STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/24/25 through 03/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RSOD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/24/25 through 03/27/25. Event ID# RSOD11. The following intakes were investigated NC00223546, NC00222724, NC00224513, NC00228434, NC00222155, and NC00223226. 2 of the 12 complaint allegations resulted in deficiency.	F 000		
F 584 SS=C	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		4/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a clean and sanitary environment by not removing a dark grey/black colored substance from 20 of 25 ceiling fans observed on 8 of 8 resident halls. Findings included: 1a. During an observation of the 600-hall on 3/27/25 at 8:26 AM 2 ceiling fans were noted with a dark grey/black colored substance on all 5 of the blades. b. During an observation of the 600-hall on 3/27/25 at 8:26 AM the ceiling fan in front of the nurse's station for the 500-hall and 600-hall was	F 584	F584 Safe/Clean/Comfortable/Homelike Environment On 4/10/25, the housekeeping supervisor cleaned all ceiling fans to ensure the dark grey/black colored substance was removed. On 4/11/2025, the Housekeeping Supervisor initiated an audit under the supervision of the Administrator of all ceiling fans in the facility. This audit is to identify any ceiling fan that needs cleaning to maintain a safe and homelike environment. The Administrator and Housekeeping Supervisor will address all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 noted with a dark grey/black colored substance on all 5 of the blades. c. An observation conducted on 3/27/25 at 8:28 AM of the 500-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades. d. An observation conducted on 3/27/25 at 8:30 AM of the 400-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades. e. An observation conducted on 3/27/25 at 8:32 AM of the 300-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades. f. An observation conducted on 3/27/25 at 8:33 AM of the ceiling fan in front of the nurse's station for the 100-hall and 200-hall revealed the ceiling fan was noted with a dark grey/black colored substance on all 5 of the blades. g. An observation conducted on 3/27/25 at 8:34 AM of the 100-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades. h. An observation conducted on 3/27/25 at 8:37 AM of the 200-hall revealed 2 ceiling fans had a dark grey/black colored substance on all 5 of the blades. i. An observation conducted on 3/27/25 at 8:41 AM of the 700 hall and 800 hall nurse's station revealed 2 ceiling fans had a dark grey/black colored substance on all 5 of the blades.	F 584	concerns identified during the audit to include but not limited to cleaning the ceiling fans when indicated. Audit will be completed by 4/17/2025. On 4/11/2025, the Administrator completed an in-service with all housekeeping staff, to include the housekeeping supervisor regarding Maintaining a Homelike Environment with emphasis on cleaning facility ceiling fans to maintain a safe and homelike environment. All newly hired housekeeping staff will be in-serviced by the SDC during orientation. The Maintenance Director will complete facility rounds to include all facility ceiling fans weekly x 4 weeks then monthly x 1 month. This audit is to identify any ceiling fan in the facility in need of cleaning to maintain a safe and homelike environment. The Administrator will address all areas of concern identified to include but not limited to ensuring ceiling fans are cleaned when indicated and retraining of staff. The Administrator will review the environmental rounds audit weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the findings of the Environmental Rounds Audit tool the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review the environmental rounds audit to determine trends and/or issues that may need further interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 j. An observation conducted on 3/27/25 at 8:42 AM of the 800-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades. k. An observation conducted on 3/27/25 at 8:42 AM of the 700-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades. On 3/27/25 at 8:46 AM an interview was conducted with Housekeeping Staff #1. She stated the housekeeping department was responsible for cleaning the ceiling fans within the facility. She further stated the ceiling fans were cleaned weekly and to her knowledge the fans were last cleaned one week ago. During visual inspection she indicated the fans required cleaning. An interview was conducted with the Housekeeping Manager on 3/27/25 at 8:49 AM. He stated the housekeeping department was responsible for cleaning the ceiling fans, and they were supposed to be cleaned weekly by the Floor Technician staff member who was responsible for this task. An interview was conducted with the Floor Technician on 3/27/25 at 8:52 AM. He stated he was responsible for cleaning the ceiling fans within the facility. He further stated the ceiling fans were usually cleaned weekly, however the ceiling fans were last cleaned 2 weeks ago, as he was on leave from the facility. An observation was conducted on halls 700 and 800 with the Housekeeping Manager and Floor Technician on 3/27/25 at 8:54 AM. Both the	F 584	put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 Housekeeping Manager and Floor Technician indicated the ceiling fans needed to be cleaned. They stated all ceiling fans in resident halls would be cleaned that day. On 3/27/25 at 10:50 AM an interview was conducted with the Director of Nursing (DON). She stated the housekeeping department was responsible for cleaning the ceiling fans. She further stated it was her expectation that housekeeping staff would clean the ceiling fans weekly and as needed. An interview was conducted with the Administrator on 3/27/25 at 1:37 PM. She stated housekeeping staff were responsible for cleaning the ceiling fans, and they followed a cleaning schedule. She further stated her expectation was that the ceiling fans were cleaned per the cleaning schedule (weekly).	F 584		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct and document care plan meetings after completion of quarterly and/or annual Minimum Data Set (MDS) assessments for 6 of 31 residents reviewed for care planning (Resident #27, Resident #100, Resident #91, Resident #45, Resident #18, and Resident #21). The findings included: 1. Resident #27 was admitted to the facility on 12/07/2020. The last care plan meeting documented in Resident #27's medical record was dated 7/9/2024. MDS assessments were completed for Resident #27 on the following dates: 9/16/2024 (quarterly), 11/11/2024 (quarterly), 1/10/2025 (quarterly) and 3/21/2025 (significant change). The significant change MDS dated 3/21/2025 indicated Resident #27 was moderately cognitively impaired.	F 657	F657 Care Plan Timing and Revision On 4/14/25, the Social Worker sent an invitation to Resident #27 and resident representative for care plan to be held on 5/8/25 with documentation provided in the electronic medical record. On 4/14/25, the Social Worker sent an invitation to Resident #100 and resident representative for care plan to be held on 5/27/25 with documentation provided in the electronic medical record. On 4/14/25, the Social Worker sent an invitation to Resident #91 and resident representative for care plan to be held on 5/1/25 with documentation provided in the electronic medical record. On 4/14/25, the Social Worker sent an invitation to Resident #45 and resident representative for care plan to be held on 5/6/25 with documentation provided in the electronic medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 On 3/27/2025 at 1:37 pm in an interview with the MDS Coordinator, she explained the Social Worker was sent the scheduled timeframe for completion of MDS assessments monthly to use for scheduling care plan meetings. On 3/26/2025 at 9:41 am in an interview with the Social Worker, she recalled Resident #27's Resident Representative changing the care plan meeting to 10/14/2024 at 3:00pm and talking with Resident #27's resident representative on the telephone while Resident #27's Resident Representative was driving home from work. The Social Worker stated she didn't know why she didn't document the care plan meeting held on 10/14/2024 in Resident #27's medical record. The Social Worker stated Resident #27 had not had a care plan meeting since 10/14/2024. She stated Resident #27 should have had a care plan meeting in January 2025 and was unable to provide a reason why a care plan meeting had not been held for Resident #27. On 3/27/2025 at11:20 am in an interview with the Administrator, she stated the Social Worker was responsible for scheduling resident care plan meetings. In a follow up interview on 3/27/2025 at 2:48 pm, she stated care plan meetings were held quarterly and she was unaware quarterly care plan meetings had not been conducted for Resident #27. 2. Resident #100 was admitted to the facility on 9/18/2024. The last care plan meeting documented in Resident #100's medical record was dated 9/26/2024.	F 657	On 4/14/25, the Social Worker sent an invitation to Resident #18 and resident representative for care plan to be held on 5/1/25 with documentation provided in the electronic medical record. On 4/14/25, the Social Worker sent an invitation to Resident #21 and resident representative for care plan to be held on 5/22/25 with documentation provided in the electronic medical record. On 4/11/2025, the Administrator and MDS Nurse initiated an audit of all residents most recent care plan meeting. This audit is to ensure that a written invitation for a care plan meeting was mailed to the resident and the resident representative with documentation in the electronic record and documentation in the electronic record as to when the care plan meeting was held. The Administrator and Director of Nursing (DON) will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting for any resident or resident representative who was not provided a written invitation per facility protocol or have written documentation of attending/declining to attend care plan meeting. The audit will be completed by 4/17/2025. On 4/11/2025, the Administrator initiated an in-service with the Social Services Director, MDS Nurses, Activities Director, Unit Managers, Dietary Manager, and Therapy Manager regarding Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 Quarterly MDS assessments were completed for Resident #100 on 11/14/2024 and 2/12/2025. The quarterly Minimum Data Set (MDS) assessment dated 2/12/2025 indicated Resident #100 was severely cognitively impaired. On 3/27/2025 at 1:37 pm in an interview with the MDS Coordinator, she explained the Social Worker was sent the scheduled timeframe for completion of MDS assessments monthly to use for scheduling care plan meetings. On 3/26/2025 at 8:19 am in an interview with the Social Worker, she stated she was unable to find documentation Resident #100 had a care meeting since 9/26/2024. She explained she used the MDS schedule for completion of assessments and updating care plans to schedule the care plan meetings. She explained she had not been able to contact Resident #100's representative for a care plan meeting and stated Resident #100's representative not attending did not prevent the facility staff from having a care plan meeting for Resident #100. The Social Worker stated Resident #100 should have had a care plan meeting in November 2024 and did not know why a care plan meeting was not conducted. On 3/27/2025 at11:20 am in an interview with the Administrator, she stated the Social Worker was responsible for scheduling resident care plan meetings. In a follow up interview on 3/27/2025 at 2:48 pm, she stated care plan meetings were held quarterly and she was unaware quarterly care plan meetings had not been conducted for Resident #100.	F 657	Care Plan Process with emphasis on conducting and documenting care plan meetings after completion of quarterly and/or annual Minimum Data Set (MDS). The in-service will be completed by 4/17/2025. All newly hired Social Services Director, MDS Nurses, Activities Director, Unit Managers, Dietary Manager, and Therapy Manager will be in-serviced by the SDC during orientation. The MDS nurses will audit 10% of completed quarterly and/or annual Minimum Data Set (MDS) assessments weekly x 4 weeks then monthly x 1 month to ensure that a written invitation for a care plan meeting has been mailed to the resident and the resident representative with documentation in the electronic record and documentation in the electronic record as to when the care plan meeting is held. The MDS nurses, Social Worker, and/or Administrator will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting per facility guidelines. The Administrator will review the care plan audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the results of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8	F 657		

3. Resident #45 was admitted to the facility on 2/1/24 with diagnosis including diabetes mellitus and hypertension.

Resident #45's electronic medical record revealed the last documented care plan meeting occurred on 8/20/24.

Minimum Data Set (MDS) assessments were completed for Resident #45 on the following dates: 9/20/24 (quarterly), 12/2/24 (annual), 12/18/24 (quarterly), 1/20/25 (significant change in status), and 2/13/25 (quarterly).

The quarterly MDS assessment dated 2/13/25 revealed Resident #45 had severely impaired cognition.

An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #45 has not had a care plan meeting since 8/20/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.

In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.

4. Resident 91 was admitted to the facility on 3/14/24 with diagnoses that included heart disease and congestive heart failure.

Minimum Data Set (MDS) assessments were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9	F 657		

completed for Resident #91 on the following dates: 10/11/24 (quarterly), 11/29/24 (quarterly), and 2/18/25 (quarterly).

Resident #91's electronic medical record revealed the last documented care plan meeting occurred on 9/17/24.

The quarterly MDS assessment dated 2/13/25 revealed Resident #91 had moderate cognitive impairment.

An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #91 had not had a care plan meeting since 9/17/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.

In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.

5. Resident #18 was admitted to the facility on 2/3/21 with diagnoses that included dementia and chronic kidney disease.

Minimum Data Set (MDS) assessments were completed for Resident #18 on the following dates: 9/23/24 (quarterly), 10/22/24 (quarterly), 1/15/25 (quarterly), and 2/4/25 (quarterly).

Resident #18's electronic medical record revealed the last documented care plan meeting occurred on 8/20/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10	F 657		

The quarterly MDS assessment dated 2/4/25 revealed Resident #18 had severe cognitive impairment.

An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #18 has not had a care plan meeting since 8/20/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.

In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.

6. Resident #21 was admitted to the facility on 8/1/124 with diagnoses that included diabetes mellitus and hypertension.

Minimum Data Set (MDS) assessments were completed for Resident #21 on the following dates: 9/2/24 (quarterly), 10/10/24 (quarterly), 1/6/25 (annual), and 2/6/25 (quarterly).

Resident #21's electronic medical record revealed the last documented care plan meeting occurred on 8/26/24.

The quarterly MDS assessment dated 2/6/25 revealed Resident #21 had moderate cognitive impairment.

An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 Resident #21 has not had a care plan meeting since 8/26/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator. The Social Worker stated she had a care plan meeting scheduled for 1/28/25 but Resident #21 was in the hospital. She stated she planned to schedule a care plan meeting for Resident #21 in April 2025. In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the careplan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have effective systems in place for identifying the development of skin breakdown	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 which delayed treatment and interventions. Resident #39's skin was intact on re-admission on 11/19/24. On 1/4/25 excoriation was noted on her buttocks. There were no further documented assessments until a wound assessment dated 1/17/2025 recorded Resident #39 developed an unstageable (full thickness skin and tissue loss where the extent of tissue damage cannot be determined due to presence of slough, a yellow/white layer of dead skin tissue, or eschar, dry dead tissue, obscuring the wound bed) 5 centimeter (cm) by 5cm right buttocks pressure wound. Resident #39's right buttocks pressure wound deteriorated and required hospitalization for an infected right buttocks/sacral pressure wound on 2/17/2025. Resident #39 received intravenous antibiotic therapy and a debridement (a medical procedure to remove dead, damaged or infected tissue from a wound to promote healing and prevent infection) of the right buttocks pressure wound while in the hospital. Resident #39 was discharged back to the facility on 2/24/25 with orders for oral antibiotics for 5 days. The deficient practice occurred for 1 of 2 residents reviewed for pressure ulcer care (Resident #39). Findings included: Resident #39 was admitted to the facility on 5/6/2024 with diagnoses including coronary artery disease and renal insufficiency. Resident #39 was discharged to the hospital and readmitted to the facility on 11/19/2024. Resident #39's skin assessment dated 11/19/2024 recorded there were no skin issues. There was no documentation observed in	F 686	On 4/5/25, resident #39 was assessed by the Treatment Nurse. Wound Ulcer flowsheet was completed with wound status noted to be improving. On 4/11/25, skin check was completed on resident # 39 with no new skin issues identified. On 4/10/25, the Unit Managers, Staff Facilitator, QA Nurse, and Treatment Nurse initiated skin check on all residents. This audit is to identify any resident with new skin concerns or wounds to ensure all concerns have been properly assessed, treatment initiated as indicated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be immediately addressed by the Unit Managers, Staff Facilitator, QA Nurse, and Treatment Nurse to include assessment of resident, completion of incident report, notification of MD/RR, initiating treatment per MD orders, documentation in Wound Ulcer Flowsheet or Non-Ulcer Flowsheet and updating care plan. Audit will be completed by 4/17/25. Beginning the week of 4/17/25 as part of the preventative monitoring, skin checks will be activated on admission and completed weekly thereafter to identify new skin concerns and to ensure the resident is properly assessed, treatment initiated as indicated, MD/RR notified,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13 Resident #39's electronic medical record or on Resident #39's Medication Administration Record (MAR) to alert the nursing staff to conduct a weekly skin assessment. The care plan dated 11/19/2024 indicated Resident #39 was a potential risk for skin breakdown. Interventions included observing the skin weekly and notifying the nurse of any changes in the development of new skin impairments. Physician orders dated 11/19/2024 included a supplement that provided additional calories and protein 60 milliliters (mL) three times a day for weight management. Resident #39's recorded weight in the medical record on 11/20/2024 was 180.2 pounds (lbs). The admission Minimum Data Set (MDS) assessment dated 11/26/2024 indicated Resident #39 was cognitively intact with severely impaired hearing. Resident #39 was always incontinent of urine and stool and required total assistance with bed mobility and activities of daily living. There were no dental issues coded on the MDS for Resident #39. The MDS assessment further indicated Resident #39 was at risk for developing a pressure ulcer but was not marked as having a pressure ulcer or skin impairment. On 12/19/24 Resident #39 was ordered a high protein nutritional supplement 30 mL daily for weight management. Resident #39's medical record documented skin assessments were conducted on 12/15/2024 with no skin issues recorded and on 1/4/2025 with	F 686	documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. In addition, staff will monitor skin integrity during routine care and will report any skin concerns to nursing staff for further evaluation. On 4/11/25, the Director of Nursing and Staff Facilitator initiated an in-service with all nurses regarding (1) Wound Process with emphasis on assessing, initiating treatment and notification of the physician/resident representative for all newly identified skin concerns or changes in wound status (2) Skin checks should be completed weekly for all residents. If an area is identified it should be properly assessed, treatment initiated as indicated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed, and care plan updated. The in-service will be completed by 4/17/25. After 4/17/25, any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced by the SDC during orientation. The Director of Nursing will complete 10 skin check audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure skin checks are completed weekly and any resident with new skin concerns or wound concerns have been properly assessed, treatment initiated as indicated,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14 skin excoriation (the act of abrading or wearing off the skin) recorded to the buttocks. There was no further documentation of the excoriation or assessment of Resident #39's skin until the Treatment Nurse's pressure wound assessment on 1/17/25. A review of nursing documentation from 11/19/2024 to 1/17/2025 in the electronic medical record recorded Resident #39 was turned and repositioned and provided incontinence care. There was no documentation of the development of a pressure wound for Resident #39. On 3/27/2025 at 1:36 pm in an interview with Nurse Aide (NA) #2, she stated Resident #39 required assistance in turning and incontinent care and Resident #39 was checked for incontinence and repositioned every two hours. She recalled Resident #39 not having any skin breakdown when admitted to the facility and stated she couldn't recall Resident #39's skin on her buttocks being red or irritated. She stated when she observed a quarter size red open area to Resident #39's buttocks while providing care, she informed the Treatment Nurse. NA #2 was unable to recall the date she informed the treatment nurse. Documentation of a wound assessment dated 1/17/2025 by the Treatment Nurse recorded Resident #39 had an unstageable 5cm by 5cm right buttocks pressure wound. The right buttocks pressure wound assessment recorded the pressure wound was 90% dark eschar (dry dead tissue) and 10% pink tissue with moderate amount of serous exudate (drainage). There was no odor, tunnelling (narrow opening or passageway extending from a wound underneath	F 686	MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be immediately addressed by the director of nursing. The Administrator will review the Skin Check audits weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the Skin Check Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Skin Check Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 15	F 686		

the skin), or undermining (erosion that occurs under the edges of a wound) recorded. The Treatment Nurse recorded the physician and Resident #39's Representative were notified, and treatment was started with the application of silver alginate (highly absorbent, antimicrobial pad) and covered with a foam dressing.

Physician orders dated 1/20/2025 included an order to cleanse the unstageable right buttock with normal saline, pat dry with gauze, apply skin prep to the periwound (skin around a wound) and allow to dry. Silver alginate was to be applied to the wound and the wound covered with a foam dressing every Monday, Wednesday and Friday.

A review of Resident #39's January 2025 Medication Administration Record recorded Resident #39 received wound care as ordered.

Resident #39's weight was recorded in the medical record on 1/24/2025 as 192.3 pounds that was a 12.1 lbs increase in weight.

Dietary notes dated 1/30/2025 reported Resident #39 had an unstageable pressure wound to the right buttocks and Resident #39 was receiving a high protein nutritional supplement 30 milliliters daily and a supplement that provides additional calories and protein for persons at high risk for malnutrition 60 milliliters three times a day to aid in wound healing. The dietary note recorded Resident #39 consumed 50-100% of a regular mechanical soft diet and recommended ordering a Multivitamin (MVI) and Ascorbic Acid (Vitamin C) 500milligrams to further aid in wound healing.

A review of Resident #39's January 2025 and February 2025 Medication Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 16	F 686		

recorded Resident #39 was started on a Multivitamin (MVI) and Ascorbic Acid on 1/31/2025 and received the two dietary supplements, MVI and Ascorbic Acid as ordered.

Documentation of the wound assessment on 2/4/2025 by the Treatment Nurse recorded Resident #39's unstageable right buttocks pressure wound measured 5 cm by 5 cm with eschar. Moderate serous exudate was recorded with no tunneling, undermining, odor or signs of infection. The wound bed was described as 90% dry, dark eschar and 10% pink tissue. The Treatment Nurse recorded the physician and Resident #39's Representative was notified. The wound was cleansed with normal saline and pat dried with gauze. Skin prep (forms a protective film on the skin) was applied to the periwound and allowed to dry. Silver alginate was applied and covered with a foam dressing.

Resident #39's weight was recorded in the medical record on 2/8/2025 as 177.3 lbs that was a 15 lbs weight loss.

Physician progress notes dated 2/14/2025 recorded the nursing staff reported Resident #39 was refusing to eat and was unable to chew food due to pain. Resident #39's gum on the left upper canines was observed swollen and Nurse Practitioner #1 ordered Amoxicillin 500 milligrams three times a day for five days.

Documentation of the wound assessment on 2/14/2025 recorded a stage IV (most severe form of pressure injury that extends through skin, underlying tissue, muscle and bone) right buttocks pressure wound measured 5cm by 5cm by 0.8 cm and there was 1 cm of undermining in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 17	F 686		

the position of 6-11 o'clock of the wound and 0.7cm from the position of 2-5 o'clock. Heavy serous exudate was documented with no odor or sign of infection. The wound bed was recorded as 50% deep red tissue, 15% fascia (layer of connective tissue below the skin), 15% muscle and necrotic (dead tissue) with 15% stringy gray colored dead tissue and 5% adipose (fat) tissue. The wound assessment recorded the physician and Resident#39's Representative were notified. Treatment of the right buttocks pressure wound included cleaning with normal saline, patting the area dry, applying skin prep to the periwound and allowing it to dry. The wound was packed with saline-moistened polyurethane foam dressing impregnated with methylene blue and covered with a foam dressing. Resident #39's dressing was ordered to be changed every Monday, Wednesday and Friday.

On 2/17/2025 a wound assessment note by the Treatment Nurse recorded Resident #39's right buttocks pressure wound was measuring 7cm by 11cm by 2cm and was recorded as a stage IV pressure ulcer with an opened area measuring 7cm by 4cm and a 7cm by 4cm patch of dark dry eschar beside the opened area. Documentation of the wound recorded the opened area was tunneling underneath the eschar area with a heavy serous exudate and 40% of the area was dark, dry eschar, 40% deep pink tissue, and 10 % fascia, 50% adipose tissue and 5% bone. The wound was cleansed with normal saline and packed with saline moistened polyurethane foam dressing impregnated with methylene blue and covered with a foam dressing. The physician and Resident #39's Representative was notified and Resident #39 was scheduled to attend an appointment at the wound clinic on 2/17/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 18	F 686		

On 3/27/2025 at 12:58 pm in an interview with the Treatment Nurse, she stated the nursing staff were to conduct and document skin assessments weekly and notify her when skin breakdown was identified. The Treatment Nurse stated she was aware of the excoriated skin to Resident #39's buttocks documented on the skin assessment dated 1/4/2025 and it was treated with barrier cream. She stated NA #2 informed her on 1/17/2025 of an area to Resident #39 buttocks that was observed as black eschar and weekly assessments and treatments were started based on the skin protocol. She explained Resident #39 wound remained a stable eschar wound tissue until 2/14/2025 when an area of the dry dead tissue was observed opened with no odor or drainage. The Treatment Nurse explained she had called the wound clinic for a referral when the right buttocks pressure wound was identified and was scheduled to go to the Wound Clinic on 2/17/2025. She stated on 2/17/2025, Resident #39's wound was observed worsening due to increase in size, drainage and odor. She explained since Resident #39 was scheduled to attend her first initial visit to the wound clinic on 2/17/2025, she called and notified the wound clinic of the change in Resident #39's right buttocks pressure wound. She stated the wound clinic requested Resident #39 to attend the scheduled appointment at the wound clinic on 2/17/2024 and if needed, the wound clinic would send Resident #39 to the hospital for admission.

The wound clinic notes dated 2/17/2025 recorded Resident #39 was presenting to the wound clinic for the first time with an existing stage IV pressure injury that had worsen. The wound clinic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19	F 686		

note recorded the right buttocks pressure wound was very foul smelling with a necrotizing (death of bodily tissue) appearance at the undermined areas that was very concerning for a necrotizing soft tissue infection (NSTI). The pressure wound located on the right buttock/sacral area was recorded measuring 3.5cm by 8cm by 2 cm with black, green, red and tan colored wound bed with moderate amount of green serous exudate. The periwound was recorded as blanchable erythema (redness) with no tunneling and 4.5 cm of undermining. The wound was cleansed and dressed, and the wound clinic consulted the hospitalist (physician that works at the hospital) to direct admit Resident #39 from the wound clinic to the hospital.

A review of the hospital discharge summary dated 2/24/2025 recorded Resident #39 was admitted from the wound clinic due to foul smelling and worsening of right buttock/sacral pressure wound on 2/17/2025. During hospitalization, Resident #39 received debridement on 2/20/2025 of the right buttock/sacral pressure wound and intravenous (medical technique that involves administering fluids, medications and nutrients directly into a vein) antibiotics. Resident #39 was discharged from the hospital and re-admitted to the facility on 2/24/2025. The discharge summary included physician orders for Amoxicillin-Potassium Clavulanate Tablet 875-125 milligram (mg) twice a day for wound infection for five days. There was no order for wound care on the discharge summary.

Physician orders dated 2/24/2025 included the following orders: Amoxicillin-Potassium Clavulanate Tablet 875-125 milligram (mg) twice a day for wound infection for five days and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20	F 686		

cleansing the right buttock/sacrum with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze, pat dry with gauze and apply skin prep to periwound and allow to dry thoroughly. The application of an enzymatic debriding ointment was ordered to the areas of yellow/white dead skin tissue and the wound packed with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze and covered with a bordered foam dressing every day for a stage IV pressure ulcer.

A review of Resident #39's February 2025 and March 2025 MAR recorded Resident #39 received the prescribed antibiotic and wound treatments.

Physician orders dated 3/25/2025 included cleansing the right buttock/sacral wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze, patting the area dry with gauze, applying a thin layer of zinc-oxide based ointment and then nystatin (antifungal medication) powder to the periwound, applying an ointment that removes dead tissue to the areas of yellow/white dead tissue and packing the wound with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze and covering with a bordered foam dressing every day and evening shift.

On 3/25/2025 at 3:03pm, the Treatment Nurse was observed changing Resident #39's right buttock/sacral pressure wound. The Treatment Nurse stated that when Resident #39 attended a wound clinic visit on the morning of 3/25/2025, the right buttock/sacral pressure wound was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

measured and wound clinic notes recorded the pressure wound as 5.3cm by 10 cm by 1 cm and ordered wound care to be performed twice a day. Resident #39 right buttocks/sacral open wound was observed with black colored tissue to the lower left portion of the wound, the center of the wound with a small white patch tissue and the remaining tissue was red in color. There was no foul odor detected from the right buttocks/sacral wound. The Treatment Nurse cleansed the wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze, applied a zinc-oxide based ointment to the edges covered with nystatin powder, applied an ointment that removes dead tissue to the dark colored tissue inside the wound and packed the wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze and covered with a foam dressing as ordered by the physician.

On 3/27/2025 at 1:25 pm in an interview with Nurse #4, she stated skin assessments were to be conducted by the nursing staff weekly and documented in Resident #39's medical record. Nurse #4 stated she did not know why Resident #39 skin assessments were not conducted weekly.

On 3/27/2025 at 12:50 pm in an interview with the Director of Nursing (DON), she stated skin checks were performed daily on residents during baths, showers, incontinence care and with weekly nursing skin assessments. She stated nursing staff were to observe for any changes in resident's skin and report to the Treatment Nurse as needed. She stated skin assessments should have been conducted and documented by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 nursing staff for Resident #39 and she was unable to provide a reason why Resident #39's skin assessment were not performed weekly. She stated Resident #39's right buttocks/sacral pressure wound was discussed in morning and evening meetings and Resident #39's wound worsened because Resident #39 stopped eating due to dental issues that were treated. On 3/27/2025 at 1:45 pm in a phone interview with the Medical Director, he stated the Treatment Nurse started providing wound care to Resident #39 when notified of the skin breakdown on 1/17/2025. He explained he reviewed the Treatment Nurse wound assessments weekly and was scheduled to be evaluated at the wound clinic on 2/17/2025. He stated there were no reports of infection to Resident #39's pressure wound until 2/17/2025 and Resident #39 was seen at the wound clinic as scheduled on 2/17/2025. He stated due to the Resident #39's comorbidities, Resident #39 was at risk for developing the pressure wound and the deterioration of the right buttock pressure wound was unavoidable.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 23 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 3 of 3 residents reviewed with urinary catheters (Resident # 8, Resident # 5 and Resident # 14). The findings included: 1. Resident # 8 was admitted to the facility on 8/13/19 with diagnoses which included acute kidney failure, urinary retention, and acute cystitis without hematuria (a lower urinary tract infection	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI On 4/10/2025 resident #8 Catheter bag was repositioned by the Director of Nursing so that catheter bag was not positioned or touching the floor. On 4/10/2025, resident #5 Catheter bag was repositioned by the Director of Nursing so that catheter bag was not positioned or touching the floor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 24 without blood in the urine). A quarterly Minimum Data Set (MDS) assessment dated 3/6/25 revealed Resident # 8 had severely impaired cognition. The assessment indicated Resident # 8 was dependent upon staff for all of his activities of daily living (ADL). Resident # 8 was coded for an indwelling urinary catheter. Resident #8's care plan dated 3/12/25 revealed Resident #8 was at the risk for infection due to the alteration pattern of urinary elimination with the use of an indwelling urinary catheter. Interventions included maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary collection bag below the level of the urinary bladder. Interventions did not include keeping the urinary collection bag and tubing off the floor. An initial observation was conducted on 3/24/25 at 12:39 pm of Resident # 8 as he was lying in his bed. A urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's left side of the bed (with a solid, blue-colored side of the bag facing the window). The entire bottom of the urinary catheter drainage bag was resting on the floor. An additional observation was conducted on 3/24/25 at 3:03 pm Resident # 8's urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's left side of the bed. The entire bottom of the urinary catheter drainage bag was resting on the floor. During an interview on 3/26/25 at 6:19 am with Nurse Aide (NA) # 1, he stated the urinary	F 690	On 4/10/2025, resident #14 Catheter bag was repositioned by the Director of Nursing so that catheter bag was not positioned or touching the floor. On 4/10/2025, the Director of Nursing completed an audit of all residents to include resident #8, resident #5, and resident #14 with catheter bags to ensure no catheter bag was positioned on or touching the floor. All areas of concern were immediately corrected during the audit by the QA Nurse to include repositioning the catheter bag, so it was not positioned on or touching the floor and the education of staff. On 4/10/2025 the Staff Facilitator initiated an in-service with all nurses and nursing assistants (NA) regarding Positioning of Catheter Bags with emphasis on not positioning catheter bags on or touching the floor. If a resident's bed must be in the lowest position possible then the catheter bag should be placed inside a black catheter sleeve to decrease the risk of infection. Attach the catheter bag to the foot of the bed and elevate the foot of the bed to a height so that the catheter bag is not positioned on or touching the floor. The in-service will be completed by 4/17/2025. After 4/17/2025, any nurse or nursing assistant who has not worked or completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses and certified nursing assistants will be in-serviced by the SDC during orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 25 catheter bags were not supposed to be touching the floor due to contamination and infection control. NA# 1 repositioned the urinary catheter drainage bag so that it was not resting on the floor. In an interview with Nurse # 1 on 3/26/25 at 6:45 am, she stated she was the hall nurse assigned to care for Resident #8. Nurse # 1 was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, "It shouldn't touch the floor." The nurse stated she thought the urinary catheter drainage bag ended up touching the floor due to the low position of Resident # 8's bed. During a subsequent observation on 3/26/25 at 10:15 am, Resident # 8 was observed in his bed with his urinary catheter drainage bag hanging from the left side of the bed and again the catheter drainage bag was touching the floor. On 3/26/2025 at 7:35 am in an interview with the Director of Nursing, she stated to prevent contamination urinary drainage bags were not to be touching or placed on the floor. 2. Resident #14 was admitted to the facility on 11/11/2019 with diagnoses including neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). The quarterly Minimum Data Set (MDS) assessment dated 2/14/2025 indicated Resident #14 was moderately cognitively impaired, was incontinent of stool and had a indwelling urinary catheter for urine elimination. Resident #14's care plan dated lasted reviewed	F 690	The QI Nurse will audit of all residents with catheter bags to include resident #8, resident #5, and resident #14 utilizing the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure catheter bags are not positioned on or touching the floor. The QI Nurse will immediately address all identified areas of concern to include repositioning of catheter bag, so it is not positioned on or touching the floor and/or re-training of staff. The DON will review the Catheter Bag Audit Tool 3 times a week x 4 week, then monthly x 1 month to ensure all areas of concern have been addressed. The DON will forward the results of Catheter Bag Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 26	F 690		

2/25/2025 listed Resident #14 at the risk for infection due to the alteration pattern of urinary elimination with the use of an indwelling urinary catheter. Interventions included maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary collection bag below the level of the urinary bladder. Interventions did not include keeping the urinary collection bag off the floor.

Review of a hospital discharge summary dated 3/12/2025 reported Resident #14 was treated for a urinary tract infection with antibiotics during the hospitalization.

On 3/26/2025 at 6:20 am, Resident #14's urinary collection bag was observed lying on the floor. Nurse Aide #1 was observed in Resident #14's room providing care to Resident #14's roommate.

On 3/26/2025 at 6:29 am, NA #1 was observed exiting Resident #14's room and Resident #14's urinary collection bag was observed lying on the floor. NA #1 stated he had attached the urinary collection bag to the bed and Resident #14's urinary collection bag must have fallen to the floor. NA #1 stated Resident #14's urinary collection bag was not to touch the floor to prevent contamination. NA #1 was observed re-entering Resident #14's room to re-attach Resident #14's urinary collection bag to the bed frame. NA #1 was observed placing the urinary collection bag into a dark blue storage bag that was hanging on the bed frame and touching the floor and raising Resident #14's bed enough to prevent the dark blue storage bag from touching the floor.

On 3/26/2025 at 7:35 am in an interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 27	F 690		

Director of Nursing, she stated to prevent contamination urinary collection bags were not to be touching or placed on the floor.

3. Resident #5 was admitted to the facility on 2/1/2024 with diagnoses including retention of urine.

Resident #5's care plan included a focus dated last revised on 8/6/24 indicating Resident #5 was at risk for an infection due to an altered pattern of urinary elimination with the use of a indwelling catheter. Interventions included the use of a suprapubic catheter (a thin, sterile tube that is inserted through a small cut in the lower belly used to drain urine from the urinary bladder) and maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary catheter collection bag below the level of the bladder. There was no intervention for keeping the catheter collection bag off the floor.

A quality assurance note dated 1/26/2025 recorded Resident #5 was admitted to the hospital from 12/10/2024 to 12/19/2024 for sepsis (a serious condition in which the body responds improperly to an infection) secondary to an urinary tract infection.

The annual Minimum Data Set (MDS) assessment dated 2/7/2025 indicated Resident #5 was severely cognitively impaired, was incontinent of stool and had an indwelling catheter for urine elimination.

On 3/24/2025 at 11:01 am, Resident #5's bed was observed in the lowest position and the urinary collection bag was observed touching the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 28 On 3/25/2025 at 9:08 am, a tube on the urinary collection bag that was used to empty the urinary collection bag was observed clamped and touching the floor. There were no staff observed in the hallway near Resident #5's room to address the concern. On 3/26/2025 at 7:35am in an interview with the Director of Nursing (DON), the DON was informed observing Resident #5's urinary collection bag and the tube used to empty the urinary collection bag touching the floor. The DON stated to prevent contamination the urinary collection bag and the tube used to empty the urinary collection bag should not be touching the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer supplemental oxygen as prescribed by the physician for 1 of 1 resident reviewed for oxygen use (Resident #27). Findings included:	F 695	F695 Respiratory/Tracheostomy Care and Suctioning On 3/26/2025, the Nurse verified the physician order for oxygen and adjusted the flowrate on the oxygen concentrator to 4 liters.	4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 29 Resident #27 was admitted to the facility on 12/07/2020 with diagnoses including chronic obstructive pulmonary disease (COPD and congestive heart failure (CHF). Physician orders dated 3/20/2025 included an order for continuous oxygen at four liters per minute by nasal cannula every shift for respiratory disease. The significant change Minimum Data Set (MDS) assessment dated 3/21/2025 indicated Resident #27 was moderately cognitively impaired and was receiving oxygen therapy. Resident #27's care plan dated 3/25/2025 included a focus for the potential or actual ineffective breathing pattern related to COPD and CHF. Interventions included oxygen at four liters per minute by nasal cannula. A review of Resident #27's March 2025 Medication Administration Record (MAR) recorded Resident #27 received four liters of oxygen via nasal cannula each shift on 3/20/2025 through 3/26/2025 and recorded oxygen saturations (measurement of how much oxygen present in the blood) ranged from 95% to 99%. On 3/25/2025 at 9:04 am, Resident #27 was observed lying in bed with the head of bed elevated and receiving oxygen by nasal cannula at two liters per minute. Resident #27 was observed with no signs or symptoms of respiratory distress. On 3/26/2025 at 6:20 am, Resident #27 was observed lying in the bed with her eyes closed	F 695	On 4/11/25 the Director of Nursing educated Nurse #3 and Nurse #2 on ensuring that oxygen is administered per physician order, accurately document the flow rate on eMAR and adjusting the flow rate when indicated. On 4/10/2025, the Director of Nursing initiated an audit of all residents with supplemental oxygen orders or residents utilizing supplemental oxygen. This audit is to ensure that oxygen was administered per physician order and that staff accurately document the flow rate on eMAR. The Director of Nursing addressed all concerns identified during the audit to include but not limited to adjusting the flow rate when indicated per physician order and education of staff. The audit will be completed by 4/10/2025. On 4/11/2025, the Staff Facilitator initiated an in-service with all nurses regarding administration of oxygen with emphasis on ensuring resident utilizing supplement oxygen have a current physician order to include flow rate and monitoring parameters and that oxygen is administered per physician orders. The in-service will be completed by 4/17/2025. After 4/17/2025, any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-serviced by the SDC during orientation. The Unit Managers will review all residents receiving supplement oxygen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 30	F 695		

and receiving oxygen at two liters per minute by nasal cannula. Resident #27 was observed with no signs or symptoms of respiratory distress.

On 3/26/2025 at 7:05 am in an interview with Nurse #2, who worked the 11:00 pm to 7:00 am shift, she stated Resident #27 wore oxygen continuously at four liters per minute and Resident #27 was known to adjust the controller of the oxygen concentrator. Nurse #2 stated the oxygen concentrator was at four liters per minute when she checked it on the 11:00pm to 7:00am shift and was unable to recall specific time it was checked.

On 3/26/2025 at 7:26 am, Nurse #2 checked the oxygen concentrator and stated Resident #27's oxygen concentrator was set at two liters per minute. Nurse #2 was observed verifying the physician order for oxygen and adjusted Resident #27's oxygen concentrator to four liters per minute.

On 3/26/2025 at 7:28 am in an interview with Nurse #3, who worked the 7:00 am to 3:00 pm shift, she stated the nursing staff were to check Resident #27's oxygen concentrator every shift to ensure the oxygen concentrator was set at four liters per minute and stated Resident #27 had been on oxygen at four liters per minute for as long as she could remember.

In a follow up interview with Nurse #3 on 3/26/2025 at 5:03pm, she stated she had charted Resident #27 on four liters of oxygen on the 3/25/26 for the 7:00 am to 3:00 pm shift because Resident #27 was supposed to receive four liters of oxygen. She stated she had not looked at the oxygen concentrator to verify the oxygen

weekly x 4 weeks then monthly x 1 month. This audit is to ensure that oxygen is administered per physician order and that staff accurately document the flow rate on eMAR. The Director of Nursing will address all concerns identified during the audit to include but not limited to adjusting the flow rate when indicated per physician order and education of staff. The Director of Nursing (DON) will review the Audit Tools weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The DON will forward the Oxygen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review to determine issues and trend to include continued monitoring frequency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 concentrator was set at four liters per minute. She stated Resident #27 had been observed turning the controller on the oxygen concentrator in the past. On 3/26/2025 at 7:40 am, in an interview with the Director of Nursing (DON) with the Administrator present, the DON stated Resident #27 had always received oxygen therapy at four liters per minute. After reviewing Resident #27's electronic medical record, the DON stated there was no order to titrate Resident #27's oxygen to two liters per minute and the nursing staff had been charting on the MAR Resident #27 was receiving oxygen at four liters per minute when checking the oxygen concentrator. The Administrator recalled the facility calling to verify Resident #27's oxygen order on 3/20/2025 for four liters per minute by nasal cannula after readmission to the facility.	F 695		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 32 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing information for 16 of 114 days reviewed for posted nurse staffing (12/9/24, 12/16/24, 12/30/24, 1/4/25, 1/14/25, 1/22/25, 1/27/25, 1/28/25, 1/30/25, 2/7/25, 2/17/25, 2/21/25, 2/23/25, 2/28/25, 3/11/25, and 3/16/25). The findings included: The daily posted nurse staffing sheets were reviewed for the period of 12/1/24 through 3/24/25 and revealed the following: -December 2024 did not have any RN documented as working for all 3 shifts on the	F 732	F732 Posted Nurse Staffing Information On 4/14/25, the Administrator and Director of Nursing (DON) updated the Daily Staffing Sheets for 12/9/24, 12/6/24, 12/30/24, 1/4/25, 1/14/25, 1/21/25, 1/27/25, 1/28/25, 1/30/25, 2/7/25, 2/17/25, 2/21/25, 2/23/25, 2/28/25, 3/11/25, and 3/16/25 to accurately reflect Registered Nurse staffing information. On 4/11/2025, the Director of Nursing initiated an audit of the Daily Staffing Sheets from 3/10/2025 to 4/11/2025 to ensure all sets were completed accurately to include but not limited to accurate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 33 following days: 12/9/24, 12/16/24, and 12/30/24. -January 2025 did not have any RN documented as working for all 3 shifts on the following days: 1/4/25, 1/14/25, 1/22/25, 1/27/25, 1/28/25, and 1/30/25. -February 2025 did not have any RN documented as working for all 3 shifts on the following days: 2/7/25, 2/17/25, 2/21/25, 2/23/25, and 2/28/25. -March 2025, for the period of 3/1/25 through 3/24/25, did not have any RN documented as working for all 3 shifts on the following days: 3/11/25 and 3/16/25. Review of employee timecard punches provided by the Administrator verified there had been RN coverage in the building for all the above dates and the Registered Nurse (RN) staffing information posted was incorrect. During an interview on 3/26/25 at 3:28 pm with the Scheduler, she stated she was responsible for the staff posting and she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing. During an interview on 3/27/25 at 2:15 pm with the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being	F 732	Registered Nursing staffing information. The Director of Nursing addressed all concerns identified during the audit to include updating the Daily Staffing sheet when indicated. The audit will be completed by 4/17/2025. On 4/11/2025, the Administrator initiated an in-service with the Director of Nursing (DON) and Scheduler regarding Posting of Daily Staffing Sheet with complete and accurate information to include but not limited to the Registered Nurse staffing information. In-service will be completed by 4/11/2025. Newly hired DON and scheduler will be in-serviced by the SDC during orientation. The Administrator will audit the Daily Staffing sheets to include weekends weekly x 4 weeks and monthly x 1 month to ensure daily posting includes complete and accurate information to include but not limited to the Registered Nurse Staffing information. Retraining will be immediately conducted by the Director of Nursing for any identified areas of concern. The Administrator will review the Daily Staffing sheets weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the Daily Staffing sheets to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 34 done, and the Scheduler did not know the posted staffing should be updated with the actual staff on each shift.	F 732	into place and to determine the need for further and/or frequency of monitoring.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to maintain an accurate medical record in documenting the administration of oxygen for 1 of 31 residents whose medical records were reviewed (Resident #27).	F 842	F842 Resident Records-Identifiable Information On 4/11/25, the Director of Nursing (DON) educated Nurse # 3 and Nurse #2 on following physician orders for oxygen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 36 Findings included: Physician orders dated 3/20/2025 included an order for continuous oxygen at four liters per minute by nasal cannula every shift for respiratory disease. A review of Resident #27's March 2025 Medication Administration Record (MAR) recorded Resident #27 received four liters of oxygen via nasal cannula each shift on 3/20/2025 through 3/26/2025 and recorded oxygen saturations (measurement of how much oxygen present in the blood) ranged from 95% to 99%. On 3/25/2025 at 9:04 am, Resident #27 was observed lying in bed with the head of bed elevated and receiving oxygen by nasal cannula at two liters per minute. Resident #27 was observed with no signs or symptoms of respiratory distress. On 3/26/2025 at 6:20 am, Resident #27 was observed lying in the bed with her eyes closed and receiving oxygen at two liters per minute by nasal cannula. Resident #27 was observed with no signs or symptoms of respiratory distress. On 3/26/2025 at 7:28 am in an interview with Nurse #3, who worked the 7:00am to 3:00 pm shift, she stated the nursing staff were to check Resident #27's oxygen concentrator every shift to ensure the oxygen concentrator was set at four liters per minute and stated Resident #27 had been on oxygen at four liters per minute for as long as she could remember. In a follow up interview with Nurse #3 on	F 842	administration with accurate documentation in the electronic record. On 3/28/2025, the Nurse clarified the physician order for the use of supplemental oxygen for resident #27 with a new order for 2liters of oxygen and updated the electronic record. On 4/10/2025, the Director of Nursing (DON) initiated an audit of all eMARs for residents receiving supplemental oxygen compared to the flow rate of oxygen being administered to ensure they are following physician orders with accurate documentation in the electronic record. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician of the resident's need for supplemental oxygen to include flow rate and monitoring parameters, ensuring oxygen was administered per physician orders with documentation in the electronic record. The audit will be completed by 4/10/2025. On 4/11/2025, the Staff Facilitator initiated an in-service with all nurses regarding Administration of Oxygen with emphasis on (1) ensuring resident utilizing supplement oxygen have a current physician order to include flow rate and monitoring parameters and (2) oxygen is administered per physician orders with accurate documentation in the electronic record. The in-service will be completed by 4/17/2025. After 4/17/2025, any nurse who has not worked or completed the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 37 3/26/2025 at 5:03pm, she stated she had charted Resident #27 on four liters of oxygen on the 3/25/26 for the 7:00 am to 3:00 pm shift because Resident #27 was supposed to receive four liters of oxygen. She stated she had not looked at the oxygen concentrator to verify the oxygen concentrator was set at four liters per minute. On 3/26/2025 at 7:40 am, in an interview with the Director of Nursing (DON) with the Administrator present, the DON stated Resident #27 had always received oxygen therapy at four liters per minute. After reviewing Resident #27's electronic medical record, the DON stated there was no order to titrate Resident #27's oxygen to two liters per minute and the nursing staff had been charting on the MAR Resident #27 was receiving oxygen at four liters per minute.	F 842	in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-serviced during orientation by SDC. The Unit Managers will review all residents eMARs for residents receiving supplemental oxygen compared to the flow rate of oxygen being administered to ensure they are following physician orders with accurate documentation in the electronic record weekly x 4 weeks then monthly x 1 month utilizing Oxygen Audit Tool. The Director of Nursing will address all concerns identified during the audit to include clarifying orders when indicated, administering oxygen per physician orders and/or re-training of staff. The Director of Nursing (DON) will review the Oxygen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the findings of the Oxygen Audit Tool to the Quality Assurance Performance Committee (QAPI) monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	