GREENDA (X4) ID PREFIX TAG	ROVIDER OR SUPPLIER	345366	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C		
GREENDA (X4) ID PREFIX TAG			B. WING		0	9/01/2022	
(X4) ID PREFIX TAG	LE FOREST NURSING		-	STREET ADDRESS, CITY, STATE, ZIP CODE			
PRÉFIX TAG		AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580			
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
F 000	investigation survey v through 9/1/2022. The compliance with the r	equirement CFR 483.73, ness. Event ID # 65O611.	F 000				
	survey was conducte 9/1/2022. Event ID# 6	complaint investigation d from 8/29/2022 through 55O611. The following ated: NC00190528 and					
F 550 SS=D	Two of 4 complaint al resulting in a deficien Resident Rights/Exer CFR(s): 483.10(a)(1)	cise of Rights	F 550	)		10/4/22	
	self-determination, ar access to persons an	ght to a dignified existence, nd communication with and					
	with respect and dign resident in a manner promotes maintenance	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and					
	access to quality care severity of condition,	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and					

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/06/2022 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345366	B. WING				C /01/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER			304 SE SECOND STREET		
				S	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	a 1		550			
1 000		ansfer, discharge, and the		550			
		under the State plan for all					
	§483.10(b) Exercise	of Diabto					
		right to exercise his or her					
		f the facility and as a citizen					
	or resident of the Uni	ted States.					
	§483.10(b)(1) The fac	cility must ensure that the					
	resident can exercise	his or her rights without					
	interference, coercior from the facility.	n, discrimination, or reprisal					
	free of interference, or reprisal from the facil rights and to be supp	sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this					
		is not met as evidenced					
	by: Based on observatio	n, record review, resident			Greendale Forest Nursing and		
	interview and staff int maintain a resident's privacy cover on an in	erviews, the facility failed to dignity by not placing a ndwelling urinary catheter ts reviewed for dignity			Rehabilitation Center acknowledges receipt of the Statement of Deficienci and proposes this Plan of Correction the extent that the summary of finding factually correct and in order to main	to gs is	
	Findings included:				compliance with applicable rules and provisions of quality of care of reside The Plan of Correction is submitted a		
	Resident #14 was ad	mitted to the facility on			written allegation of compliance.		
		es which included urinary					
		nuscular dysfunction of			Greendale Forest Nursing and		
	bladder.				Rehabilitation Center response to this Statement of Deficiencies does not	5	
	Record review of the	Minimum Data Set (MDS)			denote agreement with the Statemen	t of	
	Quarterly Assessmer	t dated 6/02/22 revealed			Deficiencies nor does it constitute an		
	Resident #14 was co	gnitively intact and had an			admission that any deficiency is accu	rate.	

Facility ID: 923035

If continuation sheet Page 2 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/06/202 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345366	B. WING		C 09/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
ODEENDA				1304 SE SECOND STREET	
GREENDA	ALE FOREST NURSING /	AND REHABILITATION CENTER		SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 550	Continued From page	a 9	F 55	50	
1 000	indwelling urinary cat During an observatio	heter. n on 8/29/22 at 10:30 am	F Sc	Further, Greendale Fores Rehabilitation Center res refute any of the deficience	erves the right to cies on this
	was observed attache	Illing urinary catheter bag ed to the left side of the bed er and urine was visible from		Statement of Deficiencies Informal Dispute Resoluti appeal procedure and/or administrative or legal pro	on, formal any other
	Resident #14 stated to bags have a privacy of this time did not have she had visitors to he	n 8/29/22 at 10:49 am the some of the catheter cover but the one they used a one. Resident #14 stated or room and did not want		F550 Resident Rights/Ex	of Nursing
		ner urine and she was sure e her urine when they		provided resident #14 a p for the Foley catheter dra maintain resident dignity.	inage bag to
	Resident #14's indwe was observed attache	n on 8/30/22 at 9:02 am Iling urinary catheter bag ed to the left side of the bed er and urine was visible from		On 9/20/22, the treatmen 100% audit of all resident Supra Pubic catheter to in #14. This audit is to ensu drainage bags were cove cover to maintain residen	is with Foley or nclude resident re all Foley red with privacy
	Resident #14 was ob wheelchair in her roo catheter bag attached	n on 8/30/22 at 2:37 pm served sitting in her power m with the indwelling urinary d to the left side of the		treatment nurse will addre identified during the audit completed by 10/4/22.	ess all concerns Audit will be
	did not have a privac from the hall.	velling urinary catheter bag y cover and urine was visible		On 9/23/22, the Staff Dev Coordinator initiated an ir nurses and nursing assis (1) Foley Catheters and (	n-service with all tants regarding 2) Resident
	Aide (NA) #2 who wa	n 8/30/22 at 2:40 pm Nurse s assigned to Resident #14 t sure if the indwelling urinary I a privacy cover.		Rights/Dignity and Respect on ensuring each resident respect and dignity and c resident in a manner and environment that promote	it is treated with are for each in an
	#6 who was assigned	n 8/30/22 at 4:11 pm Nurse I to Resident #14 revealed catheter bag required a		or enhancement of his or to include ensuring Foley are covered with privacy	her quality of life drainage bags

Facility ID: 923035

If continuation sheet Page 3 of 61

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	OMB NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
			_		с
		345366	B. WING		09/01/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		304 SE SECOND STREET NOW HILL, NC 28580	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE
F 550	Continued From pag	ge 3	F 550		
	1.0	stated the catheter bag		resident dignity. In-service will be	
		cover attached but she		completed by 10/4/22. After 10/4/22 ar	ıy 🗍
	stated a privacy cov	er was available for the		nurse or nursing assistant who has not	
a co		id not have the cover		worked or received the in-service will	
		reported the catheter privacy		complete in-service prior to next	
		le and could be placed on the atheter bag by any staff		scheduled work shift. All newly hired nurses and nursing assistants will be	
	member.	and the bag by any stan		in-serviced during orientation regarding	a
				(1) Foley Catheters and (2) Resident	
	-	on 8/30/22 at 4:20 pm the		<b>Rights/Dignity and Respect</b>	
	· ·	Coordinator (SDC) revealed			
		bags were required to have a		The treatment nurse will complete	
		ce. She stated if the catheter attached privacy cover the		observations of all residents with Foley catheters or Super Pubic catheters to	
	-	ags that were to be used.		include resident #14 weekly x 4 weeks	
		nursing staff were educated		then monthly x 1 month utilizing the Fo	
		welling urinary catheter bag		Audit Tool. This audit is to ensure all F	
		over, and any staff member		drainage bags are covered with a priva	ю
		e privacy bag on Resident		cover to maintain resident dignity. The	<i></i>
	#14's indwelling urin	lary catheter bag.		treatment nurse will address all areas of concern identified during the audit. The	
	During an interview	on 8/30/22 the Director of		DON will review and initial the Foley A	
		aled indwelling urinary		Tool weekly x 4 weeks then monthly x	
	<b>.</b> . ,	ed a privacy cover and she		month to ensure all areas of concern w	
		ccess to obtain and anyone		addressed.	
		acy cover on Resident #14's			
	indwelling urinary ca	ameter bag.		The DON will present the findings of the Foley Audit Tool to the Executive Qualit	
	During an interview	on 9/01/22 at 1:50 pm the		Assurance Performance Improvement	LY
		Resident #14's indwelling		(QAPI) committee monthly for 2 month	s.
		was to have a privacy cover.		The Executive QAPI Committee will m	
				monthly for 2 months and review the	
				Foley Audit Tool to determine trends	
				and/or issues that may need further interventions put into place and to	
				determine the need for further frequen	cy
				of monitoring.	·
F 561	Self-Determination		F 561		10/4/22

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345366	B. WING				C 01/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER			304 SE SECOND STREET NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 561	promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules ( waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signified §483.10(f)(3) The res with members of the of community activities to facility. §483.10(f)(8) The res participate in other act religious, and commu- interfere with the right facility. This REQUIREMENT by: Based on observatio and staff interviews, to dependent resident's	<ul> <li>(3)(8)</li> <li>mination.</li> <li>right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f) s section.</li> <li>ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part.</li> <li>ident has a right to make s of his or her life in the cant to the resident.</li> <li>ident has a right to interact community and participate in both inside and outside the</li> <li>ident has a right to</li> <li>itivities, including social, nity activities that do not ts of other residents in the</li> <li>is not met as evidenced</li> <li>ins, record review, resident he facility failed to honor a request to smoke at the 1 of 2 residents reviewed for</li> </ul>	F	561	F561 Self-Determination On 8/29/22, the nursing assistant assis resident #70 outside to smoke per resident preference	ited	
	The findings included				resident preference.		

Facility ID: 923035

If continuation sheet Page 5 of 61

CENTERS FOR MEDICARE & MEDICARE & MEDICARE S         OMB NO. 0338-039           AND PLAN OF CORRECTION         (X1) PROVIDER/DESPECTRCUM         (X2) MULTIPLE CONSTRUCTION         (X0) DUTE JUNCY           AND OF CORRECTION         (X1) PROVIDER/DESPECTRCUM         (X2) MULTIPLE CONSTRUCTION         (X0) DUTE JUNCY           AND OF CORRECTION         345366         (X1) MULTIPLE CONSTRUCTION         (X0) DUTE JUNCY           GREENALE FOREST NURSING AND REHABILITATION CENTER         STREET ADDRESS. CITY, STATE, ZP CODE         (X1) DUTE JUNCY           TV0         SUMMAY STREAM OF DEFICIENCIES         (X1) DUTE JUNCY         STREET ADDRESS. CITY, STATE, ZP CODE         (X1) DUTE JUNCY           TV0         SUMMAY STREAM OF DEFICIENCIES         (X1) DUTE JUNCY         STREET ADDRESS. CITY, STATE, ZP CODE         (X1) DUTE JUNCY           TV0         SUMMAY STREAM OF DEFICIENCIES         (X1) DUTE JUNCY         (X1) DUTE JUNCY         (X1) DUTE JUNCY           TV0         SUMMAY STREAM OF DEFICIENCIES         (X1) DUTE JUNCY         (X1) DUTE JUNCY         (X1) DUTE JUNCY           TV0         SUMMAY STREAM OF DEFICIENCIES         (X1) DUTE JUNCY         (X1) DUTE JUNCY         (X1) DUTE JUNCY           F 561         Continued From page 5         (X1) DUTE JUNCY         (X1) DUTE JUNCY         (X1) DUTE JUNCY           Revelate H70% or sustas and fully         JUNCY         (			ID HUMAN SERVICES				FORM	): 10/06/2022 MAPPROVED ). 0938-0391
343366         B: WNC         09/01/2022           NME OF PROVIDER OR SUPPLIER         STREET ADDRESS.CVT, STATE.2/P COOL 134 SF SECOND STREET SNOW HILL, NC 23560         134 SF SECOND STREET SNOW HILL, NC 23500         134 SF SECOND STREET SNOW HILL, NC 23500         134 SF SECOND STREET SNOW HILL, NC 23500         00/01/2022           Image: Xit in the Coll content of the Coll co	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	`, ´			(X3) DATE COMP	SURVEY LETED
GREENDALE FOREST NURSING AND REHABILITATION CENTER         134 SE SECOND STREET SNOW NLL, NC 2858           (PA) D PREFIX NG         SUMMARY STATEMENT OF DEFICIENCIES (EXAL ORRECTIVE ACTION SHOULD BE REGULATORY OR LSC DENDITYING INFORMATION)         IP         IP         (CAL) CORRECTIVE ACTION SHOULD BE (CAL) CORRECTION (USE) (CAL) CAL) (CAL) CORRECTION (USE) (CAL) CAL) (CAL) CAL) CAL) CORRECTION (USE) (CAL) CAL) (CAL) CAL) (			345366	B. WING _				-
GREENPALE FOREST NURSING AND REHABILITATION CENTER         SNOW HILL, NC 28580           (M) ID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACL DEFICIENCY MUST & BENCEDED & YTUL RECOLLITIONY MUST & BENCEDED & YTUL RESOLUTIONY MUST & BENCED & BENCE RESOLUTIONY MUST & BENCED & BENCE RESOLUTIONY MUST & BENCEDED & YTUL RESOLUTIONY MUST & BENCED & BENCE RESOLUTIONY MUST & BENCE RESOLUTI	NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAIST & PROCEEDED & FULL REQUILATORY OR LSC DERVIEWING INFORMATION)         Deficiency PREFX TAG         PROVIDENTS IF AN OF CORRECTION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD BE CROSS-REFERENCED TO THE ASTING DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION SHOULD APPROPRIATE DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION (EACH CORRECT & ACTION SHOULD APPROPRIATE DIFFICUENCY)         COMPLETION (EACH CORRECT & ACTION (EACH CORRECT & ACTION SHOULD APPROPRIATE DIFFICU					13	804 SE SECOND STREET		
Prefix Txg         CEACH DEFICIENCY MIST BE PRECEDED BY FULL REGULTATORY OR LSC IDENTIFYING INFORMATION)         PREFIX Txg         CEACH DEFICIENCY ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE         Committing DEFICIENCY           F 561         Continued From page 5         F 561         On 9/20/22, the Social Worker initiated resident #70 was readmitted to the facility on 11/9/20 with diagnoses that included stroke with less of strength on the left non-dominant side and muscle weakness.         F 561         On 9/20/22, the Social Worker initiated resident #70's quarterly MDS dated 7/26/22 revealed he was severely cognitively impaired and was totally dependent on 2 staff persons with transfers.         F 561         On 9/23/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident #70 was assessed as a supervised smoker, and he did not have adequate hand dexterity (skill in performing tasks) or use of his upper stremities (arms, wrists, and hands).         F 561         On 9/23/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident Preferences to include getting out of bed, shower, wake/sleep times, meattime preferences to include gettime, meating preferences to include gettime, meating preferences and activities such as smoke time preference cannot be honored for any reason. In-service will be completed by 10/4/22. After 10/4/22, any nurses on Inursing assistants will be in-service prior to next scheduled work shift. In newly hired nurses and nursing assistants will be in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-service will correct end to the other residents on the 100 hall.           During a follow-up interview with NA #3 o	GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER		S	NOW HILL, NC 28580		
On 9/20/22, the Social Worker initiated resident #70 was readmitted to the facility on 11/9/20 with diagnoses that included stoke with loss of strength on the left non-dominant side and muscle weakness.Resident #70's quarterly MDS dated 7/26/22 revealed he was severely cognitively impaired and was totally dependent on 2 staff persons with transfers.The social Worker and Director of Nursing (DON) will address all coordinator initiated an in-service will all in the resident questionaires with all all residents regarding Smoking. The suduits to identify any concerns related to staff assisting residents who desire to smoke. The Social Worker and Director of Nursing (DON) will address all coordinator initiated an in-service will all preferences to include getting out of preferences to include getting out of bed, shower, wakes/sleep times, meatime preferences and activities such as smoke time preference for smokers and notify the DON if preference and notify the DON if preferences and notify the DON if preferences.An interview with nurse aide (NA) #3 on 8/29/22 at 10:47 AM revealed Resident #70 was a supervised smoker. She stated he wanted to go out to smoke. But she would get him up last after she attended to the other residents on the 100 hall.On 8/29/22 at 10:33 AM, Resident #70 was a supervised smoker. She stated he was not alb to take Resident #70 wut to smoke beforeThe Social Worker will complete 10 Resident Preferences to include resident #70 weekly x 4 weeks then monthly x 1 moth. This audit is to ensure the staff honored tresident preferences for smoke time. The	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
Resident #70 was readmitted to the facility on 11/9/20 with diagnoses that included stroke with loss of strength on the left non-dominant side and muscle weakness.resident questionnairs with all alert and oriented to staff assisting residents who desire to smoke. The Social Worker and During a follow-up interview with NA #3 on 8/31/22 at 9:36 AM, she revealed she would get him up last after she attended to the other residents on the 100 hall.resident free fracesident and commit alt haler and oriented to preferences to include pustion and staff must attempt to hoor resident preferences to include resident #70 was assessed as a supervised and runs as and nursing assistant who has not worked or received the in-service will complete in-service will be oriented to get out of bed to smoke. He was then instructed to use the call bell for assistant with alert and schedu	F 561	Continued From page	e 5	F 5	61			
Resident #70 was readmitted to the facility on 11/9/20 with diagnoses that included stroke with loss of strength on the left non-dominant side and muscle weakness.resident questionnairs with all alert and oriented to staff assisting residents who desire to smoke. The Social Worker and During a follow-up interview with NA #3 on 8/31/22 at 9:36 AM, she revealed she would get him up last after she attended to the other residents on the 100 hall.resident free fracesident and commit alt haler and oriented to preferences to include pustion and staff must attempt to hoor resident preferences to include resident #70 was assessed as a supervised and runs as and nursing assistant who has not worked or received the in-service will complete in-service will be oriented to get out of bed to smoke. He was then instructed to use the call bell for assistant with alert and schedu						On 9/20/22, the Social Worker initiated	d	
11/9/20 with diagnoses that included stroke with loss of strength on the left non-dominant side and muscle weakness.oriented residents regarding Smoking. This audit is to identify any concerns related to staff assisting residents who desire to smoke. The Social Worker and Director of Nursing (DON) will address all concerns identified during the audit. The audit will be completed by 10/4/22Review of the smoking assessment dated 8/8/22 revealed Resident #70 was assessed as a supervised smoker, and he did not have adequate hand dexterity (skill in performing tasks) or use of his upper extremities (arms, wrists, and hands).On 9/323/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident #70 was assessed as a supervised smoker, and he did not have adequate hand dexterity (skill in performing tasks) or use of his upper extremities (arms, wrists, and hands).On 9/323/22, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants regarding Resident #70 was a supervised smoking times in the morning of 10:00 AM and 11:30 AM.On 8/29/22 at 10:33 AM, Resident #70 stated he wanted to get out of bed to smoke. He was then instructed to use the call bell for assistance.Completed by 10/4/22, After 10/4/22, any nurses on nursing assistants will be completed by 10/4/22, After 10/4/22, any nurses on nursing assistants will be in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-service during orientation regarding Resident Preferences.An interview with nurse aide (NA) #3 on 8/29/22 at 10:47 AM revealed Resident #70 was a supervised smoker. She stated he wanted to go out to smoke, but she was not able to take Resident #70 out to smoke before </td <td></td> <td>Resident #70 was rea</td> <td>admitted to the facility on</td> <td></td> <td></td> <td></td> <td></td> <td></td>		Resident #70 was rea	admitted to the facility on					
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Facility ID: 923035

If continuation sheet Page 6 of 61

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STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345366	B. WING				C / <b>01/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA		AND REHABILITATION CENTER		13	304 SE SECOND STREET		
GREENDA	ALE FOREST NORSING A	AND REHABILITATION CENTER		S	NOW HILL, NC 28580		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	Continued From page lift, and then she had indicated there were of 200 halls that day. During an interview w (DON) on 9/1/22 at 92 facility encouraged te choices. The DON st gotten another staff m mechanical lift and he bed to smoke if that w An interview was con Administrator on 9/1/2 Resident #70 should and smoke at the des that was his choice. Personal Privacy/Cor CFR(s): 483.10(h)(1)- §483.10(h) Privacy ar The resident has a rig confidentiality of his of records. §483.10(h)(I) Persona accommodations, me telephone communica and meetings of famil	e 6 to leave for the day. She only 2 NA for both 100 and with the Director of Nursing (17 AM, she revealed the amwork to fulfill resident tated NA #3 could have hember to retrieve the elped Resident #70 out of vas his desire. ducted with the 22 at 10:21 AM. She stated have been able to go out signated smoking times if affidentiality of Records -(3)(i)(ii) and Confidentiality. ght to personal privacy and or her personal and medical al privacy includes edical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a	F	561		erns he t hs. neet or	10/4/22
	right to privacy in his	cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including					

If continuation sheet Page 7 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/06/ FORM APPRO OMB NO. 0938-0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345366	B. WING		09/01/2022	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	•	
GREENDA		AND REHABILITATION CENTER		1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET	
F 583	Continued From page	e 7	F 58	3		
		promptly receive unopened	1 30			
		, packages and other				
		the facility for the resident,				
		ered through a means other				
	than a postal service.					
	(400, 40/k)(0) Theorem					
		sident has a right to secure onal and medical records.				
		he right to refuse the release				
		cal records except as				
	-	i)(2) or other applicable				
	federal or state laws.					
	(ii) The facility must a	Illow representatives of the				
		ng-Term Care Ombudsman				
		t's medical, social, and				
		s in accordance with State				
	law.					
	by:	is not met as evidenced				
		iew, observation, resident		F583 Personal Privacy/Confi	dentiality of	
		erviews, the facility failed to		Records		
		providing personal care to 1				
		wed for privacy. (Resident				
	#98)			On 9/1/22, the Director of Nur		
				educated nursing assistant #4		
	Findings included:			regarding resident right to priv		
	Desident #00			emphasis on pulling curtain a		
	Resident #98 was ad 6/26/2018.	mitted to the facility on		shutting door when providing include emptying foley draina		
	0/20/2010.			observation of secure cathete		
	The quarterly Minimu	m Data Set (MDS)		catheters.		
		5/2022 indicated Resident				
		cognitively impaired and		On 9/20/22, the Staff Develop	oment	
	,	lling catheter for urine		Coordinator initiated Resident		
	elimination.			(Privacy) with all nurses, nurs	-	
				assistants and therapy staff.		
		p.m., Nurse Aide (NA) #4		to ensure staff honored reside	-	
		B's room to empty the urine		privacy to include privacy duri		
	collection leg bag. W	hile Resident #98 laid on his		treatment. The Staff Developr	nent	

Facility ID: 923035

If continuation sheet Page 8 of 61

ATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY IPLETED
		345366	B. WING			C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	05	9/01/2022
	NOVIDER OR SOLT EIER					
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIO DATE
F 583	Continued From pag	e 8	F 583			
		erved emptying the urinary	1 000	Coordinator will address all conce	arne	
		hout closing the door to the		identified during the audit to inclu		
		he privacy curtain between		providing resident privacy and ec		
		s roommate, Resident #88.		of staff. Audit will be completed b		
		rinary collection leg bag with		10/4/22.	-	
		ot pulled between the two				
		or open, NA #4 exposed		On 9/23/22, the Staff Developme	nt	
	Resident #98's right	groin area for observation of		Coordinator initiated an in-service	e with all	
	the abdominal urinar	y suprapubic catheter secure		nurses, nursing assistants and th	erapy	
	-	the left thigh and penis for		staff regarding Resident Rights/E		
		ond urinary suprapubic		and Respect with emphasis on ri		
		erneath the penis. Resident		privacy during care and treatmen		
		ved positioned parallel to		In-service will be completed by 1		
		and he was observed lying		After 10/4/22 any nurse or nursin	-	
		d during the provision of care		assistant who has not worked or		
	to Resident #98.			the in-service will complete in-ser		
	On 8/20/2022 at 4.20			prior to next scheduled work shift		
		) p.m. in an interview with NA uld had closed the door to		newly hired nurses, nursing assis and therapy staff will be in-servic		
		ed the privacy curtain		orientation regarding Resident	eu uunng	
		98 and Resident #88 before		Rights/Dignity and Respect.		
		sident #98. He stated the				
		not provided was because		The Unit Managers will complete	10	
	state surveyor was p	-		Resident Care Audits (Privacy) to		
	,			resident #98 weekly x 4 weeks th		
	On 8/30/2022 at 9:30	) a.m. in an interview with		monthly x 1 month. This audit is t		
	Resident #98, he sta	ted the nursing staff did not		staff honored resident right to priv		
	always pull the priva	cy curtain when providing		include privacy during care and t		
		ted the nursing staff should		The Unit Managers will address a		
		cy curtain on 8/29/2022		concerns identified during the au		
		rinary collection leg bag and		include providing resident privacy		
		ary secure devices because		education of staff. The Director o	0	
		t need to see everything		will review Resident Care Audits		
	wnen the nursing sta	ff provided him care.		weekly x 4 weeks then monthly x to ensure all concerns were addr		
	On 9/1/2022 at 3:18	p.m. in an interview with the				
		she stated resident #98's		The DON will present the finding	s of the	
	-	d and privacy curtains		Resident Care Audits (Privacy) to		
	should be pull betwe			Executive Quality Assurance Per		

Facility ID: 923035

If continuation sheet Page 9 of 61

		ND HUMAN SERVICES	-		FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345366	B. WING		09/01/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 304 SE SECOND STREET SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO
F 583	privacy during resident care.		F 583	Improvement (QAPI) committee mor for 2 months. The Executive QAPI Committee will meet monthly for 2 m and review the Resident Care Audits (Privacy) to determine trends and/or issues that may need further interve put into place and to determine the r for further frequency of monitoring.	nonths s ntions
F 637 SS=D	CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) Wit determines, or should there has been a sigu resident's physical or purpose of this section means a major declin resident's status that itself without further i implementing standa interventions, that has one area of the resid requires interdisciplin care plan, or both.) This REQUIREMENT by:	(ii) hin 14 days after the facility d have determined, that hificant change in the mental condition. (For on, a "significant change" he or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical s an impact on more than ent's health status, and hary review or revision of the T is not met as evidenced	F 637		10/4/22
	Based on record rev facility failed to comp (MDS) Significant Ch within 14 days of bein of 1 resident reviewe #10). The findings included Resident #10 was rea	iew and staff interviews, the lete a Minimum Data Set ange in Status Assessment ng admitted to hospice for 1 d for Hospice (Resident d: admitted to the facility on osis of heart failure and		<ul> <li>F637 Comprehensive Assessment / Significant Change</li> <li>On 8/30/22, the Minimum Data Set N (MDS) completed resident #10 MDS assessment for significant change re to hospice services.</li> <li>On 9/20/22, the MDS Consultant alc with the MDS nurse initiated an audi residents MDS assessments for</li> </ul>	Nurse Belated

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 10 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10 FORM APF OMB NO. 093	PROVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		345366	B. WING		09/01/20	022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•	
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	(X5) MPLETIOI DATE
F 637	Continued From page	e 10	F 63	37		
	5/27/22 revealed Rescognitive impairment. A physician order war "hospice consult per of A review of a "Patient from the hospice serve was admitted to Hosp A MDS Significant Ch dated 8/18/22 was of Reference Date (ARE completed and was in On 8/31/22 at 1:07 Pl interviewed, and she from the ARD to com Resident #10 was ad and the ARD should 1 8/18/22. She stated should have been con An interview was con Administrator on 9/1/2	s dated 8/11/22 and read, decline." t Comfort Care Kit" form vice revealed Resident #10 bice on 8/12/22. nange in Status Assessment bserved with an Assessment D) of 8/18/22 was not n process. M the MDS nurse was stated they had 14 days plete the MDS. She stated mitted to hospice on 8/12/22 have been 8/12/22 and not the MDS was late and mpleted and processed.		<ul> <li>and residents receiving hosy This audit is to ensure assession completed within 14 days aff determines, or should have that there has been a signifi in the resident's physical or condition to include but not be residents receiving hospice Director of Nursing (DON) a consultant will address all con- identified during the audit. A completed by 10/4/22.</li> <li>On 9/23/22, the MDS consultant is completed by 10/4/22.</li> <li>On 9/23/22, the MDS consultant is completed with after the facility determines, have determined, that there significant change in the rest physical or mental condition hired MDS nurses will be in- during orientation regarding Assessment for Significant Con- in-service will be completed</li> <li>The Unit Manager will audit assessments related to sign to include assessments for r weekly x 4 weeks then mon- utilizing the MDS Audit Tool. to ensure assessments were within 14 days after the facili determines, or should have that there has been a signifi in the resident's physical or</li> </ul>	ssments were ter the facility determined, cant change mental limited to services. The nd MDS oncerns Audit will be Itant initiated nurse for Significant nsuring ithin 14 days or should has been a ident's . All newly eserviced MDS Change. by 10/4/22. all new MDS ificant change resident #10 thly x 1 month . This audit is e completed ity determined, cant change	

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 11 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES					ED: 10/06/20 RM APPROVI IO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	· /	TE SURVEY MPLETED C	
		345366	B. WING			0	09/01/2022	
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		1304	EET ADDRESS, CITY, STATE, ZIP CODE 4 SE SECOND STREET DW HILL, NC 28580	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 637	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi facility failed to code I assessments accurate reviewed in the areas 97), nutrition (Residen (Resident #79).	ents		541	Unit Manager will address all concern identified during the audit to include completion of the assessment and/or re-training of staff. The DON will revie the MDS Audit Tool weekly x 4 weeks monthly x 1 month to ensure all concern were addressed. The DON will present the findings of the MDS Audit Tool to the Executive Qua Assurance Performance Improvement (QAPI) committee monthly for 2 month The Executive QAPI Committee will r monthly for 2 months and review the Audit Tool to determine trends and/or issues that may need further interven put into place and to determine the ne for further frequency of monitoring. F641 Accuracy of Assessments On 09/01/22 The Minimum Data Set Coordinator (MDS) completed a modification to prior comprehensive assessment for Resident # 97 to reflection	ew then erns he lity t hs. neet MDS tions eed	10/4/22	
	Findings included: 1. Resident #97 was a 1/14/2022.	admitted to the facility on			accurate coding for colostomy. On 09/21/22 The MDS Coordinator completed a modification to prior comprehensive assessment for Resic	lent		

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 12 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	2
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLE	ETION
F 641	Continued From page	a 12	F 641			
1 041			F 041	# 95 to reflect accurate coding of		
	The admission Minim assessment dated 1/2	21/2022 indicated Resident		diagnosis of dysphagia and gas		
		ntact and required extensive		5 51 5 5	,	
	assistance with toileti	ing. The MDS indicated		On 09/23/22 The MDS Coordina	ator	
		s not rated and ostomy was		completed a modification to price		
	not indicated.			comprehensive assessment for		
	<u>-</u>			# 79 to reflect accurate coding of	of mental	
		1/27/2022 revealed Resident olostomy due to a stage IV		illness to include diagnosis of Schizophrenia and PASARR lev		
		tions included Resident #97				
	performing ostomy ca			On 08/31/22 the Social Worker	submitted	
	colostomy bag.			for review of level II PASARR fo		
	, ,			#79. Resident was determined t		
	In an interview with th 9/1/2022 at 9:10 a.m.	ne MDS Nurse #1 on ., she stated Resident #97		11.		
	had a colostomy and	missed coding the		On 09/23/22 the MDS consultar	nt initiated	
		colostomy. She stated she		an audit of section H for all resid	lents most	
	-	the admission MDS for		current MDS assessment, to inc	lude	
	presence of a colosto	omy.		resident #97 to ensure all MDS	11	
	In an interview with th	ne Administrator on 9/1/2022		assessments completed are coo		
		ed MDS assessments		accurately for bowel to include of The MDS completed modification	-	
	should be coded acci			concerns identified during the a		
				will be completed by 10/04/22.		
	2. Resident #95 was	admitted to the facility on				
	-	oses included dysphagia		On 09/23/22 the MDS consultar		
	and gastrostomy.			an audit of section K for all resid		
		aion and an data d 5/47/0000		current MDS assessment, to inc	lude	
		cian orders dated 5/17/2022 95 was ordered enteral		resident #95 to ensure all MDS	hed	
		ss than fifty percent of her		assessments completed are coor accurately for enteral feedings		
		hes every six hours, and		(gastrostomy). The MDS compl	eted	
		ed 7/13/2022 revealed		modifications for all concerns id		
		dered a bolus enteral feeding		during the audit. Audit will be co		
	once a day via gastro	•		by 10/04/22.		
	A review of July 2022	2 and August 2022		On 09/23/22 the MDS consultar	nt initiated	
	-	ation Record revealed		an audit of section A for all resid		
	Resident #95 was ad	ministered bolus enteral		current comprehensive MDS as	sessment,	

Facility ID: 923035

If continuation sheet Page 13 of 61

		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		E SURVEY PLETED
						С
		345366	B. WING		09	/01/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIF	CODE	
		AND REHABILITATION CENTER		1304 SE SECOND STREET		
SKELND				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From page	e 13	F 64	41		
		eals and at bedtime and		to include resident #79 to	ensure all MDS	
	received water flushe			assessments completed		
		2		accurately for Level II PA		
	The quarterly Minimu	m Data Set (MDS)		resident has level II qualit		
a: #! re di di R	assessment dated 8/3	3/2022 indicated Resident		include but not limited to		
	#95 was severely cog	nitively impaired and		The MDS completed mod	lifications for all	
	required extensive as	sistance with eating. Active		concerns identified during	g the audit. Audit	
	diagnoses included a	gastrostomy. There was no		will be completed by 10/0	4/22	
	documentation on the	e MDS that indicated				
	Resident #95 receive	d enteral feedings for		On 09/20/22 the Social W	/orker initiated	
	nutrition via gastrosto	omy tube.		an audit of diagnosis for a a Level I PASARR. This a		
	In an interview on 9/1	/2022 at 9:18 a.m. with MDS		any resident with a newly		
		Resident #95 was not using		PASARR qualifying diagn		
	the gastrostomy tube	for nutrition and was the		resident assessed for nee	ed to re-submit	
	•	was not marked on the MDS.		PASARR for evaluation.		
	÷ .	nysician orders and July and		Worker and/or Admission		
		ion administration records,		address all concerns ider	•	
		y feeding tube should had		audit to include submission		
		uld modify the MDS for		PASARR evaluation/re-ev		
	Resident #95.			will be completed by 10/0	4/22.	
	In an interview with th	ne Administrator on 9/1/2022		On 09/23/22 the MDS Co	onsultant	
	at 3:35 p.m., she stat	ed MDS assessments		completed an in-service v		
	should be coded accu	urately.		Coordinator and MDS nu	rse regarding	
				MDS Assessments and C	• •	
	3. Resident #79 was	admitted to the facility on		Resident Assessment Ins	trument (RAI)	
	11/11/2019, and his d	liagnoses included		Manual with emphasis or	completing	
	Schizophrenia.			assessment accurately a		
				All newly hired MDS Coo		
		6/25/2020 revealed Resident		MDS nurse will be in-serv		
	•	ychotropic drugs due to		Director of Nursing during		
		hrenia, and interventions		regarding MDS Assessme	ents and Coding.	
	-	s interactions with others				
	and monitoring his m	ental status.		On 09/23/22 the MDS Co		
				an in-service on Level II F		
	The annual Minimum	. ,		the Admission Director, S		
		1/2022 indicated Resident		Minimum Data Set Nurse		
	#19 was severely cog	gnitively impaired and had an		of Nursing with emphasis	on referral for	

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 14 of 61

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:				IPLETED C
		345366	B. WING		09	9/01/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
		AND REHABILITATION CENTER	1304 SE SECOND STREET			
GREEND	ALE FOREST NORSING	AND REPABILITATION CENTER	s	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	of unusual behaviors mental illness for the and Resident Review In an interview with M 9:21 p.m., she stated mental illness (SMI) of and was not coded w not have a PASARR Resident #79 should mental illness, and sh Resident #79 not hav screening with a diag	chizophrenia with no display . There was no indication of Preadmission Screening (PASARR). IDS Nurse #1 on 9/1/2022 at Resident #79 had a severe diagnosis, Schizophrenia, ith a SMI because she did Level II. She stated had been coded with a he should have questioned ring a PASARR Level II nosis of Schizophrenia. he Administrator on 9/1/2022 ed MDS assessments	F 641	evaluation/re-evaluation of PASA following changes in mental heat or newly Level II qualifying diagn newly hired Admission Director, Worker, Minimum Data Set Nurs and Director of Nursing will be in during orientation on PASARRs referral for re-evaluation followin changes in mental health status. 10% audit of all resident □s most MDS assessments section A, se and section K will be completed Director of Nursing, Quality Assu Nurse and/or Facility Consultant the MDS Audit Tool weekly x 4 w monthly x 1 month. This audit is accurate and complete coding of assessment to include section H continence to include colostomy, K for enteral feedings (gastrostor section A for level II PASARR wh resident has a level II PASARR of diagnosis. The MDS Coordinator Administrator and/or Director of I will address all areas of concern during the audit to include comple resident assessment and/or retra	th status osis. All Social e (MDS), -serviced regarding g recent ction H, by the trance utilizing reeks then to ensure the MDS for bowel section my), hen a uualifying c, Nursing identified etion of	
				the Social Worker/ MDS nurses indicated. The Administrator will and initial the MDS Accuracy Too x 4 weeks then monthly x 1 mon ensure any areas of concerns we addressed. The Administrator will forward the of MDS Audit Tool to the Executi Assurance Performance Improve	review of weekly th to ere e results ve Quality	

Facility ID: 923035

If continuation sheet Page 15 of 61

			(1/0) 1/11/7			IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		345366	B. WING		C 09/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE
F 641	Continued From page	e 15	F 64	The Executive QAPI Commi monthly x 2 months and rev Audit Tool to determine trend issues that may need furthe put into place and to determ for further and / or frequency monitoring.	iew the MDS ds and / or r interventions ine the need	
F 658 SS=D	CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provided as outlined by the com must- (i) Meet professional This REQUIREMENT	ehensive Care Plans d or arranged by the facility, nprehensive care plan,	F 65	C C		10/4/22
	interviews, the facility order for finger-stick I	iew, staff and physician failed to obtain a physician blood sugar checks for 1 of		F658 Services Provided Me Professional Standards	eet	
	Findings included: Record review of the dated 8/01/22 reveals order to continue at th	or insulin (Resident #73). hospital discharge record ed Resident #73 had an ne facility for Insulin Lantus 00 units/milliliter (mL) inject r the skin at noon.		On 08/31/22 the Unit Manag order for Lantus insulin for re- include parameter instructio insulin and finger stick gluco monitoring. The medication record (MAR) was updated Manager	esident #73 to ns on holding ose administration by the Unit	
	8/01/22 with diagnose and dementia. A physician order dat Solution 100 unit/mL	mitted to the facility on es which included diabetes ed 8/01/22 for Lantus inject 40 units ime a day for Diabetes		On 08/31/22 the Unit Manage an audit of all residents rece medications to include insuli is to ensure all residents rec medications to include insuli defined orders for blood glue monitoring. The Unit Manage all concerns identified during	iving diabetic in. This audit æiving diabetic in have clearly cose er will address	

Facility ID: 923035

If continuation sheet Page 16 of 61

	S FOR MEDICARE &	MEDICAID SERVICES				DMB NO. 0938-	-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C 09/01/2022	<b>。</b>
NAME OF P	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE	09/01/2022	2
				1304 SE SECO			
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	D.4.T	ETIO
F 658	Continued From page	e 16	F 65	8			
	discontinued on 8/10/		1 00		alood alucoso monitoring for a	nv	
		122.			blood glucose monitoring for ar receiving diabetic medications		
	Record review of the	Minimum Data Set (MDS)			sulin. Audit will be completed b		
		Admission Assessment dated 8/08/22 revealed				·	
	Resident #73 had mo	oderate cognitive impairment					
	and received insulin i	injections.			/22 the SDC initiated an		
					with all nurses regarding Bloo	bd	
		ted 8/10/22 for Lantus			Monitoring with emphasis on		
	Solution 100 unit/mL	-			with the physician the need for		
	-	time a day for Diabetes t noon hold if blood sugar			cose monitoring for any resider diabetic medications to include		
	(BS) is 150 or below.	•			d/or any order that does not		
					fine frequency/parameters of		
	Record review of the	Pharmacy Consultant			cose monitoring. In-service will	I	
		Review dated 8/17/22			eted by 10/04/22. After 10/04/2		
		'3 had an order for Lantus		any nurse	who has not worked or receiv	/ed	
		tion of orders for finger-stick			vice will complete in-service		
	blood sugar (FSBS) o	check frequency.			ext scheduled work shift. All ed nurses will be in-serviced		
	Record review of the	Blood Sugar Summary			entation regarding Blood		
		73 revealed the FSBS was			Monitoring.		
	documented as obtai	ned on 8/9/22 with a BS of			-		
	114, 8/15/22 with a B	S of 186, and 8/31/22 with a			Manager will audit all newly		
	BS of 287.				readmitted residents three x a		
					weeks then monthly x 1 month	ו ו	
		Medication Administration		-	ne Blood Glucose Monitoring		
	, ,	lated 8/11/22 revealed Nurse of 138 for Resident #73.			<ol> <li>This audit is to ensure receiving diabetic medications</li> </ol>	.	
					insulin have clearly defined	>	
	Record review of the	Medication Administration			blood glucose monitoring. The	e	
		lated 8/12/22 revealed Nurse			ager will address all concerns	-	
		of 148 for Resident #73.			during the audit to include		
					with the physician the need for	r	
		Medication Administration		-	cose monitoring for any reside	nt	
		lated 8/16/22 revealed Nurse			diabetic medications. The	.	
	#2 obtained a FSBS	of 140 for Resident #73.			of Nursing will review the Blood		
	Dependent of the	Madiantian Advantation (1			Monitoring Audit Tool weekly x		
		Medication Administration			en monthly x 1 month to ensure	e	
	Record (IVIAR) NOTE O	lated 8/17/22 revealed Nurse		all concer	rns were addressed.		

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 17 of 61

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/06/2023 M APPROVEI D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COM	E SURVEY PLETED
		345366	B. WING				C / <b>01/2022</b>
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
ODEENDA				130	4 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SN	OW HILL, NC 28580		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From page	o 17					
F 030	Continued From page		F 6	58			
	#2 obtained a FSBS	of 124 for Resident #73.			The Director of Nursing will forward th	۹	
	Record review of the	Medication Administration			results of Blood Glucose Monitoring A		
	Record (MAR) note of	dated 8/18/22 revealed Nurse			Tool to the Executive Quality Assurance		
	#2 obtained a FSBS	of 120 for Resident #73.			Performance Improvement Committee	;	
	Depart review of Dby	ysician Standing orders for			(QAPI) monthly x 2 months. The Executive QAPI Committee will meet		
		ysician #2 revealed no			monthly x 2 months and review the Blo	bod	
	-	ger-stick blood sugar check			Glucose Monitoring Audit Tool to	500	
	was in place.	5			determine trends and / or issues that r	nay	
					need further interventions put into place		
		nterview on 8/31/22 at 7:26			and to determine the need for further a	and	
	pm Nurse #4 reveale	ent #73. She stated she			/ or frequency of monitoring.		
		rder as written from the					
	hospital discharge re	cord. Nurse #4 stated there					
		FSBS or hold parameters on					
	0	. She stated Lantus insulin					
		sulin that did not usually have S checks associated with the					
		4 stated Nurse Manager #1					
		orders and would clarify if					
	there were any conce	erns.					
	During an interview of	on 8/31/22 at 1:05 pm Nurse					
		that they usually have an					
		but not all physicians write					
	them, and the nurse	was able to use her a FSBS. She stated the					
		I the admission should have					
		nysician if they wanted a					
	FSBS. The Nurse M	anager #1 stated she					
	•	#1 and notified him of the					
		Resident #73 was ordered					
	order a FSBS. She						
		e day after the admission but					
		until the end of the month.					
	Nurse Manager #1 st	tated she received the					

CENTER		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345366	B. WING			9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/01/2022
				1304 SE SECOND STREET	-	
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From non	- 10	E 05			
F 000	10		F 658	3		
	•	t Medication Regimen				
	Review dated 8/17/2					
		FSBS check frequency on prompt to enter the FSBS but				
		r for blood sugar checks for				
	Resident #73.	i lei sieca cagai cheche lei				
	During an interview of	on 8/31/22 at 1:01 pm Nurse				
		fied Physician #2 on 8/10/22				
		S was low and requested to				
		r to the insulin order to hold if				
		he stated she added the hold				
	to obtain FSBS befor	er but did not add the order				
		2 stated she completed the				
	FSBS for Resident #	•				
		ulin without a physician order				
	because it was her s	afety net to ensure the BS				
		e stated it was her nursing				
	judgement to check a	a blood sugar without a				
		se #2 stated she did not ask				
		om Physician #2 but should				
		the order to check Resident				
	to hold for the param	when the order was changed				
	During a telephone ir	nterview on 8/31/22 at 6:56				
		ed she was assigned to				
		ident #73 on the weekends				
		She stated she checked				
	Resident #73 's bloo					
		without a physician order				
		not give insulin without				
		r first. Nurse #3 stated the Nurse Manager should have				
		sician to obtain the order to				
		ar. Nurse #3 stated she did				
	-	to obtain an order to check				
	Resident #73 ' s bloo		1			

If continuation sheet Page 19 of 61

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345366	B. WING				C 01/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER			304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Director of Nursing (D were expected to entr clarify if the FSBS cho stated admission orded day in the clinical meet Manager would clarify needed. The DON w order for the finger sti missed for Resident # During a telephone in pm Physician #1 reve added a hold parame Lantus order because He stated an order fo been obtained from th the facility had standie entered into the medi stated the nurse shou Physician #2 for the of Resident #73. During a telephone in pm Physician #2 reve #2 who reported Resi was running low, and parameter for the Lar there was an existing check but she did not nurse should have cla was not an order for F parameter for Lantus.	Lantus. n 8/31/22 at 1:24 pm the DON) revealed the nurses er physician orders and to eck was needed. The DON ers were reviewed the next eting and the Nurse y any orders that were as unable to state how the ick blood sugar check was #73. terview on 8/31/22 at 3:49 ealed he would not have ter to Resident #73 ' s e it was a long-acting insulin. r FSBS checks should have he ordering physician or if ng orders the order could be cal record. Physician #1 Id have clarified with him or order to obtain FSBS for terview on 8/31/22 at 4:48 ealed she spoke with Nurse ident #73 ' s blood sugar she requested a hold ntus. Physician #2 thought order in place for the FSBS i confirm. She stated the arified with her when there FSBS checks with the hold	F	658			
	Administrator reveale	d the nursing staff was a physician order for FSBS					

Facility ID: 923035

If continuation sheet Page 20 of 61

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	2
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	ETION
F 658			F 65	8		
	check for Resident #7 ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F 67	7	10/4/22	2
	out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on record revi interviews the facility and nail care for 1 of reviewed who were d activities of daily living The findings included Resident #46 was ad with diagnoses that in strength/paralysis to t epilepsy, and diabete Review of the quarter assessment dated 7/6 had severely impaired cognitively impaired v behaviors. He was to person for personal h An observation on 8/2 Resident #46 had a y bottom lip. During a phone interv Responsible Party (R she revealed she had	is not met as evidenced iew, observations and staff failed to provide oral care 5 residents (Resident #46) ependent on facility staff for g (ADL). mitted to the facility 11/30/20 ncluded stroke with loss of the right dominant side, s. ly Minimum Data Set (MDS) 6/22 revealed Resident #46 d vision and was severely with no rejection of care otally dependent on 1 staff		<ul> <li>F677 ADL Care Provided for Depend Residents</li> <li>On 8/31/22, the nursing assistant provided oral care to resident #46.</li> <li>On 08/31/22 the NA cleaned and trimpresident #46 nails.</li> <li>On 09/22/22 the Medical Records Director, Central Supply Clerk, Sched and NA/Transporter initiated an audit activities of daily living (ADLs) for all residents to include resident #46. This audit is to ensure staff provide assistant to any resident who is unable to carry activities of daily living to include but r limited to oral hygiene and nail care to maintain good nutrition, grooming and personal/oral hygiene. The DON will address all concerns identified during audit.</li> <li>On 09/23/22 the SDC initiated an in-service with all nurses and nursing assistants regarding Activities of Daily Living (ADL) with emphasis on staff responsibility to provide assistance to</li> </ul>	med uler, of since out not o t the	

Facility ID: 923035

If continuation sheet Page 21 of 61

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · · ·	IPLETED
			AL DOILDING			С
		345366	B. WING		09	9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				1304 SE SECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETIO DATE
F 677	Continued From page	e 21	F 67	77		
	visit on 8/28/22. She	stated his fingernails were		resident who is unable to c	arry out	
		s afraid he would scratch		activities of daily living to ir		
	himself.			limited to oral hygiene and		
				maintain good nutrition, gro		
		30/22 at 8:36 AM revealed		personal/oral hygiene. In-s		
		m lip had a yellow, dried		completed by 10/04/22. Aft		
	coating.			any nurse or nursing assist		
	An interview was con	ducted with Nurse #2 on		not worked or received the		
		She revealed Resident #46		complete in-service prior to scheduled work shift. All ne		
		d required daily ADL care		nurses and nursing assista	-	
		oes. She stated sponges		in-serviced during orientati		
		ut his mouth, but sometimes		Activities of Daily Living.	33	
		Nurse #2 indicated nursing		, , ,		
	staff were informed o	f daily care needs by the		The Medical Records Direc	ctor, Central	
	resident care plan.			Supply Clerk, Scheduler ar	nd NA/	
				Transporter will review ADI		
		31/22 at 8:36 AM revealed		residents to include resider	•	
		and lips were cleaned, and		4 weeks then monthly x 1 r		
	all 10 of his fingernai	ls were at least ¾ inch long.		the ADL Audit Tool. This au		
	During on interview			the staff provide assistance		
		vith Nurse Aide (NA) #5 on she revealed she had given		resident who is unable to c		
		ed bath yesterday (8/30/22)		activities of daily living to ir limited to oral hygiene and		
		he indicated she did notice		maintain good nutrition, gro		
		stance on his lips prior to his		personal/oral hygiene. The	-	
	-	5 stated she normally		address all concerns identi		
		his nails when bed baths		audit to include but not limi	-	
		ne had forgotten to do so the		residents with ADL care wh	-	
	day prior.			and/or re-training of staff.		
				Nursing will review the ADI		
		1/22 8:43 AM revealed		weekly x 4 weeks then more		
		gernails were at least ¾		to ensure all concerns were	e addressed.	
	inches long.	ka maia wa sitta Niversa 40 a sa			indiana of the -	
		terview with Nurse #2 on		The DON will present the f	-	
		ne revealed she had not cut ecause she had not even		ADL Audit Tool to the Exec	•	
		se #2 stated podiatrists cut		Assurance Performance In (QAPI) committee monthly		
	toenails for diabetics	-		The Executive QAPI Com		

Facility ID: 923035

If continuation sheet Page 22 of 61

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345366	B. WING			9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETIO DATE
F 677	Continued From page	e 22	F 67	7		
	fingernails.			monthly for 2 months and rev	view the	
				Resident ADL Audit Tool to de		
		ducted on 9/1/22 at 9:28 AM		trends and/or issues that may		
	from 7:00 AM - 3:00 I	worked with Resident #46		further interventions put into determine the need for furthe		
		routine was to give all		of monitoring.	rinoquonoy	
		a full bed bath, perform		5		
		nd change their bed sheets if				
		NA #6 stated she had				
		6's shoulders, groin and s face.  She indicated the				
		ce was on his lips daily, and				
	-	oo hard then they would				
		she was not able to give				
		ed bath on 8/29 because she				
	time.	he 200 hall and did not have				
	An interview was con	ducted on 9/1/22 at 9:00 AM				
		ad worked with Resident				
		:00 PM on 8/29/22. She				
		even notice his nails that ited she usually assisted with				
	nail care for diabetic					
	During an interview w	vith the Director of Nursing				
	, , , , , , , , , , , , , , , , , , ,	:13 AM, she revealed				
		displayed a dirty face/mouth, nave provided cleaning				
	-	cated there should never be				
		stance on Resident #46's				
	mouth, and daily clea	aning should have been				
		t all shifts. The DON stated				
	-	ve been cut by the nurse ared long, and the nurse				
		I Resident #46's nails daily				
		etic. If any staff member did				
	not feel comfortable o	cutting nails, they should				
	notify the nurse mana	agor				

If continuation sheet Page 23 of 61

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 677	Continued From page	e 23	F 677			
F 684 SS=D	revealed her expecta face/mouth to be clea The Administrator sta	ducted with the 22 at 010:22 AM. She tion was for Resident #46's aned daily and as needed. Ited nail care should be staff and attended to as	F 684		10/4/22	
	§ 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Base assessment of a residents received accordance with profe practice, the comprete care plan, and the rest This REQUIREMENT by: Based on record reve facility failed to comp	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered		F684 Quality of Care On 09/23/22 the hall nurse assessed resident #44 skin/wounds. The treatr nurse notified the physician of all concerns identified during the		
	Resident #44 was ad 3/31/20 with diagnose infarction and type 2 A review of the quarte (MDS) dated 7/2/22 r moderate cognitive in extensive assessment			assessment, initiated treatment per f protocol and/or physician order and updated the treatment administration record (TAR) for all new orders. On 09/20/22 the Treatment Nurse initia a 100% audit of all TARs from for the 14 days to ensure treatments were completed per physician □s order. Th DON will address all areas of concer	itiated e past	

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 24 of 61

TATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION		E SURVEY IPLETED
		345366	B. WING _		09	C 9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, Z		
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From pag	o 24	F 6	204		
1 004			FC			
	was independent wit			identified during the aud		
		t #44 was not coded for		assessment of the resid	,	
	refusal of care.			MD of treatment omission instructions and educati		
	Record review for B	esident #44 revealed the		Audit will be completed		
	following physician o				by 10/04/22.	
				On 09/23/22 the SDC in	itiated an	
	Hvdrogen Peroxide S	Solution 3% apply to left hand		in-service with all nurses		
	topically two times a			Documentation/Treatme		
		entire hand in half hydrogen		on nurse⊡s responsibili	-	
	peroxide and half wa	irm water solution for 30		treatments or completing	g treatments per	
	minutes. After soakir	ng hand, dry the area and		physician order with doo	cumentation in the	
	place dry gauze			electronic treatment rec	ord. In-service will	
	over the incisions an	d wrap with dry kerlix. The		be completed by 10/04/2	22 After 10/04/22	
		8/22 and was discontinued on		any nurse who has not v		
		as scheduled 2 times a day		the in-service will compl		
	at 8:00 AM and 8:00	PM.		prior to next scheduled		
				newly hired nurses will b		
		led Resident #44 was		during orientation regard	-	
	-	icillin Staph Aureus (MRSA)		Documentation/Treatme	ents	
	with cellulitis to the le	eft hand.			D. da anna an tatlan	
	A new device of the Tree of			The DON will review TA		
		ment Administration Record 2 revealed the order was not		5 times a week x 4 weel 1 month to include weel	-	
		pleted on $3/1/22$ , $3/2/22$ ,		Medication Administratio	-	
	3/4/22, 3/7/22, and 3	-		treatments. This audit is	-	
	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<i>"0,22 at 0.00 F M</i> .		treatments are complete		
	Record review revea	led Medication Aid #3 was		physician □s order with o	•	
		the facility on 3/1/22 from		the electronic record. The		
		PM and assigned to Resident		address all concerns ide		
	#44.	5		audit. The Director of N	•	
				the Medication Administ		
	Medication Aid #3 wa	as interviewed on 9/1/22 at		Report for treatments 5	times a week x 4	
	10:16 AM and she st	ated she was from an		weeks then monthly x 1	month to ensure	
	agency and worked	at the facility a few times.		all areas of concern wer	e addressed.	
		not do dressing changes				
	and doesn ' t recall if			The DON will present th		
	Resident #44 had a t	treatment ordered.		Medication Administration		
				the Executive Quality As	ouropoo	

Facility ID: 923035

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMF	PLETED
		245266				С
	ROVIDER OR SUPPLIER	345366		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2022
NAME OF PI	ROVIDER OR SUPPLIER			1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 25	F 684			
	with MA #4 who work PM on 3/4/22 and 3/7 Resident #44. She si Resident #44. She si Resident #44 having change. MA #4 state treatments and doesn has a treatment order of the medication aids treatments, but she h them. On 09/01/22 at 10:05 conducted with MA # assigned to work from 3/2/22 and 3/8/22 and She stated she does does not look to see treatment. The wound nurse war 10:36 AM and was as getting his dressing co 8:00 PM. She stated social and wouldn't sh periods of time. She encourage him to let changes. The wound the evening dressing charted because Res			Performance Improvement (QAF committee monthly for 2 months Executive QAPI Committee will r monthly for 2 months and review Medication Administration Audit I determine trends and/or issues t need further interventions put int and to determine the need for fur frequency of monitoring.	. The neet 7 the Report to hat may o place	
	who was taking care about Resident #44 ' wound nurse recalled	o Resident #44 ' s physician of his hand and telling her s resistance to care. The I the physician had stated to are doing and just monitor				

If continuation sheet Page 26 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345366	B. WING _				C 01/2022
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 104 SE SECOND STREET NOW HILL, NC 28580		
(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 B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETI	
F 684	stated the nurse woul wound treatments on medication aids could she does not track tre are being completed. Nurse #10 was interv AM. She stated if she was supervising MA # remembers Resident his hand but doesn ' t dressing change for h completed a dressing she would have docu Nurse #4 was intervie and she stated she w 3:00 PM until 11:00 P supervising MA#4 wh #44. Nurse #4 stated one soak and dressing but could not rememb	e Manager #1, and she d be responsible for doing Resident #44 if the I not do them. She stated eatments to make sure they iewed on 9/1/22 at 11:07 e was working 3/1/22 and #3. She stated she #44 having a problem with remember if she did a nim. She stated if she had change on Resident #44, mented it. ewed on 9/1/22 at 11:51 AM as working on 3/4/22 from M. She stated she was o was assigned to Resident I she remembered doing g change for Resident #44 ber what day.	F6	584			
F 761 SS=E	On 09/01/22 at 12:34 interviewed, and she wounds treatments ge the electronic record. Label/Store Drugs an CFR(s): 483.45(g)(h) §483.45(g) Labeling o Drugs and biologicals	stated it is her expectation et completed and charted in d Biologicals	F 7	761			10/4/22

Facility ID: 923035

If continuation sheet Page 27 of 61

		ND HUMAN SERVICES			PRINTED: 10/06/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345366	B. WING		C 09/01/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		304 SE SECOND STREET	
				NOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 761	Continued From page	e 27	F 761		
	professional principle		1 /01		
	appropriate accessor				
	instructions, and the				
	applicable.				
	§483.45(h) Storage of Drugs and Biologicals				
	Federal laws, the fac biologicals in locked	ordance with State and ility must store all drugs and compartments under proper , and permit only authorized cess to the keys.			
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distribu	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can			
		is not met as evidenced			
	Based on observation	ns, record review and staff / failed to label medications		F761 Label/Store Drugs and Biologi	cals
		tion and with the date the		On 08/31/22 the DON removed and	
		ed and an expiration date on		destroyed all medications that were	not
	2 of 7 medication car	ts (800-hall and 700-hall		labeled with an open date and/or	
	,	failed to discard expired		expiration date and any expired	
		medication carts (300-hall		medications from the 300, 400, 700 a	
		ion cart) and in 1 of 2		800 hall medication carts and 300-40	
	medication storage re	•		hall medication storage room per fac	anty
	of medication storage ro	oom) inspected for storage		protocol.	
				On 09/22/22 the Unit Manager and 0	וכ
	Finding included:			Nurse an audit of all medication carts	
	J			include 300, 400, 700 and 800 hall	
	1. An observation of	the 800-hall medication cart		medication carts and medication roo	ms to

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 28 of 61

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		E SURVEY
		345366	B. WING _		09	C 9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(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 C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From pag	ie 28	F7	761		
		' p.m. was conducted in the		include 300-400 medication	storade room	
		ion Aide (MA) #1. The		This audit is to ensure the n	-	
	-	a Soliqua Insulin pen for		medication aid labeled med		
		label that read expires		open date/expiration date w		
		ter opening. There was no		expired medications are ren		
	open date or expirati	ion date observed written on		destroyed per facility protoc	ol, and that all	
	the Soliqua Insulin p	en label.		carts were locked when not	supervised by	
				assigned nurse. The DON v		
		MA#1 on 8/31/2022 at 3:19		concerns identified during the		
	•	did not administer insulin to		include labeling mediations		
		d she did not know when the		date/expiration date when ir		
		was opened, and there was		removing expired medicatio	•	
	not a date written on			protocol and locking medica		
		Soliqua Insulin pen was		audit will be completed by 1	0/04/22.	
		the label indicated the				
		expired twenty-eight days ere was no date written on		On 09/23/22 the Staff Devel Coordinator (SDC) initiated	•	
		when the Soliqua Insulin pen		with all nurses and medicati		
	would expire.	men me Soliqua insulin pen		regarding Medication Storag		
	would expire.			emphasis on (1) labeling me		
	On 8/31/2022 at 3:2	1 p.m., the Director of		an open date/expiration date		
		present for the continuation		protocol (2) nurse/medicatio		
		cation cart observation. There		responsibility to check medi		
		of an opened Lantus Insulin		cart/medication storage room		
		l with an open date of		expired medications and dis		
	7/28/2022 on the lab			expired medications per pha		
	_ ·	rved written on the label. The		and (3) storage of medication	-	
		nsulin pen stated the Lantus		medication cart when not di	•	
		wenty -eight days after		supervised by assigned nur		
		Basaglar Insulin pen for		will be completed by 10/04/2		
		served with no open date and		10/04/22 any nurse or medi		
	no expiration date w	ritten on the pharmacy label.		who has not worked or rece		
	On 8/31/2022 at 2:21	3 p.m., the DON stated the		in-service will complete in-s		
		as expired based on the date		next scheduled work shift. A nurses or medication aides	-	
	-	ed the Lantus Insulin pen in		in-serviced during orientatio		
		She stated there was no date		Medication Storage.		
		acy label when the Basaglar				
		carded the Basaglar Insulin		The Unit Manager and QI N	uraa will audit	

Facility ID: 923035

If continuation sheet Page 29 of 61

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345366	B. WING		0	C 9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 761	Continued From pag	e 20	F 76	1		
F 701			F 70	all medication carts and medica	tion	
		oosal. The DON stated the date Inulin pens were		storage rooms weekly x 4 week		
		nacy label and an expiration		monthly x 1 month utilizing the		
		umber of days for expiration		Cart/Medication Storage Room		
	provided on the phar			This audit is to ensure the nurse		
				medication aid labeled medicat	ion with an	
	On 8/31/2022 at 3:27	7 p.m., Unit Manager #1		open date/expiration date when	indicated,	
	stated to the DON sh			expired medications are remove		
		/29/2022, and she opened		destroyed per facility protocol, a		
		en on 8/29/2022. Unit		carts were locked when not sup	-	
		served writing 9/26/2022 as		assigned nurse. The DON will a		
		the label for the Soliqua		concerns identified during the a		
	pen was opened on t	ot write a date the Soliqua		include labeling mediations with date/expiration date when indic	•	
	pen was opened on t			removing expired medications		
	On 8/31/2022 at 3:33	3 p.m., Nurse #8 stated she		protocol and locking medication	-	
		medication cart on 8/31/2022		Director of Nursing (DON) will r		
	for the 7:00 a.m. to 3	:00 p.m. shift. She stated		Medication Cart/Medication Sto		
		received insulin coverage		Room Audit Tool weekly x 4 we	eks then	
	for that shift, and Res	sident #11 received her		monthly x 1 month to ensure all	concerns	
		ua Insulin. She stated she		were addressed. for completion		
	did not recall checkin to administrating the	ng for an expiration date prior Soliqua Insulin.		ensure all areas of concerns we		
	2 On 0/21/2022 -+ 2	2:25 nm on chaoniction of		The DON will present the findin Medication Cart/Medication Sto		
		3:35 p.m., an observation of ion cart was conducted with		Room Audit Tool to the Executiv	0	
		ng (DON) and Nurse #9		Assurance Performance Improv		
		Lantus Insulin pen was		(QAPI) committee monthly for 2		
	· · ·	ident identification and no		The Executive QAPI Committee		
		piration date was written on		monthly for 2 months and revie		
	the pharmacy label.	Nurse #9 disposed the		Medication Cart/Medication Sto	rage	
	Lantus Insulin pen in	to the sharp disposal.		Room Audit Tool to determine to		
				and/or issues that may need fur		
		7 p.m., in an interview with		interventions put into place and		
		#9, Nurse #9 stated she was		determine the need for further f	requency	
		.m. to 11:00p.m. shift and		of monitoring.		
		700-medication cart. They				
		us Insulin pen was opened				

Facility ID: 923035

If continuation sheet Page 30 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345366	B. WING_				C 101/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CREEND		AND REHABILITATION CENTER		1;	304 SE SECOND STREET		
GREENDA	ALE FOREST NORSING F	AND REPABILITATION CENTER		S	SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 761	opened. They also sta should be labeled with 3. On 8/31/2022 at 3: the 300-hall medication the Director of Nursin Insulin pen was obser as the expiration date probably wrote the op- line. An opened vial of observed on the 300- expiration date 8/18/2 DON discarded the La- Lantus Insulin vial inter- container. 4. On 8/31/2022 at 4: the 300-400 hall medi- conducted with the Di- the refrigerator, a both with an expiration date and two intravenous a observed dated with a DON stated the resider receiving the medication she stated the antibio- back to the pharmacy 5. On 8/31/2022 at 4: the 400-hall medication Unit Manager #2. Sev milligram suppositories 7/2022 were observer cart. Unit Manger #2.	label from pharmacy, the pharmacy label when ated the Lantus Insulin pen in resident information. 49 p.m., an observation of on cart was conducted with g (DON). An opened Lantus rved with 8/16/2022 written e. The DON stated the nurse bened date on the wrong of Lantus Insulin was hall medication cart with an 2022 written on the vial. The antus Insulin pen and the or the sharp disposal 00 p.m., an observation of ication storage room was irrector of Nursing (DON). In the of magic mouth wash e 8/11/2022 was observed antibiotic bulbs were an expiration 8/8/2022. The ents were no longer ions and discarded the edication disposal container. otics should had been sent v.	F	761			

Facility ID: 923035

If continuation sheet Page 31 of 61

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 0. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
		345366	B. WING		0	C 9/01/2022
NAME OF PF	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO		
0055100			1	304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER	s	SNOW HILL, NC 28580		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From pag	o 31	F 761			
1 /01			F /01			
		Managers for expired items he checked her medications				
	On 8/31/2022 at 4:1	9 p.m. in an interview with				
		before administration of				
		dication was checked to				
		on was the right medication,				
	-	, the right dose, right route				
		. She stated the medication				
		weekly for expiration of stock Init managers, and Insulin				
	-	high doses that resulted in				
		ore frequently. She stated				
		nsulin pens or vials, the				
	opening date and ex the pharmacy label of	piration date were written on on the insulin.				
	On 9/1/2022 at 9:00	a.m. in an interview with				
		the Unit Managers were				
		king the medication carts for				
	expirations weekly, a					
	medication cart daily	ations on her assigned ⁄.				
	On 9/1/2022 at 3:11	p.m. in an interview with the				
		she stated the pharmacy				
		tion monthly for expirations				
		ate when the pharmacy last				
		tion carts. She stated nedication carts were to				
	0	n cart and medications for				
		bre administering medication				
		e stated Unit Managers were				
	responsible for chec	king their assigned				
		l medication storage rooms				
	for expired medication	-				
F 812	Food Procurement.S	Store/Prepare/Serve-Sanitary	F 812			10/4/22

Facility ID: 923035

If continuation sheet Page 32 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345366	B. WING				C 101/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0 1/2022
GREEND	ALE FOREST NURSING A	AND REHABILITATION CENTER			804 SE SECOND STREET NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	CFR(s): 483.60(i)(1)(1) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accorda standards for food set This REQUIREMENT by: Based on observation facility failed to 1) labo items and 2) remove in 1 of 2 nourishment between the 700 and Findings included: An observation of the between the 700 and 8/31/22 at 9:14 AM, a were inspected. The inside the refrigerator mixed fruit not labeled of 8/29/22, 2 expired 3	2) by requirements. re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ince with professional rvice safety. ' is not met as evidenced n and staff interview, the el and date leftover food expired food stored for use refrigerators located in 800 resident halls.	F	312	F812 Food Procurement, Store/Prepare/Serve On 8/31/22, the housekeeping staff removed all expired items and/or items not labeled per facility protocol from th 700/800 nourishment room refrigerator On 09/22/22 the Activities Director initiated an audit of all nourishment roor refrigerators and refrigerators in reside rooms to ensure all food items were da and/or expired items were discarded p facility protocol. The Activities Director address all concerns identified during fa audit to include removing all expired ite	e r. om ent ated er will the	

Facility ID: 923035

If continuation sheet Page 33 of 61

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345366	B. WING		0	9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 33	F 81	2		
		utritional supplement		and/or items not labeled per faci	litv	
		c bag that appeared to be		protocol and education of staff.	•	
		labeled/dated, 1 plastic bag		be completed by 10/04/22.		
	of cut pineapple fruit	without a name or date, 1				
		½ filled with water without a		On 09/23/22 the SDC initiated a		
		opened bottles of salad		in-service with all nurses, nursin		
		ot labeled or dated. Also, an		assistants, dietary staff and hous		
		y with lunch items (spaghetti, was found on top of the		staff regarding Monitoring Nouris and Resident Refrigerators with		
	fridge.	was found on top of the		on nurse, nursing assistant, diet		
	indge.			housekeeping staff responsibility	-	
	During an interview v	vith the Dietary Manager on		monitoring nourishment room re		
	8/31/22 at 9:21 AM, s	she revealed it was the		and refrigerators in resident roor	ns to	
		ekeeping/nursing staff to		ensure items are dated per facili	-	
	manage the content	of nourishment room		protocol and all expired items re		
	refrigerators.			and discarded. In-service will be completed by 10/04/22. After 10		
	On 8/31/22 at 0.25 A	M, accompanied by the		any nurse, nursing assistant, die		
		DON), the 700/800 hall		and/or housekeeping staff who h	•	
		ator was inspected a second		worked or received the in-service		
	-	l unlabeled contents were no		complete in-service prior to next		
	longer in the refrigera	ator. The DON revealed the		scheduled work shift. All newly h	ired	
		vere managed by nursing		nurses or medication aides will b		
		milies brought outside food		in-serviced during orientation reg		
		ld have been labeled and		Monitoring Nourishment and Res	sident	
		icated her expectation was hment rooms be monitored		Refrigerators.		
	and cleaned daily by			The Activities Director will audit	all	
		nouooniooping.		nourishment room refrigerators a		
	Housekeeping Attend	dant #1 was interviewed on		resident room refrigerators week		
		and she revealed that she		weeks then monthly x 1 month u		
	-	l expired/unlabeled items		Nourishment Room Audit Tool. T		
	from the 700/800 hal	I nourishment refrigerator.		is to ensure all food items in nou		
	During an interview	with the Administrates and		room and resident rooms were d		
		vith the Administrator on		and/or expired items were discal		
	process in-place for o	she revealed there was a		facility protocol. Activities Director address all concerns identified d		
		ods from the nourishment		audit to include removing all exp	-	
		erformed by housekeeping		and/or items not labeled per faci		

Facility ID: 923035

If continuation sheet Page 34 of 61

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345366	B. WING		0	C 9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER	1	1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 812	daily. She stated all t	e 34 food in nourishment room been labeled and dated	F 812	protocol and education of staff/res The Administrator will review the Nourishment Room Audit Tool we		
				weeks then monthly x 1 month to all concerns were addressed.	ensure	
				The Director of Nursing (DON) will present the findings of the Nourish Room Audit Tool. to the Executive Assurance Performance Improver (QAPI) committee monthly for 2 m The Executive QAPI Committee w monthly for 2 months and review t Nourishment Room Audit Tool to determine trends and/or issues the need further interventions put into and to determine the need for furth frequency of monitoring.	nment Quality nent nonths. vill meet he at may place	
F 842 SS=D	Resident Records - Io CFR(s): 483.20(f)(5),		F 842			10/4/22
	<ul> <li>(i) A facility may not resident-identifiable to</li> <li>(ii) The facility may represent the facility may represent the facility may represent the factor of the factor</li></ul>	lease information that is				
	-					

Facility ID: 923035

If continuation sheet Page 35 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345366	B. WING				C 01/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREEND	ALE FOREST NURSING A	AND REHABILITATION CENTER		1 S			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	<ul> <li>(iii) Readily accessible</li> <li>(iv) Systematically org</li> <li>§483.70(i)(2) The fact all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law;</li> <li>(iii) For treatment, pay operations, as permit with 45 CFR 164.506</li> <li>(iv) For public health neglect, or domestic was activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to he by and in compliance</li> <li>§483.70(i)(3) The fact record information ag unauthorized use.</li> <li>§483.70(i)(4) Medical for-</li> <li>(i) The period of time</li> <li>(ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State</li> <li>§483.70(i)(5) The me</li> <li>(i) A record of the rest</li> </ul>	e; and ganized ility must keep confidential hed in the resident's records, h or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, boses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident;	F	842			

Facility ID: 923035

If continuation sheet Page 36 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/06/2 FORM APPRO OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET		
		{	SNOW HILL, NC 28580	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI	
F 842	and resident review e determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on record rev facility failed to maint Administration Recor reviewed for wound of to document blood su record for 1 of 1 resid (Resident #73). The findings included 1. Resident #7 was r 9/2/21. Her diagnose hypertension. The quarterly Minimu 5/20/22 revealed Res	y preadmission screening evaluations and locted by the State; es, and other licensed ss notes; and logy and other diagnostic equired under §483.50. T is not met as evidenced iew and staff interview the ain accurate Treatment ds (TAR) for 1 of 2 residents eare (Resident #7) and failed ligar results in medical lent reviewed for insulin use the e-admitted to the facility on es included stroke and m Data Set (MDS) dated sident #7 was cognitively	F 842	F842 Resident Records - Identifia Information On 09/20/22 the DON initiated a 1 audit of all TARs to include TAR for resident #7 for the past 14 days to treatments were completed per physician □s order. The DON will a all areas of concern identified duri audit to include assessment of the resident, notification of MD of treat omission for further instructions ar education of the nurse. Audit will b completed by 10/04/22. On 08/31/22 the Unit Manager cor	00% or o ensure address ng the tment nd oe	
	bed mobility and toile with transfers. Resid ulcers at the time of t She was coded at ris ulcers.	k for developing pressure		an audit of all residents to include #73 with orders for blood glucose monitoring. This audit is to ensure nurse is completing blood glucose monitoring per physician order wit documentation of finger stick blood (FSBS) in the electronic record an patification of the physician when	e the e h d sugar id	
	breakdown or develo	e planned for risk of skin pment of pressure ulcers. cian orders for Resident #7 g orders:		notification of the physician when outside of ordered parameters for recommendations. The Unit Mana address all concerns identified dur audit to include but not limited to assessment of the resident, updat	further iger will ring the	

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 37 of 61

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED
				C	
		345366	B. WING		09/01/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
GREENDA	I E FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET	
01122112/1				SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE
F 842	Continued From page	e 37	F 84	2	
		with normal saline and pat	1 04	electronic record for FSBS a	nd/or
		Apply skin prep and allow to		notification of the physician w	
		r with 4x4 foam dressing.		outside of ordered parameter	
	This order started on discontinued on 7/11/	6/14/22 and was		be completed by 10/04/22.	
				On 09/23/22 the Staff Develo	opment
	A review of the Treat	ment Administration Record		Coordinator (SDC) initiated a	
	(TAR) from July 1, 20	22, through July 11, 2022,		with all nurses regarding TAF	
		ntation of completing the		Documentation/Treatments v	
	dressing change on 7			on nurse⊡s responsibility on	-
	0 0			treatments or completing treat	-
	b. Buttock: Cleanse	with normal saline and pat		physician order with docume	-
		Apply Medi honey (a gel to		electronic treatment record. I	
		ng) to wound bed and cover		be completed by SDC. After	
	with 4x4 foam dressin			nurse who has not worked or	-
		tarted on 7/12/22 and was		in-service will complete in-se	
	discontinued on 8/4/2			next scheduled work shift. Al	-
				nurses will be in-serviced du	-
	A review of the Treat	ment Administration Record		orientation regarding TAR	
		2022, through July 31, 2022,		Documentation/Treatments	
		ntation of completing the			
	dressing changes on			On 09/23/22 the SDC initiate	d an
	3			in-service with all nurses reg	
	An interview was con	ducted with the Medication		Glucose Monitoring with emp	
		ned as the Treatment Aid on		obtaining FSBS per physicial	
	-	22, and 7/29/22. She stated		documentation of FSBS in th	
		change for Resident #7 on		record and notification of the	
	-	22, and 7/29/22 but she failed		when FSBS is outside ordere	
		being completed on the		parameters for further recom	
		could not remember why		In-service will be completed I	by 10/04/22.
	she didn ' t complete	-		After 10/04/22 any nurse who	
				worked or received the in-ser	
	On 09/01/22 at 12:34	PM the Director of Nursing		complete in-service prior to n	next
		she stated her expectation		scheduled work shift. All new	
		nents get completed and if		nurses will be in-serviced dur	-
		e charted in the electronic		orientation regarding Blood G	-
	record.			Monitoring.	

Facility ID: 923035

If continuation sheet Page 38 of 61

		ND HUMAN SERVICES				FOR	D: 10/06/202
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	<u>O. 0938-039</u> E SURVEY PLETED
		345366	B. WING			С	
	ROVIDER OR SUPPLIER	0.0000		ет	REET ADDRESS, CITY, STATE, ZIP CODE	08	/01/2022
	NOVIDER OR OUT FLER				04 SE SECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER			NOW HILL, NC 28580		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION
F 842	Continued From page	e 38	F 8	342			
					5 times a week x 4 weeks then mont	hlv x	
					1 month to include weekends utilizing	•	
	2. Resident #73 was	admitted to the facility on			Medication Administration Audit Repo	-	
	8/01/22 with diagnos	es which included diabetes			treatments. This audit is to ensure al		
	and dementia.				treatments are completed per		
					physician⊡s order with documentation	n in	
		ted 8/10/22 for Lantus			the electronic record. The DON will		
	Solution 100 unit/mL				address all concerns identified during		
		time a day for Diabetes			audit. The Director of Nursing will rev the Medication Administration Audit	lew	
	(BS) is 150 or below.	t noon hold if blood sugar			Report for treatments 5 times a week	× 1	
					weeks then monthly x 1 month to ens		
		August 2022 MAR revealed tus insulin was administered			all areas of concern were addressed		
	on 8/14/22, 8/19/22,	8/20/22, 8/21/22, 8/23/22,			The Unit Manager will audit all reside	ents	
	8/24/22, 8/25/22, 8/2	6/22, 8/27/22, 8/28/22,			with orders for FSBS monitoring to in	clude	
		without record of blood			resident #73 three times a week x 4		
		ed and documented in the			weeks then monthly x 1 month utilizing	•	
	medical record.				Blood Glucose Monitoring Audit Tool		
	<b>.</b>				audit is to ensure the nurse is comple	•	
		on 8/31/22 at 1:01 pm Nurse d insulin to Resident #73 on			blood glucose monitoring per physici order with documentation of finger st		
		3/22, 8/24/22, 8/25/22,			blood sugar (FSBS) in the electronic		
		stated she completed the			record and notification of the physicia	an	
	FSBS for Resident #	•			when FSBS is outside of ordered		
	administered the insu	ulin, but she did not			parameters for further recommendati	ons.	
	document in the med	lical record because there			The Unit Manager will address all		
		er the blood sugar. Nurse			concerns identified during the audit to		
		obtained and entered the			include but not limited to assessmen		
		she forgot to add the prompt			the resident, updating electronic reco		
	to enter the blood su	gar result.			FSBS and/or notification of the physi when FSBS is outside of ordered	cian	
	During an interview o	on 8/31/22 at 1:05 pm Nurse			parameters. The Director of Nursing	will	
		she corrected the order and			review the Blood Glucose Monitoring		
		document Resident #73 ' s			Tool weekly x 4 weeks then monthly		
		22. She stated she reviewed			month to ensure all concerns were		
	•	on and again monthly.			addressed.		
	During an interview o	on 8/31/22 at 1:24 pm the			The DON will present the findings of	the	
ORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID:650		Faci	lity ID: 923035 If cont	inuation she	et Page 39 of

	S FOR MEDICARE &			CONSTRUCTION	OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					с
		345366	B. WING		09/01/2022
IAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
REENDA	LE FOREST NURSING	AND REHABILITATION CENTER		304 SE SECOND STREET	
				5NOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTIC
F 842	Continued From page	e 39	F 842		
		OON) revealed the nurses		Medication Administration Audit Repor	t
	-	er physician orders correctly.		and Blood Glucose Monitoring Audit To	loo
	The DON stated the i	nurses were able to 73 ' s blood sugar in the vital		to the Executive Quality Assurance Performance Improvement (QAPI)	
		edical record if no prompt		committee monthly for 2 months. The	
	was added to the ord			Executive QAPI Committee will meet	
	Dunin n e talankana in	tom inverse 0/04/00 at 0.50		monthly for 2 months and review the	
		terview on 8/31/22 at 6:56 d she administered insulin to		Medication Administration Audit Repor and Blood Glucose Monitoring Audit To	
		6/22, 8/14/22, 8/20/22,		to determine trends and/or issues that	
		8/28/22. She reported she		may need further interventions put into	<b>D</b>
		gar before administering the cument the blood sugar in		place and to determine the need for further frequency of monitoring.	
		ecause the order did not		initial frequency of monitoring.	
	have a prompt to ente	er the information. Nurse #3			
		ord of the blood sugar			
	information into the m	ook but did not enter the nedical record.			
		n 9/01/22 at 1:47 pm the			
		d the nurse was expected to 73 ' s blood sugar in the			
	medical record.				
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F 867		10/4/22
	§483.75(g) Quality as	ssessment and assurance.			
	§483.75(g)(2) The quassurance committee	ality assessment and must:			
	action to correct iden This REQUIREMENT	ement appropriate plans of tified quality deficiencies; is not met as evidenced			
	and staff interviews, a	ns, record review, resident and physician interviews the		F867 QAPI/QAA Improvement Activiti	es
	facility's Quality Asse	ssment and Assurance			

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 40 of 61

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
						С
		345366	B. WING		0	9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET		
	1			SNOW HILL, NC 28580		
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 867	Continued From pag	e 40	F 86	7		
		es and monitor interventions		initiated an audit of previous of	citations and	
		to place following the		action plans within the past tw		
		complaint surveys conducted		include F550 Dignity and Res	•	
		and 10/16/20. This was for		resident right to smoke, F583		
	five deficiencies cite	d in resident rights (F550),		privacy during care, F661 rec	apitulation of	
		561), personal privacy and		stay and F880 infection contr		
		), discharge summary (F661),		the QA committee has mainta		
		(F880). The duplicate		monitored interventions that w		
		federal surveys of record		place. Action plans were revis		
	sustain an effective (	the facility's inability to		updated and presented to the Committee by the Administration		
	Sustain an ellective v	QAA program.		concerns identified. The Facil		
	Findings Included:			Consultant will address all co	•	
				identified during the audit to in		
	This tag was cross-r	eferenced to:		not limited to education of sta		
				be completed by 10/04/22.		
		oservation, record review,				
		d staff interviews, the facility		On 09/23/22 the Facility Cons		
		esident's dignity by not		initiated an in-service with the		
		ver on an indwelling urinary		Administrator, Director of Nur	• • •	
		2 residents reviewed for		and Quality Assurance (QA) I		
	dignity (Resident #14	+).		regarding the Quality Assurar process to include implement		
	During the recertifica	ation survey that concluded		Action Plans, Monitoring Tool		
		ty failed to assist the resident		Evaluation of the QA process		
		e meal tray was delivered to		modification and correction if		
	-	sident observed who required		prevent the reoccurrence of d		
	assistance with feed	ing.		practice to include profession		
				In-service also included ident		
		as interviewed on 9/1/22 at		that warrant development and		
		vealed the QAA committee		a system to monitor the corre		
	-	iss various issues that did not		implement changes when the	-	
	catheters.	d to privacy covers on		outcome is not achieved and an effective QA process. In-se	•	
				completed by 9/26/22. All nev		
	2. F561 Based on of	oservations, record review,		Administrator, DON and QA r	•	
		erviews, the facility failed to		educated during orientation re		
		esident's request to smoke at		QA Process.	J	
		for 1 of 2 residents reviewed				

Facility ID: 923035

If continuation sheet Page 41 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (	PPROVE
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
		345366	B. WING		C 09/01	/2022
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1304 SE SECOND STREET		
GREENDALE FOREST NURSING AND REHABILITATION CENTER			SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 867	Continued From page	- /1	F 867	7		
1 007			F 00/			
	for smoking (Residen	μ <i>#τ</i> υ).		All data collected for identified a concerns to include dignity and		
	During the recertificat	tion and complaint survey		resident rights, privacy, recapitu		
		20/21, the facility failed to		stay and infection control will be		
	allow independent/sa			the Quality Assurance committee		
	-	nd whenever they wanted		review monthly x 6 months by th		
	for 2 of 2 residents re	viewed for choices.		Administrator. The Quality Assu	rance	
				committee will review the data a		
		s interviewed on 9/1/22 at		determine if plan of corrections i		
		ealed the QAA committee		followed, if changes in plans of a		
		ss various concerns in the		required to improve outcomes, it		
	facility that did not inc	clude resident choice.		staff education is needed, and if		
	2 EE92 Based on reg	cord review, observation,		monitoring is required. Minutes of Quality Assurance Committee w		
		d staff interviews, the facility		documented monthly at each me		
		acy when providing personal		the QA Nurse.	setting by	
		nts reviewed for privacy				
	(Resident #98).			The Facility Nurse Consultant w	ill ensure	
	(			the facility is maintaining an effe		
	During the COVID-19	focused survey that		program by reviewing and initial		
	concluded on 10/16/2	20, the facility failed to		Executive committee Quarterly r	meeting	
	provide privacy to Re	sident #1 during a sacral		minutes and ensuring implemen	ted	
		ng change by leaving the		procedures and monitoring prac		
		or open when the resident		address interventions, to include	coding	
	-	e waist down and not		accuracy of Minimum Data Set		
		idents observed during		Assessments, environmental se		
	care.			activities of daily living care and	-	
	The Administrator wa	s interviewed on 9/1/22 at		staffing requirements and all cur citations and QA plans are follow		
		vealed the QAA committee		maintained Quarterly x2. The Fa		
		ss various concerns in the		Consultant will immediately retra	-	
	facility that did not inc			Administrator, DON and QA nur		
				identified areas of concern.	,	
	4. F661 Based on re	cord review and staff				
	interviews, the facility	-		The results of the Monthly Quali		
		at the facility for 1 of 1		Assurance meeting minutes will		
	resident reviewed for	discharges (Resident #103).		presented by the Quality Assura		
	<b>_</b>			to the Executive Committee Qua	-	
	During the recertification	tion and complaint survey		for review and the identification	of trends,	

Facility ID: 923035

If continuation sheet Page 42 of 61

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		345366	B. WING			C / <b>01/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE		ZIP CODE	
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 867	Continued From page	e 42	F 86	67		
	that concluded non 5/20/21, the facility failed to provide a discharge summary that included a recapitulation of the resident's stay for 1 of 1 resident reviewed for discharges.			development of action p to determine the need a continued monitoring.		
	with the Administrator was assigned the dis- forgot to enter/docum because she was at I took Resident #103 of Administrator further distracted and forgot returned from break.	stated the nurse got to enter the note when she				
	staff and resident inter (1) implement the Ce Prevention (CDC) gu precautions for those to date with the COV/ following the broad-b- testing (Resident #94 #77, Resident #80, R and Resident #45) ar isolation gown and gl isolation room (Nurse in COVID-19 outbrea Record review of the COVID-19 facility test and five staff member the month of August 2	ased approach for outbreak esident #44, Resident esident #5, Resident #16, ad (2) failed to remove oves before exiting an e Aide #7). The facility was k status as of 6/06/22. prior four-week period of ting revealed two residents rs had tested positive during 2022. The dates of the most ent positive COVID-19				
	During the COVID-19 complaint investigation 10/16/20, the facility f					

Facility ID: 923035

If continuation sheet Page 43 of 61

	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED	
		345366	B. WING		09	C 9/01/2022	
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP COD	DE		
GREEND	ALE FOREST NURSING A	AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 867	wound cleanser, (that resident's dressing ch resident's bed-not on resident's bed and did placing it in back into residents reviewed for During the recertificat on 5/20/21, the facility surveyors who entered signs and symptoms The Administrator wa 3:56 PM, and she rev met monthly and infect The Administrator stat had impacted the rep control. The plan of c immediately after last month after the state Infection Prevention & CFR(s): 483.80(a)(1)) §483.80 Infection Con The facility must estat infection prevention a designed to provide a comfortable environm development and trar diseases and infection program. The facility must estat	a nurse took a bottle of a was used during a nange and placed on the the clean field barrier), off a d not clean the bottle prior to the treatment cart for 1 of 5 r infection control. ion survey that concluded y failed to screen two state ed the building after hours for of COVID-19. s interviewed on 9/1/22 at ealed the QAA committee ction control was discussed. ted that change of staffing eated citation of infection prection was implemented year's survey and ended 1 follow-up survey. & Control (2)(4)(e)(f) htrol blish and maintain an nd control program a safe, sanitary and hent and to help prevent the hsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at	F 867			10/4/22	

If continuation sheet Page 44 of 61

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345366	B. WING				C 01/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA	ALE FOREST NURSING A	ND REHABILITATION CENTER			304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	§483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicab- infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco- resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir	em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other can spread to other se or infections should be ismission-based precautions ent spread of infections; lation should be used for a t not limited to: at not limited to: at not limited to: at not limited to the isolation, infectious agent or organism t the isolation should be the oble for the resident under the s under which the facility ees with a communicable cin lesions from direct or their food, if direct ne disease; and procedures to be followed	F	880			

If continuation sheet Page 45 of 61

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/06/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345366	B. WING		09/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CREENDA		AND REHABILITATION CENTER		1304 SE SECOND STREET	
				SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 880	Continued From page	e 45	F 880		
	identified under the fa	acility's IPCP and the			
		lle, store, process, and s to prevent the spread of			
	IPCP and update the	view. lot an annual review of its ir program, as necessary. is not met as evidenced			
	Based on observation resident interviews, the	ns, record review, staff and ne facility failed to (1) rs for Disease Control &		FF880 Infection Prevention & Col	ntrol
	Prevention (CDC) gu precautions for those to date with the COV	idance to initiate isolation residents that were not up ID-19 vaccine when		On 08/29/22 the DON initiated iso precautions for residents #94, resi #44, resident #77, resident #80, re	ident esident
	testing (Resident #94 #77, Resident #80, R and Resident #45) ar isolation gown and gl isolation room (Nurse	ased approach for outbreak , Resident #44, Resident esident #5, Resident #16, nd (2) failed to remove oves before exiting an e Aide #7). The facility was		#5, resident #16, and resident #45 Centers for Disease Control & Pre (CDC) guidance for residents that not up to date with the COVID 19 Appropriate signage for isolation r placed on each resident door.	were vaccine.
	Record review of the COVID-19 facility tes and five staff member the month of August 2	k status as of 6/06/22. prior four-week period of ting revealed two residents rs had tested positive during 2022. The dates of the most ent positive COVID-19 and 8/27/22.		On 09/16/22 the DON verbally edu nurse aide #7 regarding donning/o PPE with emphasis on removing F prior to exiting resident room and removal/changing N95 mask betw isolation rooms.	doffing PE
	Findings included:			On 09/20/22 the Administrator init audit of all residents not up to date	
	and Control Recomm SARS-CoV-2 Spread	nterim Infection Prevention endations to Prevent in Nursing Homes" dated		COVID 19 vaccine. This audit is to the facility implemented isolation precautions for those residents that	o ensure at were
	2/02/22 stated outbre	ak testing should be		not up to date with the COVID-19	vaccine

Facility ID: 923035

If continuation sheet Page 46 of 61

OLIVIEN		MEDICAID SERVICES				IO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING	<u> </u>			
			5.14/010			С	
		345366	B. WING		0	9/01/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEND	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET			
				SNOW HILL, NC 28580			
(X4) ID	-		ID	PROVIDER'S PLAN OF CORF		(X5) COMPLETIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		DATE	
F 880	Continued From page	e 46	F 88	0			
	conducted in respons	se to newly identified		when following the broad-based	d approach		
		pad-based approach those		for outbreak testing. The Admin			
	-	t up to date on vaccination		address all concerns identified	during the		
		estricted to their rooms,		audit to include but not limited t			
	• •	ative and cared for by staff		implementing isolation precauti			
		er-level respirator, eye		CDC guidance and education o			
	protection, gloves, an	nd gown.		Audit will be completed by 10/0	4/22.		
	Record review of the	facility policy titled		On 9/23/22, the Facility Consult	tant		
		and Quarantine for Close		initiated an in-service the Direct			
	-	nd Community Visits" dated		Nursing, Administrator and Infe			
	July 2022 stated the	outbreak response when a		Preventionist on facility Guidelin	nes for		
	-	se of Covid-19 was identified		COVID Testing and Quarantine			
		sed approach for residents		responsibility of the Administrat			
		COVID-19 vaccinations		of Nursing and Isolation Preven			
		estricted to their rooms,		initiate new guidance timely, ed			
	-	egative, and care for by staff		facility staff on all updated guidated to ensure appropriate monitorin			
	using N95 or higher-leprotection, gown, and			infection control practices are in			
		gioves.		In-service will be completed by			
	During the entrance of	conference on 8/29/22 at					
		trator revealed the facility		On 09/23 22 the Director of Nu	rsing and		
	had been in COVID-1	19 outbreak status since		Infection Preventionist initiated			
	6/06/22.			in-service with all staff to includ	,		
				nursing assistants, accounts pa			
		he Resident Vaccination log		accounts receivable, social wor			
	-	g rooms were required to be		staff, therapy staff, administrate	-		
		e facility outbreak when sed approach for outbreak		staff, maintenance staff, recepti medical records director and	ionist,		
	response.	See approach for oubleak		housekeeping staff. regarding (	Guidelines		
				for COVID Testing and Quarant			
	a. An observation on	8/29/22 at 10:00 am		emphasis on initiating appropria			
	revealed Room #804	did not have isolation		isolation for residents not up to			
		lies in place. Resident #94		COVID vaccine during outbreak			
		ho resided in Room #804,		status per CDC guidance. In-se			
	declined the COVID-	19 vaccinations.		be completed by 10/04/22. After			
				any nurse, nursing assistant, di			
	b. An observation on			and/or housekeeping staff who			
	revealed Room #311	did not have isolation		worked or received the in-service	ce will		

Facility ID: 923035

If continuation sheet Page 47 of 61

		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345366	B. WING	C 09/01/2022	
	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	09/01/2022
		AND REHABILITATION CENTER			
JREENDA	ALE FOREST NORSING A	AND REHABILITATION CENTER		SNOW HILL, NC 28580	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 880	Continued From page	e 47	F 88		
	signage or PPE supplies in place. Resident #77, who resided in Room #311, declined the COVID-19 vaccinations.			complete in-service prior to next scheduled work shift. All newly h nurses nursing assistants, accou	
	c. An observation on			payable, accounts receivable, so worker, dietary staff, therapy sta	ff,
	revealed Room #402 did not have isolation signage or PPE supplies in place. Resident #80, who resided in Room #402, declined the COVID-19 vaccinations.			administrator, activity staff, main staff, receptionist, medical record director and housekeeping staff, in-serviced during orientation reg	ds will be
	d. An observation on			Guidelines for COVID Testing an Quarantine.	-
		did not have isolation lies in place. Resident #5, #710, was partially		On 09/23/22 the Infection Prever initiated an in-service with return	
	vaccinated with one o			demonstration with all nurses, nu assistants, therapy staff, dietary	ursing
	e. An observation on	8/29/22 at 10:30 am		housekeeping staff, Accounts Re Administrator, Accounts Payable	eceivable,
		did not have isolation lies in place. Resident #16,		records, receptionist, screener, s worker and maintenance staff in	
	who resided in Room receive the second C			facility Guidelines for PPE Use. I is on appropriate donning/doffing	-
	vaccination on 8/19/2 vaccination.	2 but declined the		include but not limited to gowns/ and use of PPE when enter resid	dent
	f. An observation on 8/29/22 at 12:15 pm revealed Room #206 did not have isolation signage or PPE supplies in place. Resident #45,			rooms and/or quarantine rooms CDC guidelines. In-service will b completed by 10/04/22. After 10 any staff who has not received th	e //04/22
	who resided in Room COVID-19 vaccinatio	#206, declined the		in-service will be in-serviced upo scheduled work shift. All newly h will be in-serviced with return	n next
	#1 revealed she was was placed on isolation	n 8/29/22 at 11:36 am Nurse not sure why Room #311 on but stated possibly		demonstration during orientation regarding facility Guidelines for F	
	find out the reason.	vaccination status but would		The Administrator will monitor all not up to date with COVID 19 va	ccines
		d reported Room #311 was ecause the facility was in		and boosters weekly x 4 weeks t monthly x 1 month utilizing the	hen

Facility ID: 923035

If continuation sheet Page 48 of 61

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
F 880	Continued From page	e 48	F 88	0		
	COVID-19 vaccinatio During an interview o Infection Preventionis Administrator and Dir were responsible for t monitoring. She state was not discussed wi hearing the DON talk requirement for reside with the COVID-19 va IP was unable to state DON did not impleme During an interview o Corporate Clinical Dir utilized the broad-bas COVID-19 outbreak a not up to date on the were required to be o instructed the facility precautions for the re date with COVID-19 va arrived at the facility of Clinical Director revea following CDC guideli missed the updated g Corporate Clinical Dir policy was provided to which included the cu- recommendations but the facility had not im policy regarding isola	n 8/30/22 at 12:11 pm the ector of Nursing (DON) the COVID-19 vaccination ed the updated guidance th her, but she recalled ing about the isolation ents that were not up to date accine with someone. The e why the Administrator and ent the changes. In 8/30/22 at 11:57 am the rector revealed the facility sed testing during a and that residents that were COVID-19 vaccinations in isolation. She stated she to implement isolation esidents that were not up to vaccinations when she on 8/29/22. The Corporate aled the facility was not ines and the corporation had guidance from the CDC. The rector reported an updated o the facility in July 2022		Quarantine/Isolation Audit Tool to the facility implemented isolation precautions for those residents the not up to date with the COVID-19 when following the broad-based a for outbreak testing. The Adminis address all concerns identified du audit to include but not limited to implementing isolation precaution CDC guidance and education of state Director of Nursing will review the Quarantine/Isolation Audit Tool w weeks then monthly x 1 month to all concerns were addressed.The DON will complete 10 staff observations to include staff on a weekly x 4 weeks then monthly x utilizing a PPE Audit Tool. This at ensure staff donned/doffed PPE appropriately when entering/exitin resident room when isolation prec were required. The DON will add concerns identified during the audiinclude re-training of staff. The D Nursing (DON) will review the PP Tool weekly x 4 weeks then month month to ensure all areas of condition of the Quarantine/Isolation Audit Tool an PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool an PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool an PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Tool to the Executive Quarantine/Isolation Audit Tool and PPE Audit Too	at were vaccine approach trator will uring the as per staff. The eekly x 4 ensure Il shifts 1 month udit is to ag cautions ress all dit to irector of PE Audit hly x 1 cerns ill ad the Quality	
	received. During an interview o	n 8/30/22 at 11:47 am with N, and Corporate Clinical		(QAPI) committee monthly for 2 r The Executive QAPI Committee monthly for 2 months and review Quarantine/Isolation Audit Tool ar	nonths. vill meet the	

Facility ID: 923035

		MEDICAID SERVICES	(X2) MI II TIP		CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	IPLETED
							С
		345366	B. WING			0	9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GREEND	LE FOREST NURSING	AND REHABILITATION CENTER		130 SN			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 49	F 88	30			
	Director the Administ	rator revealed she and the			PPE Audit Tool to determine trends	and/or	
	DON were responsible for the COVID-19				issues that may need further interve		
	vaccination effort and monitoring the status of				put into place and to determine the	need	
	immunization eligibilit	ty.			for further frequency of monitoring.		
	During an interview of Administrator revealed updated policy in July implementing it, but the all residents to accept they would not have the						
	made of Nurse Aide ( which had signage po- alerted staff that the r restrictions and requi utilized when providir instructed to wear a g and eye protection up observed wearing a g protection. NA #7 wa with gown, gloves, Na on and taking the gow hallway and placing t the hallway.	gown, N95 mask, gloves, bon entry. NA #7 was gown, N95, gloves and eye as observed exiting the room 95 mask, and eye protection wn and gloves off in the hem in a trash can located in					
	she stated she was n mask and gown off in before coming out int stated she was not ea	ed on 8/30/22 at 9:26 am and not educated to take her iside a room at the doorway to the hallway. She also ducated on disposing of the g a new one when coming					
	Infection Preventionis educated on donning	on 8/31/22 at 9:21 am the st (IP) revealed the staff was and doffing PPE for hire, annually, and random					

Facility ID: 923035

If continuation sheet Page 50 of 61

<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938	ROVE 8-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		345366	B. WING _		C 09/01/202	2
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	P CODE	
GREENDA		AND REHABILITATION CENTER		1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT	ETIO
F 880	Continued From page	e 50	F 8	380		
1 000	individual education		FC			
		irred. The IP stated she was				
	available if a staff me					
		procedure for the use of				
	PPE.					
		on 9/01/22 at 9:01 am the				
		ed the facility had provided use of PPE which included				
		PE as in person education as				
	well as computer train	-				
F 881	Antibiotic Stewardshi	-	F8	381	10/4/2	22
SS=C	CFR(s): 483.80(a)(3)					
	§483.80(a) Infection program.	prevention and control				
		blish an infection prevention				
		(IPCP) that must include, at				
	a minimum, the follow					
		ibiotic stewardship program				
		c use protocols and a				
	system to monitor an					
	by:	is not met as evidenced				
		iew, staff interviews, and		F881 Antibiotic Steward	Iship Program	
	physician interviews,					
		tic Stewardship Program.		On 09/23/22 the Directo	r of Nursing and	
		. 2		Infection Preventionist ir	-	
	Findings included:			all current residents with		
				antibiotic therapy for the		
		Antibiotics Stewardship		This audit is to ensure the		
		and revised 1/22/2018 vas responsible to utilize the		monitored antibiotic use Stewardship Protocol. T		
		and/or others regarding the		Facilitator will address a		
		itibiotics, provide prescribing		identified during the aud		
		bal or written feedback on		notification of the physic		
		ibing practices quarterly, and		concerns related to repe		

Facility ID: 923035

If continuation sheet Page 51 of 61

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345366	B. WING		0	C 9/01/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEND	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET		
	1			SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 881	Continued From page	e 51	F 881			
	education offerings o any developed antibi	n antibiotic stewardship and otic use protocols will occur bing practitioners and facility		use, organisms identified and ed the nurse. Audit will be complete 10/04/22		
	During an interview of Infection Preventionis IP for the past 5-6 ye reported she was res of antibiotic use at the the facility infection ra the quarterly Quality. She stated the pharm antibiotics ordered m with the pharmacy consul meetings. The IP rep familiar with the quar practices of prescribi she had not discusse any physicians or pro- stated antibiotic stew	on 8/31/22 at 9:21 am the st (IP) revealed she was the ears at the facility. The IP sponsible for the monitoring e facility and she reported ate and infection trends at Assurance (QA) meetings. hacy consultant reported the ionthly, but she has not met onsultant to discuss ntibiotics and did not recall tant attending the QA borted she did was not terly antibiotic prescribing ing practitioners report and ed antibiotic prescribing with oviders in the facility. She rardship education was not ing practitioners or facility		<ul> <li>On 09/23/22 the Facility Consultation initiated an in-service with the Din Nursing, Medical Providers and I Preventionist regarding Antibiotic Stewardship. Emphasis is on more and tracking antibiotic use within facility. In-service will be completed 10/04/22. All newly hired DON, M Providers and Infection Prevention be in-serviced during orientation Antibiotic Stewardship.</li> <li>The Director of Nursing will revies antibiotic use within the facility weeks then monthly x 1 month u Antibiotic Audit Tool. This audit is ensure the facility maintained a smonitoring and tracking antibiotic within the facility. The DON will a all concerns identified during the include retraining of the Infection</li> </ul>	rector of nfection whitoring the aed by Medical onist will regarding w all eekly x4 tilizing the s to system for c use address audit to	
	During a telephone ir am the Pharmacy Co not know the details of Stewardship Program attended QA meeting stewardship and anti with the IP. The Pha was able to assist with of the facility.	During a telephone interview on 8/31/22 at 10:18 am the Pharmacy Consultant revealed she did not know the details of the facility 's Antibiotic Stewardship Program. She stated she had not attended QA meetings or discussed antibiotic stewardship and antibiotic usage and monitoring with the IP. The Pharmacy Consultant stated was able to assist with the program at the request of the facility. During an interview on 8/31/22 at 10:55 am the Medical Director revealed he was not familiar with the Antibiotic Stewardship Program and had		Preventionist. The Administrator review the Antibiotic Audit Tool w weeks then monthly x 1 month to all concerns were addressed. The Administrator will forward the of the Antibiotic Audit Tool to the Quality Assurance Committee m months. The Executive Quality A Committee will meet monthly x 2 and review the Antibiotic Audit To determine trends and/or issues t need further interventions put int	will eekly x 4 o ensure e results Executive onthly x 2 ssurance months pol to hat may	

Facility ID: 923035

If continuation sheet Page 52 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRC OMB NO. 0938-	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
		345366	B. WING		C 09/01/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	)E	
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER		1304 SE SECOND STREET		
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLE E APPROPRIATE DATE	
F 881	Continued From page	ə 52	F 88	1		
	was not aware of a po to antibiotic usage. T	th the facility. He stated he blicy or procedure pertaining The Medical Director stated Iship Program was not		frequency of monitoring.		
	During an interview o Director of Nursing (E tracked antibiotics an	n 9/01/22 at 9:00 am the DON) revealed the IP d infections. She stated the cility infection rate and trends				
	Administrator reporter infection trends were other antibiotic inform the QA meetings.	n 9/01/22 at 9:01 am the d the infection rate and reported by the IP, but no lation was reviewed during				
F 883 SS=D		ococcal Immunizations (2)	F 88	3	10/4/22	
	policies and procedur (i) Before offering the each resident or the r receives education re potential side effects (ii) Each resident is or immunization Octobe annually, unless the in contraindicated or the immunized during this (iii) The resident or th has the opportunity to (iv)The resident's met	za. The facility must develop res to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically e resident has already been s time period; e resident's representative o refuse immunization; and				

Facility ID: 923035

If continuation sheet Page 53 of 61

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/06/202 M APPROVE D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING				C / <b>01/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREEND		AND REHABILITATION CENTER		13	04 SE SECOND STREET		
UNLEND,				SI	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 002		- 50					
F 883	1.0		F 8	383			
		or resident's representative					
	-	ion regarding the benefits					
	and potential side eff	rects of influenza					
	immunization; and	either received the influenza					
		not receive the influenza					
		medical contraindications or					
	refusal.						
		nococcal disease. The facility					
		s and procedures to ensure					
	that-						
	(i) Before offering the						
		esident or the resident's					
	benefits and potentia	ves education regarding the					
	immunization;						
	,	offered a pneumococcal					
	immunization, unless	-					
		ated or the resident has					
	already been immun	ized;					
		ne resident's representative					
		o refuse immunization; and					
		edical record includes					
		ndicates, at a minimum, the					
	following:	or resident's representative					
		or resident's representative ion regarding the benefits					
	· ·	fects of pneumococcal					
	immunization; and						
	(B) That the resident	either received the					
		nization or did not receive					
		nmunization due to medical					
	contraindication or re						
		T is not met as evidenced					
	by:						
		view and staff interviews, the			F883 Influenza and Pneumococcal		
		de documentation in the			Immunizations		
	medical record of ed	ucation regarding the					

Facility ID: 923035

If continuation sheet Page 54 of 61

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/06/2022 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345366	B. WING _				C / <b>01/2022</b>	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
				13	304 SE SECOND STREET			
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		S	NOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 883	and pneumococcal im residents reviewed for pneumococcal immun Resident #77). Findings included: Record review of the Immunization Policy of 10/18/2017 revealed influenza or pneumoor resident 's legal repri- education regarding to side effects of these if documentation in the 1. Resident #77 was 3/04/2019. Record review of the Annual Assessment of Resident #77 received on 12/15/21 at the fact declined the pneumoor Record review of Res revealed no document provided regarding the effects of the influenza immunizations. During an interview of Infection Preventionis was to be provided to influenza and the pneumont	I side effects of the influenza inmunizations for 2 of 5 or influenza and hizations (Resident #44 and facility policy titled dated 1/2009 and revised on that prior to offering the coccal vaccines, residents or esentative will be provided the benefits and potential mmunizations with medical record. admitted to the facility on Minimum Data Set (MDS) dated 7/29/22 revealed d the influenza vaccination cility and was offered and coccal vaccine. sident #77 ' s medical record thation of the education the benefits and potential side ta or pneumococcal an 8/31/22 at 9:21 am the st (IP) revealed education to Resident #77 for the eumococcal vaccines. She	F	383	DON and Infection preventionist will a immunization history to include flu, pneumonia, and COVID for residents and resident #77. The resident or residents and benefits of receiving/declinin vaccine, consent obtained when india and MD notified to obtain order per resident preference. Vaccines will be provided per physician sorder and/d documentation of resident refusal following education of risk/benefits of vaccine by 10/4/22. On 09/23/22 the DON and Infection Control Preventionist initiated an aud Influenza and Pneumonia immunizati for all current residents. This audit wai dentify any resident who had not be provided the Influenza or Pneumonia vaccine or have a documented refusal immunization per facility protocol and ensure residents/resident representa was educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record The Don and Infection Preventionist identified during audit to include education of the resident/resident representative of risks/benefits of receiving/refusing of vaccine with documentation in the electronic record, providing vaccine president preference and/or education staff. Audit will be completed by 10/0	#44 ident ie g cated, or the it of ions as to en al of to tive d. will g the per of		
	vaccine was offered r	was to be provided when the regardless of consent or ccines. The IP reported the			On 09/23/22 the SDC initiated an in-service with all nurses regarding Immunizations. Emphasis is on educ	ating		

Facility ID: 923035

If continuation sheet Page 55 of 61

		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 10/06/2022 RM APPROVED IO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345366	B. WING		0	C 9/01/2022
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI		
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 883	Continued From page	e 55	F 88	3		
		nented in the medical record.	1 00		ivo on tho	
	education was docum			resident/resident representat risks/benefits or receiving/ref		
	2. Resident #44 was	admitted to the facility on		vaccines, obtaining consent	-	
	3/31/20.	-		order for vaccine per residen		
				administering vaccine per ph	ysician order	
		MDS Quarterly Assessment		with documentation in the ele		
		ed Resident #44 was offered		record and/or documentation		
		ienza and pneumococcal		refusal if vaccine declined. In		
	immunizations.			be completed by 10/04/22. A		
	Depend not investigated	sident #444 is used is all used and		any nurse who has not worke		
		sident #44 ' s medical record /ided education on the		the in-service will complete in prior to next scheduled work		
	influenza vaccination			newly hired nurses will be in-		
	documentation of the			during orientation regarding		
		s and potential side effects		Immunizations.		
	During on interview of	on 8/31/22 at 9:21 am the		The DON and Infection Cont Preventionist will audit 10% (		
	Infection Preventionis			immunization record weekly		
		led to all residents even if the		then monthly x 1 month utiliz		
		I. She stated the education		Immunization Audit Tool. This		
		provided in the medical		ensure residents were educa		
	record.			risks/benefits of receiving/ref	using	
				Influenza and Pneumonia va		
	-	n 8/31/22 at 11:30 am the		obtaining consent and physic		
	÷ ,	DON) revealed the education		vaccine per resident preferer		
	was to be provided to			administering vaccine per ph		
		edical record as provided.		with documentation in the ele		
		nentation could be in a		record and/or documentation		
		ked on the immunization		refusal if vaccine declined for	-	
	-	e medical record. The DON		education. The DON and Infe Preventionist will address all	-	
		vhy the education was not edical record as provided for		identified during the audit. Th		
	Resident #44 or Resi	•		review the Immunization Aud		
				x 4 weeks then monthly x 1 r	•	
	-	n 9/1/22 at 3:07 pm the		ensure all concerns were add		
		Resident #44 and Resident		The Director of Nursing will f	onward the	
		education on the influenza nmunizations and the		The Director of Nursing will for results of the Immunization A		

Facility ID: 923035

If continuation sheet Page 56 of 61

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/06/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345366	B. WING _				01/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	•
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER			304 SE SECOND STREET		
				SI	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page	- 56	F	383			
		o be entered in the medical	F C	000	the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and revie the Immunization Audit Tool to determin trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	W	
F 887 SS=E			F8	387			10/4/22
	LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID- immunization is medi resident or staff mem immunized; (ii) Before offering CO members are provide regarding the benefits effects associated wit (iii) Before offering CO resident or the reside receives education re- risks and potential sid the COVID-19 vaccin (iv) In situations when requires multiple dost resident representation provided with current additional doses, incl benefits or risks and associated with the C	accine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been OVID-19 vaccine, all staff ed with education is and risks and potential side th the vaccine; OVID-19 vaccine, each int representative egarding the benefits and de effects associated with e; re COVID-19 vaccination es, the resident, ve, or staff member is information regarding those uding any changes in the					

Facility ID: 923035

If continuation sheet Page 57 of 61

	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/06/202 RM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345366	B. WING _			0	9/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA		AND REHABILITATION CENTER		130	4 SE SECOND STREET		
UNEEND,				SN	OW HILL, NC 28580		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 887	Continued From pag	e 57	F 8	87			
	additional doses;			,01			
		esident representative, has					
		cept or refuse a COVID-19					
	vaccine, and change	•					
		not subject to the Interim					
	-	3415-IFC], must comply with					
		80(d)(3)(v) that apply to staff					
	under IFC-5 [CMS-34 and	414-IFC]					
		edical record includes					
		ndicates, at a minimum,					
	the following:						
	•	or resident representative					
	was provided educat	<b>v</b>					
	-	l risks associated with					
	COVID-19 vaccine; a						
		VID-19 vaccine administered					
	to the resident; or $(C)$ If the resident did	I not receive the COVID-19					
	vaccine due to medic						
	contraindications or r						
		tains documentation related					
	to staff COVID-19 va						
	includes at a minimu						
		rovided education regarding					
	the benefits and pote						
	associated with COV						
		d the COVID-19 vaccine or ning COVID-19 vaccine; and					
		accine status of staff and					
		s indicated by the Centers for					
		Prevention's National					
	Healthcare Safety Ne	etwork (NHSN).					
		T is not met as evidenced					
	by:						
		view and staff interviews, the			F887 COVID-19 Immunization		
		de documentation in the			DON and Infaction Control Dev	vantion:-t	
		ucation regarding the			DON and Infection Control Pre-		
	benefits and potentia				will clarify immunization history	to include	

Facility ID: 923035

If continuation sheet Page 58 of 61

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/06/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345366	B. WING				/01/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CREEND		AND REHABILITATION CENTER		13	304 SE SECOND STREET		
GREENDA	ALE FOREST NORSING /	AND REHABILITATION CENTER		S	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 887	Continued From page	59					
F 007	Continued From page		F	887		4 -	
		tion for 5 of 5 residents 19 immunizations (Resident			flu, pneumonia, and COVID for reside #44, resident #77, resident #80, resid		
		esident #80, Resident #92,			#92 and resident #94. The resident of		
	and Resident #94).	,			resident representative will be educat on the risk and benefits of		
	Findings included:				receiving/declining vaccine, consent obtained when indicated, and MD not	ified	
		policy titled Immunization			to obtain order per resident preferenc		
		and revised on 10/18/2017			Vaccines will be provided per physicia		
	-	offering immunizations, the			order and/or documentation of reside		
		' s legal representative will n regarding the benefits and			refusal following education of risk/ber of the vaccine by 10/04/22.	lents	
		of these immunizations with					
	documentation in the				On 09/23/22 the DON, Unit Manger a	nd	
					QI Nurse initiated an audit of COVID		
		admitted to the facility on			vaccination status for all current resid		
	3/31/20.				This audit was to identify any resident		
					not up to date on COVID vaccine or h	ave	
		Minimum Data Set (MDS)			a documented refusal of vaccine per		
	-	nt dated 7/02/22 revealed ered and declined the			facility protocol and to ensure residents/resident representative was		
	COVID-19 immunizat				educated on the risk/benefits of		
					receiving/refusing vaccine with		
	Record review of Res	sident #44 ' s medical record			documentation in the electronic record	d.	
		o documentation of the			The QI Nurse will address all concern	S	
		egarding the benefits and			identified during the audit to include		
	potential side effects	of the COVID-19			education of the resident/resident		
	immunization.				representative of risks/benefits of		
	h Resident #77 was	admitted to the facility on			receiving/refusing of vaccine with documentation in the electronic record	Ч	
	3/04/19.	definition to the facility off			providing vaccine per resident prefere		
					and/or education of staff. Audit will be		
	Record review of the	MDS Annual Assessment			completed by 10/04/22.		
		ed Resident #77 was offered					
	and declined the CO	VID-19 immunization.			On 09/23/22 the SDC initiated an		
					in-service with all nurses regarding		
		sident #77 's medical record			Immunizations. Emphasis is on educa		
		ntation of the education			resident/resident representative on th risks/benefits or receiving/refusing	е	
	provided regarding in	e benefits and potential side			instancements of receiving/relusing		

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 59 of 61

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/06/2022 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING				C 01/2022
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENDA		AND REHABILITATION CENTER		13	04 SE SECOND STREET		
GIVE END/				SI	NOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 887	Continued From page	e 59	F 8	87			
	effects of the COVID-				vaccines, obtaining consent and phys	ician	
					order for vaccine per resident preferen	nce,	
	c. Resident #80 was 5/22/14.	admitted to the facility on			administering vaccine per physician o	rder	
	5/22/14.				with documentation in the electronic record and/or documentation of reside	ent	
	Record review of the	MDS Quarterly Assessment			refusal if vaccine declined. In-service		
		ed Resident #80 was offered			be completed by 10/04/22. After 10/04		
	and declined the CO	VID-19 immunization.			any nurse who has not worked or rece the in-service will complete in-service	eived	
	Record review of Res	sident #80 ' s medical record			prior to next scheduled work shift. All		
	revealed no documer	ntation of the education			newly hired nurses will be in-serviced		
		e benefits and potential side			during orientation regarding		
	effects of the COVID-	-19 immunization.			Immunizations.		
	d. Resident #92 was 2/28/19.	admitted to the facility on			The QI Nurse will audit 10% of reside immunization record weekly x4 weeks then monthly x 1 month utilizing the		
		MDS Annual Assessment			Immunization Audit Tool. This audit is	to	
	and declined the CO	ed Resident #92 was offered VID-19 immunization.			ensure residents were educated on risks/benefits of receiving/refusing CC vaccines, obtaining consent and phys		
	Record review of Res	sident #92 ' s medical record			order for vaccine per resident prefere		
		ntation of the education			administering vaccine per physician o		
	provided regarding th effects of the COVID-	e benefits and potential side			with documentation in the electronic record and/or documentation of reside	nt	
					refusal if vaccine declined following	:::L	
	e. Resident #94 was	admitted to the facility on			education. The QI Nurse will address	all	
	3/18/21.				concerns identified during the audit. T		
	Record review of the	MDS Quarterly Assessment			DON will review the Immunization Aud Tool weekly x 4 weeks then monthly x		
		ed Resident #94 was offered			month to ensure all concerns were	I	
		VID-19 immunization.			addressed.		
		sident #94 ' s medical record			The Director of Nursing will forward th		
		ntation of the education			results of the Immunization Audit Tool	to	
	provided regarding th effects of the COVID-	e benefits and potential side			the Executive Quality Assurance Committee monthly x 2 months. The		
					Executive Quality Assurance Committ	ee	
	During an interview o	on 8/31/22 at 9:21 am the			will meet monthly x 2 months and revi		

Event ID: 650611

Facility ID: 923035

If continuation sheet Page 60 of 61

OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	D. 0938-039 SURVEY PLETED
	245255				С
				09	/01/2022
	AND REHABILITATION CENTER		1304 SE SECOND STREET		
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	IOULD BE COMPLETION	
Infection Preventionis COVID-19 immuniza provided to the reside declination of the imm the education was do note in the medical re During an interview of Director of Nursing (I immunization educat residents and docum as provided. She sta be in a progress note immunization tracking record. The DON wa COVID-19 immunizat documented in the m During an interview of Administrator stated education should hav residents and the door	st (IP) revealed the tion education was to be ents regardless of consent or munization. The IP reported boumented in a progress ecord. on 8/31/22 at 11:30 am the DON) revealed the ion was required for all tented in the medical record ated the documentation could e or marked on the g section in the medical as unable to state why the tion education was not nedical record as provided. on 9/1/22 at 3:07 pm the the COVID-19 immunization ve been provided to the cumented in the medical	F 88	the Immunization Audit Tool to de trends and/or issues that may ne further interventions put into plac	ed e and	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag Infection Preventionis COVID-19 immuniza provided to the residu declination of the imm the education was do note in the medical re During an interview of Director of Nursing (I immunization educat residents and docum as provided. She sta be in a progress note immunization trackin record. The DON wa COVID-19 immuniza documented in the m During an interview of Administrator stated education should hav residents and the do	F CORRECTION IDENTIFICATION NUMBER: 345366 ROVIDER OR SUPPLIER ALE FOREST NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345366       B. WING	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         345366       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         ALE FOREST NURSING AND REHABILITATION CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRE (EACH OBRICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 60       Infection Preventionist (IP) revealed the COVID-19 immunization education was to be provided to the residents regardless of consent or declination of the immunization. The IP reported the education was documented in a progress note in the medical record.       F 887         During an interview on 8/31/22 at 11:30 am the Director of Nursing (DON) revealed the covide. She stated the documentation could be in a progress note or marked on the immunization education was not documented in the medical record as provided. She stated the documentation could be in a progress note or marked on the immunization rtacking section in the medical record. The DON was unable to state why the COVID-19 immunization education was not documented in the medical record as provided.       F         During an interview on 9/1/22 at 3:07 pm the Administrator stated the COVID-19 immunization education should have been provided to the residents and the documented in the medical	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COME         345366       B. WING       09         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       1304 SE SECOND STREET         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER OF OR SUPPLIER       1304 SE SECOND STREET         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       (EACH CORRECTIVE ACTION SHOLD BE         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PREFIX       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continued From page 60       F 887       The Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.         During an interview on 8/31/22 at 11:30 am the Director of Nursing (DON) revealed the immunization education was required for all residents and documented in the medical record. The DON was unable to state why the COVID-19 immunization education was not documented in the medical record as provided.       F 807         During an interview on 9/1/22 at 3:07 pm the Administrator stated the COVID-19 immunization education should have been provided to the residents and the documented in the medical       Link on the course of the covid to the

Facility ID: 923035

If continuation sheet Page 61 of 61