion and She dated the gauze end the dressing from his left small amount of light yellow sing. The area on his left small amount of light yellow sing. The area on his left er than the size of a dime, in white edges. She cleaned mal saline, applied the ze, a foam heel cushion and She dated the gauze served to wash her hands es in between the old and	F3	314	each resident treatment administration record. This education also covered on what to do when a pressure ulcer is identified and documentation for reside who refuse their wound care treatment be done. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Developme Coordinator (SDC). This educated was initiated on 4-6-201 for all licensed nursing staff to include fitime, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nursing staff not educated by 4/27/2011 will not be allowed to work until educate. This education was also added to new hire process for all new licensed nurses effective 4/27/17 and also will be provided annually. Monitoring Process: Effectively 4/27/2017; Director of nursing Assistant Director of Nursing, Staff development Coordinator and/or Quality Assurance nurse will audit all treatment records daily (Monday Friday) and the week-end supervisor or nurse in-charge will audit treatment records on (Saturday & Sundays), to ensure they have been completed and signed for as ordered be physician. This review will take place daily for 2	nts to nt 7 ed. s ded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , ,	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
	345006	B. WING		03	C 3/ 30/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		730/2017	
			3724 WIRELESS DRIVE			
BLUMENTHAL NURSING & REHABILI	TATION CENTER		GREENSBORO, NC 27455			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 314 Continued From page 28 F 314		14				
An interview with the word 10:00 am revealed she progression for Resident #22 Monday stated that the resident 'responsible for completing weekends. She confirmed was to be completed everometer was to be completed everometer with the word pressure ulcer because from the pain when his heels were an interview on 3/29/17 arevealed she had been the #22 on 3/25/16 and 3/26/26 am. She stated that she wasn't aware that he and his heels and she though prep to the areas. She stoke weekends the day shift now wound treatments for resident #22 resided in a Resident #22 resident #22 resided in a Resident #22 resided in a Resident #22 resident #22 resident #22 resident #22 r	and nurse on 3/29/17 at rovided the wound care of through Friday. She is assigned nurse was go his wound care on the dothat his wound care ry day. She stated that was classified as a me had complained of experience for Resident 16 from 7:00 pm to 7:00 did not do any wound 1622. She stated that she y actual breakdown on the just received skin atted that on the urse was responsible for idents in the "A" beds se was responsible for idents in the "B" beds. The nurse for Resident 17 from 7:00 am to 7:00 reatment for Resident y skin prep and that required to be placed on the area on his left heel area of all follar and was approximately the not confirm that she	F 3'	weeks, weekly x 4 weeks, the 3 months. Any negative finding be addressed promptly. Qual nurse will report findings of the facility Quality Assurance Per Improvement Committee more months for any additional moneeds or modifications of this	ngs noted will ity assurance his audit to formance hthly x 4 nitoring		

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 323 4 SS=D ()	familiar with the wound he believed the areas pressure from his heed bedals and his compresed and his compresed that it was leaded to he can always and that receive wound care in only sician 's orders. An interview on 3/30/20 prector of Nursing (Director of Nursing	t #22 revealed that he was ds to his heels. He stated were a combination of els resting on his wheelchair omised circulatory system. his expectation that sings were changed daily as 17 at 1:36pm with the iON) revealed that it was esidents with wounds would a accordance with the (3) FREE OF ACCIDENT SION/DEVICES are that - conment remains as free as as is possible; and elives adequate supervision es to prevent accidents. accility must attempt to use es prior to installing a side or de rail is used, the facility installation, use, and elints. ant for risk of entrapment		314			4/27/17

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F 323	Continued From page		F 32	23		
	informed consent price	or to installation.				
	This REQUIREMENT by:	ed's dimensions are sident's size and weight. is not met as evidenced iew, observations and		Immediate Action		
				Ininediate Action		
	was in good repair to sit to stand lift for 1 or in a potential for an a The facility additional use of planned interv had fallen resulting in	views the facility failed to use a lift pad that in good repair to transfer a resident using the stand lift for 1 of 5 residents which resulted potential for an accident (Resident # 185). Facility additionally failed to implement the of planned interventions for a resident who fallen resulting in injury for 1 of 5 residents in resulted in the risk for additional falls ident #263)		Resident #185 -Lift pad used on during survey was discarded on by the Assistant Administrator. Resident #263 fall mat was place the bed, a bed and chair alarm vous put in place per resident care place quality assurance nurse on 3/31.	3/29/17 eed beside was also an by the	
	Findings Included:			Resident's care card was update reflect the use of floor mat, bed a alarm by the Quality Assurance	ed to and chair	
	The operator's manua	al dated 2013 for the sit to		3/31/2017 as well.	011	
	one assistant should	the use of the patient lift by be based on the evaluation fessional for each individual		Identification of Others		
	case." The manual also stated that the "belt must be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, causing possible injury."			32 other facility lift pads currently were inspected by the Assistant Administrator on 3/29/2017. One pad was removed and discarded Assistant Administrator due to its	e other lift d by the	
		s admitted on 4/4/16 with the weakness, urinary tract normality.		unfavorable condition caused by tear.		
	The Quarterly Minimu 3/6/17 revealed the recognitively impaired. extensive assistance locomotion off the un and toilet support. The	um Data Set (MDS) dated		100% audit of all fall care plans residents completed on 4/25/2014/26/2017 & 4/27/2017 by the Resident with the consultant #1 to determine intervention put in place was impand communicated to the nurse appropriately.	17, egional le if any plemented	

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F 323	urine. The resident had a comodate of the stand lift for transformation people. Nursing Assistant #1 at 10:11 AM. She stated she would change the lift with assistant with the resident to the bang wheelchair on 3/29/1 Assistant #1 asked in help her with resident finished with helping Assistant #2 never restransfer the resident placed the sit to stand #185's lower back in placed in front of the went under the resident connected via circular band that went around that went around the sitting position to assistance with 1 states Assistant #1). Reside while the resident was and the resident was and the resident was and the resident was a single people.	and frequently incontinent of are plan for falls updated on ations included to use the sit ers with assistance with 2 was interviewed on 3/29/17 ated the resident used the sit e changed the resident. She ange the resident in bed or tance from 2 people. A) #1 was observed taking athroom on 600 hall via 7 at 11:02 AM. Nursing Jursing Assistant #2 to come at #185 when she was another resident. Nursing eturned. NA #1 began to without assistance. NA #1 d lift pad behind resident the wheelchair. The lift was resident and the lift pad ent's arms and was ar loops to the lift. The waist and the resident's waist was ne waist straps were left resident. The resident was upport under her arms from a standing position with aff member (Nursing ent #185's brief was changed as in the standing position	F	323	Findings of this audit was documented "fall intervention audit tool". No function documented process of communication identified to be in place for communication ourse's aides, thus, 100% of other residents with interventions to be implemented by nurse's aide had a potential to affect by this alleged noncompliance. Systemic Changes Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident's individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of resident When using mechanical lift, at least 2 person will assists each resident, unless resident's evaluation by healthcare professional documented on resident profeasional documented on resident profeasional documented on resident profeasional lift, per manufacturer guidelines. Effectively 4/27/2017; Resident's Care Cards were initiated as a communication to alert nurse's aides of appropriate method to transfer each resident togeth with minimum number of staff required the Activity of daily Living (ADL), specifically transfer to take place. Care Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse's aides. This include but not limited to fall interventions such	eal n tion of ts. ss lan ener for	

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F 323	Continued From page	e 32	F 3	23		
F 323	Nursing Assistant #1 at 1:55 PM. She stated able to stand or help with the sit to stand li under the resident's is resident's wheelchair stated that technically lift but that NA #2 new the time the resident have been busy. She mostly an easy transbelt on the lift pad was not snapped dur She stated the lift par prongs on the belt the She stated the other being used when she Resident # 185. On 3/29/17 at 2:01 P The sling's waist belt three plastic prongs or insertion of the plastit However, the observences on the waist is was broken off of the supposed to wrap are The receiving end of would not fit properly broken prong. The Director of Nursion 3/29/17 at 2:40 Pt known of any probler stated she would experience in the supposed to wrap are the prong.	was interviewed on 3/29/17 ed the resident was not really with the transfer. She stated ft, she would put the lift pad her arms and locked the then lift the resident up. She y they used 2 people with the ver came back to help her by was lifted up. NA #2 must e stated the resident was fer. She stated that the waist as broken which was why it ing the observed transfer. d she used only had 2 plastic at would not stay fastened. sit to stand lift pads were e used the sit to stand lift for M, The sling was observed. was supposed to clasp via on one end and a socket for c prongs on the other end. ed lift pad only had 2 plastic belt. The 3rd plastic prong waist belt that was bund the resident's waist. the lift's pad waist band in the insertion end with the mg (DON) was interviewed M. She stated she had not ms with the lift pads. She beet that if a lift pad was t used on a resident and was t used on a resident and was	F 3	bed in low position, fall mat Chair/bed alarm. Three ring "Care Cards" places at each station for easy access by the ides. This process was put the collaboration among the Clinical Consultant #2, Direct Nursing, Assistant Director Quality Assurance nurse, M Coordinator #1, MDS Coord MDS coordinator #3 and the Development Coordinator 100% active residents in factories re-assessed for individualized This re-assessment was conducted to 4/25/2017, 4/26/2017 & 4/25/2017, 4/26/2017 & 4/25/2017, 4/26/2017 & 4/25/2017, 4/26/2017 & 4/25/	binders titled in nurse's the nurse's the nurse's to place with a Regional ctor of of Nursing, IDS dinator #2, as Staff cility were ed care needs. Impleted on 7/2017 by the #1, Director of antion was put resident's ards will be a admitting quarterly and int plan, related a safety, by the plinary care be carried out led to be part clude licensed are in-serviced al lifts,	
	broken prong. The Director of Nursi on 3/29/17 at 2:40 PI known of any probler stated she would exp broken that it was no to be reported. She v in the bathroom and	ng (DON) was interviewed M. She stated she had not ns with the lift pads. She pect that if a lift pad was		plan team. Interventions to by nursing aides will be add of each resident care cards 100% of nursing staff, to inc nurses and nurse's aides w	be carried out led to be part clude licensed are in-serviced al lifts, t pads to the nimum of 2	

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Continued From p	page 33	F 3	23	
at 9:48 AM. She s was broken she w She stated about pad that had a tea taken to the laund same time, a mor stand pad had a p where it snapped used that pad and other pads to use Nurse #1 was into AM. She stated s problems with the an issue staff wou She stated if she with the lift pad on	stated that if she saw a pad that would not use it and report it. one month ago, there was a lift ar in one of the loops and it was dry. She stated that about the atth ago, she did hear that a sit to plastic prong that was broken around the waist, but she never a said that there were several to erviewed on 3/30/17 at 10:30 the was not made aware of any e lift pads or lifts and if there was all usually go get another one was made aware of a problem or lift, and stated she would tell		otherwise, removing any pubroken, frayed or in poor coirculation and notifying ceand/or nurse administrative ADON, QA nurse, supervision development coordinator) are placements could be ord. This education also covered care cards as the communuse of such cards and how new card on admission and the care card with any chat reatment plan. Nursing aid educated on how to access.	ads that were condition out of ntral supply a staff (DON, sor, and/or Staff so that ered. ad the use of ication tool. cated on the a to initiate a d how to revise nges in les ware s, the care
used for residents The DON was int PM. She stated s staff would check each resident. 2. Resident #263 3/20/17 and his d disease. An admission mir been completed f An interim care pi #263 revealed he related to history Interventions includes	erviewed on 3/30/17 on 6:07 he would expect that the nursing and use safe equipment for was admitted to the facility on iagnoses included Alzheimer 's himum data set (MDS) had not or Resident #263. lan dated 3/20/17 for Resident was at risk for injury from falls of falls and actual fall. uded for staff to frequently check		Nursing (DON), Assistant I (ADON) of Nursing or Staff Coordinator (SDC). This e initiated on 4-6-2017 for al include full time, part time, employees. This education will be com 4/27/2017, any staff not ed 4/27/2017 will not be allow educated. This education added to new hire process employees effective 4/27/1 be provided annually. Monitoring Process:	Director Development ducated was I nursing staff to and as needed pleted by ucated by ed to work until was also for all new 7 and also will
	ROVIDER OR SUPPLIER SUMMAR (EACH DEFIC REGULATORY) Continued From p Nursing Assistant at 9:48 AM. She s was broken she v She stated about pad that had a teataken to the laund same time, a mor stand pad had ap where it snapped used that pad and other pads to use Nurse #1 was interested and the pads to use with the lift pad on maintenance about used for residents. The DON was interested from the pads to use with the lift pad on maintenance about the pads to use with the lift pad of maintenance about the pads to use with the lift pad of maintenance about the pads of the pad	THAL NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 Nursing Assistant #3 was interviewed on 3/30/17 at 9:48 AM. She stated that if she saw a pad that was broken she would not use it and report it. She stated about one month ago, there was a lift pad that had a tear in one of the loops and it was taken to the laundry. She stated that about the same time, a month ago, she did hear that a sit to stand pad had a plastic prong that was broken where it snapped around the waist, but she never used that pad and said that there were several other pads to use. Nurse #1 was interviewed on 3/30/17 at 10:30 AM. She stated she was not made aware of any problems with the lift pads or lifts and if there was an issue staff would usually go get another one. She stated if she was made aware of a problem with the lift pad or lift, and stated she would tell maintenance about it and that it would not be used for residents. The DON was interviewed on 3/30/17 on 6:07 PM. She stated she would expect that the nursing staff would check and use safe equipment for each resident. 2. Resident #263 was admitted to the facility on 3/20/17 and his diagnoses included Alzheimer 's	ROVIDER OR SUPPLIER THAL NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 Nursing Assistant #3 was interviewed on 3/30/17 at 9:48 AM. She stated that if she saw a pad that was broken she would not use it and report it. She stated about one month ago, there was a lift pad that had a tear in one of the loops and it was taken to the laundry. She stated that about the same time, a month ago, she did hear that a sit to stand pad had a plastic prong that was broken where it snapped around the waist, but she never used that pad and said that there were several other pads to use. Nurse #1 was interviewed on 3/30/17 at 10:30 AM. She stated she was not made aware of any problems with the lift pads or lifts and if there was an issue staff would usually go get another one. She stated if she was made aware of a problem with the lift pad or lift, and stated she would tell maintenance about it and that it would not be used for residents. The DON was interviewed on 3/30/17 on 6:07 PM. She stated she would expect that the nursing staff would check and use safe equipment for each residents. 2. Resident #263 was admitted to the facility on 3/20/17 and his diagnoses included Alzheimer 's disease. An admission minimum data set (MDS) had not been completed for Resident #263. An interim care plan dated 3/20/17 for Resident #263 revealed he was at risk for injury from falls related to history of falls and actual fall. Interventions included for staff to frequently check	ROVIDER OR SUPPLIER THAL NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: DENTIFYING INFORMATION) Continued From page 33 Nursing Assistant #3 was interviewed on 3/30/17 at 9.48 AM. 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An admission minimum data set (MDS) had not been completed for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An interim care plan dated 3/20/17 for Resident #263. An int

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F 323	Continued From pag	ne 34	F;	323			
		a fall and a therapy screen			will be reviewed by the clinical		
		ervention. An update was			interdisciplinary team daily (Monday the	CLI	
		n on 3/24/17 related to			Friday), and by the week-end supervisor		
		nats, bed alarm, chair alarm			or nurse in-charge on (Saturday &	,	
		est position were added as			Sundays), to ensure its presence and		
	interventions.	oot pooliion word added as			accuracy as appropriate. This team will	l	
	intorvontiono.				consist of but not limited to the DON,		
	A review of an incide	ent report for Resident #263			ADON, QA Nurse, SDC, MDS#1, MDS	#2.	
		ctor of Nursing (DON)			and/or MDS#3. , this review will take pl		
	revealed he had a fall on 3/20/17 at 8:02 pm. He				daily (Monday thru Friday) for 4 weeks		
		in a chair and fell. He had			then weekly x 4 weeks, then monthly x		
		ns to be taken included his			months.		
	bed was to be in low						
		•			Any negative findings noted will be		
	A review of an incide	ent report for Resident #263			addressed by the member of the		
	provided by the DON	l revealed on 3/23/17 at 5:45			interdisciplinary team promptly. Quality	<i>y</i>	
	am Resident #263 w	as found on the floor in front			Assurance nurse will report findings to		
	of his dresser. Resid	lent stated he hit his right arm			facility Quality Assurance Performance		
	and a very light gree	nish area was noted to his			Improvement Committee for any		
	right upper arm and	a skin tear was noted to his			additional monitoring needs or		
	right lateral hand. A	ctions taken included active			modifications of this requirement		
		pper and lower extremities,					
	skin assessment, vit	al signs and that his bed was			Effectively 4/27/2017; Director of nursir	ıg,	
	to be in a low positio	n.			Assistant Director of Nursing, Staff		
					development Coordinator and/or Qualit	.y	
		ent report for Resident #263			Assurance nurse will audit all new		
		N revealed on 3/24/17 at 5:30			admission for previous day, daily (Mon-	-	
		as found lying on the floor in			thru Friday) and the week-end supervis	or	
	_	side. He had some redness			or nurse in-charge will audit all new		
	_	s head. Actions taken			admits on (Saturday & Sundays), to		
	_	al checks, ice applied to the			ensure that resident care cards are		
		d, observations and bed in			completed and accurate, this review wi		
	low position.				take place daily (Monday thru Friday) fo		
		10=11= 1 0 01			weeks then weekly x 4 weeks, then		
		/27/17 at 2:21 pm of Resident			monthly x 3 months.		
		as sitting in a chair in his					
		not in a low position. There			Any negative findings noted will be		
	were no fall mats, ch place.	nair alarm or bed alarm in			addressed promptly QAPI nurse will re findings to facility Quality Assurance	port	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 323	revealed that he had bed to be in low posi alarm and chair alarm. An observation on 3/Resident #263 reveal in his room. His bed. There were no fall min place. An observation on 3/#263 revealed he was exit his room. He sat surveyor entered his to be in a low position chair alarm or bed al. An interview on 3/30/Assistant (NA) #2 revealed to use a was confused. She salarm because he was checked his room and no bed or chair alarm they should have been of aware that he was mats. An interview on 3/30/revealed that Reside have a bed and chair March 2017 medicati (MAR) for Resident #alarms had been significant.	3/28/17 for Resident #263 an order on 3/24/17 for his tion, fall mat beside bed, bed n. 28/17 at 10:29 am of led he was sitting in a chair was not in a low position. ats, chair alarm or bed alarm 30/17 at 1:45 pm of Resident as standing up and starting to down in his chair when this room. His bed was observed n. There were no fall mats,	F 32	Performance Improvement C any additional monitoring nee modifications of this requirem Effective 4/27/2017, central s or Quality Assurance nurse w condition of slings in the facilit determine functionality. Any sunfavorable condition will be from circulation promptly and will be ordered. Quality Assur Central supplies Clerk will repof this audit to facility Quality Performance Improvement C any additional monitoring neemodifications of this requirem	eds or nent upplies clerk vill inspect the lity to sling noted in removed new sling rance or port findings Assurance ommittee for eds or		

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F 323	supposed to have fall listed on his MAR. An interview on 3/30/ Director of Nursing (Dexpectation that fall in ensure the safety of the safety	mats and they were not 17 at 1:36 pm with the OON) revealed it was her nterventions were in place to he resident.		3323			
F 329 SS=E	FROM UNNECESSA 483.45(d) Unnecessa Each resident's drug unnecessary drugs. drug when used (1) In excessive dose therapy); or (2) For excessive dur (3) Without adequate (4) Without adequate	ary Drugs-General. regimen must be free from An unnecessary drug is any (including duplicate drug ation; or		3329			4/27/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	` '	DATE SURVEY COMPLETED
		345006	B. WING _			C 03/30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	DE	03/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	paragraphs (d)(1) the 483.45(e) Psychotro Based on a compreh resident, the facility r (1) Residents who had drugs are not given to medication is necess condition as diagnos clinical record; (2) Residents who us gradual dose reducti interventions, unless an effort to discontin This REQUIREMENT by: Based on record rev	s of the reasons stated in rough (5) of this section. Dic Drugs. Dic Drugs.	F3	,		
	test as ordered by the effects of a medicatic sampled residents (Funnecessary medication). The findings included Resident #2 was addrom the hospital. He included hypothyroid gland). A review of the resid revealed her medication in medication in the findings included the residual revealed her medication in the findings included the residual revealed her medication in the first and the first	nitted to the facility on 9/3/12 er cumulative diagnoses ism (an underactive thyroid ent 's medical record tions included 112		medication adjusted and lab 4/5/2017. Level was high. Me adjusted and TSH will be re in 6 weeks. All residents on medications therapeutic monitoring of labs potential to be affected. Measures put into place or sy changes made to ensure that practice will not re-occur: A medication review and lab completed of all Residents che 4/24/17 by the contracted phasecond 100% audit was com	edication was independent of the deficient audit was marts on armacist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				30/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2017
				37	24 WIRELESS DRIVE		
BLUMENT	THAL NURSING & REH	ABILITATION CENTER		GI	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From pag	ge 38	F3	329			
F 329	hypothyroidism) give once daily (ordered Thyroid Stimulating test was drawn to he replacement therapy TSH level was report 0.27 - 4.20). (A low excessive amounts medication in those underactive thyroid revealed no change was made at that tim On 12/9/16, a physic decrease Resident among to 88 mcg to be mouth once daily. TSH level should be (1/20/17). A review of Residen Minimum Data Set (1/6/17 revealed the impaired cognitive so the required extens Activities of Daily Livexception of being to locomotion. A review of the residence of focus for hypothyroid crisis hypothyroid crisis hypothyroidism and management. The gand, it was last revisibandwritten notation	en as one tablet by mouth on 5/1/15). On 9/8/16, a Hormone (TSH) laboratory elp monitor the thyroid y she was receiving. The ted as 0.07 (normal range TSH level may reflect of thyroid hormone who are being treated for an gland.) The medical record in the levothyroxine dosage ne. cian 's order was received to #2 's levothyroxine from 112 elegiven as one tablet by the order also indicated the rechecked in 6 weeks It #2 's most recent quarterly MDS) assessment dated resident had severely kills for daily decision making. Every exity assistance for all of her ving (ADLs), with the ordally dependent on staff for the need for medication goal was initiated on 1/30/15; seed on 1/13/17 with a to continue with the current ins. The interventions		329	lab orders to include meds requiring monitoring on 4/25/17 by administrative nursing staff. A lab tickler file and caler was also initiated to assure labs are drawn timely. All nurses and unit secretaries were in-serviced on the new system on 4/19/17 by the DON. Monitoring Process: All charts will be audited monthly by Pharmacist for all lab orders. A second audit of all due and new labs ordered whereviewed for by DON, ADON and Quanties weekly for compliance with this requirement to assure labs were drawn timely as ordered. Labs will be audited weekly by DON, ADON and QAPI nurse as stated above x 4 week, Then monthly x4 month Pharmacist will audit all labs monthly formeds requiring monitoring, as well as other therapeutic lab levels as well as auditing that labs were drawn timely, audits will be completed monthly x 4 months or until 100% compliance is achieved. DON will report findings from nursing audits and pharmacist audit to the facil Quality Assurance Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of this requirement.	vill API hs	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 3724 WIRELESS DRIVE GREENSBORO, NC 27455	CODE	03/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA	
F 329	Continued From page An interview was co AM with the Unit Setthe hall where Reside of the laboratory repselectronic system, the September 2016 level drawn for Residence An interview was co AM with the facility upon her request. Trecord review was donfirmed the last Twith a result of 0.07 would expect labs to physician or NP. A telephone interview at 12:40 PM with the (MD). When asked about the 3 month late TSH level of 0.07 are dose of levothyroxin depended on the clindid not have any clir MD reported he may away. The MD was recommend a TSH I resident's levothyroxin the MD reported it was reported it was recommended in the clinding the may away. The MD reported it was recommended in the may away are on the may resident's levothyroxin the MD reported it was recommended in the may are commended in the may are co	ge 39 Inducted on 3/29/17 at 10:40 Cretary assigned to work on Ient #2 resided. Upon review Orts available via the facility ' the Unit Secretary reported OTSH level was the last TSH Ident #2. Inducted on 3/30/17 at 11:15 Is Director of Nursing (DON) Inde DON reported that a Inducted on 9/8/16 Inducted on 3/30/17 at 11:15 Inducted on 3/30/17 Induct	F 3	DEFICIENC		
	change. Resident # and it was noted a T be done 6 weeks aft was changed on 12/ what his thoughts w not having been dor after the levothyroxii	- 8 weeks after a dose 2 's history was reviewed SH recheck was ordered to er her levothyroxine dose 9/16. Upon inquiry as to ere about the TSH recheck the to date (3 and ½ months the dose change), the MD not have happened. They				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 03/30/2017
	ROVIDER OR SUPPLIER THAL NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8724 WIRELESS DRIVE GREENSBORO, NC 27455	33.00.20
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 329 F 332 SS=D	the labs done." 483.45(f)(1) FREE O RATES OF 5% OR M (f) Medication Errors. that its- (1) Medication error r greater; This REQUIREMENT by: Based on observation interviews, the facility error rate less than 5 medication errors our resulting in a medica of 6 residents (Resid medication pass. The findings included 1) A review of the fact Medication Administr Enteral Tube Medicat 11/1/11) included the "6) Administer each r flushing tube with wa On 3/29/17 at 9:58 A as she pulled medical	F MEDICATION ERROR IORE The facility must ensure ates are not 5 percent or is not met as evidenced as evidenced by 2 of 26 opportunities, tion error rate of 7.6%, for 1 ent #174) observed during il: ility 's policy, "Specific ation Procedures; #13. tion Administration" (Revised following procedural step: nedication separately,	F 329		on onal as y ved
	percutaneous endoso which is a feeding tul stomach). The media administration include	copic gastrostomy (or PEG, be put directly into the cations pulled for ed the following: one - 100 rinol tablet (an antigout		affected. Measures put into place or systematic changes made to ensure that the deficience practice will not re-occur:	ient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _			1	30/2017	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2017	
	10 115211 011 001 1 21211				724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER			REENSBORO, NC 27455			
				_				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 332	Continued From pag	e 41	F3	332				
	• •	dication); one - 81 mg			All Nurses and med aids were educate	d		
	• •	elet; one - 80 mg atorvastatin			on Medication Administration Procedur			
		used to treat high blood			for oral, PEG tube, eye drops, inhalers			
	•	6 mg colchicine tablet (an			ear drops, IM injections, subcutaneous			
		- 1 mg folic acid tablet (a			injections and IV infusions between 4/6			
	• • •	; one - 100 mg hydralazine			and 4/23/17 by Regional clinical			
		ensive medication); one - 325			consultant and regional QAPI nurse .			
		t (a mineral supplement); one			9			
	_	initrate tablet (a medication			All Nurses were given a post test for P	EG		
	used to prevent angi	na or chest pain); one - 100			tube drug administration by 4/24/27.			
	mg Vitamin B1 table	t; one - 1000 microgram			100% of all Nurses and Med aids had			
	(mcg) Vitamin B12 ta	ablet; one - 1000 unit Vitamin			competency med- pass observations			
	D3 tablet; one - 25 m	ng carvedilol tablet (an			completed that required a 0% error rate	e to		
	* ·	dication); 5 milliliters (ml) of			continue passing meds to facility			
	100 mg/ml levetirace	etam (an anticonvulsant			Residents.			
		250/50 mcg Advair Diskus						
	•	nedication used to manage			Competency evaluations were completed	ed		
	chronic obstructive p	oulmonary disease or			by DON, Regional Nurse Consultant,			
	asthma).				Pharmacist and ADON. Competency			
					check off were initiated on 4/6/17 and			
		AM, Nurse #2 was observed			were completed with observation of me			
		blets into a plastic sleeve,			pass of all nurses and all shifts to inclu	ıde		
		er, and poured the powder			weekends on 4/24/17.			
		p. She then placed five sleeve, crushed them			All Nurses and med- aid new hires will	ho		
	-	this powder into a second				DE		
		e nurse repeated this process			required to pass a competency medication pass observation during the	∍ir		
	•	ve tablets and poured the			orientation on the floor with their mento			
		ablets into a third medication			prior to completing orientation. They w			
	•	ted the resident had an order			also have medication administration			
		te tablet orally mixed with			policies reviewed in orientation.			
		placed the iron tablet into a			F			
		cup. She then poured the			Monitoring Process:			
		nto another medication cup.			3			
	•	rved as she went to Resident			Medication administration reviews will	be		
		sitioned the resident, raised			completed with 20% of Nurses and			
		and checked for residual /			med-aids on all shifts weekly to include	,		
		e. At 10:15 AM, the nurse			weekends by DON, ADON and			
	tipped over one of th	e medication cups containing			Pharmacist x 4 weeks then monthly x 3	3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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				3724 WIRELESS DRIVE			
BLUMENT	THAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 332	Continued From pag	ge 42	F 3	32			
. 502	crushed medications not know which med over so she would not over so she pulled the sall observed from the management of the sall observed. The together using the sall observed. However medications were divided to the sall of the sall	s. Nurse #2 stated she did lications had been tipped		months. Nurses with more is medication errors will not be continue passing medication receive further education as substantial compliance errors. DON will present the finding Medication Administration in Quality Assurance and Perf Improvement (QAPI) Comm for 4 months or until pattern is achieved. QAPI will be maccording to outcomes as indetermined by QAPI comm	e allowed to ins until they and achieve or rate below gs of eviews to the formance inittee monthly a of compliance iodified ineeded and		
	AM with the facility ' During the interview, expectation was that	nducted on 3/30/17 at 9:04 s Director of Nursing (DON). , the DON stated her t the nurses would separate minister them individually via					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		ATE SURVEY MPLETED
		345006	B. WING _			C 03/30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3724 WIRELESS DRIVE GREENSBORO, NC 27455		35/35/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 332	water used to flush the medication administed 2) On 3/29/17 at 9:58 observed as she pull medication cart for a #174. The medication included one - 20 mg medication used to p Nurse #2 was observisosorbide dinitrate to preparation for admin A continuous observed went to Resident #17 resident, raised the h for residual / placementhe nurse tipped ove containing crushed in she did not know who tipped over so she word of the medication was a other medications. A re-entered Resident dinitrate to the resident. A review of Resident medication orders reorder for isosorbide of the solution of the served as she admit the resident.	with the correct amount of the tube in between each breed. B AM, Nurse #2 was a ged medications from the diministration to Resident ons pulled for administration is isosorbide dinitrate tablet (a prevent angina or chest pain). Wed as she crushed the ablet with four other tablets in inistration to Resident #174. The ation was made as the nurse read of his bed, and checked and of the tube. At 10:15 AM, or one of the medication cups inedications. Nurse #2 stated in initration to start again. AM, Nurse #2 was observed the medications previously ed cart for administration to in included one - 20 mg ablet. The isosorbide gain crushed together with the total and the medication to make the start again.	F3	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345006	B. WING			03/	30/2017
	ROVIDER OR SUPPLIER THAL NURSING & REHA	BILITATION CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353 SS=E	AM with Nurse #2. D nurse confirmed only isosorbide dinitrate w #174 during the medi observation. Upon rethe nurse stated she was supposed to recof isosorbide dinitrate. The nurse stated she give the resident and isosorbide dinitrate. An interview was con AM with the facility 's During the interview, the nurse to give the physician's order." 483.35(a)(1)-(4) SUF STAFF PER CARE P 483.35 Nursing Service The facility must have the appropriate comp provide nursing and resident safety and at practicable physical, well-being of each resident assessments and considering the midiagnoses of the faciliaccordance with the fat §483.70(e). [As linked to Facility A	ducted on 3/29/17 at 10:42 uring the interview, the one tablet of 20 mg as administered to Resident cation administration eview of the resident's MAR, did not realize the resident eviev 2 tablets (20 mg each) for a total dose of 40 mg. would need to go back and ther 20-mg tablet of ducted on 3/30/17 at 9:04 Director of Nursing (DON). the DON stated, "I expect medications according to the FICIENT 24-HR NURSING LANS ces e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care		3332			4/27/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, ,	E SURVEY MPLETED
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 353	sufficient numbers of personnel on a 24 nursing care to all refresident care plans: (i) Except when wain this section, licensed (ii) Other nursing pelimited to nurse aide (a)(2) Except when this section, the facinurse to serve as a duty. (a)(3) The facility munurses have the spesets necessary to calidentified through redescribed in the plan (a)(4) Providing care assessing, evaluating resident care plans aneeds. This REQUIREMEN by: Based on observation with resident, staff a facility failed to provious quantity and quality and to prevent acciderequired assistance.	ust provide services by f each of the following types d-hour basis to provide esidents in accordance with yed under paragraph (e) of d nurses; and rsonnel, including but not s. waived under paragraph (e) of ity must designate a licensed charge nurse on each tour of ust ensure that licensed cific competencies and skill are for residents' needs, as sident assessments, and	F3	Immediate Action Resident #22, resident #185, an #263 care and services explaine rendered on stated dates here u the nursing staff with appropriate competencies and skill set to pro those nursing and related servic assure resident safety. Such car	ed below ander by e ovide es to	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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				3724 WIRELESS DRIVE			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
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F 353	Continued From page	e 46	F 35	33			
	Finding included:			provided based on resident as	ssessments		
				and individual plans of care.			
	This tag is cross refe	renced to		Decident #22: Treetment rene			
	F 314 Based on obse	ervations, record review,		Resident #22: Treatment reno physician order by a treatmen	•		
		nd staff interviews the facility		3/29/2017. Wound was asset			
	failed to provide wound care as ordered by the			Regional Nurse Consultant #2			
	physician for 1 of 2 residents reviewed for			treatment nurse on 3/30/2017	. No		
	pressure ulcers (Res	ident #22).		deterioration in the wound wa	s noted from		
				treatment nurse assessment			
	I .	rd review, observations and		3/27/2017. Treatment was de			
	_	failed to use a lift pad that		appropriate for wounds and w			
		transfer a resident using the f 6 residents which resulted		showed improvement from pri assessments.	ior		
		ccident (Resident # 185).		Performance improvement ac	tion were		
		ly failed to implement the		implemented for weekend lice			
		entions for a resident who		who was responsible for resid			
	1	injury for 1 of 6 residents		treatment on 3/25/2017 & 3/2			
	which resulted in the	risk for additional falls		during day shift (7AM-7PM).	This action		
	(Resident #263).			was put forth by the Director of	of Nursing on		
				4/6/2017.			
	_	vith Nurse # 26 on March 26,		Resident #185 -Lift pad used			
		#26 revealed that she works		during survey was discarded			
		. Nurse #26 stated that we staff to replace them. Nurse #		by the Assistant Administrator	•		
		was a problem. Nurse #26		Resident #263 fall mat was pl	aced beside		
		nsus because March 26,		the bed, a bed and chair alarr			
		only March 24, 2017 this		put in place per resident care			
	was Friday census of			quality assurance nurse on 3/			
	-			Resident's care card was upd	ated to		
		ith the Nursing Assistant #2		reflect the use of floor mat, be			
	I .	t 2:10 PM. NA #2 stated that		alarm by the Quality Assurance	ce on		
		uired the assistance of two		3/31/2017 as well.			
	1 7 7	at we use lifts on required		Identification of Others			
		ed that these residents would		Identification of Others			
	nave to wait longer to	get help because the facility		Facility staffing pattern re-ass	essed by the		
	residents.	Set the ficeus of the		Regional nurse consultant #2	•		
				Assistant Administrator on 4/1			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345006	B. WING _			0	3/30/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				37	724 WIRELESS DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 353	Continued From page	e 47	F3	353			
F 353	During an interview w (DON) on March 29, stated that she had o 13, 2017. She indicat informed of the staffir during the week and indicated that her exp facility have sufficient needs During an interview w March 29, 2017 at 2: Administrator stated March 19, 2017. He is been identified as an However his expecta enough staff to meet During an interview w Assurance (QAA) Nu 5:50 PM. She stated since January, 2017. multiple in-services o hand washing and bil discussed every mor	with the Director of Nursing 2017 at 2:30 PM. DON only been here since March ted that she had been ng concerns and call out weekend. DON also bectation would be that the transfer to meet the resident's with the Administrator on 30 PM at 2:30 PM. The had only been here since indicated that staffing had issue here in the facility. Ition was that the facility have all the resident's needs. With Quality Assessment and arse on March 30, 2017 at she had only been here She stated they have done on hand washing lately on ood spills. Staffing is ning during the morning expect that if there are QA	F3	853	determine opportunities to maximize direct care nursing hours, to meet resident's individual needs. This audit identified opportunities for improvement, including lack of enforcement on attendance policy, employee call out protocol as well as la on on-call schedule to cover when ano nursing employee is unable to report to work, to ensure continuous quality of cwith sufficient nursing staff. 100% audit of all active resident's with wound care orders completed by the Regional nurse Consultant #2, and the treatment nurse to ensure that Physicial orders matched the treatment administration records record on 4/12/as well as the documentation for completion of such orders are noted in resident's record per order and to inclusaturdays and Sundays 100% of all active residents with pressulcers were assessed by Treatment nurse and by Certified wound nurse from sist facility on 4/27/2017. No pressure ulce were noted to have deteriorated from the previous documented assessment.	ther of are are dans dans dans dans de ure ure er rs heir	
					32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear tear.	lift e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP COL	<u> </u> DF	03/30/2017	
				3724 WIRELESS DRIVE			
BLUMENT	THAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE	N
F 353	Continued From pag	e 48	F3	100% audit of all fall care pla residents completed on 4/25/4/26/2017 & 4/27/2017 by the Nurse consultant #1 to deterr intervention put in place was and communicated to the nur appropriately. Findings of this audit was dod "fall intervention audit tool". No documented process of commidentified to be in place for commoditied to a feet to nurse's aide potential to affected by this an acompliance Systemic Changes: Effective 4/27/2017, open poor classification of nursing staff, nurses, Licensed Practical Nurses, Licensed Practical Nurseing aides will be posted of worldwide staffing advertisem for easier attraction of new his such needs arise, the Human will coordinate the posting of positions. Effective 4/27/2017 Human redepartment will conduct job for once quarterly for recruiting sincentive program that aide of recruitments put in place effer 4/27/2017. Facility will utilize as the last resort to ensure sinumber is staff is maintained	/2017, e Regional mine if any implement rse aides cumented of function munication of other of other of the end a illeged non rses and/ on a nent websitines. When on Resource in Resource istaff. New of staff ective agency sta ufficient	ted on al ion II d or tes es	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345006	B. WING				C
		343000	B. Wiite			03/	/30/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RILIMENT	THAL NURSING & REH	ARII ITATION CENTER		37	724 WIRELESS DRIVE		
DEGINERA	TIAL NORONO & REIN	ABILITATION GENTLIN		G	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	ge 49	F	353	Effective 4/27/2017, any call-in, (nursine mployee unable to report to work), for any nursing staff will be reported to the Director of nursing and to the staffing coordinator so replacement can be made for call ins to assure adequate staffing maintained to meet the need of each resident. Each employee is expected to contact the facility at the minimum of two hours before the beginning of their shift will be unable to come to work. Directo Nursing will oversee the assurance of sufficient staff in the facility. Effective 4/27/2017, staff development coordinator will ensure that each nursing staff has appropriate competencies and skill set to provide nursing and related services to assure resident safety and attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by resident assessments a individual plans of care. Effective 4/27/2017, each resident treatment is rendered per physician ord On- coming nurse will check treatment records for omissions prior to accepting cart form previous shift nurse. On- com Nurse will not accept cart until treatment are completed or reconciled. 100% of licensed nurses employed by facility ware re-educated on ensuring treatment orders are rendered per physician order, completed on the	de is ovo t if r of der. g ning nts	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTI G		(X3) DATE SURVEY COMPLETED
		345006	B. WING			C 03/30/2017
	ROVIDER OR SUPPLIER			3724 WIRELES	SS, CITY, STATE, ZIP CODE S DRIVE RO, NC 27455	03/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 353	Continued From page	e 50	F3	frequency each resist record. To what to didentified who refuse be done. This education and as needucation any licensed will be proposed added to licensed will be proposed in gappropriate recommendation with the person was person was resident's profession of care in transferre	y ordered and documented on ident treatment administration his education also covered on to when a pressure ulcer is and documentation for reside se their wound care treatment cation provided by Director of (DON), Assistant Director of Nursing or Staff Developmentor (SDC). This educated was on 4-6-2017 for all licensed staff to include full time, part timeded employees. This in will be completed by 4/27/20 seed nursing staff not educated 7 will not be allowed to work ution. This education was also new hire process for all new nurses effective 4/27/17 and a ovided annually. 4/27/2017, nursing assistants in utilizing appropriate number on the process of the p	ents ent ent s me, 017, d by intil also s of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345006	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343000	5: 11:10	STREET ADDRESS, CITY, STATE, ZIP CO	 	03/30/2017
NAME OF T	NOVIDEN ON 3011 EIEN			3724 WIRELESS DRIVE	<i>,</i> DL	
BLUMEN ⁻	THAL NURSING & RE	HABILITATION CENTER		GREENSBORO, NC 27455		
(V4) ID	SLIMMAD	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 353	Continued From p	page 51	F3	Effectively 4/27/2017; Residence Cards were initiated as a control to alert nurse's aides of method to transfer each resident with minimum number of state the Activity of daily Living (Aspecifically transfer to take Cards also include other information about each resident that denecessary for individual resident rendered by nurse's aides. But not limited to fall interversed in low position, fall mat Chair/bed alarm. Three ring "Care Cards" places at each station for easy access by the aides. This process was put the collaboration among the Clinical Consultant #2, Direct Nursing, Assistant Director Quality Assurance nurse, Maccordinator #1, MDS Coord MDS coordinator #3, and the Development Coordinator #3 and the Development Coordinator #3. Regional Nurse consultant in nursing and/or Assistant Director and added to each care card. Effective 4/27/2017 Care calinitiated on admission by the nurse and updated at least with any change in treatments.	ommunication of appropriate sident together aff required for ADL), place. Care formation emed ident care This include ntions such as on floor and/or binders titled in nurse's the nurse's to in place with exegional ctor of of Nursing, IDS dinator #2, the Staff care needs. In the staff of the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345006	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER		B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		3/30/2017
NAME OF T	NOVIDEN ON 3011 EIEN			3724 WIRELESS DRIVE	-DE	
BLUMENT	THAL NURSING & RE	EHABILITATION CENTER		GREENSBORO, NC 27455		
(V4) ID	SLIMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICI	OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 353	Continued From p	page 52	F3	to resident's direct care and	safety, by the	
				hall nurses and/or interdiscip		
				plan team. Interventions to b		
				by nursing aides will be adde	ed to be part	
				of each resident care cards.		
				100% of nursing staff, to inc	lude licensed	
				nurses and nurse's aides wa		
				on proper use of mechanica		
				attaching the appropriate lift	•	
				lift and ensuring that the min persons are present during a		
				lift transfer, unless the plan		
				otherwise, removing any pag	ds that were	
				broken, frayed or in poor cor		
				circulation and notifying cent and/or nurse administrative		
				ADON, QA nurse, superviso		
				development coordinator) so	o that	
				replacements could be order		
				education also covered the cards as the communication		
				Licensed nurses ware educa		
				use of such cards and how t		
				new card on admission and		
				the care card with any chang	•	
				treatment plan. Nursing aide educated on how to access,		
				cards and how to obtain info		
				such.		
				This education provided by I		
				Nursing (DON), Assistant Di		
				(ADON) of Nursing or Staff I Coordinator (SDC). This ed		
				initiated on 4-6-2017 for all r		
				include full time, part time, a		
				employees. This education		
				completed by 4/27/2017, an	y staff not	

			(X3) DATE COMP	SURVEY LETED			
		345006	B. WING _				30/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2017
				37	24 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		GI	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page			353		ved f all also g ed. / x will the gs	
					Performance Improvement Committee monthly x 4 months for any additional monitoring needs or modifications of th plan. Effective 4/27/2017, Assistant administrator will review staffing sheets for the week to ensure facility had sufficient nursing staffing to meet the need of resident based on determined		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION S		ATE SURVEY OMPLETED
		345006	B. WING			C 03/30/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		33/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From page	e 54	F 35	minimum hours per patient day requirements. This review will to weekly x 12 weeks, then month months. Any negative findings be addressed promptly. Staffing coordinator, Director of Nursing assistant administrator will report of this audit to facility Quality As Performance Improvement Cormonthly x 6 months for any additional monitoring needs or modification plan. Effectively 4/27/2017; Director of Assistant Director of Nursing, Significant development Coordinator and/or Assurance nurse will audit all transport of the surface	ake place hly x 3 noted will g g and/or the ort findings ssurance mmittee ditional ons of this of nursing, Staff or Quality reatments and the in-charge (Saturday we been rdered by place daily then tive findings tly. Quality dings of this ce mmittee ditional ons of this are cards onday thru supervisor y &	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 03/30/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	03/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 353	Continued From pag	e 55	F 35	accuracy as appropriate. This team we consist of but not limited to the DON, ADON, QA Nurse, SDC, MDS#1, ME and/or MDS#3., this review will take daily (Monday thru Friday) for 4 week then weekly x 4 weeks, then monthly months. Any negative findings noted be addressed by the member of the interdisciplinary team promptly. Qua Assurance nurse will report findings of facility Quality Assurance Performance Improvement Committee for any additional monitoring needs or modifications of this requirement Effectively 4/27/2017; Director of nur Assistant Director of Nursing, Staff development Coordinator and/or Qua Assurance nurse will audit all new admission for previous day, daily (Mothru Friday) and the week-end superor nurse in-charge will audit all new admits on (Saturday & Sundays), to ensure that resident care cards are completed and accurate, this review take place daily (Monday thru Friday) weeks then weekly x 4 weeks, then monthly x 3 months. Any negative fin noted will be addressed promptly QA nurse will report findings to facility Qu Assurance Performance Improvemer Committee for any additional monitor needs or modifications of this require Effective 4/27/2017, central supplies or Quality Assurance nurse will inspecondition of slings in the facility to determine functionality. Any sling not unfavorable condition will be remove	DS#2, place ks v x 3 will lity to ce sing, ality broady visor will of for 4 adings kPl puality intering ement clerk ect the ted in

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345006	B. WING			C 03/30/2017
	ROVIDER OR SUPPLIER HAL NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		00/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	Continued From pag	e 56	F 3	from circulation promptly and new will be ordered. Quality Assurance Central supplies Clerk will report to f this audit to facility Quality Assu Performance Improvement Commany additional monitoring needs comodifications of this requirement.	e or findings urance nittee for	
F 356 SS=B	483.35(g)(1)-(4) POS INFORMATION	STED NURSE STAFFING	F 3	· ·		4/24/17
	483.35 (g) Nurse Staffing Int (1) Data requirement the following information (i) Facility name.	nts. The facility must post				
	(ii) The current date.					
	by the following cate	and the actual hours worked gories of licensed and taff directly responsible for ft:				
	(A) Registered nurse	S.				
	(B) Licensed practical vocational nurses (as	al nurses or licensed s defined under State law)				
	(C) Certified nurse a	des.				
	(iv) Resident census					
	(2) Posting requirem	ents.				
		ost the nurse staffing data wh (g)(1) of this section on a ginning of each shift.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345006	B. WING		C 03/30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	03/30/2017
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 356	Continued From page	e 57	F 35	6	
	(ii) Data must be pos	ted as follows:			
	(A) Clear and readab	le format.			
	(B) In a prominent pla residents and visitors	ace readily accessible to			
	The facility must, upo	posted nurse staffing data. In oral or written request, Idata available to the public ot to exceed the community			
	facility must maintain staffing data for a mil required by State law	tion requirements. The the posted daily nurse nimum of 18 months, or as y, whichever is greater.			
	Based on observation interviews, the facility	ons, record reviews and staff or failed to post daily nurse uring one (1) of four (4)		No residents were affected by this alleged deficient practice	
	days; and the facility resident census on the	failed to post the correct ne daily nurse staffing (3) of four (4) days during		Measures put into place or systematic changes made to ensure that the deficient practice will not re-occur:	
	Finding included;			Staffing Coordinator, Receptionist and nurses were educated on the correct to complete and post the Nurse Staffin	way
	the daily nurse staffir	26/2017 at 8:30 PM revealed ag information for 3/24/2017		Information.	
	stand on top of a des	ic see-through cover on a k in the facility's front lobby. on was not posted for		Staffing Coordinator will complete pos sheets for the week. Nurse managers or hall nurses will modify posting as needed for any staffing changes.	
		27/2017 at 10 AM revealed formation was posted in a		Receptionist will check to assure that posted nurse staffing information is	the

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X DENTIFICATION NUMBER: (X DESCRIPTION A. BUILDING			X3) DATE SURVEY COMPLETED		
		345006	B. WING _			C 3/30/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	3/30/2017
				3724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & RE	HABILITATION CENTER		GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 356	Continued From p	age 58	F 3	56		
	plastic see-through desk in the facility 3/27/2017. The fac	h cover on a stand on top of a 's front lobby and was dated cility's resident census sheet		correct and has the correct of on a daily basis.	·	
	The nursing staff p	re 121 residents on 3/27/2017. costed included all residents in ng the assisted living residents.		Assistant Administrator will r sheets once a week x 4 wee monthly x 3 months to assur staffing information was posi	eks then re Nurse	
	the daily nurse sta a plastic see-throu desk in the facility' 3/28/2017. The face revealed there we number on the pos- assisted living resi residents. An observation on revealed the daily	a 3/28/2017 at 11 AM revealed offing information was posted in a right cover on a stand on top of a right strength of the results of the resu		Monitoring Process: Staffing reviews will be compared by basis x 4 weeks then months. Results of reviews were ported to the Quality Assult Performance Improvement (Committee by the Assistant monthly for 4 months or until compliance is achieved. QAI modified according to outcorneeded and determined by Compared Compar	pleted on a nonthly x 3 will be rance and QAPI) Administrator I pattern of PI will be mes as	
	on top of a desk in was dated 3/29/20 number on the posassisted living resiresidents. An interview with t 3/29/2017 at 4:10 was 124 on 3/29/2	the facility's front lobby and on. The resident census sting continued to combine idents with the skilled nursing the Director of Nursing on PM revealed that the census 2017. She stated that she was ting included assisted living		committee.	20 W T	
	at 4:20 PM reveals nursing was 115 o census posted sho Living residents. H expectation that the	the Administrator on 3/29/2017 ed that the census for skilled on 3/29/2017 and that the build not include the Assisted de stated that it was his ne posted nurse staffing be mbine the nursing home and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345006	B. WING		03/:	30/2017
	ROVIDER OR SUPPLIER THAL NURSING & REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3724 WIRELESS DRIVE GREENSBORO, NC 27455	•	50/2011
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 356	Continued From page assisted living reside		F 35	66		
F 371 SS=F	483.60(i)(1)-(3) FOOI STORE/PREPARE/S		F 37	11		4/27/17
		rom sources approved or ry by federal, state or local				
	` '	ood items obtained directly subject to applicable State ulations.				
	facilities from using p	es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices.				
		es not preclude residents s not procured by the facility.				
		, distribute and serve food in essional standards for food				
	foods brought to residusitors to ensure safe handling, and consur	egarding use and storage of dents by family and other e and sanitary storage, nption. is not met as evidenced				
	facility failed to ensur were stored in sealed clean, in good repair equipment and ceiling employee 's with fac while working in the k	ns and staff interviews the e opened food products d containers, dishware were and allowed to air dry, g vents were clean and male ial hair wore beard guards citchen. This had the e 112 residents who resided		Immediate Action The open and unsealed case fillets and sausage in the walk and unsealed box of rice in th storage room ware discarded Dietary Manager on 3/27/201 A male employee with facial h	k-in freezer, e dry by the 7.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			= 5.==	_		С		
		345006	B. WING _			03/30/2017		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RIIIMENI	HAL NURSING & REHA	RII ITATION CENTER		37	24 WIRELESS DRIVE			
BLOWLIN	TIAL NORSING & RETIA	BILITATION GENTER		GF	REENSBORO, NC 27455			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 371	Continued From page	e 60	F3	371				
	in the facility.				noted with no beard guard on while he			
					was preparing desert for the lunch mea			
	Findings Included:				re-educated on 3/27/2017 by Dietary			
					manager and worm a beard guard rite			
	1. An observation of			away.				
	9:15 am with the Dietary Manager revealed the				The ceiling vent in the beverage			
	following:				preparation area was cleaned and is fr	ee		
	a. In the kitchen 's w	alk-in freezer an open,			of dust on 3/27/2017 by Dietary Manag			
	unsealed case of okra	a; an open, unsealed case			, ,			
		pen, unsealed case of			The storage cart that contained clean			
	sausage patties were	stored exposed to the air.			meal trays observed on 3/27/2017 was	;		
	h In the kitchen 'e de	ny ataraga raam an anan			cleaned by Dietary Manager on 3/27/2017.			
		ry storage room an open, was stored exposed to the			3/2//2017.			
	air.	was stored exposed to the			15 meal trays that had dark staining,			
					cracks and exposed metal edges ware			
		vith facial hair did not have a			discarded on 3/29/2017 by Dietary			
	_	he was preparing dessert			manager and The Registered Dietician	. •		
	for the lunch meal.							
	d. A ceiling vent locat	ed in the heverage			Four divided plates noted with dried for particles ware cleaned, sanitized, dried			
	_	ne kitchen had a thick layer			and stored properly on 3/29/2017 by	1		
	of dust on the grates.				Dietary aide #1			
	e. A storage cart that	contained clean meal trays			12- 8 ounce clear glasses were cleane	d.		
	_	and food particles on it.			re-sanitized, air dried on 3/29/2017 and			
		•			stored appropriately, by Dietary aide #	1,		
		Dietary Manager on 3/27/17			Solid tray that prevented those glasses	;		
		hat all opened food items			from air drying on 3/29/2017 removed			
		or placed in sealed plastic			from being a surface used to air dry			
		sure to the air. She stated			dishes in the facility by Dietary Manage on 3/29/2017.	31		
		ee should have had a beard ng in the kitchen; especially if			011 3/28/2017.			
	•	od preparation. She stated						
		lid need to be cleaned and			Identification of others:			
		for the meal trays should be						
	cleaned before storin	<u> </u>			100% audit of all food storage areas			
					inspected by dietary Manager and/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C 03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	5/30/2017	
				3724 WIRELESS DRIVE	_		
BLUMENTHAL NURSING & REHABILITATION CENTER		ABILITATION CENTER		GREENSBORO, NC 27455			
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F 371	Continued From pag	e 61	F 3	71			
	Administrator reveals opened food product exposed to the air. I male employees with guards on while worl additionally stated the clean and on the clean and on the clean and on the Reference of the following: a. 15 meal tray that I exposed metal edge cart ready to be used b. 4 of 6 divided plas particles on them and	2/17 at 6:11 pm with the ed it was his expectation that its were fully sealed and not le stated that he expected in facial hair would have beard king in the kitchen. He lat he expected vents to be aning schedule. If the kitchen on 3/29/17 at egistered Dietitian revealed in a storage d for lunch meal service. It is plates had dried food d were stored on a shelf lunch meal services.		Registered Dietician 3/27/201 any other open item that is ur and/or not sored appropriatel items identified as being inap stored. 100% of dietary staff working 3/27/2017, re-educated by the manager on the importance of hair cover and/or beard guard preparing resident's meals. A employees noted to have hair and/or beard guard while prepresidents' meal on 3/27/2017 100% inspection of all ceiling kitchen audited by Dietary Mand/or Registered Dietician of 3/27/2017to identify its cleanly other ceiling vent in the Kitcher be unclean or with dust.	on duty on e Dietary of wearing d while all other r cover paring vents in the anager n iness. No		
	on a solid tray that p drying. An interview on 3/30 Dietary Manager rev trays should have be and discarded. She dishware to be clean to air dry before they additionally stated th tray storage rack she schedule. An interview on 3/30 Administrator revealed.	glasses were wet and stored revented them from air /17 at 3:43 pm with the ealed that the damaged meal een removed from service stated that she expected all and left in the drying racks were stored. She at the ceiling vents and the build be added to the cleaning /17 at 6:11 pm with the ed it was his expectation that air dried and in good		100% inspection of all storage completed on 3/27/2017 by the Manager and/or Registered Elidentify any other cart that ne cleaned and sanitized. No other storage cart noted to be uncleased and sanitized and sanitized and storage cart noted to be uncleased in the storage cart noted to be uncleased in the storage cart noted to be uncleased in the storage cart noted to be uncleased by the dietary Mark Registered Dietician on 3/29/20 meal trays noted with cracks exposed metal edges. Those ware discarded immediately the Manager and/or Registered Elicentification and the storage complete the storage cart noted to be uncleased to the storage cart noted to be u	ne Dietary Dietician to eds to be ner dietary ean rays nager and/or 2017, 7 other and/or seven trays by the Dietary Dietician.		
	condition.	ali ulieu aliu ili 9000		plates, cups, glasses, spoon	_		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING _			C 03/30/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2017
					24 WIRELESS DRIVE		
BLUMENT	THAL NURSING & REHA	BILITATION CENTER			REENSBORO, NC 27455		
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F 371	Continued From page	e 62	F3	371	rewashed on 3/29/2017 by Dietary aide to ensure cleanliness and sanitation. A being, dish wares allowed to air dry, no other dishware noted to be unclean. 100% inspection of all surfaces used for dish ware air drying process inspected Dietary Manager and the Registered Dietician on 3/29/2017 to ensure no oth surface can potentially obstruct air drying process. All other storage surfaces identifies as being capable of allowing dishes to air dry with no obstruction. Systemic Changes: Effective 4/27/2017 A new Dietary Manager was hired and trained and will oversee dietary services, sanitation, for storage and employee practices to ensumpliance. Root cause of such allege compliances concluded to be staff train and managerial supervision. Effective 4/27/2017, A cook on duty is designated to work as a Kitchen supervisor on duty. On the absence of dietary manager, the cook on duty will oversee kitchen sanitation, proper storation of foods, ensuring dish wares are allow to air dry, cleanness of dishware before use, employee compliance with wearin beard guard and hair cover while preparing resident food as well as ensuring any dish wares not in good repair are removed out of circulation immediately. 100% of dietary employees, to include	fter or by ner ng I od ure d ing the	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	e 63	F	371	cooks and dietary aides ware re-educa on proper storage of food in all food storing location to include but not limite to freezer, Walk-in refrigerator, reach ir refrigerator and dry storage food, proper use of beard guards & hair cover while preparing residents' food, proper clean of the ceiling vents and the proper way clean storage carts for meal trays. This re-education also covered and emphasized on proper technique to cle and store plates and glasses to allow a drying as well as how to identify damage trays for disposal, and notifying Dietary Manager so that replacements could be ordered. This education provided by Dietary Manager and/or Registered Dietician. This educated was initiated of 3/27/2017 for all dietary staff to include time, part time, and as needed employees. This education will be completed by 4/27/2017, any dietary stant educated by 4/27/2017 will not be allowed to work until educated. This education was also added to new hire process for all new employees effective 4/27/17 and also will be provided annual. Monitoring Process: Effective 4/27/2017 The Registered Dietician, Dietary Manager, designated cook, and or designated dietary aide with monitor compliance with proper food storage all food storing locations, to include but not limited to freezer, Walk-refrigerator, reach in refrigerator and dietary and dietary and dietary refrigerator, reach in refrigerator and dietary an	d n er ing to an ir ged e on full aff	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	03/30/2017
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F 371	c) Drug Regimen Rev (1) The drug regimen reviewed at least onc pharmacist. (3) A psychotropic drug.	RUG REGIMEN REVIEW, IR, ACT ON	F 42	storage food, proper use of beard gual & hair cover while preparing residents' food, proper cleaning of the ceiling ver and the proper way to clean storage of for meal trays. This monitoring will also assure proper technique to clean and store plates & glasses to allow air drying as well as monitoring any damaged tray for disposal. Effective 4/27/2017, This monitoring process will be accomplished, and findings will be documented in a daily Daily Kitchen Rounds Audit Tool and a Sanitation Checklist daily for 2 weeks, then 3 times a week for 2 weeks then weekly times 12 week, then monthly x months afterwards, or until the pattern compliance is maintained. Effective 4/27/2017 the Dietary Managor Registered Dietician will report finding of this audit to facility Quality Assurance Performance Improvement Committee any additional monitoring needs or modifications of this requirement mont x 6 months,	arts o ng nys 6 of er ngs ee for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 428	(ii) Anti-psychotic; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iv) Hypnotic. (4) The pharmacist to the attending phy facility's medical dir and these reports in (i) Irregularities including that meets the (d) of this section for (ii) Any irregularities during this review in separate, written reattending physician director and director and director minimum, the reside and the irregularity (iii) The attending president's medical rirregularity has been action has been take be no change in the physician should do the resident's medical (5) The facility must	must report any irregularities visician and the ector and director of nursing, nust be acted upon. ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the ecord that the identified on reviewed and what, if any, een to address it. If there is to emedication, the attending ocument his or her rationale in cal record.	F 42	8		
	review that include, frames for the differ	the monthly drug regimen but are not limited to, time ent steps in the process and st must take when he or she				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/30/2017	
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F 428	Continued From pag	ge 66	F 428			
	to protect the reside	rity that requires urgent action nt. T is not met as evidenced				
	Based on record re facility staff interview maintain documenta monthly Medication within the facility and sampled residents (I	views and pharmacy and vs, the facility failed to ation of the pharmacist's Regimen Review (MRR) d readily available for 4 of 5 Resident #2, #49, #61, and annecessary medications.		A Complete Pharmacy Review was conducted for Resident # 2, Resident # 49, Resident # 61 and Resident # 70 of 3/27/17 by the Contracted Pharmacist recommendations for Nursing and Physicians received appropriate follow and reconciliation.	on . All	
	9/3/12 from the hosp diagnoses included depression, anxiety	d: admitted to the facility on bital. Her cumulative dementia, hypothyroidism, and psychotic disorder. t #2 's most recent quarterly		Corrective action will be accomplished those residents having potential to be affected by the same deficient practice facility residents have potential to be affected and will receive monthly Pharmacy reviews with timely interventions.		
	Minimum Data Set (1/6/17 revealed the antipsychotic, antiar	MDS) assessment dated resident received an exiety, and antidepressant on during the look back period.		Measures put into place or systematic changes made to ensure that the defic practice will not re-occur:	cient	
	medical records revipharmacist conducted Review (MRR) on 60 not available for the 2016, or September pharmacist MRR was	ed a Medication Regimen /30/16. However, MRRs were months of July 2016, August 2016. A consultant as next completed and		DON and unit managers were trained Regional Nurse Consultant on proper Processing of Resident Pharmacy rev on 4/21/17. Medical Records was in-serviced on timely filing of pharmac Reviews on Residents charts by the Regional Nurse Consultant on 4/21/17	iews y	
	and, once each mor most recent pharma An interview was co PM with the facility '	nedical record on 10/28/16; hth thereafter up through the cist review dated 3/27/17. nducted on 3/29/17 at 5:20 s Director of Nursing (DON).		All Pharmacy Reviews will be discussed on exit, rather than simply emailed by Contracted pharmacist with either the and or DON, and or Regional Nurse Consultant. DON will receive a hard or Pharmacy recommendations in add	the ED, ppy	
	During the interview	, an inquiry was made as to		to emailed copy. Any critical areas		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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F 428	Continued From page	ge 67	F4	128			
	Regimen Reviews (I	t pharmacist ' s Medication MRRs) for the months of July			requiring immediate attention will be called to the attention of the DON and	or	
	located. A review of	and September 2016 were f Resident #2 's paper and ecords revealed the monthly			ED immediately in addition to inclusion formal report.	in	
		e consecutive months were			The DON or ADON will disseminate the orders to the appropriate provider.	е	
	at 9:04 AM with the	was conducted on 3/30/17 DON. During the interview,			Physician recommendations will be pla in a folder in physician⊡s box to be	iced	
	the DON reported she and her team tried to find the missing MRRs, but were not yet able to locate				completed on next physician visit.		
	these records. The DON stated she had placed a call to the consultant pharmacist to further check on the missing MRRs.				Physicians were made aware of the expectation for all recommendations to addressed promptly within 5 business days by the ED on 4/25/17.) be	
		nducted with the DON on Upon inquiry, the DON			Upon completion of Pharmacy		
	stated she would ex	pect medication regimen and addressed on each			recommendations, Physician, will give competed folder to the DON for	the	
	(resident 's) chart m	•			processing. DON will then assure that orders are written and processed		
	AM with the facility '	nducted on 3/30/17 at 10:07 s Nurse Consultant. During			according to doctors orders.		
	facility was not sure	urse Consultant reported the where the communication ng the 3 months of missing			Nursing recommendations will be give to unit managers for completion and w be returned to the DON and signed as	ill	
		ne added, "We will fix it going			completed by unit managers DON will check to make sure she has received a recommendations back from physician	all	
	at 11:50 AM with the	w was conducted on 3/30/17 e facility 's consultant			and unit managers by comparing them her original email to assure all	ı to	
	she was the current	nsultant pharmacist reported consultant pharmacist for the e pharmacist stated she was			recommendations are accounted for a completed timely within 5 business day		
	on leave from May 2 She was unable to p consultant pharmaci	2016 until December of 2016. provide insight as to how the list coverage was provided to be months she was on leave.			Once Physician recommendations are completed they will be placed on the resident⊡s charts under pharmacy tab medical records. All Pharmacy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	5/30/2017	
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BLUMEN	THAL NURSING & RE	HABILITATION CENTER			REENSBORO, NC 27455			
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F 428	Continued From p	page 68	F ₄	428				
		3		0	recommendations are to be addressed	4		
	A telephone interview was conducted on 3/30/17 at 1:36 PM with the Clinical Director of the				within 5 business days.	4		
		eted to provide consultant			Pharmacy will audit 100% of resident			
	pharmacist services to the facility. During the				charts and review their previous			
	interview, the Clinical Director reported she had				recommendations when they do the no	ext		
	hired a new consultant pharmacist to cover the				month□s pharmacy reviews. Any review	€WS		
	facility for the months of July, August, and				or recommendations found without			
	September of 2016. She recalled the new				appropriate follow up will be dictated o			
		puter could not replicate her			the following months pharmacy review	/S		
		t in the facility 's electronic			and sent to DON, Administrator and			
		herefore, the residents 'MRRs y sent to the DON (who was no			Regional Clinical Director for prompt intervention and modification as neede	nd		
		the facility) for July, August, and			to systems implemented.	J U		
		When asked, the Clinical			to systems implemented.			
	1 -	she typically would have			Monitoring Process:			
		of these notes to have been put			3			
		charts. The Clinical Director			Contacted Pharmacist will audit			
	reported the miss	ing MRRs would be in the			compliance with previous months□			
	1 -	puter system. The Clinical			reviews on a monthly basis x 6 months			
		ed she could email the MRRs to			Results of audits will be reported to the	9		
	the facility so they	would be available for review.			Quality Assurance and Performance			
					Improvement (QAPI) Committee by the	е		
		1 PM, an interview was			Contracted Pharmacist monthly for 6	:_		
		e DON. During the interview,			months or until pattern of compliance i			
		as to whether the facility had ing MRRs via an electronic			achieved. QAPI will be modified accor to outcomes as needed and determine	_		
		om the pharmacy 's Clinical			by QAPI committee.	;u		
		N indicated she would follow-up			by QAI I committee.			
	on this.	it indicated one would follow up						
		6 PM, the facility provided a						
		#2 's consultant pharmacist 's						
	1	016 and August 2016 for review.						
	_	w conducted at that time, the						
		indicated she was not able to						
	1	mber 2016 MRR for this						
		eview of the resident 's medical Consultant confirmed the						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING		03/30/2017	
	NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	1 00/00/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 428	Continued From pag	ge 69	F 428			
	resident was in the f September 2016.	acility during the month of				
		PM, the facility provided a 's September 2016 MRR for				
	7/29/09, with reentry Her cumulative diag hypothyroidism, ede	s admitted to the facility on of from the hospital on 12/6/09. noses included diabetes, ama (fluid retention), atrial heart beat), anxiety disorder,				
	Data Set (MDS) ass revealed the resider daily decision makin assistance for all of (ADLs), with the excassistance from staff for eating, and was on the unit. Section resident received in antidepressant, and of the 7 days during	t #49 's annual Minimum essment dated 1/10/17 It had intact cognitive skills for g. She required limited her Activities of Daily Living reption of requiring extensive if for bed mobility, supervision independent for locomotion N of the MDS indicated the sulin, an anticoagulant, diuretic medication on each the look back period. She ety medication on 1 of the 7 Is back period.				
	medical records revipharmacist conducted Review (MRR) on 6 available for the mode 2016, or September pharmacist MRR was documented in the rand, once each more	ed a Medication Regimen /30/16. MRRs were not nths of July 2016, August 2016. A consultant				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 3724 WIRELESS DRIVE GREENSBORO, NC 27455	E	00/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	ge 70	F 4	28		
	PM with the facility During the interview where the consultar Regimen Reviews (2016, August 2016, located. A review of electronic medical remaissing. A follow-up interview at 9:04 AM with the the DON reported so the missing MRRs, these records. The call to the consultant on the missing MRR. An interview was consultant on the missing MRR.	s Director of Nursing (DON). It, an inquiry was made as to at pharmacist 's Medication MRRs) for the months of July and September 2016 were of Resident #49 's paper and ecords revealed the monthly see consecutive months were on was conducted on 3/30/17 DON. During the interview, the and her team tried to find but were not yet able to locate DON stated she had placed a transparent to further check as. Inducted with the DON on Upon inquiry, the DON pect medication regimen and addressed on each				
	AM with the facility 'the interview, the Nu facility was not sure breakdown was dur	nducted on 3/30/17 at 10:07 s Nurse Consultant. During urse Consultant reported the where the communication ing the 3 months of missing he added, "We will fix it going				
	at 11:50 AM with the pharmacist. The co she was the current	w was conducted on 3/30/17 e facility 's consultant nsultant pharmacist reported consultant pharmacist for the ne pharmacist stated she was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 3724 WIRELESS DRIVE GREENSBORO, NC 27455		5/00/2011	
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F 428	She was unable to consultant pharma the facility during the pharmacy contract pharmacist service interview, the Clinic hired a new consultation report medical record. The were electronically longer working at the September 2016. Director indicated sexpected a copy of on the residents of the facility so they on 3/30/17 at 2:51 conducted with the inquiry was made a received the missing communication fro Director. The DON on this.	2016 until December of 2016. provide insight as to how the cist coverage was provided to the months she was on leave. ew was conducted on 3/30/17 to Clinical Director of the ed to provide consultant is to the facility. During the cal Director reported she had tant pharmacist to cover the this of July, August, and is. She recalled the new utter could not replicate her in the facility 's electronic interefore, the residents ' MRRs sent to the DON (who was no the facility) for July, August, and when asked, the Clinical is these notes to have been put charts. The Clinical Director in MRRs would be in the utter system. The Clinical Director in MRRs would be in the utter system. The Clinical dishe could email the MRRs to would be available for review. PM, an interview was DON. During the interview, as to whether the facility had ing MRRs via an electronic in the pharmacy 's Clinical I indicated she would follow-up PM, the facility provided a gome with the months of the pharmacy in the pharmacy of the provided and market form July, August, and gome months are to have been put the pharmacy of the pharmacy in the pharmacy is Clinical I indicated she would follow-up	F	428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	HABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	00/00/2011	
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F 428	Continued From pa	nge 72	F 428	3		
		ns admitted on 1/22/15 with the f dementia, anxiety and				
	1/23/17 revealed the cognitively impaired or behaviors. The rediagnoses of anxiet disorder. The residual of th	num Data Set (MDS) dated ne resident was severely d. The resident had no moods esident had an active ty, depression and a psychotic ent was on an Antipsychotic hys and antidepressant hys.				
	risk of side effects fuse. An intervention	care plan dated 6/16/16 for from psychotropic medication in included pharmacy medications monthly.				
	PM with the facility' During the interview where the consulta Regimen Reviews	onducted on 3/29/17 at 5:20 s Director of Nursing (DON). v, an inquiry was made as to nt pharmacist's Medication (MRRs) for the months of July, and September 2016 were				
	reviewed were reviewed 3/2016. Monthly Phavailable at the facinesident's medical resident's medical resident	0/17, monthly pharmacy ewed from 6/2016 through narmacy reviews were not illity and were missing in the record for the months of July, 6 and September, 2016.				
	at 9:04 AM with the the DON reported s try and find the mis	w was conducted on 3/30/17 and DON. During the interview, she and her team went back to sing MRRs but were not yet be records. The DON stated				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345006	B. WING _			C 03/30/2017
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 3724 WIRELESS DRIVE GREENSBORO, NC 27455	DE	03/30/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	
F 428	Continued From pageshe had placed a capharmacist to further MRRs. An interview was considered as a capharmacist to further MRRs. An interview was considered as a capharmacist of the work of the considered as a capharmacist. The considered as a consultant pharmacist of the co	ge 73	F 4	DEFICIENCY		
	at 1:36 PM with the pharmacy contracte pharmacy services interview, the Clinical hired a new consult facility for the month September of 2016. pharmacist's computation report i	w was conducted on 3/30/17 Clinical Director of the d to provide consultant to the facility. During the al Director reported she had ant pharmacist to cover the as of July, August, and She recalled the ter could not replicate her in the facility's electronic erefore, electronic chart notes				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345006	B. WING		، ا	C 03/30/2017	
	ROVIDER OR SUPPLIER THAL NURSING & REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	'	350002011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	DON (who was no When asked, the C typically would have have been put on the Clinical Director regin the pharmacy's could email these to available for review On 3/30/17 at 2:51 conducted with the inquiry was made a received the missin communication from Director. On 3/30/17 at 4:07 provided a copy of which were emailed 2016, August, 2016 The DON was inter PM. She stated that pharmacy to conducted. 4. Resident #70 was Parkinson's disease anxiety. Resident #70 Minim 1/17/17 revealed the intact. The resident 7 days, insulin for 7 medication for 7 dafor 6 days, an antided days and a diuretic support of the conducted support of the conducte	mation were emailed to the longer working at the facility). Ilinical Director indicated she e expected these notes to the residents' charts. The ported the missing MRRs were computer system and she to the facility so they would be	F 43	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING		C 03/30/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	1 00/00/2011	
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F 428	disorder. An interview was comply with the facility's During the interview where the consultar Regimen Reviews (2016, August 2016, located. The morning of 3/30 reviewed were reviewed were reviewed were reviewallable at the facility serviewed resident's medical resident's medic	on, anxiety and psychotic anducted on 3/29/17 at 5:20 be Director of Nursing (DON). by, an inquiry was made as to at pharmacist's Medication MRRs) for the months of July and September 2016 were 0/17, monthly pharmacy ewed from 6/2016 through armacy reviews were not lity and were missing in the eccord for the months of July, and September, 2016. by was conducted on 3/30/17 DON. During the interview, the and her team went back to using MRRs but were not yet records. The DON stated	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	C (X3) DATE SURVEY		
		345006	B. WING		03/30/2017	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	33.00.20	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 428	at 11:50 AM with the pharmacist. The consultant pharmacist has a unable to consultant pharmacist the facility during the pharmacy contracts pharmacy services interview, the Clinich hired a new consultacility for the mont September of 2016 pharmacist's compound consultation report medical record. The with the MRR inform DON (who was nown When asked, the Compound the pharmacy's could email these the available for review on 3/30/17 at 2:51 conducted with the inquiry was made a received the missing the same than the consultation of the pharmacy's could email these than the pharmacy's could email the pharmacy's could email these than the pharmacy's could email	ew was conducted on 3/30/17 the facility's consultant consultant pharmacist reported to consultant pharmacist for the the pharmacist stated she was 2016 until December of 2016. provide insight as to how the cist coverage was provided to the months she was on leave. The Clinical Director of the ted to provide consultant to the facility. During the cal Director reported she had tant pharmacist to cover the ths of July, August, and the she was conducted the tuter could not replicate her in the facility's electronic therefore, electronic chart notes mation were emailed to the longer working at the facility). The clinical Director indicated she the expected these notes to the residents' charts. The corted the missing MRRs were computer system and she to the facility so they would be	F 428	8		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X A. BUILDING			SURVEY PLETED			
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		345006	B. WING		03	/30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3724 WIRELESS DRIVE GREENSBORO, NC 27455	DE	
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F 428	Continued From page		F	428		
	provided a copy of the which were emailed to 2016, and September facility on 3/30/17, the	M, The Director of Nursing the monthly Pharmacy reviews to her for the months of July, ther, 2016. Upon exit of the the facility was unable to the pharmacy's monthly review				
F 431	PM. She stated that spharmacy to conduct required. 483.45(b)(2)(3)(g)(h)	drug regiment reviews as DRUG RECORDS,	F	431		4/27/17
SS=D	drugs and biologicals them under an agree §483.70(g) of this pa	vide routine and emergency is to its residents, or obtain ement described in rt. The facility may permit I to administer drugs if State under the general				
	that assure the accur dispensing, and adm	cility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident.				
		tion. The facility must services of a licensed				
	disposition of all cont	tem of records of receipt and crolled drugs in sufficient ecurate reconciliation; and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345006	B. WING		C 03/30/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	03/30/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 431	that an account of a maintained and period maintained and period maintained and period maintained and period program and biological labeled in accordan professional princip appropriate access instructions, and the applicable. (h) Storage of Drugg (1) In accordance with facility must stored to the facility must stored compartment controls, and permit have access to the controlled drugs list. Comprehensive Drugg Control Act of 1976 abuse, except where package drug distrit quantity stored is more be readily detected. This REQUIREMENT by: Based on observation of 6 medication pass with direct observation the medications; 2) inside of 1 of 6 medication a medication and a medication and a medication and a medications; 2) inside of 1 of 6 medication and a medication and a medication and a medication and a medications; 2) inside of 1 of 6 medication and a medication a	drug records are in order and II controlled drugs is odically reconciled. Is and Biologicals. Is used in the facility must be ce with currently accepted es, and include the ory and cautionary expiration date when Is and Biologicals. Ith State and Federal laws, e all drugs and biologicals in its under proper temperature only authorized personnel to keys. In provide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the nimal and a missing dose can	F 4	Immediate Action Nurse #3 was re-educated by Regio Nurse Consultants #2 and Staff Development Coordinator (SDC). Or 4/6/2017, on the proper way to lock med-cart and were reminded that it is unacceptable to wait for the med-cal lock itself after 2 minute time out.	n the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345006	B. WING		C 03/30/2017	
NAME OF PI	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2011	
				3724 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER		GREENSBORO, NC 27455		
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F 431	Continued From pag	e 79	F 43	1		
	store a medication in	edications; and, 3) Failed to accordance with the mmendations on 1 of 6 hall med cart).		Nurse #2 was re-educated on policy for storage of drugs and biologicals. This re-education was conducted on 4/6/17 Regional		
	The findings included	d:		Nurse Consultants #2 and Staff Development Coordinator (SDC).		
	Medication Administr	cility 's policy, "Specific ration Procedures; #1. to Follow for All Medications"		Emphasis was placed on not leaving medications on top of cart unattended		
	(Revised 11/1/11) ind procedural step:	cluded the following to be kept locked at all		One opened bottle of prednisone acer 1% ophthalmic suspension noted lying down in its side in the 500 hall medica	9	
		away from the cart, unless in		cart on 3/30/2017, discarded by the Regional Nurse Consultant on 3/30/20 and new bottle for resident #70		
	as she left the 700 H administer medication	M, Nurse #3 was observed all medication cart to us to a resident without		re-ordered.		
	cart was placed alon	g the wall of the hallway		Identification of Others:		
		It was not within view of went into the resident 's		100% walk though of the facility conducted by Regional nurse consulta	ant	
		observation of the med cart		#1 to identify if any other medication of		
	was made during the	e nurse 's absence.		noted to be unlocked while the cart is		
		served to self-propel himself		under the direct observation of the		
		the hallway and was two		administering nursing staff (Licensed		
		ere the med cart was		nurses or Medication Aides) on 3/28/2		
	•	PM, the med cart lock		No any other medication cart noted to		
	mechanism was hea			unlocked without a direct observation		
	engaged the lock on			the medication/treatment administerin nursing staff.	g	
	· ·	Nurse #3 was observed as		1000/ walk though of the facility		
		medication cart unlocked to ns to Resident #39. The		100% walk though of the facility conducted by Regional nurse consulta	ant	
		hin view of Nurse #3 when		#1 to identify if any medication is note		
		sident's room. When the		be stored on top of medication cart,	u 10	
		dent's room at 4:58 PM,		without a direct observation of the		
		pserved to be sitting in his		administering nursing staff (Licensed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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		345006	B. WING _		03	3/30/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE,	ZIP CODE		
				3724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER		GREENSBORO, NC 27455			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 431	Continued From pag	e 80	F 4	31			
	the nurse. The med engaged the lock on and was locked upon			nurses or Medication A No any other medication stored on top of the ca observation of the medication administering nursing s	on noted to be rt without a direct lication/treatment		
	as she left the 700 H to do a blood glucos administer insulin for was not within view of into the resident 's r nurse realized she h along for the blood go the med cart to retrie			100% audits of all med facility completed by th consultant #1 on 3/31/2 any other medication n against manufacturer's No other medication id against manufacturer r	ne Regional Nurse 2017 to identify if noted to be stored a recommendation. entified as stored		
	the med cart to retrieve one. After the blood glucose check was completed and the insulin administered to the resident in her room, Nurse #3 returned to the medication cart at 5:09 PM. Upon the nurse 's return to the med cart, the green light in the front right corner of the cart was blinking, indicating the cart was unlocked. At that time, the top drawer of the medication cart was pulled open to confirm the medication cart was unlocked.			Effective 4/27/2017 all nurse and active medication carts w from the cart is not in tobservation while on d Effective 4/27/2017 all nurses and active med	cation aides locks hen they walk away heir direct uty. active licensed		
	PM with Nurse #3. It medication cart was during her medication could not lock the cashe, "did not have a reported the med ca "after a while." Nurs cart automatically locher numerical code to cart.	Inducted on 3/28/17 at 5:10 Upon inquiry as to why the left unlocked multiple times in pass, the nurse stated she int when she left it because key to unlock it." The nurse int would lock automatically e #3 stated after the med locked itself, she could input o electronically unlock the		not allowed to leave ar top of their cart while the direct observation while Effective 4/27/2017, a guide" per manufacture for most commonly use available for nurses to second source of information to medication label. The available on each med medication rooms for each source of the second source of information label.	ny medication on the cart is not in their e on duty. "storage guidelines er recommendation ed drugs are kept review as the mation in addition ese guides will be ication cart and		
	to electronically lock	AM, Nurse #2 was observed the 700 Hall medication cart cart to administer medications		licensed nurses. 100% of nursing staff v	vho allowed to pass		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				30/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2017
					24 WIRELESS DRIVE		
BLUMENT	HAL NURSING & REHA	BILITATION CENTER					
				GREENSBORO, NC 27455			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	e 81	F 4	431			
F 431	to a resident during a was not used to lock. This was the same me in use by Nurse ## An interview was con AM with the facility 's During the interview, expectation was for the locked when the nurse cart. 2) On 3/29/17 at 9:58 observed as she pullimedication cart for ac #174. The medication included one - 325 medication cup and semed cart. On 3/29/17 at 10:10 as she went to Resid administer his medication to the room of Nurse #2 when 's room. When Nurse medication cart at 10 tablet left on top of the gone. An interview was contact the same and the same an	the med cart. nedication cart observed to a the afternoon of 3/28/17. Inducted on 3/30/17 at 9:04 and Director of Nursing (DON). The DON reported her the medication cart to be see was not within view of the diministration to Resident the pulled for administration and giron sulfate tablet (a which was placed in a seet on top of the 700 Hall AM, Nurse #2 was observed ent #174 's room to ations. The iron sulfate medication cup on top of the rich medication cup on top of the rich medication to the resident medication to the resident medication cup on top of the rich medication to the resident medication the resident medicat	F	131	medication and have access to drugs a Biologicals in accordance with North Carolina State and Federal laws to include Licensed Nurses & Medication aides, ware re-educated on the policy procedures for storage drugs and biologicals, with the emphasis on locking of medication cart while the cart is not direct observation of the medication administering nursing staff, proper store of medications (not to be left on top of cart), and storage of medications to be stored upright per manufacturer recommendation. This education provided by Regional nurse consultant #2, Director of Nursing (DON), Assistant Director (ADON) of Nursing and/or Staff Development Coordinator (SDC). This educated was initiated on 4-6-2017 for all licensed nurses and Medication aides, to include full time, part time, and as needed employees. This education will be completed by 4/27/2017, any licensed nurse or medication aide not educated 4/27/2017 will not be allowed to administer medication or have access any drugs and biologicals until educated This education was also added to new hire process for all new employees effective 4/27/17 and also will be providentally.	& ng on age g s de by to ed.	
	sulfate tablet left on t during the med pass stated she was told the	op of the medication cart administration, Nurse #2 his tablet was noticed by r. She reported the tablet			Monitoring Process: Effective 4/27/2017 Medication administration reviews will be complete	ad.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	MULTIPLE CONSTRUCTION IILDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				C 30/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011	
				37	724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			REENSBORO, NC 27455			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 431	Continued From pag		F 4	131	with 20% of Nurses and med-aids on al	II		
	AM with the facility 's During the interview, expectation was that	medications would not be			shifts to include weekends, weekly by DON, ADON, SDC, QA Nurse and/or Licensed Pharmacist x 4 weeks then monthly x 3 months.			
	stored on top of the med cart without supervision. 3) An observation of the 500 Hall medication cart on 3/30/17 at 3:36 PM revealed an opened bottle of prednisolone acetate 1% ophthalmic suspension eye drops (a steroid medication) was stored lying down on its side in a drawer of the medication cart. The eye drops were dispensed from the pharmacy on 12/16/16 and labeled for use by Resident #70. The manufacturer's storage instructions printed on the eye drop bottle read, in part, "Store in upright position."				The emphasis during observation will be to determine whether each nurse or medication aide store medication appropriately per manufacturer recommendation, lock the medication of when the medication cart is not on direct observation the observed staff and no medication is left on top of medication cart. Findings of this monitoring process will be documented on medication pass observation sheet.	art ct		
	PM with Nurse #5. N 500 Hall medication confirmed the manuf prednisolone acetate medication needed to eye drop bottle had be side in the drawer of	ducted on 3/30/17 at 3:38 Jurse #5 was assigned to the cart. Upon inquiry, Nurse #5 acturer 's labeling on the eye drops indicated the bestored upright, and the been stored lying down on its the med cart. The nurse share this information with r of Nursing (DON).			Medication carts and medication storag areas will be audited by DON, ADON, SDC, QA Nurse and/or Pharmacist duri medication pass competencies weekly weeks and monthly x 3 months for prop storage of medications. Negative finding will be reported on med-pass observations sheet. Pharmacy nurse will also audit a carts and med rooms for proper storage of medications per manufacturer's recommendations monthly.	ng x 4 per gs on		
	current medication o 1% ophthalmic suspons as one drop instilled An interview was cor PM with the DON. Discreported she was toler	#70 's March 2017 ealed the resident had a rder for prednisolone acetate ension eye drops to be given into the right eye twice daily. Inducted on 3/30/17 at 4:50 Furing the interview, the DON d of the prednisolone acetate p stored on its side in the			DON and/or ADON will present the findings of Medication Administration reviews to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 4 months or unt pattern of compliance is achieved. QAF committee will modify this monitoring process as deemed appropriate to assurance continue compliance.	Pl		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345006	B. WING _		03/30/2017	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLET	TION
F 431	these eye drops ned had instructed the n reported a replacem had been ordered fr	e DON stated she was aware eded to be stored upright and urse to discard them. She lent bottle of the eye drops om the pharmacy.	F4			
F 441 SS=D	(a) Infection prevent The facility must est	ion and control program. ablish an infection prevention (IPCP) that must include, at	F 4	41	4/27/17	
	investigating, and communicable disease volunteers, visitors, providing services userrangement based conducted according	upon the facility assessment g to §483.70(e) and following andards (facility assessment				
	for the program, wh limited to: (i) A system of surve possible communication	s, policies, and procedures ich must include, but are not eillance designed to identify able diseases or infections ead to other persons in the				
	communicable diseareported;	om possible incidents of ase or infections should be ansmission-based precautions				
	communicable diseareported;					

	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP		(X3) DATE SURVEY COMPLETED			
		345006	B. WING_		C 03/30/2017	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3724 WIRELESS DRIVE GREENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
F 441	(iv) When and how resident; including (A) The type and depending upon to involved, and (B) A requirement least restrictive positive circumstances. (v) The circumstances or infected contact with residic contact will transmit (vi) The hand hygoby staff involved in (4) A system for required the facility's actions taken by the (e) Linens. Personate process, and transpread of infection (f) Annual review of information of the program, as necental transmit (program, as necental transmit (program, as necental transmit (program, as necental transmit (program)	orevent spread of infections; w isolation should be used for a g but not limited to: duration of the isolation, he infectious agent or organism that the isolation should be the ossible for the resident under the ossible for the resident under the onces under which the facility ployees with a communicable d skin lesions from direct ents or their food, if direct ents or their food, if direct ents or their food, if direct entered in the disease; and diene procedures to be followed in direct resident contact. The facility. The facility will conduct an tes IPCP and update their	F	Resident #1 was effectively sarcoptes scabiei var homir and was placed on Contact	nis on 12/15/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		SURVEY					
		345006	B. WING_				C (20/2047
NAME OF D	ROVIDER OR SUPPLIER	343000	5: :::::0 _		FREET ADDRESS, CITY, STATE, ZIP CODE	03/	30/2017
NAME OF FI	NOVIDER OR SUFFLIER						
BLUMENT	HAL NURSING & REHA	BILITATION CENTER			724 WIRELESS DRIVE		
				G	REENSBORO, NC 27455		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	e 85	F4	141			
	The findings included				have rashes or symptoms of sarcoptes scablel var hominis as a result of cross contamination during this time period.		
	from the hospital. He included dementia. A medical record includ note dated 12/13/16. Resident #2 was seen	n for an itchy rash to chest, The NP indicated a referral			Corrective action will be accomplished those residents having potential to be affected by the same deficient practice facility residents have potential to be affected. all residents have the potential for facility acquired contagious disease and infectious outbreaks and require infection control surveilance.	. All	
	visit on 12/14/16. The from the dermatologisthere was no need to determine scabies. Tresident's clinical proadequate to make this medications were init permethrin cream (as treat parasites and scapply the topical creat jawline down on days upon awakening; and acetonide cream (a topical cream) are view of the resider revealed Resident #2 Precautions 12/15/16	dermatology consultation e "Report of Consultation" st (dated 12/14/16) indicated do a skin scraping to the dermatologist noted the esentation was "more than s diagnosis." Two fated and included: 5% topical medication used to eabies) with instructions to m at bedtime from the 1, 2, and 7 and to wash , 0.1% triamcinolone spical steroidal cream) with the cream topically twice reas as needed for itching.			Measures put into place or systematic changes made to ensure that the deficipractice will not re-occur: All Employees were in-serviced on facipolicy for treating scabies and preventiscabies outbreak on 4/6/17 by the Regional nurse Consultant. Housekeeping staff were In-serviced of 4/19/17 and 4/20/17 for deep cleaning Residents room and belongings to prevent out- break per facility policy by House-keeping/Laundry Supervisor. QAPI nurse, DON and SDC were train on proper way to conduct surveillance, infection control, Ad hoc meeting and monitoring with any contagious outbread by the Regional Nurse Consultant on 4/22/17. QAPI nurse and DON will complete all	lity ng n of the ed	
	An interview was con AM with the facility 's	ducted on 3/30/17 at 10:31 Quality			infection control reports, surveillance trending and monitoring of infections.		

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		345006	B. WING _				C 3 0/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2011
DITIMENT	THAT NUIDEING & DEHAT	DII ITATION CENTED		37	24 WIRELESS DRIVE		
BLUWEN	HAL NURSING & REHA	BILITATION CENTER		G	REENSBORO, NC 27455		
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F 441	Continued From page	e 86	F 4	41			
		Assurance (QI/QA) Nurse			Monitoring Process:		
	QI/QA nurse was reported control responsibilities SDC shared some restraining) with her. Bowere new to the facility QI/QA nurse reported Quality Assessment as reports from Decemb surveillance of infection there were no notes of any residents (includifacility. Upon further stated there was no a available to indicate it facility were diagnose. An interview was confacility 's Director of I inquiry, the DON state for contagious disease.	er 2016 regarding ons. However, she reported of scabies on this report for ng Resident #2) in the inquiry, the QI/QA nurse additional information f any other residents in the ed with scabies. ducted on 3/30/17 with the Nursing (DON). Upon ed her expectation would be uses (such as scabies) to be			DON and QAPI nurse will audit Infectic control schematics reports weekly x 4weeks then monthly x 3 months to assure that any trends or infectious process have been identified and appropriate interventions and surveillar was initiated. Audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee month for 4 months by the QAPI nurse or unti pattern of compliance is achieved. QAF will be modified according to outcomes needed and determined by QAPI committee.	nce nly I	
	reported and followed	d for infection control					
F 456 SS=E	OPERATING CONDI	chanical, electrical, and	F 4	-56			4/27/17
	(e) Resident Rooms Resident rooms must for adequate nursing residents. This REQUIREMENT by:	be designed and equipped care, comfort, and privacy of is not met as evidenced iew, observations, and			Immediate Action		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	
		345006	B. WING			03/5	30/2017
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	30/2017
	HAL NURSING & REHA	BILITATION CENTER		37	724 WIRELESS DRIVE REENSBORO, NC 27455		
	OUR MAR DV OT	ATEMENT OF REFIGIENCIES	I		·		
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F 456	Continued From page	e 87	F 4	456			
	four lift slings used fo working condition.	failed to maintain one of r the sit to stand lift in safe			Resident #185 -Lift pad used on reside during survey was discarded on 3/29/1 by the Assistant Administrator.		
	Findings Included:				Identification of Others		
	stand lift stated that "l or broken slings are u injury. Discard immed sling's attachments ex removed and replace	d, to ensure that it is ore the patient is removed			32 other facility lift pads currently in use were inspected by the Assistant Administrator on 3/29/2017. One other pad was removed and discarded by the Assistant Administrator due to its unfavorable condition caused by wear a tear.	lift e	
	the resident to the ba	A) #1 was observed taking throom on 600 hall via			Systemic Changes		
	the sit to stand lift slin				Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident's individual care plan. Staff also use lift pads in good repair, applies such pads	of	
	connected via circular band that went around not connected and the	r loops to the lift. The waist d the resident's waist was e waist straps were left esident. The resident was			appropriately per manufacturer recommendation for transfer of residen When using mechanical lift, at least 2 person will assists each resident, unles	ts.	
	lifted only with sling s the sitting position to assistance with 1 stat Assistant #1). Reside while the resident was and the resident was	upport under her arms from a standing position with f member (Nursing nt #185's brief was changed s in the standing position			resident's evaluation by healthcare professional documented on resident p of care indicate resident could be transferred by one person assist with mechanical lift, per manufacturer guidelines.		
	Assistant #1). Nursing Assistant #1 at 1:55 PM. She state lift sling was broken, v	was interviewed on 3/29/17 and that the waist belt on the which was why it was not oserved transfer. She stated			100% of nursing staff, to include license nurses and nurse's aides ware in-service on proper use of mechanical lifts, attaching the appropriate lift pads to the lift and ensuring that the minimum of 2 persons are present during a mechanic	ced e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDII	NG _		l .	С
		345006	B. WING _			1	/30/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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BLUMEN	THAL NURSING & REHA	ABILITATION CENTER		G	REENSBORO, NC 27455		
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F 456	the lift sling she user secure the belt to the slip out of the sling. stand lift slings were On 3/29/17 at 2:01 F on the 700 hall. The designed to clasp via end of the sling and the plastic prongs or observed lift sling or waist belt. The 3rd pof the waist belt. The sling waist band woo insertion end with the NA #2 was interview. She stated that she weights in the facility 5 slings for the sit to of any problems with broken, staff would rewould not use it if broken of any proble stated she would exproken that it was not to be reported. She sling in the bathroon	d only had 2 plastic prongs to e lift and the resident would She stated the other sit to being used. PM, the sling was observed sling's waist belt was a three plastic prongs on one three sockets for insertion of a the other end. However, the ally had 2 plastic prongs on the plastic prong was broken off e receiving end of the lift's alld not fit properly in the e broken prong. The don 3/29/17 at 2:36 PM. The obtained the residents' The She stated there were 4 to stand lift and had not known in the lift slings. If a sling was report it, put it away and	F	456	lift transfer, unless the plan of care star otherwise, removing any pads that wer broken, frayed or in poor condition out circulation and notifying central supply and/or nurse administrative staff (DON ADON, QA nurse, supervisor, and/or Sidevelopment coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revithe care card with any changes in treatment plan. Nursing aides ware educated on how to access, the care cards and how to obtain information frosuch. This education provided by Director of Nursing (DON), Assistant Director (ADON) of Nursing or Staff Developme Coordinator (SDC). This educated wa initiated on 4-6-2017 for all nursing stainclude full time, part time, and as need employees. This education will be completed by 4/27/2017, any staff not educated by 4/27/2017 will not be allowed to work unequality to the ducated. This education was also added to new hire process for all new employees effective 4/27/17 and also we may be a supplementation of the staff of the supplementation of the s	re of I, Staff e e rise om ent s iff to ded	
	Nursing Assistant #3 at 9:48 AM. She stat was broken she wou She stated that abou	B was interviewed on 3/30/17 ted that if she saw a sling that all not use it and report it.			be provided annually. Monitoring Process: Effective 4/27/2017, central supplies of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE	SURVEY
		245000	B. WING				С
		345006	B. WING			03/	30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE GREENSBORO, NC 27455		
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F 456	but she never used the were several other sline. The DON was intervied PM. She stated she was a several but she was a several to the several but she was a	snapped around the waist, nat sling and said that there ngs to use. ewed on 3/30/17 on 6:07 would expect that the nursing I use safe equipment for		456 520	or Quality Assurance nurse will inspect condition of slings in the facility to determine functionality. Any sling noted unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance nurse or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee any additional monitoring needs or modifications of this requirement.	d in	4/27/17
SS=F	COMMITTEE-MEMBI QUARTERLY/PLANS (g) Quality assessme (1) A facility must mai and assurance comminimum of: (i) The director of nurse (ii) The Medical Direct (iii) At least three others staff, at least one of wadministrator, owner, individual in a leaders (g)(2) The quality assecommittee must: (i) Meet at least quart coordinate and evaluate (g)	erly and as needed to		5520			4/2////

PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		345006	B. WING			03/:	30/2017
	ROVIDER OR SUPPLIER	BILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE BREENSBORO, NC 27455	1 00/	50/2517
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F 520	action to correct identify (h) Disclosure of informode secretary may not records of such commode such disclosure is released to committee with section. (i) Sanctions. Good factor committee to identify deficiencies will not be sanctions. This REQUIREMENT by: Based on observation interviews, the facility Assurance Committee procedures and monicommittee put into plator five (5) recited deficited in May 26, 2016 survey and on the curcomplaint survey. The of housekeeping and Data Set accuracy, so Services. The continue during two surveys show the survey shows the survey show the survey shows the survey show the surv	ement appropriate plans of tified quality deficiencies; rmation. A State or the quire disclosure of the mittee except in so far as ated to the compliance of the requirements of this was ated as a basis for is not met as evidenced ans, record reviews and staff as Quality Assessment and the failed to maintain tor the interventions that the face on May 2016. This was ficiency, which was originally a during a recertification and the deficiency was in the area maintenance, Minimum sufficient staffing, and dietary used failure of the facility nowed a pattern of the listain an effective Quality gram.	F	520	F520 The quality assurance and performance improvement committee approved the following plan to resolve alleged non compliance for identified residents immediately. The white towel that appears to be saturated with red spots removed from resident #40 room by Housekeeping/Laundry supervisor on 3/28/2017 and discarded in biohazard Resident #40s bathroom has been cleaned and disinfected by the House keeping supervisor on 3/28/17, red/bro spots removed from bathroom floor. 200 Hall Room 213 Blinds replaced by the maintenance supervisor and or assista maintenance supervisor on 3/31/2017	bin. wn	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345006	B. WING _				30/2017
	ROVIDER OR SUPPLIER HAL NURSING & REHA	BILITATION CENTER		37	TREET ADDRESS, CITY, STATE, ZIP CODE 724 WIRELESS DRIVE REENSBORO, NC 27455		
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F 520	facility staff interviews and disinfect a reside observation was mad spots on the floor for (for Resident #40) ob substance in the bath maintain housekeepin services provide clea clean toilets in reside maintained, safe and 7 residents halls. (Ha and Hall 700) F 278 Based on recounts facility failed to accide diagnosis of myoclon Set (MDS) assessme received Hospice ser (Resident #214). F 353 Based on recounts facility failed to provide quantity and quality to accident for resident This affected (2) out to 22 and Resident # 18 F 371 Based on obsetthe facility failed to enwere stored in sealed clean, in good repair equipment and ceiling employee 's with facility while working in the key substance of the sealed while working in the key substance of the sealed clean, in good repair equipment and ceiling employee 's with facility working in the key substance of the sealed while working in the key substance of the sealed clean, in good repair equipment and ceiling employee 's with facility working in the key substance of the sealed control of the sealed clean, in good repair equipment and ceiling employee 's with facility working in the key substance of the sealed clean, in good repair equipment and ceiling employee 's with facility working in the key substance of the sealed clean in good repair equipment and ceiling employee is with facility	ervations, record review, and s, the facility failed to clean ent's bathroom floor after an le of red/brown smears and 1 of 1 resident bathrooms served to have a red/brown aroom and facility failed to an and maintenance in resident's rooms and int's bathroom and proved a comfortable interior on 4 of ill 200, Hall 500, Hall 600. The review and staff interview courately code the active ic jerk on the Minimum Data ent for 1 of 2 residents who evices within the facility. The review, interviews with interview and observation the de staffing of sufficient to provide pressure sore and who required assistance. Of 40 residents (Resident # 85) Ervations and staff interviews in sure opened food products in containers, dishware were and allowed to air dry, govents were clean and male ial hair wore beard guards	F	520	500 Hall Room 502 Wall Paper removed by the maintenance supervisor and or assistar maintenance supervisor on 3/31/2017. Room 503 White patch painted, back or bathroom door repaired and dripping faucet repaired by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 504 Wall Paper removed, corner behind bed A painted and door has been cleaned by maintenance supervisor on 3/31/2017. Room 506 Bathroom and bathroom doof frame has been repainted, Drawer undown TV has been properly repaired, Wall Paper has been removed and door sanded and re-stained by the maintenance supervisor and or assistant maintenance supervisor on 3/31/2017. Room 600 Hall Room 601 Wall Paper removed and flomolding in bathroom repaired by maintenance supervisor and or assistant maintenance supervisor on 04/04/2017. Room 603 Wall by drawers have been painted, door frame near bathroom has been painted and faucet has been repaired (tighten and dripping fixed) by maintenance supervisor and or assistant maintenance supervisor on 04/06/2017	f ce ren d or er nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345006	B. WING _				C / 30/2017	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2017	
	10 1.52.1 011 00. 1 2.2.1				724 WIRELESS DRIVE			
BLUMENT	HAL NURSING & REHA	ABILITATION CENTER			GREENSBORO, NC 27455			
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F 520	Continued From pag	ge 92	F t	520				
	F 456 Based on reco	ord review, observations, and			Room 604 Bathroom door frame			
		y failed to maintain one of			repainted, Drawer handle under TV			
		or the sit to stand lift in safe			repaired and area under dresser and			
	working condition.				closet cleaned by the maintenance			
	J				supervisor and or assistant maintenand	ce		
		ites in May 2016 during the when the facility failed to			supervisor on 04/04/2017.			
	•	ing and maintenance			Hall 700			
	-	sident's room and bathroom.			Room 720 Night stand replaced and 6			
		code the Minimum Data Set			holes in bathroom repaired by			
	· ·	flect a resident unnecessary			maintenance supervisor and or assista	nt		
		ed to provide staffing of			maintenance supervisor on 04/06/2017			
	sufficient quantity an							
		pileting, nail care, and snack			Room 716 Room wall has been repaire	ed		
		uired assist with Activities of			and painted by maintenance superviso			
	•	The facility failed to remove			and or assistant maintenance supervis			
		aintain a clean kitchen. The			on 04/06/2017.			
	facility failed to main	tain floor, baseboards and a						
	sink in clean, workin	g condition in the kitchen.			Room 709 Bathroom floor around toiled cleaned and stains removed by	t		
	The Quality Assessn	nent Assurance Nurse was			Housekeeping and Laundry supervisor	on		
	interview on March 3	30/ 2017 at 5:50 PM. She			04/06/2017.			
	stated she had only	been here since January,						
	2017. She stated the	ey have done multiple			Room 711 Hole in bathroom wall repair	red		
	in-services on hand	washing lately on hand			and painted by maintenance superviso	r		
	washing and blood s	spills. Staffing is discussed			and or assistant maintenance supervis	or		
		g the morning meeting. She			on 04/06/2017			
		some equipment that was						
	•	ne last 2 months it had been			Room 702 Door sanded and repaired b	-		
		them fixed (stove, ice			maintenance supervisor and/or assista			
		akers, air conditioning units.) She would expect at if there are QA issues that they would be			maintenance supervisor on 04/06/2017	,		
	fixed.				Room 708 Residents bathroom walls a	ınd		
					floor cleaned by Housekeeping and			
	The Director of Nurs	ing was interviewed on			Laundry supervisor on 04/06/2017			
		6:07 PM. She would expect						
		uld check and only use safe			Room 706 Door sanded and repaired b	-		
		resident. She stated that she to identify areas of concern			maintenance supervisor and or assista maintenance supervisor on 04/06/2017			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	NSTRUCTION (X3) DATE SURV COMPLETED		Y
		345006	B. WING _		_	C 03/30/201	17
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, S 3724 WIRELESS DRIVE GREENSBORO, NC 27-		00/00/20	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	E COMP	X5) PLETION ATE
F 520	Continued From pagand follow up with a		F5	F 278 Step Minimuresident #214 date modified/corrected 3/30/2017, to including diagnosis of a myo Modified assessment and accepted in C 3/30/2017 F353: Resident #2 resident #263 care below rendered on under by the nursing competencies and those nursing and assure resident saprovided based on and individual plan Resident #22: Trephysician order by 3/29/2017. Wound Regional Nurse Cotreatment nurse or deterioration in the treatment nurse as 3/27/2017. Treatmappropriate for wo showed improvem assessments. Performance improvem implemented for who was responsible treatment on 3/25/during day shift (7/ was put forth by th 4/6/2017. Resident #185 -Life	de in section I of MD pelonic jerk diagnosis ent was re-transmitted MS data base on e. 22, resident #185, and e. and services explain a stated dates here and services to related services to related services to resident assessment of care. The eatment rendered per a treatment nurse of diagnosis was assessed by the consultant #2 and an 3/30/2017. No expend was assessed by the consultant #2 and an another than the expension of the	on os a sed of one of one	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345006	B. WING _			C 03/30/2017
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 3724 WIRELESS DRIVE GREENSBORO, NC 27455	ZIP CODE	03/30/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE.
F 520	Continued From page	ge 94	F	Resident #263 fall mat the bed, a bed and cha put in place per resider quality assurance nurse Resident scare card was reflect the use of floor ralarm by the Quality As 3/31/2017 as well. F371: The open and unsealed fillets and sausage in the and unsealed box of rice storage room ware disconditional process of the storage and worm a beaway. The ceiling vent in the storage cart that condition area was confidust on 3/27/2017 by the storage cart that conditional process of the storage cart that conditio	air alarm was also at care plan by the en 3/31/2017. Was updated to mat, bed and chassurance on a case of Okra, for exalk-in freeze to in the dry carded by the 27/2017. Facial hair who was ard on while he for the lunch mean of the lunch mean of the property beard guard rite abeverage aleaned and is free y Dietary Managontained clean and 3/27/2017 was mager on a dark staining, etal edges ware of by Dietary bistered Dietician and the dietal edges ware of the lunch mean of the dietal edges ware	one air fish er, vas al ee ler. dd

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED			
		345006	B. WING			1	30/2017
	ROVIDER OR SUPPLIER			3724 WI	ADDRESS, CITY, STATE, ZIP CODE IRELESS DRIVE NSBORO, NC 27455	1 03/	30/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From pag	e 95	F	fror disk on Residur by Ide 100 lass the 4/2 cital def cor 100 to it hou or the by on hou blo 100 fac sup 4/2 roo ide	m air drying on 3/29/2017 removed m being a surface used to air dry hes in the facility by Dietary Manage 3/29/2017. sident #185 -Lift pad used on residering survey was discarded on 3/29/1 the Assistant Administrator. Intification of Others: O'w audit of all cited deficiencies for at 2 years, 2016 and 2017 completed Regional Clinical Consultant #2 on 25/2017 to identify if any other repeatation is noted, other than the identification during this survey. No other citeficiencies noted as a repeated non impliance. O'w audit of all resident rooms audited dentify any other room with usekeeping needs to include any bloody fluids. This audit was complete housekeeping and laundry supervis 3/28/17. No other rooms noted with use keeping needs such as cleaning od or body fluids. O'w audits of all resident rooms in the illity conducted by the Maintenance previsor and/or assistant maintenance previsor and/or assistant maintenance of the conducted by the resident rooms in the illity conducted by the Maintenance of the conducted by t	the ded ed ed or e ce t rns;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345006	B. WING			C 03/30/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 3724 WIRELESS DRIVE GREENSBORO, NC 27458		03/30/2017	
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F 520	Continued From pag	e 96	F	replaced the blinds of identified rooms on 4 and 4/21/2017. 2. Missing Wall paper and/or not in a good rooms identified not the Maintenance superviser maintenance superviser removed and/or replated 158 identified room and to be completed room not repaired by removed out of services. 3. Wall Repair, Door molding, Door frames rooms identified to be more repair of identification. Maintenance assistant maintenance assistant maintenance assistant maintenance assistant maintenance assistant maintenance assistant maintenance. 4.Resident Bathroom leaking faucet(s), bathed and paints. 26 other repaired. 4.Resident Bathroom leaking faucet (s), bathed and paints. 26 other repaired. 4.Resident Bathroom noted with needs. Maintenance assistant maintenance assistant maintenance assistant maintenance repaired, all identified rooms started on 4/6/2012 bathroom not repaired be removed out of see	ar, torn wall paper, repair; 58 other to be in a good repairs or and/or assistant isor repaired, aced wall papers on as started on 4/6/201 by 4/27/2017 will be ce until repaired. Repair, Floor spainting; 36 other in need of one or fied areas mentioner supervisor and/or ce supervisor and/or ce supervisor oved all identified oms started on ompleted by a not repaired by noved out of services throom floor, walls, residents' has maintenance supervisor and/or ce supervisor dareas in 26 noted 1/2017 and to be 1/2017 will	t 17 d	

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F 520	REGULATORY OR LSC IDENTIFYING INFORMATION)		F 5	5. Condition of residents: other furniture noted with needs. Maintenance sup- assistant maintenance su- repaired all identified furr rooms on 4/6/2017, 4/7/2 F278: 100% audit comple and 4/22/2017 of all activ the most recent MDS ass conducted by Regional M #1, Regional MDS consu- Nurse #1, MDS Nurse #2 Nurse #3 to ensure all ac- were coded appropriately MDS. 19 Other resident inaccurate coding in sect Modifications/corrections Minimum Data Set as inc. Resident Assessment Ins guidelines on 4/22/2017 MDS Nurse #1, MDS Nur MDS Nurse #3. F353: Facility staffing pat by the Regional nurse co the Assistant Administrat- to determine opportunitie	5. Condition of residents □' furniture; 9 other furniture noted with maintenance needs. Maintenance supervisor and/or assistant maintenance supervisor repaired all identified furniture in 9 note rooms on 4/6/2017, 4/7/2017 & 4/8/201 F278: 100% audit completed on 4/21/1 and 4/22/2017 of all active residents for the most recent MDS assessment was conducted by Regional MDS consultan #1, Regional MDS consultan #2, MDS Nurse #1, MDS Nurse #2 and/or MDS Nurse #3 to ensure all active diagnoses were coded appropriately in section I of MDS. 19 Other residents noted with inaccurate coding in section I. Modifications/corrections were done to Minimum Data Set as indicated per Resident Assessment Instrument (RAI) guidelines on 4/22/2017 to 4/27/2017 bd MDS Nurse #1, MDS Nurse #2 and/or	
				resident s individual need identified opportunities for including lack of enforcer attendance policy, employ protocol as well as lack of schedule to cover when a employee is unable to refersure continuous quality.	eds. This audit or improvement ment on oyee call out on on-call another nursing port to work, to	t,

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F 520	Continued From pag	e 98	F	sufficient nursi 100% audit of wound care or Regional nurse treatment nursi orders matche administration as well as the completion of s resident □s recisions and by Gertifie facility on 4/21 were noted to previous docur 32 other facility were inspected Administrator of pad was remon Assistant Adm unfavorable con tear. 100% audit of residents comp 4/26/2017 & 4/ Nurse consulta intervention put and communica appropriately documented o No functional of communication communication communication communication	f all active resident □s with orders completed by the electron Consultant #2, and the set to ensure that Physicial and the treatment records record on 4/12/documentation for such orders are noted in cord per order and to incl	ans 117, lude ure urse er rs heir e and ive and y nted s oool.		

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F 520	Continued From page	ge 99	F 52	to be implemented by nurse saide had potential to affected by this alleged not compliance F371 100% audit of all food storage areas inspected by dietary Manager and/or Registered Dietician 3/27/2017 to iden any other open item that is unsealed and/or not sored appropriately. No other items identified as being inappropriately stored. 100% of dietary staff working on duty of 3/27/2017, re-educated by the Dietary manager on the importance of wearing hair cover and/or beard guard while preparing resident smeals. All other employees noted to have hair cover and/or beard guard while preparing residents meal on 3/27/2017 100% inspection of all ceiling vents in kitchen audited by Dietary Manager and/or Registered Dietician on 3/27/2017 to identify its cleanliness. No other ceiling vent in the Kitchen noted be unclean or with dust. 100% inspection of all storage carts completed on 3/27/2017 by the Dietary Manager and/or Registered Dietician to identify any other cart that needs to be cleaned and sanitized. No other dietary storage cart noted to be unclean 100% inspection of all meal trays completed by the dietary Manager and Registered Dietician on 3/29/2017, 7 of meal trays noted with cracks and/or exposed metal edges. Those seven traware discarded immediately by the Dietary Manager and/or Registered Dietician.	ttify er ly on g tthe o to y o e y d/or other ays			

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F 520	Continued From page	ge 100	F5	100% of all resident me plates, cups, glasses, sy rewashed on 3/29/2017 to ensure cleanliness ar being, dish wares allow other dishware noted to 100% inspection of all sy dish ware air drying production of all sy dish ware air drying production on 3/29/2017 to surface can potentially of process. All other storage identifies as being capad dishes to air dry with no F456 and the storage identifies as being capad dishes to air dry with no F456 and the storage inspected by the Antificial Administrator on 3/29/20 pad was removed and control of the storage in t	poon and forks by Dietary aide and sanitation. Af ed to air dry, no be unclean. surfaces used fo cess inspected to ensure no oth obstruct air drying ge surfaces ble of allowing obstruction. currently in use assistant 017. One other discarded by the due to its aused by wear a expected the revised rmance the test of the community to another and usly cited to n put in place is the QAPI committe the to sanitation.	s fter r by her ng lift and at	

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F 520	Continued From pag	e 101	F 52	deemed appropriate to ensure that if facility remains in substantial complication of the complete state of the	ouse n room by the work station n be t hese / d that t cacted ng and nal l of ody and/or ation ve

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F 520	Continued From page	e 102	F 5	include full time, part timemployees. This educated by 4/27/201 keeping/Laundry staff r 4/27/2017 will not be all educated. This education new hire process for keeping/laundry employ 4/27/17 and also will be 100% of active facility educated on the new morequest log and Proced maintenance needs by (DON), Assistant Direct Nursing or Staff Develot (SDC). This education 4-6-2017 for all active educated by 4/27/201 educated by 4/	ation will be 7, any house not educated by llowed to work u on was also add all new house yees effective e provided annua employees will b naintenance dure to request a Director of Nurse tor (ADON) of opment Coordina was initiated on employees to me, and as need ation will be 7, any staff not will not be allow This education of hire process for we 4/27/17 and v 017, MDS nurse MDS nurse #3 w s diagnosis, Doctor, a nurse an assistant, in the essment reference e of this review is physician ost recent history e summaries, an	ntil led ally. ee any sing ator ded r all vill #1, ill	

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F 520	Continued From pag	e 103	F 5	medication and/or treatment is with a date falls in the last 60 ARD. Once a diagnosis is ided documented in the last 60 day Nurse #1, MDS nurse #2 and/nurse #3 will determine if the active. (Active diagnosis are thaffect the resident is function of care during the last 7 days, diagnosis except, Item I2300 Infection (UTI), which has specriteria and does not use the alook back period). MDS nurse code the diagnosis in section resident is MDS assessment criterion above are met. UTI with by MDS nurse #1, #2, and/or determined to be active based guidelines for UTI assessment coding. Effective 4/27/17 prior to submit MDS Nurse #1, #2, and or #3 Nurse #2 (Whomever is not sisection I, on the assessment) completed MDS assessment accurate coding of diagnosis in per RAI guidelines. Any assessment with inaccurate coding in Modifications/corrections will be Minimum Data Set as indicated guidelines promptly by MDS Nand or #3. MDS nurse #1, MDS 2 and/or re-educated by MDS Consultated proper ways of coding MDS aspecifically section I on 4/6/20	days of ntified as ys, MDS /or MDS diagnosis hose that ing or plar, for all Urinary Trecific codir active 7-dae will then I of that when the will be cod #3 when don RAI and mission, and/or MI igning off will review to ensure in Section be done to de per RAI Nurse #1, and #3 ant #1 on assessment in sessment in section be done to the per RAI Nurse #1, and #3 ant #1 on assessment in sessment in section be done to the per RAI Nurse #1, and #3 ant #1 on assessment in sessment in sessment in section be done to the per RAI Nurse #1, and #3 ant #1 on assessment in sessment in sessment in sessment in section be done to the per RAI Nurse #1, and #3 ant #1 on assessment in sessment in sessmen	is n ract ng ay led DS w I I, 0 I #2,		

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F 520	Continued From page	e 104	F 5	education is also added to new process for all MDS nurses 4/2 also will be provided annually. F353: Effective 4/27/2017, open pos classification of nursing staff, I nurses, Licensed Practical Nu nursing aides will be posted or worldwide staffing advertiseme for easier attraction of new him such needs arise, the Human will coordinate the posting of spositions. Effective 4/27/2017 Human redepartment will conduct job fa once quarterly for recruiting st incentive program that aide of recruitments put in place effect 4/27/2017. Facility will utilize as the last resort to ensure sur number is staff is maintained effective 4/27/2017 Effective 4/27/2017, any call-inemployee unable to report to vany nursing staff will be report Director of nursing and to the scoordinator so replacement cafor call ins to assure adequate maintained to meet the need or resident. Each employee is excontact the facility at the minin hours before the beginning of will be unable to come to work Nursing will oversee the assur sufficient staff in the facility. Effective 4/27/2017, staff devective 4/27/2017, staff de	cition for all Registere crises and/on a cent websites. When Resource could at least caff. New course agency stafficient effective agency staffing an be made staffing an be made staffing an be made staffing in the course of th	II door tes es e	

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F 520	Continued From pag	e 105	F	services to as attain or main physical, men well-being of determined be individual plateffective 4/27 treatment is in On- coming in records for or cart form prevalues will not are complete. 100% of licer facility ware in treatment or physician orderequency or each residen record. This ewhat to do whice it is education. This education will any licensed 4/27/2017 will educated. Tadded to new	7/2017, each resident rendered per physician orchurse will check treatment missions prior to accepting vious shift nurse. On-combit accept cart until treatment ad or reconciled. Insed nurses employed by re-educated on ensuring ders are rendered per der, completed on the dered and documented on the treatment administration education also covered on hen a pressure ulcer is didocumentation for reside heir wound care treatment on provided by Director of N), Assistant Director lursing or Staff Developme (SDC). This educated was 6-2017 for all licensed to include full time, part tired employees. This libe completed by 4/27/20 nursing staff not educated within the difference of the process for all new see effective 4/27/17 and a see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new see effective 4/27/17 and a second or the process for all new second or the	nd der. g ning nts the n n ents to ent s me, d by intil	

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F 520	Continued From page	e 106	F	520	Effective 4/27/2017, nursing assistants has been utilizing appropriate number of staff during transfers per resident individual care plan. Staff also use lift pads in good repair, applies such pads appropriately per manufacturer recommendation for transfer of resident when using mechanical lift, at least 2 person will assists each resident, unless resident sevaluation by healthcare professional documented on resident professional lift, per manufacturer guidelines. Effectively 4/27/2017; Resident Card Cards were initiated as a communication tool to alert nurse aides of appropriate method to transfer each resident togeth with minimum number of staff required the Activity of daily Living (ADL), specifically transfer to take place. Card Cards also include other information about each resident that deemed necessary for individual resident care rendered by nurse aides. This included but not limited to fall interventions such bed in low position, fall mat on floor and Chair/bed alarm. Three ring binders title Care Cards places at each nurse station for easy access by the nurse station	of ints. essolan econ ete her for de as d/or ed			

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F 520	Continued From pag	e 107	F		100% active residents in facility were re-assessed for individualized care need. This re-assessment was completed on 4/25/2017, 4/26/2017 & 4/27/2017 by the Regional Nurse consultant #1, Director nursing and/or Assistant Director of nursing. Appropriate intervention was prince in place and added to each resident scare card. Effective 4/27/2017 Care cards will be initiated on admission by the admitting nurse and updated at least quarterly arwith any change in treatment plan, relatoresident direct care and safety, by the hall nurses and/or interdisciplinary care plan team. Interventions to be card out by nursing aides will be added to be part of each resident care cards. 100% of nursing staff, to include licensonurses and nurse aides ware in-serviced on proper use of mechanicalifts, attaching the appropriate lift pads the lift and ensuring that the minimum opersons are present during a mechanicalift transfer, unless the plan of care state otherwise, removing any pads that were broken, frayed or in poor condition out circulation and notifying central supply and/or nurse administrative staff (DON ADON, QA nurse, supervisor, and/or Sevelopment coordinator) so that replacements could be ordered. This education also covered the use of care cards as the communication tool. Licensed nurses ware educated on the use of such cards and how to initiate a new card on admission and how to revithe care card with any changes in treatment plan. Nursing aides ware	ne of out nd ted c ried e ed al to of 2 cal ees e of , taff	

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F 520	Continued From pag	e 108	F 5	educated on how to access, the cards and how to obtain inform such. This education provided by Din Nursing (DON), Assistant Direction (ADON) of Nursing or Staff Decoordinator (SDC). This educinitiated on 4-6-2017 for all nursing full time, part time, and employees. This education we completed by 4/27/2017, any educated by 4/27/2017 will not to work until educated. This was also added to new hire part new employees effective 4/27 will be provided annually. F371 Effective 4/27/2017 A new Manager was hired and trained oversee dietary services, sand storage and employee practice compliance. Root cause of succompliances concluded to be and managerial supervision. Effective 4/27/2017, A cook of designated to work as a Kitch supervisor on duty. On the abdietary manager, the cook on oversee kitchen sanitation, proof foods, ensuring dish wares to air dry, cleanness of dishwares are removed out of circ immediately. 100% of dietary employees, to cooks and dietary aides ware	mation from the mation from the mation from the mation from the mation and the mation and the mation and the mation are mation are mation are mation and the mation are mation	nt if to ed all lso / od ure d ing the age ed ed

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F 520	Continued From p	page 109	F 52	on proper storage of food in a storing location to include but to freezer, Walk-in refrigerator refrigerator and dry storage for use of beard guards & hair compreparing residents ☐ food, procleaning of the ceiling vents a proper way to clean storage of trays. This re-education also demphasized on proper technic and store plates and glasses drying as well as how to ident trays for disposal, and notifying Manager so that replacement ordered. This education provious Dietary Manager and/or Regist Dietician. This educated was 3/27/2017 for all dietary staff time, part time, and as needed employees. This education work completed by 4/27/2017, any not educated by 4/27/2017, any n	not limited r, reach in rod, proper over while oper and the earts for meal covered and que to clean to allow air ify damaged ng Dietary s could be ded by stered initiated on to include full d rill be dietary staff ll not be d. This new hire s effective ded annually. assistants number of dent s o use lift uch pads er of residents. t least 2 ent, unless hcare resident plan		

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F 520	Continued From pag	e 110	F 5	transferred by one person as mechanical lift, per manufact guidelines. 100% of nursing staff, to incomurses and nurse s aides was on proper use of mechanica attaching the appropriate lift lift and ensuring that the mir persons are present during a lift transfer, unless the plant otherwise, removing any part broken, frayed or in poor coldicirculation and notifying centand/or nurse administrative ADON, QA nurse, supervisor development coordinator) so replacements could be ordereducation also covered the coards as the communication Licensed nurses ware educated use of such cards and how the new card on admission and the care card with any change treatment plan. Nursing aided educated on how to obtain information. This education provided by Nursing (DON), Assistant Discondinator (SDC). This education for such. This education provided by Incomplete the coordinator (SDC). This education for such. This education will be complete the complete t	cturer clude license are in-service lifts, at pads to the inmum of 2 are stated of care stated streat supply staff (DON or, and/or So that ered. This use of care in tool. atted on the to initiate a how to reviges in es ware attended on the care or mation from the care of the care or mation from the care of the care or mation from the care of the care o	ced e cal des e of , dataff ise		

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NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		3/30/2017
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F 520	Continued From page	e 111	F 52	4/27/2017 will not be allowed to we ducated. This education was all added to new hire process for all employees effective 4/27/17 and abe provided annually. Regional Clinical Director #1 re-end the Quality Assurance committee revised process necessary to ider quality deficiencies in the facility at to establish plans to ensure such non-compliance will not re-occur. re-education was rendered on 4/2 to The Administrator, Director of N Quality Assurance nurse, Social staffing clerk, who is also a certification ursing aide and Central supply come of the educated QAPI commembers. Monitoring Process: Effective 4/27/2017, the administre monitor the compliance of the quality assurance committee incorporation cited deficiencies in a QAPI meeting monthly from one annual survey the another and review the areas precited to ensure the plan of action place is accurately followed. This monitoring process will be dome in x 6 months or until the pattern of compliance is maintained. Effective 4/27/17 Director of nursing Assistant Director of Nursing, and Maintenance supervisor will review maintenance request books week	ducated on the ntify and how This 25/2017 Nursing, services, s, led clerk was mittee rator will ality on of all ing to viously put in monthly ing, 1/or w the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	03/30/2017
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F 520	Continued From pag	ge 112	F 52	weeks, then monthly x 3 months on a halls to assure service requests had followed up appropriately. Effective 4/27/17 Housekeeping supervisor will complete environment Infection control audits weekly x 4 we then monthly x 3 months on all halls assure floors and surfaces are cleane properly. Results of audits will be reported to Quality assurance performance improvement committee meeting mox 4 months by the Housekeeping/laur supervisor, or until pattern of complia is achieved. QAPI committee will modify this plan as deemed appropria ensure continuous compliance. Maintenance supervisor and/or Administrator will review maintenance work books to ensure compliance with work orders. This review will be completed weekly x 4 weeks, then monthly x 3 months or until the pattern compliance is maintained. Findings of monitoring process will be reported to facility quality assurance and perform improvement committee monthly x 3 months or until pattern of compliance achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. F278: Effective 4/17/17 MDS Section reviews will take place Monday throu Friday for 4 weeks on all completed Massessments, 50% of all completed Massessments.	tal seks, to ed onthly ndry nce ate to e h on of of this onance is d I gh MDS

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F 520	Continued From page	÷ 113	F 5	assessments weekly for 4 wee 25% of all completed MDS ass weekly x 4 weeks or until compachieved by MDS nurse #1, #2 MDS nurse #3 will present the this audit to the Quality Assura Performance Improvement (Quality Performance Improvement Improveme	sessments pliance is 2, and or # 2, and/or 2, findings of ance and API) months or achieved. ording to ermined by fficient urs and cussed in a ay thru pervisor or ing pattern ensure er of staff to iffied g process unsure not affected by for 2 n monthly if gs noted wing g and/or th port finding Assurance ommittee Iditional ions of this	esa. of d. x viill ne s	

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F 520	Continued From page	e 114	F5	for the week to ensure fa sufficient nursing staffing need of resident based or minimum hours per paties requirements. This review weekly x 12 weeks, then months. Any negative fin be addressed promptly. Socordinator, Director of Nassistant administrator woof this audit to facility Quent Performance Improveme monthly x 6 months for a monitoring needs or modiplan. Effectively 4/27/2017; Director of Nurselevelopment Coordinator Assurance nurse will audit records daily (Monday Frederich and signed for physician. This review with for 2 weeks, weekly x 4 wonthly x 3 months. Any noted will be addressed passurance nurse will repeated in the facility Quality As Performance Improveme monthly x 4 months for a monitoring needs or modiplan. Effective 4/27/2017, residually, and by the week weeks and by the cointerdisciplinary team daired priday), and by the weeks and by th	to meet the on determined and day (PPD) will take place monthly x 3 dings noted wistaffing dursing and/or will report findinality Assurance and Committee my additional diffications of the first all treatment and/or Quality and the nurse in-chargeds on (Saturdate) and the nurse in-chargeds on (Saturdate) have been as ordered by the deep have been as ordered by the place of weeks, then an engative findings of the surance and Committee my additional diffications of the dent care carded linical dily (Monday three).	the gs e is ng, y tts e ay y ailly ngs lity this is s	

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F 520 C	Continued From page	ge 115	F	or nurse in Sundays), accuracy a consist of ADON, Quand/or ME daily (Morthen week months. A be address interdiscip Assurance facility Qual Improvem additional modification. Effectively Assistant developm. Assurance admission thru Friday or nurse in admits on ensure the completed take place weeks the monthly x noted will nurse will Assurance Committee needs or requirement.	n-charge on (Saturday & to ensure its presence and as appropriate. This team will but not limited to the DON, A Nurse, SDC, MDS#1, MDS DS#3. , this review will take proday thru Friday) for 4 weeks kly x 4 weeks, then monthly x any negative findings noted weeks by the member of the oblinary team promptly. Qualities nurse will report findings to ality Assurance Performance arent Committee for any monitoring needs or ons of this requirement. If 4/27/2017; Director of nursing Director of Nursing, Staff ent Coordinator and/or Qualities nurse will audit all new in for previous day, daily (Mondy) and the week-end supervising-charge will audit all new (Saturday & Sundays), to at resident care cards are did and accurate, this review were daily (Monday thru Friday) for weekly x 4 weeks, then 3 months. Any negative findings to facility Qualities and the proport findings to facility Qualities and the proport findings to facility Qualities and the proport findings to facility Qualities and proport findings to f	t#2, lace 3 vill y ty day sor ill for 4 ings I dity		

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NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER			1	STREET ADDRESS, CITY, STA 3724 WIRELESS DRIVE GREENSBORO, NC 2748		33/33/2311	
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F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	condition of slings in determine functional unfavorable condition from circulation prorion will be ordered. Qual Central supplies Cles of this audit to facility Performance Improvany additional monity modifications of this. F371 Effective 4/27/Dietician, Dietary Macook, and or designation monitor compliance storage all food stor include but not limited refrigerator, reach in storage food, proper & hair cover while phood, proper cleaning and the proper way for meal trays. This assure proper technistore plates & glassing as well as monitoring for disposal. Effective 4/27/2017, process will be accompliance will be documentation. Sanitation Checklist then 3 times a week weekly times 12 week weekly times 10 weekly times 12 weekly tim	lity. Any sling noted on will be removed mptly and new sling ality Assurance or erk will report finding by Quality Assurance wement Committee toring needs or requirement. In the Register anager, designated ated dietary aide with proper food ing locations, to ed to freezer, Walk-narefrigerator and draws of beard guard reparing residents of the ceiling ventoclean storage cannonitoring will also nique to clean and es to allow air drying any damaged tray of the ceiling ventoclean and es to allow air drying any damaged tray of the ceiling ventoclean and es to allow air drying any damaged tray of the ceiling ventoclean and es to allow air drying any damaged tray of the ceiling ventoclean and es to allow air drying any damaged tray of the ceiling and the ceiling the cei	gs er for ed II in y ds ets ets ets ets ets ets ets ets ets et	

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F 520	Continued From page	• 117	F5	520	of this audit to facility Quality Assurance Performance Improvement Committee any additional monitoring needs or modifications of this requirement month x 6 months, F456: Effective 4/27/2017, central supplies cloor Quality Assurance nurse will inspect condition of slings in the facility to determine functionality. Any sling noted unfavorable condition will be removed from circulation promptly and new sling will be ordered. Quality Assurance nurse or Central supplies Clerk will report findings of this audit to facility Quality Assurance Performance Improvement Committee any additional monitoring needs or modifications of this requirement.	for hly erk the d in		