PRINTED: 04/22/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345366	B. WING _			C <b>03/27/2025</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/27/2023	
				1304 SE SECOND STREET			
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E	000			
F 000	investigation survey was through 03/27/25. The compliance with the r	eertification and complaint was conducted on 03/24/25 ne facility was found in requirement CFR 483.73, Iness. Event ID #RSOD11.	F	000			
	survey was conducte 03/27/25. Event ID# intakes were investig.	224513, NC00228434,					
F 584 SS=C	deficiency.	allegations resulted in ble/Homelike Environment (7)	F	584		4/17/25	
	§483.10(i) Safe Envir The resident has a ric comfortable and hom but not limited to rece supports for daily livir	ght to a safe, clean, elike environment, including eiving treatment and					
	homelike environmentuse his or her persont possible.  (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall e	clean, comfortable, and at, allowing the resident to all belongings to the extent aring that the resident can vices safely and that the facility maximizes resident coes not pose a safety risk. Exercise reasonable care for resident's property from loss					
ARODATORY		SLIPPLIER REPRESENTATIVE'S SIGNATURE		TITI E		(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		PLETED
		345366	B. WING _		l	C / <b>27/2025</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET  SNOW HILL, NC 28580	03/	2112025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 584	Continued From page	e 1	F 5	84		
		eeping and maintenance o maintain a sanitary, orderly, ior;				
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are				
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);				
	§483.10(i)(5) Adequa	te and comfortable lighting				
	levels. Facilities initia	table and safe temperature Ily certified after October 1, a temperature range of 71 to				
	sound levels.	maintenance of comfortable  is not met as evidenced				
	Based on observation facility failed to provide environment by not re	ons and staff interviews, the de a clean and sanitary emoving a dark grey/black om 20 of 25 ceiling fans esident halls.		F584 Safe/Clean/Comfortable/Ho Environment  On 4/10/25, the housekeeping sup cleaned all ceiling fans to ensure t	ervisor	
	Findings included:			grey/black colored substance was removed.		
	3/27/25 at 8:26 AM 2	ation of the 600-hall on ceiling fans were noted with ored substance on all 5 of		On 4/11/2025, the Housekeeping Supervisor initiated an audit under supervision of the Administrator of ceiling fans in the facility. This aud identify any ceiling fan that needs	all it is to	
	3/27/25 at 8:26 AM th	tion of the 600-hall on ne ceiling fan in front of the e 500-hall and 600-hall was		to maintain a safe and homelike environment. The Administrator ar Housekeeping Supervisor will add	ıd	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION		E SURVEY IPLETED
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NAME OF D	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	•	3/27/2025
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GREENDA	ALE FOREST NURSI	NG AND REHABILITATION CENTER				
				SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	Continued From p	page 2	F 5	584		
	noted with a dark	grey/black colored substance		concerns identified during the	audit to	
	on all 5 of the blad	- ·		include but not limited to clear		
				ceiling fans when indicated. A		
		conducted on 3/27/25 at 8:28		completed by 4/17/2025.		
		l revealed 3 ceiling fans had a				
		olored substance on all 5 of the		On 4/11/2025, the Administrate		
	blades.			completed an in-service with a		
	d An chaorication	conducted on 3/27/25 at 8:30		housekeeping staff, to include housekeeping supervisor rega		
		I revealed 3 ceiling fans had a		Maintaining a Homelike Enviro	•	
		blored substance on all 5 of the		emphasis on cleaning facility of		
	blades.	siered capetaries on all o or the		to maintain a safe and homelik		
				environment. All newly hired		
	e. An observation	conducted on 3/27/25 at 8:32		housekeeping staff will be in-s	erviced by	
	AM of the 300-hal	l revealed 1 ceiling fan had a		the SDC during orientation.		
		olored substance on all 5 of the				
	blades.			The Maintenance Director will	•	
	f An absorbation	conducted on 2/27/25 at 9:22		facility rounds to include all fac		
		conducted on 3/27/25 at 8:33 fan in front of the nurse's station		fans weekly x 4 weeks then m month. This audit is to identify		
		nd 200-hall revealed the ceiling		fan in the facility in need of cle		
		h a dark grey/black colored		maintain a safe and homelike	dilling to	
	substance on all 5	<b>.</b>		environment. The Administrato	or will	
				address all areas of concern id	dentified to	
	0	conducted on 3/27/25 at 8:34		include but not limited to ensu	ring ceiling	
		I revealed 3 ceiling fans had a		fans are cleaned when indicat		
		plored substance on all 5 of the		retraining of staff. The Adminis		
	blades.			review the environmental roun		
	h An observation	conducted on 3/27/25 at 8:37		weekly x 4 weeks then monthl to ensure all areas of concern	•	
		Il revealed 2 ceiling fans had a		addressed.	aic	
		blored substance on all 5 of the		344,0004.		
	blades.			The Administrator will present	the findings	
				of the Environmental Rounds	•	
	i. An observation	conducted on 3/27/25 at 8:41		the Quality Assurance Perform		
		l and 800 hall nurse's station		Improvement (QAPI) committe		
	_	fans had a dark grey/black		for 2 months to review the env		
	colored substance	e on all 5 of the blades.		rounds audit to determine tren		
				issues that may need further in	nterventions	

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	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		13	REET ADDRESS, CITY, STATE, ZIP CODE 04 SE SECOND STREET NOW HILL, NC 28580	1 03/	21/2023
(X4) ID PREFIX TAG			ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	j. An observation con	e 3 ducted on 3/27/25 at 8:42 vealed 1 ceiling fan had a	F 5	84	put into place and to determine the need for further frequency of monitoring.	ed	
	dark grey/black colore blades.	ed substance on all 5 of the anducted on 3/27/25 at 8:42					
	AM of the 700-hall re	vealed 11 siz7/25 at 6.42 vealed 1 ceiling fan had a ed substance on all 5 of the					
	stated the housekeep responsible for cleani facility. She further st cleaned weekly and t	ekeeping Staff #1. She bing department was ing the ceiling fans within the ated the ceiling fans were o her knowledge the fans e week ago. During visual					
	He stated the housek responsible for cleani were supposed to be	ducted with the ger on 3/27/25 at 8:49 AM. seeping department was ing the ceiling fans, and they cleaned weekly by the Floor ber who was responsible for					
	was responsible for c within the facility. He fans were usually cle	5 at 8:52 AM. He stated he leaning the ceiling fans further stated the ceiling aned weekly, however the cleaned 2 weeks ago, as he					
	800 with the Houseke	conducted on halls 700 and eeping Manager and Floor 5 at 8:54 AM. Both the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		MPLETED
		345366	B. WING _			C 03/27/2025
	ROVIDER OR SUPPLIER	S AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	1 4	33/21/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
F 584	indicated the ceiling. They stated all ceiling be cleaned that day.  On 3/27/25 at 10:50 conducted with the She stated the hous responsible for clear further stated it was housekeeping staff weekly and as need. An interview was conducted with the ceiling fans, and schedule. She furth that the ceiling fans cleaning schedule (Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b)(2) A combetion of the comprehensive (ii) Developed within the comprehensive (iii) Prepared by an includes but is not lie (A) The attending price of the state of the ceiling fans cleaning schedule (iii) Prepared by an includes but is not lie (A) The attending price of the state of the ceiling fans cleaning schedule (iii) Prepared by an includes but is not lie (A) The attending price of the state of the ceiling fans cleaning schedule (iii) Prepared by an includes but is not lie (A) The attending price of the state of the ceiling fans cleaning schedule (iii) Prepared by an includes but is not lie (A) The attending price of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling fans cleaning schedule (III) Prepared by an include of the ceiling schedule (III) Prepare	ager and Floor Technician I fans needed to be cleaned. Ing fans in resident halls would I.  O AM an interview was Director of Nursing (DON). I sekeeping department was ning the ceiling fans. She I her expectation that would clean the ceiling fans Ided.  I her expectation that would clean the ceiling fans I her expectation was I her expectation that I her expectat	F	584		4/17/25
	resident. (C) A nurse aide wit resident. (D) A member of for (E) To the extent pro	th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345366	B. WING _		0:	C 3/27/2025
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
				1304 SE SECOND STREET		
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580		
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F 657	medical record if the and their resident report practicable for the resident's care plan. (F) Other appropriated disciplines as determor as requested by the filli) Reviewed and reviteam after each assessments. This REQUIREMENT by:  Based on record revifacility failed to condimeetings after compannual Minimum Data for 6 of 31 residents (Resident #27, Resident #45, Resident #45, Resident #45, Resident #27 was 12/07/2020.  The last care plan mesident #27's meditation meditation meditation included the findings included the fi	be included in a resident's participation of the resident presentative is determined to development of the estaff or professionals in nined by the resident's needs the resident. Vised by the interdisciplinary resident, including both the quarterly review  This not met as evidenced riews and staff interviews, the fuct and document care plan reletion of quarterly and/or as Set (MDS) assessments reviewed for care planning thent #100, Resident #91, rent #18, and Resident #21).  The difference of the facility on the detail of the facility on the facility on the facility of	F6	*	sent an esident be held on ided in the sent an resident be held on vided in sent an esident be held on ided in the	
	The significant chang indicated Resident # cognitively impaired.	-		representative for care plan to be 5/6/25 with documentation provelectronic medical record.	e held on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345366	B. WING _			1	27/ <b>2025</b>	
NAME OF P	ROVIDER OR SUPPLIER	1 1111		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112023	
TVAINE OF T	NOVIDEN ON OUT FIELD							
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET SNOW HILL, NC 28580				
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F 657	Continued From page	e 6	F	657				
	MDS Coordinator, sh Worker was sent the completion of MDS a for scheduling care p  On 3/26/2025 at 9:41 Social Worker, she re Resident Representate meeting to 10/14/202 Resident #27's reside telephone while Resi Representative was a Social Worker stated didn't document the control of 10/14/2024 in Resident Worker stated care plan meeting sir Resident #27 should meeting in January 2 provide a reason why not been held for Resident #27 should meeting in January 2 provide a reason why not been held for Resident #27 should meeting in January 2 provide a reason why not been held for Resident #27/2025 at 11:20 Administrator, she stresponsible for sched meetings. In a follow at 2:48 pm, she state held quarterly and she	am in an interview with the ecalled Resident #27's ative changing the care plan 24 at 3:00pm and talking with ent representative on the dent #27's Resident driving home from work. The she didn't know why she care plan meeting held on ent #27's medical record. The Resident #27 had not had a noce 10/14/2024. She stated have had a care plan 1025 and was unable to y a care plan meeting had			On 4/14/25, the Social Worker sent an invitation to Resident #18 and resident representative for care plan to be held 5/1/25 with documentation provided in 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 5/22/25 with documentation provided in the electronic medical record.  On 4/11/2025, the Administrator and M Nurse initiated an audit of all residents most recent care plan meeting. This act is to ensure that a written invitation for 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 presenting was held. The Administrator and Director of Nursing (DON) will address 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 attending/declining to attend care plan meeting. The audit will be completed to	on the on DS udit a e		
	2. Resident #100 was 9/18/2024. The last care plan me	s admitted to the facility on eeting documented in lical record was dated			4/17/2025.  On 4/11/2025, the Administrator initiate an in-service with the Social Services Director, MDS Nurses, Activities Direct Unit Managers, Dietary Manager, and Therapy Manager regarding Resident	ed		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345366	B. WING _				27/ <b>2025</b>
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GREENDA	LE FOREST NURSING A	AND REHABILITATION CENTER			OW HILL, NC 28580		
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F 657	-	sments were completed for	F 6		Care Plan Process with emphasis on conducting and documenting care plan		
	The quarterly Minimu assessment dated 2/ #100 was severely co	12/2025 indicated Resident gnitively impaired.  pm in an interview with the		- - -	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 Service Director, MDS Nurses, Activities Direct Unit Managers, Dietary Manager, and Therapy Manager will be in-serviced by	ces or,	
	Worker was sent the completion of MDS as for scheduling care pl	e explained the Social scheduled timeframe for ssessments monthly to use an meetings.  am in an interview with the		-	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 more		
	Social Worker, she st documentation Resid meeting since 9/26/20 used the MDS schedul assessments and upon schedule the care plated she had not been abburepresentative for a contract of the Resident #100's representative for a contract of the prevent the facility plan meeting for Residual Worker stated Resides	ated she was unable to find ent #100 had a care 024. She explained she alle for completion of lating care plans to n meetings. She explained et to contact Resident #100's are plan meeting and stated esentative not attending did of staff from having a care dent #100. The Social ent #100 should have had a November 2024 and did not			to ensure that a written invitation for a care plan meeting has been mailed to tresident and the resident representative with documentation in the electronic record and documentation in the electronic record as to when the care peresenting is held. The MDS nurses, Soc Worker, and/or Administrator will addreall concerns identified during the audit include but not limited to scheduling a care plan meeting per facility guidelines. The Administrator will review the care paudit weekly x 4 weeks then monthly x month to ensure all concerns are addressed.	he e lan cial ss to s.	
	Administrator, she staresponsible for sched meetings. In a follow at 2:48 pm, she state held quarterly and she	am in an interview with the ated the Social Worker was uling resident care plan up interview on 3/27/2025 d care plan meetings were was unaware quarterly ad not been conducted for		1	The Administrator will forward the resul of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months review to determine trends and / or issuthat may need further interventions put into place and to determine the need for further and / or frequency of monitoring	for ues or	

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F 657		e 8 admitted to the facility on including diabetes mellitus	F	857			
	and hypertension.  Resident #45's electr	ronic medical record umented care plan meeting					
	completed for Reside dates: 9/20/24 (quart	MDS) assessments were ent #45 on the following erly), 12/2/24 (annual), 1/20/25 (significant change 5 (quarterly).					
		ssessment dated 2/13/25 45 had severely impaired					
	Worker on 3/26/25 at Resident #45 has no since 8/20/24. She no the care plan meeting as she used the list of	t had a care plan meeting eported she was unsure why gs had not been scheduled					
	at 11:20 pm, she stat responsible for sched meetings. She repor	ne Administrator on 3/27/25 ged the Social Worker was duling the care plan ted the care plan meetings according to the federal					
		idmitted to the facility on es that included heart ive heart failure.					
	Minimum Data Set (N	MDS) assessments were					

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F 657	dates: 10/11/24 (quand 2/18/25 (quarter Resident #91's electorevealed the last doccurred on 9/17/2  The quarterly MDS revealed Resident impairment.  An interview was on Worker on 3/26/25 Resident #91 had resince 9/17/24. She the care plan meeting as she used the list assessments provided in an interview with at 11:20 pm, she storesponsible for schemeetings. She rep	dent #91 on the following larterly), 11/29/24 (quarterly), erly).  Stronic medical record ocumented care plan meeting 4.  assessment dated 2/13/25 #91 had moderate cognitive  Conducted with the facility Social at 3:04 PM who stated not had a care plan meeting e reported she was unsure why ings had not been scheduled	F 68	57		
	2/3/21 with diagnos chronic kidney dise Minimum Data Set completed for Resi dates: 9/23/24 (qua 1/15/25 (quarterly), Resident #18's elec	(MDS) assessments were dent #18 on the following arterly), 10/22/24 (quarterly), and 2/4/25 (quarterly).				

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F 657	Continued From page	e 10	F 6	557			
		ssessment dated 2/4/25 8 had severe cognitive					
	Worker on 3/26/25 at Resident #18 has not since 8/20/24. She re the care plan meeting as she used the list of assessments provide. In an interview with that 11:20 pm, she stat responsible for sched meetings. She report	t had a care plan meeting eported she was unsure why gs had not been scheduled f upcoming MDS d by the MDS Coordinator.  The Administrator on 3/27/25 ed the Social Worker was					
		admitted to the facility on es that included diabetes asion.					
	completed for Reside	MDS) assessments were ent #21 on the following rly), 10/10/24 (quarterly), 2/6/25 (quarterly).					
	Resident #21's electr revealed the last doc occurred on 8/26/24.	onic medical record umented care plan meeting					
		ssessment dated 2/6/25 1 had moderate cognitive					
	An interview was con Worker on 3/26/25 at	ducted with the facility Social 3:04 PM who stated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345366	B. WING		C 03/27/2025
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 304 SE SECOND STREET SNOW HILL, NC 28580	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D.4TE
F 657	since 8/26/24. She in the care plan meeting as she used the list of assessments provided. The Social Worker st meeting scheduled for was in the hospital. Suchedule a care plan April 2025.  In an interview with the at 11:20 pm, she stated responsible for scheduled according. Treatment/Svcs to Pr. CFR(s): 483.25(b)(1)  §483.25(b) Skin Integ. §483.25(b)(1) Pressure and on the compressional standard pressure ulcers and online ulcers unless the indicated according to the compressional standard pressure ulcers and online ulcers unless the indicated according to the facility in the facility	thad a care plan meeting eported she was unsure why gs had not been scheduled of upcoming MDS and by the MDS Coordinator. Atted she had a care plan for 1/28/25 but Resident #21 She stated she planned to meeting for Resident #21 in the Administrator on 3/27/25 and the Social Worker was duling the careplan meetings. The plan meetings should be to the federal timeframes. The event/Heal Pressure Ulcer (i)(ii)  The grity for the same of a must ensure that a care, consistent with the soft practice, to prevent does not develop pressure vidual's clinical condition any were unavoidable; and the essure ulcers receives and services, consistent and ards of practice, to vent infection and prevent	F 686		4/17/25 Heal

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	ATE SURVEY DMPLETED
						С
		345366	B. WING _			03/27/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
				1304 SE SECOND STREET		
GREENDA	ALE FOREST NURSIN	IG AND REHABILITATION CENTER		SNOW HILL, NC 28580		
(X4) ID PREFIX	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFIX		ON SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY		
F 686	Continued From p	age 12	F 6	86		
		atment and interventions.		On 4/5/25, resident #39 was	assessed by	
	Resident #39's sk	in was intact on re-admission		the Treatment Nurse. Woun	d Ulcer	
	on 11/19/24. On 1	1/4/25 excoriation was noted on		flowsheet was completed w	ith wound	
	her buttocks. Ther	e were no further documented		status noted to be improving	<b>j</b> .	
	assessments until	a wound assessment dated				
	1/17/2025 recorde	ed Resident #39 developed an		On 4/11/25, skin check was	completed on	
	unstageable (full t	hickness skin and tissue loss		resident # 39 with no new sl	kin issues	
		of tissue damage cannot be		identified.		
		presence of slough, a				
	1 -	of dead skin tissue, or eschar,		On 4/10/25, the Unit Manag		
		bscuring the wound bed) 5		Facilitator, QA Nurse, and T		
		y 5cm right buttocks pressure		Nurse initiated skin check of		
		#39's right buttocks pressure		This audit is to identify any r		
		d and required hospitalization		new skin concerns or wound		
	_	nt buttocks/sacral pressure		all concerns have been prop	-	
		25. Resident #39 received		assessed, treatment initiate		
		otic therapy and a debridement		MD/RR notified, documenta		
		ure to remove dead, damaged		completed in the Wound Uld		
		from a wound to promote		or Non-Ulcer Flowsheet, inc	•	
		nt infection) of the right		completed for any newly ide		
		wound while in the hospital.		and care plan updated. All a		
		discharged back to the facility		concern will be immediately		
		ders for oral antibiotics for 5		the Unit Managers, Staff Fa		
	I -	nt practice occurred for 1 of 2		Nurse, and Treatment Nurse		
		d for pressure ulcer care		assessment of resident, con		
	(Resident #39).			incident report, notification of		
	Finalis and in about a de			initiating treatment per MD o		
	Findings included:			documentation in Wound UI		
	Desident #20 wee	admitted to the facility on		or Non-Ulcer Flowsheet and		
		admitted to the facility on		care plan. Audit will be com	pieted by	
	_	noses including coronary artery insufficiency. Resident #39 was		4/17/25.		
		•		Deginning the week of 4/17/	IDE as part of	
	facility on 11/19/20	hospital and readmitted to the		Beginning the week of 4/17/ the preventative monitoring,		
	1aUIIII   011   11/19/20	JZ7.		will be activated on admission		
	Resident #20's ald	in assessment dated		completed weekly thereafter		
		in assessment dated led there were no skin issues.		new skin concerns and to ei	•	
	11/19/2024 160010	eu iliele wele 110 SKIII 155065.		resident is properly assesse		
	There was no doo	umentation observed in		initiated as indicated, MD/R		
	i ilicic was IIU uUU	amontation observed ill	1	i initiatou as inuloatou, MD/N	A HOUHEU,	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		B) DATE SURVEY COMPLETED	
		345366	B. WING _			C 03/27/2025	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	00/21/2020	
				1304 SE SECOND STREET			
GREENDA	LE FOREST NURSING	S AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	Continued From page	ge 13	F 6	86			
	Resident #39's Med (MAR) to alert the n weekly skin assessi			documentation completed ir Ulcer Flowsheet or Non-Ulc incident report completed fo identified wounds and care In addition, staff will monitor	er Flowsheet, or any newly plan updated. r skin integrity		
	Resident #39 was a breakdown. Intervel skin weekly and not	d 11/19/2024 indicated potential risk for skin ntions included observing the difying the nurse of any elopment of new skin		during routine care and will concerns to nursing staff for evaluation.  On 4/11/25, the Director of N	further		
	impairments.			Staff Facilitator initiated an i all nurses regarding (1) Wo	in-service with		
	supplement that pro protein 60 milliliters weight managemen	ated 11/19/2024 included a povided additional calories and (mL) three times a day for at.		with emphasis on assessing treatment and notification of physician/resident represen newly identified skin concer in wound status (2) Skin che completed weekly for all res	f the tative for all ns or changes ecks should be		
	record on 11/20/202	24 was 180.2 pounds (lbs).		area is identified it should be assessed, treatment initiate	e properly d as indicated,		
	assessment dated #39 was cognitively hearing. Resident # urine and stool and bed mobility and ac were no dental issu Resident #39. The I indicated Resident #	mum Data Set (MDS) 11/26/2024 indicated Resident intact with severely impaired 39 was always incontinent of required total assistance with tivities of daily living. There es coded on the MDS for MDS assessment further #39 was at risk for developing t was not marked as having a kin impairment.		MD/RR notified, documenta completed in the Wound Uld or Non-Ulcer Flowsheet, incompleted, and care plan up in-service will be completed After 4/17/25, any nurse who worked or received the in-secomplete in-service prior to scheduled work shift. All new nurses will be in-serviced by during orientation.	cer Flowsheet cident report pdated. The by 4/17/25. o has not ervice will next wly hired		
	protein nutritional si weight managemen Resident #39's med assessments were	ent #39 was ordered a high upplement 30mL daily for it.  dical record documented skin conducted on 12/15/2024 with orded and on 1/4/2025 with		The Director of Nursing will skin check audits weekly x 4 monthly x 1 month. This aud skin checks are completed any resident with new skin wound concerns have been assessed, treatment initiate.	4 weeks then dit is to ensure weekly and concerns or properly		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE	
		245266	B. WING				
		345366	B. WING _			03/2	27/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GREEND	ALE FOREST NURSIN	G AND REHABILITATION CENTER		1304 SE SECOND STREET			
01(22,10)	122 1 011201 110110111			SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 686	Continued From pa	age 14	F 6	86			
F 686	skin excoriation (the off the skin) record no further docume assessment of Restreatment Nurse's on 1/17/25.  A review of nursing 11/19/2024 to 1/17 record recorded Restrepositioned and partner was no doct of a pressure would not be recalled Resident incontinence and restreated she couldn't her buttocks being when she observe to Resident #39's Is she informed the Tunable to recall the treatment nurse.  Documentation of 1/17/2025 by the Talestone would as pressure wound we pressure wound we pressure wound we should be skingly the talest and right buttocks pressure wound we pressure wound we satisfact the skingly she informed the Talestreatment nurse.	lee act of abrading or wearing led to the buttocks. There was intation of the excoriation or sident #39's skin until the pressure wound assessment and documentation from 1/2025 in the electronic medical lesident #39 was turned and rovided incontinence care. Lumentation of the development and for Resident #39.  36 pm in an interview with 2, she stated Resident #39 in turning and incontinent #39 was checked for epositioned every two hours. Hent #39 not having any skin and mitted to the facility and the recall Resident #39's skin on red or irritated. She stated do a quarter size red open area puttocks while providing care, freatment Nurse. NA #2 was the date she informed the say wound assessment dated freatment Nurse recorded an unstageable 5cm by 5cm sure wound. The right buttocks assessment recorded the as 90% dark eschar (dry dead nk tissue with moderate	F6	MD/RR notified, documental completed in the Wound Ull or Non-Ulcer Flowsheet, incompleted for any newly ideand care plan updated. All concern will be immediately the director of nursing. The will review the Skin Check 4 weeks then monthly x 1 rensure all concerns were at The Administrator will press of the Skin Check Audits to Assurance Performance Im (QAPI) committee monthly The QAPI Committee will infor 2 months and review the Audits to determine trends that may need further intensinto place and to determine further frequency of monito	Icer Flowshe cident report entified would areas of y addressed addressed. Administrat audits weekl month to addressed. The Quality approvement for 2 months neet monthly e Skin Check and/or issue wentions put the need for the cident weekler for the cident for th	t Inds I by tor Ily x Ings / s. y k es	
	Documentation of 1/17/2025 by the TResident #39 had right buttocks prespressure wound as pressure wound wissue) and 10% piamount of serous on odor, tunnelling	a wound assessment dated freatment Nurse recorded an unstageable 5cm by 5cm sure wound. The right buttocks ssessment recorded the as 90% dark eschar (dry dead					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345366	B. WING _			C 03/27/2025
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1304 SE SECOND STREET SNOW HILL, NC 28580	DDE	1 00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD B HE APPROPRIA	
F 686	under the edges of a Treatment Nurse red Resident #39's Repitreatment was started silver alginate (highligh) and covered with a review of Resident with normal saline, prep to the periwour allow to dry. Silver at the wound and the widressing every Mone A review of Resident Medication Administ Resident #39 received Resident #39's weig medical record on 1, that was a 12.1 lbs in Dietary notes dated #39 had an unstage right buttocks and Resident was a 12.1 lbs in Dietary notes dated with a supplemental protein nutrition daily and a supplemental protein malnutrition 60 millill in wound healing. The Resident #39 consumechanical soft diet a Multivitamin (MVI) C) 500milligrams to	ining (erosion that occurs a wound) recorded. The corded the physician and resentative were notified, and ed with the application of y absorbent, antimicrobial ith a foam dressing.  Ited 1/20/2025 included an unstageable right buttock but dry with gauze, apply skin and (skin around a wound) and alginate was to be applied to wound covered with a foam day, Wednesday and Friday.  It #39's January 2025 ration Record recorded ed wound care as ordered.  It was recorded in the 1/24/2025 as 192.3 pounds norease in weight.  1/30/2025 reported Resident able pressure wound to the esident #39 was receiving a hal supplement 30 milliliters ent that provides additional for persons at high risk for iters three times a day to aid the dietary note recorded med 50-100% of a regular and recommended ordering and Ascorbic Acid (Vitamin further aid in wound healing.	F	586		
	C) 500milligrams to  A review of Residen	further aid in wound healing.				

NAME OF PROVIDER OR SUPPLIER  GREENDALE FOREST NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		OATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER  GREENDALE FOREST NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION)  F 686  Continued From page 16 recorded Resident #39 was started on a Multivitamin (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			345366	B. WING _			C 03/27/2025
F 686  Continued From page 16 recorded Resident #39 was started on a Multivitamin (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			G AND REHABILITATION CENTER		1304 SE SECOND STREET	•	03/21/2020
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	PRÉFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
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	F 686	recorded Resident Multivitamin (MVI) a 1/31/2025 and recesupplements, MVI a Documentation of the 2/4/2025 by the Treatment #39's unsuppressure wound meeschar. Moderate swith no tunneling, unifection. The woundry, dark eschar and Treatment Nurse reatment Nurse reatment Nurse reatment was cleaned with gauze. Sfilm on the skin) was and allowed to dry, and covered with a Resident #39's weight medical record on 2 a 15 lbs weight loss. Physician progress recorded the nursing was refusing to eat due to pain. Resident #39's weight loss. Physician progress recorded the nursing was refusing to eat due to pain. Resident #39's weight loss. Physician progress recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was observed the pain. Resident #39's recorded the nursing was observed the pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was observed the pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain. Resident #39's recorded the nursing was refusing to eat due to pain.	#39 was started on a and Ascorbic Acid on sived the two dietary and Ascorbic Acid as ordered.  The wound assessment on eatment Nurse recorded tageable right buttocks easured 5 cm by 5 cm with serous exudate was recorded undermining, odor or signs of and bed was described as 90% and 10% pink tissue. The ecorded the physician and presentative was notified. The ed with normal saline and pat kin prep (forms a protective as applied to the periwound Silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded the physician and be ecorded in the 2/8/2025 as 177.3 lbs that was a silver alginate was applied foam dressing.  The ecorded the physician and be ecorded to the periwound assessment on the left upper and was unable to chew food and the ecorded the physician and the ecorded the ecorded the physician and th	F6	886		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345366	B. WING			C 2/27/2025
	ROVIDER OR SUPPLIER	NG AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1304 SE SECOND STREET SNOW HILL, NC 28580	•	3/27/2025
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	0.7cm from the poserous exudate with sign of infection. To 50% deep red tiss connective tissue and necrotic (dead colored dead tissue and Resident#39's Treatment of the rincluded cleaning area dry, applying allowing it to dry. saline-moistened impregnated with with a foam dress was ordered to be Wednesday and Formation of the wound reconstruction by 2cm and pressure ulcer with 7cm by 2cm and pressure ulcer with 7cm by 4cm and a eschar beside the of the wound reconstruction	1 o'clock of the wound and sition of 2-5 o'clock. Heavy as documented with no odor or The wound bed was recorded as true, 15% fascia (layer of below the skin), 15% muscle d tissue) with 15% stringy gray are and 5% adipose (fat) tissue. It is sment recorded the physician as Representative were notified. It is buttocks pressure wound with normal saline, patting the skin prep to the periwound and The wound was packed with polyurethane foam dressing methylene blue and covered ing. Resident #39's dressing changed every Monday,	F6	86		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345366	B. WING				27/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ODEENDA	L E FOREST NURSING	AND DELIABILITATION CENTED		1	304 SE SECOND STREET		
GREENDA	ALE FOREST NURSING	AND REHABILITATION CENTER		S	NOW HILL, NC 28580		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREF	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
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F 686	Continued From paç	ge 18	F	686			
	On 3/27/2025 at 12:	58 pm in an interview with the					
		ne stated the nursing staff					
		I document skin assessments					
	weekly and notify her when skin breakdown was						
	identified. The Treat	ment Nurse stated she was					
	aware of the excoria	ited skin to Resident #39's					
	buttocks documented on the skin assessment						
		it was treated with barrier					
	cream. She stated N						
	1/17/2025 of an area						
		s black eschar and weekly					
		eatments were started based					
	•	She explained Resident #39					
		n an area of the dry dead					
		d opened with no odor or					
		ment Nurse explained she					
	_	d clinic for a referral when the					
		ure wound was identified and					
		to the Wound Clinic on					
	_	ed on 2/17/2025, Resident					
	#39's wound was ob	served worsening due to					
		inage and odor. She					
	explained since Res	ident #39 was scheduled to					
		I visit to the wound clinic on				ſ	
		ed and notified the wound					
		in Resident #39's right					
		ound. She stated the wound					
	-	sident #39 to attend the					
		ent at the wound clinic on					
		eded, the wound clinic would to the hospital for admission.					
		tes dated 2/17/2025 recorded				ĺ	
		resenting to the wound clinic					
		an existing stage IV had worsen. The wound clinic				ĺ	
	pressure injury inat	nau worsen. The would dillic					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
	345366	B. WING			C	
ROVIDER OR SUPPLIER	04000	1	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u> E	03/2//2025	
LE FOREST NURSING	AND REHABILITATION CENTER		SNOW HILL, NC 28580			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	DATE	ON
note recorded the rig was very foul smellin bodily tissue) appear areas that was very of soft tissue infection (I located on the right be recorded measuring to black, green, red and moderate amount of	ht buttocks pressure wound g with a necrotizing (death of ance at the undermined concerning for a necrotizing NSTI). The pressure wound uttock/sacral area was 3.5cm by 8cm by 2 cm with I tan colored wound bed with green serous exudate. The	F€	86			
(redness) with no tun undermining. The wo dressed, and the wou hospitalist (physician	neling and 4.5 cm of und was cleansed and und clinic consulted the that works at the hospital) to					
2/24/2025 recorded F from the wound clinic worsening of right but on 2/17/2025. During #39 received debride right buttock/sacral p intravenous (medical administering fluids, a directly into a vein) at discharged from the latthe facility on 2/24/20 included physician or Amoxicillin-Potassium 875-125 milligram (minfection for five days wound care on the difference of the discharged from the discharged form the latthe facility on 2/24/20 included physician or Amoxicillin-Potassium 875-125 milligram (minfection for five days wound care on the discharged following orders: Amore Clavulanate Tablet 8	Resident #39 was admitted a due to foul smelling and ttock/sacral pressure wound hospitalization, Resident ment on 2/20/2025 of the ressure wound and technique that involves medications and nutrients ntibiotics. Resident #39 was nospital and re-admitted to 25. The discharge summary ders for n Clavulanate Tablet 19 twice a day for wound 15. There was no order for scharge summary.					
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENCE REGULATORY OR  Continued From page note recorded the rig was very foul smellin bodily tissue) appear areas that was very continued measuring in the second measurement in the second measuring in the second measuring in the second measuring in the second measurement in the second meas	CORRECTION  JA5366  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  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 BUILDIN  345366  B. WING _  SOVIDER OR SUPPLIER  LE FOREST NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  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). 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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 BUILDING  345366  ROVIDER OR SUPPLIER  LLE FOREST NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19 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 clinic consulted the hospitalist (physician that works at the hospital) to direct admit Resident #39 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) bwice 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 (mg) twice	A BUILDING  345366  345366  B WING  STREETADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET SNOW HILL, NC 28580  SUMMARY STATEMENT OF DEPCIENCIES  SUMMARY STATEMENT OF DEPCIENCIES  (EACH DEPCIENCY) WISE TO PROVIDE A PROVIDERS PLAN OF CORRECTION.  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 19  F 686  F 687  F 686  F 686	A BUILDING COMPLETED  345366  B. WING  STREET ADDRESS, CITY, STATE, 2IP CODE  1394 SE SECOND STREET SNOW HILL, NC 28580  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICEMENT WILL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 19  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 necrolizing soft tissue infection (NSTI). The pressure wound located on the right buttockscarcal area was recorded as bianchable erythema (redness) with no tunneling and 4.5 cm of undermining. The wound was cleansed and dressed, and the wound clinic consulted the hospital its objective in the wound clinic to the hospital.  A review of the hospital discharge summary dated 22/24/2025 recorded Resident #39 was admitted from the wound clinic to the hospital.  A review of the hospital and re-admitted to 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 admitted from the wound clinic clother fluid to the facility on 2/24/2025. The discharge summary included physician orders for Amoxicillin-Potassium Clavulanate Tablet 875-125 milligram (mg) wice a day for wound infection for five days. There was no order for wound care on the discharge summary.  Physician orders of a dated 2/24/2025 included the following orders: Amoxicillin-Potassium.

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345366	B. WING _			C <b>03/27/2025</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1304 SE SECOND STREET SNOW HILL, NC 28580	ODE	00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENCE	ION SHOULD BE HE APPROPRIA	DATE
F 686	super-oxidated solutic bacteria and facilitate gauze, pat dry with geriwound and allow application of an enzignation of	attock/sacrum with a topical on formulated to combat a wound healing moistened auze and apply skin prep to to dry thoroughly. The ymatic debriding ointment reas of yellow/white dead ound packed with a topical on formulated to combat a wound healing moistened with a bordered foam or a stage IV pressure ulcer.  #39's February 2025 and corded Resident #39 and antibiotic and wound  and 3/25/2025 included attock/sacral wound with a contains pure hypochlorous ria and infection moistened are dry with gauze, applying a see based ointment and then nedication) powder to the an ointment that removes eas of yellow/white dead are wound with a topical on formulated to combat a wound healing moistened with a bordered foam	F 6	886		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345366	B. WING			C
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1304 SE SECOND STREET SNOW HILL, NC 28580		3/27/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	pressure wound as a ordered wound care Resident #39 right be was observed with b lower left portion of t wound with a small was remaining tissue was foul odor detected frow wound. The Treatme wound with a wound hypochlorous acid the infection moistened go based ointment to the nystatin powder, appremoves dead tissue inside the wound and wound solution that acid that fights bacted gauze and covered wordered by the physical of the wound in Residuate wound and wound solution that acid that fights bacted gauze and covered wordered by the physical of the wound in Residuate wound and wound solution that acid that fights bacted gauze and covered wordered by the physical of the wound in Residuate wordered by the documented in Residuate weekly.  On 3/27/2025 at 12:50 Director of Nursing (Inchecks were perform baths, showers, incompaths, showers,	d clinic notes recorded the 5.3cm by 10 cm by 1 cm and to be performed twice a day. attocks/sacral open wound lack colored tissue to the he wound, the center of the white patch tissue and the sered in color. There was no om the right buttocks/sacral ant Nurse cleansed the solution that contains pure at fights bacteria and gauze, applied a zinc-oxide e edges covered with blied an ointment that to the dark colored tissue di packed the wound with a contains pure hypochlorous ria and infection moistened with a foam dressing as	F 68	36		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345366	B. WING			C 03/27/2025
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET  SNOW HILL, NC 28580		03/27/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690 SS=D	nursing staff for Resi unable to provide a r skin assessment were stated Resident #39' pressure wound was evening meetings and worsened because F due to dental issues.  On 3/27/2025 at 1:45 with the Medical Direct Nurse started providi #39 when notified of 1/17/2025. He explain Treatment Nurse worden and was scheduled to clinic on 2/17/2025. He ports of infection to wound until 2/17/202 seen at the wound of 2/17/2025. He stated comorbidities, Resided eveloping the pressed eterioration of the rife was unavoidable.  Bowel/Bladder Incon CFR(s): 483.25(e)(1)  §483.25(e) Incontine §483.25(e)(1) The fare resident who is contiliad mission receives semaintain continence condition is or become not possible to maintilise.	dent #39 and she was eason why Resident #39's e not performed weekly. She is right buttocks/sacral discussed in morning and d Resident #39's wound desident #39 stopped eating that were treated.  If pm in a phone interview ctor, he stated the Treatment ing wound care to Resident the skin breakdown on ined he reviewed the und assessments weekly to be evaluated at the wound de stated there were no in Resident #39's pressure inic as scheduled on ind due to the Resident #39's ent #39 was at risk for ure wound and the ght buttock pressure wound tinence, Catheter, UTI -(3) ince. cility must ensure that inent of bladder and bowel on ervices and assistance to unless his or her clinical ines such that continence is ain. esident with urinary	F6			4/17/25
	not possible to maint	ain. esident with urinary				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345366	B. WING			C 3/27/2025
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1304 SE SECOND STREET SNOW HILL, NC 28580		3/21/2029
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 690	ensure that- (i) A resident who en indwelling catheter is resident's clinical co- catheterization was (ii) A resident who en indwelling catheter is assessed for remain as possible unless the demonstrates that cand (iii) A resident who is receives appropriate prevent urinary tract continence to the extensive asset of the extensive appropriate prevent urinary tract continence, based comprehensive asset ensure that a reside receives appropriate restore as much nor possible.  This REQUIREMEN by:  Based on record regimery interviews the facility catheter bag from to risk of infection for 3 urinary catheters (Resident # 14).  The findings include  1. Resident # 8 was 8/13/19 with diagnostication was a series of the extensive facility catheters.	essment, the facility must  atters the facility without an a not catheterized unless the indition demonstrates that necessary; Inters the facility with an are subsequently receives one oval of the catheter as soon ne resident's clinical condition atheterization is necessary; Inters the facility receives one oval of the catheter as soon ne resident's clinical condition atheterization is necessary; Inters the facility receives one oval of the catheter as soon ne resident's clinical condition atheterization is necessary; Inters the facility receives one oval of the catheter as soon ne resident's clinical condition at the resident and services to infections and to restore tent possible.  Intersident with fecal on the resident's resident with fecal on the resident's resident and services to mal bowel function as  In it is not met as evidenced or it is not met as eviden	F 6	F690 Bowel/Bladder Incontine Catheter, UTI  On 4/10/2025 resident #8 Catheter bag was repositioned by the Direct Nursing so that catheter bag was repositioned or touching the flow on 4/10/2025, resident #5 Catheter bag was repositioned by the Direct Nursing so that catheter bag was repositioned by the Dir	theter bag ctor of was not or. atheter bag ctor of was not	
	8/13/19 with diagnos kidney failure, urinar			was repositioned by the Direc	ctor of was not	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		, ,	(X3) DATE SURVEY COMPLETED  C 03/27/2025	
		345366					
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE		3/2//2025	
TVAIVIL OF T	TO VIDER OR GOLT EIER						
GREENDA	LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET			
			SNOW HILL, NC 28580				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 690	Continued From page	e 24	F 69	00			
	without blood in the u	ırine).		On 4/10/2025, resident #14 Car			
		D + 0 + (14D0)		was repositioned by the Directo			
	A quarterly Minimum			Nursing so that catheter bag wa			
		6/25 revealed Resident # 8		positioned or touching the floor			
	had severely impaire	•		O- 4/40/0005 H Di			
	assessment indicated			On 4/10/2025, the Director of N			
		f for all of his activities of		completed an audit of all reside			
	indwelling urinary cat	esident # 8 was coded for an		include resident #8, resident #5 resident #14 with catheter bags			
	indweiling unitary cat	nietei.		no catheter bag was positioned			
	Resident #8's care n	an dated 3/12/25 revealed		touching the floor. All areas of o			
		ne risk for infection due to		were immediately corrected dur			
	the alteration pattern of urinary elimination with			audit by the QA Nurse to includ	-		
	the use of an indwelli			repositioning the catheter bag,			
		d maintaining a closed		not positioned on or touching th			
		an unobstructed urine flow		the education of staff.			
		ary collection bag below the					
		adder. Interventions did not		On 4/10/2025 the Staff Facilitat	or initiated		
		ırinary collection bag and		an in-service with all nurses and	d nursing		
	tubing off the floor.			assistants (NA) regarding Posit	ioning of		
				Catheter Bags with emphasis o	n not		
	An initial observation	was conducted on 3/24/25		positioning catheter bags on or	touching		
		ent # 8 as he was lying in his		the floor. If a resident's bed mu	st be in the		
	bed. A urinary cathet			lowest position possible then th			
	_	ing off the bedframe on the		bag should be placed inside a b			
	resident's left side of	•		catheter sleeve to decrease the			
		he bag facing the window).		infection. Attach the catheter ba	•		
		the urinary catheter drainage		foot of the bed and elevate the			
	bag was resting on th	ne floor.		bed to a height so that the cath	•		
				not positioned on or touching th			
		ation was conducted on		The in-service will be completed			
	3/24/25 at 3:03 pm R			4/17/2025. After 4/17/2025, any			
		g was observed to be		nursing assistant who has not v		<b> </b>	
		ame on the resident's left		completed the in-service will co	•		
		entire bottom of the urinary		upon the next scheduled work s			
	catheter drainage bag was resting on the floor.			newly hired nurses and certified			
	During on interview -	on 2/26/25 at 6:10 am with		assistants will be in-serviced by	iile SDC		
	Nurse Aide (NA) # 1,	on 3/26/25 at 6:19 am with he stated the urinary		during orientation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345366		B. WING			C <b>03/27/2025</b>		
NAME OF P	ROVIDER OR SUPPLIER		<del>                                     </del>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	03/	2112025	
TVAINE OF T	TO VIDER OR OUT FIER							
GREENDA	GREENDALE FOREST NURSING AND REHABILITATION CENTER				04 SE SECOND STREET			
				SN	IOW 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From page	÷ 25	F 6	90				
F 690	catheter bags were not the floor due to contain control. NA# 1 reposition drainage bag so that if floor.  In an interview with N am, she stated she we to care for Resident # what her thoughts we resident's urinary cathes shouldn't touch the floor thought the urinary caup touching the floor of Resident # 8's bed.  During a subsequent 10:15 am, Resident # with his urinary cathes from the left side of the catheter drainage bag.  On 3/26/2025 at 7:35 Director of Nursing, secontamination urinary be touching or placed 2. Resident #14 was a 11/11/2019 with diagribladder (lack of bladd spinal cord or nerve potential through the diagrible of the catheter drainage bag. The quarterly Minimulassessment dated 2/2 #14 was moderately of the control of the control of the catheter drainage bag.	ot supposed to be touching mination and infection tioned the urinary catheter it was not resting on the urse # 1 on 3/26/25 at 6:45 as the hall nurse assigned #8. Nurse # 1 was asked re about the position of the neter bag. She replied, "It por." The nurse stated she atheter drainage bag ended due to the low position of observation on 3/26/25 at 8 was observed in his bed ter drainage bag hanging he bed and again the grown to understand the stated to prevent a drainage bags were not to no the floor.  admitted to the facility on noses including neurogenic for control due to brain, problems).	F 6	690	The QI Nurse will audit of all residents with catheter bags to include resident # resident #5, and resident #14 utilizing to Catheter Bag Audit Tool 3 times a weel 4 week, then monthly x 1 month to ensicatheter bags are not positioned on or touching the floor. The QI Nurse will immediately address all identified areas concern to include repositioning of catheter bag, so it is not positioned on touching the floor and/or re-training of staff. The DON will review the Catheter Bag Audit Tool 3 times a week x 4 weethen 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 review and to determine trends and / or issues that may need further intervention put into place and to determine the need for further and / or frequency of monitoring.	he  K X  ure  s of  or  k,  for  r  ons		
	catheter for urine elim Resident #14's care p	olan dated lasted reviewed				_		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345366	B. WING _				27/ <b>2025</b>		
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1304 SE SECOND STREET SNOW HILL, NC 28580	DE	1 00.	2172020		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 690	infection due to the a elimination with the ucatheter. Intervention closed drainage systeurine flow and keepin below the level of the Interventions did not collection bag off the Review of a hospital 3/12/2025 reported Raurinary tract infection hospitalization.  On 3/26/2025 at 6:20 collection bag was of Nurse Aide #1 was or room providing care for the collection bag to the urinary collection bag floor. NA #1 stated he collection bag was not prevent contamination re-entering Resident #14's urinary collection bag into a collection and raising Resident floor and raising Resident the floor.	dent #14 at the risk for Iteration pattern of urinary se of an indwelling urinary is included maintaining a sem with an unobstructed graph the urinary collection bag urinary bladder. Sinclude keeping the urinary floor.  discharge summary dated desident #14 was treated for on with antibiotics during the served lying on the floor. Served in Resident #14's no Resident #14's roommate.  am, NA #1 was observed is room and Resident #14's was observed lying on the served and Resident #14's must have fallen to the sesident #14's urinary oped and Resident #14's urinary oped and Resident #14's urinary oped and Resident #14's urinary sesident #14's urinary	F6	90					

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C 03/27/2025	
	ROVIDER OR SUPPLIER	NG AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1304 SE SECOND STREET SNOW HILL, NC 28580		1112020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	contamination uring be touching or plate touching or plate 3. Resident #5 was 2/1/2024 with diagrams.  Resident #5's care last revised on 8/6 at risk for an infecturinary elimination catheter. Interven suprapubic catheter inserted through a used to drain uring maintaining a closunobstructed uring catheter collection bladder. There we the catheter collection bladder. There we the catheter collection bladder are corded Residen hospital from 12/1 (a serious condition improperly to an information of stock and the serious condition of the annual Minimassessment dated #5 was severely concentrated for urine on 3/24/2025 at 1 was observed in the continent of stock and the continent of the c	g, she stated to prevent hary collection bags were not to need on the floor.  It is admitted to the facility on gnoses including retention of the plan included a focus dated 6/24 indicating Resident #5 was stion due to an altered pattern of an with the use of a indwelling tions included the use of a ter (a thin, sterile tube that is a small cut in the lower belly the from the urinary bladder) and sed drainage system with an the flow and keeping the urinary in bag below the level of the as no intervention for keeping cition bag off the floor.  The note dated 1/26/2025 the	F	690			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345366	B. WING		1	27/ <b>2025</b>
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET  SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695 SS=D	collection bag that wa collection bag was obtouching the floor. The in the hallway near R address the concern.  On 3/26/2025 at 7:35 Director of Nursing (Dinformed observing R collection bag and the urinary collection bag DON stated to prever collection bag and the urinary collection bag floor.  Respiratory/Tracheos CFR(s): 483.25(i)  § 483.25(i) Respirator tracheostomy care and The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sul This REQUIREMENT by:  Based on record reviinterviews, the facility supplemental oxygen	am, a tube on the urinary as used to empty the urinary as used to empty the urinary as userved clamped and ere were no staff observed esident #5's room to  am in an interview with the DON), the DON was resident #5's urinary at tube used to empty the touching the floor. The not contamination the urinary at tube used to empty the should not be touching the should not be touching the stomy Care and Suctioning.  The transport of the professional standards	Fé		ed	4/17/25

F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
345366 B. WI		B WING			C	
DOVIDED OD CLIDDLIED	343300	1 2: 11:10	CTREET ADDRESS CITY STATE ZID CODE	1 0	3/27/2025	
OVIDER OR SUPPLIER						
LE FOREST NURSING	AND REHABILITATION CENTER		1304 SE SECOND STREET			
			SNOW HILL, NC 28580			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
Continued From page	÷ 29	F 69	5			
12/07/2020 with diagrobstructive pulmonary congestive heart failure. Physician orders date order for continuous of minute by nasal cannulisease.  The significant changrassessment dated 3/2 #27 was moderately or receiving oxygen there. Resident #27's care princluded a focus for the ineffective breathing part CHF. Interventions in	doses including chronic y disease (COPD and re (CHF).  ed 3/20/2025 included an oxygen at four liters per ula every shift for respiratory  e Minimum Data Set (MDS) 21/2025 indicated Resident cognitively impaired and was rapy.  clan dated 3/25/2025 he potential or actual pattern related to COPD and cluded oxygen at four liters		educated Nurse #3 and Nurse # ensuring that oxygen is administ physician order, accurately document flow rate on eMAR and adjusting rate when indicated.  On 4/10/2025, the Director of Nurinitiated an audit of all residents supplemental oxygen orders or rutilizing supplemental oxygen. T is to ensure that oxygen was address per physician order and that staff accurately document the flow rate eMAR. The Director of Nursing a all concerns identified during the include but not limited to adjusting rate when indicated per physicial and education of staff. The audit	2 on ered per ment the g the flow  ursing with residents his audit ministered f te on addressed audit to ng the flow n order		
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			On 4/11/2025, the Staff Facilitate an in-service with all nurses regard administration of oxygen with en on ensuring resident utilizing suppoxygen have a current physician include flow rate and monitoring parameters and that oxygen is administered per physician order in-service will be completed by 4 After 4/17/2025, any nurse who worked or completed the in-service myllete it at the next scheduled shift. All newly hired nurses will be in-serviced by the SDC during of the Unit Managers will review at	arding apphasis applement order to  rs. The //17/2025. has not ice will d work be rientation.		
	CORRECTION  COVIDER OR SUPPLIER  LE FOREST NURSING A  SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I.  Continued From page  Resident #27 was add 12/07/2020 with diagr obstructive pulmonary congestive heart failu  Physician orders date order for continuous of minute by nasal cann disease.  The significant chang assessment dated 3/2 #27 was moderately of receiving oxygen ther  Resident #27's care pr included a focus for the ineffective breathing pr CHF. Interventions in per minute by nasal cann Medication Administrate recorded Resident #2 oxygen via nasal cann through 3/26/2025 an saturations (measure present in the blood)  On 3/25/2025 at 9:04 observed lying in bed elevated and receivin at two liters per minut observed with no sign respiratory distress.  On 3/26/2025 at 6:20	CORRECTION  A45366  COVIDER OR SUPPLIER  LE FOREST NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	A BUILDING  345366  B. WING  B. PREFIX  TAG  F. 69  Resident #27 was admitted to the facility on  12/07/2020 with diagnoses including chronic  cobstructive 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	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's care plan dated 3/20/2025 through 3/26/2025 at 9:04 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.  On 3/26/2025 at 6:20 am, Resident #27 was observed with no signs or symptoms of respiratory distress.	A BUILDING  345366  B, WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET SNOW HILL, NC 28560  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 29  February  Continued From page 29  February  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 active state of the season of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING			C 03/27/2025		
NAME OF D	ROVIDER OR SUPPLIER	343300	5:		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2025	
NAME OF PI	ROVIDER OR SUPPLIER							
GREENDA	GREENDALE FOREST NURSING AND REHABILITATION CENTER				304 SE SECOND STREET			
				S	NOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From pag	ne 30	F	395				
	and receiving oxyger	n at two liters per minute by			weekly x 4 weeks then monthly x 1 mo	nth.		
		dent #27 was observed with			This audit is to ensure that oxygen is			
		ns of respiratory distress.			administered per physician order and t	hat		
					staff accurately document the flow rate			
	On 3/26/2025 at 7:05	5 am in an interview with			eMAR. The Director of Nursing will			
	Nurse #2, who worke	ed the 11:00 pm to 7:00 am			address all concerns identified during t	he		
		ident #27 wore oxygen			audit to include but not limited to adjus			
	continuously at four				the flow rate when indicated per physic	cian		
	Resident #27 was kr	nown to adjust the controller			order and education of staff. The Direct	tor		
	of the oxygen concentrator. Nurse #2 stated the oxygen concentrator was at four liters per minute				of Nursing (DON) will review the Audit			
					Tools weekly x 4 weeks then monthly x	(1		
		on the 11:00pm to 7:00am			month to ensure all concerns are			
	shift and was unable checked.	to recall specific time it was			addressed.			
					The DON will forward the Oxygen Audi	t		
		6 am, Nurse #2 checked the			Tool to the Quality Assurance			
		and stated Resident #27's			Performance Improvement (QAPI)			
	, , ,	was set at two liters per			committee monthly x 2 months for review			
		as observed verifying the			to determine issues and trend to include	le		
		xygen and adjusted Resident			continued monitoring frequency.			
	, , ,	ntrator to four liters per						
	minute.							
	On 3/26/2025 at 7:29	8 am in an interview with						
		ed the 7:00 am to 3:00 pm						
		nursing staff were to check						
		en concentrator every shift to						
		oncentrator was set at four						
	, , ,	stated Resident #27 had						
		our liters per minute for as						
	long as she could re	-						
	In a follow up intervie							
		n, she stated she had charted						
		r liters of oxygen on the						
		am to 3:00 pm shift because						
		upposed to receive four liters						
		ed she had not looked at the						
	oxygen concentrator	to verify the oxygen						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
		345366	B. WING _		03/	27/2025
	NAME OF PROVIDER OR SUPPLIER  GREENDALE FOREST NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET  SNOW HILL, NC 28580		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 732 SS=B	concentrator was set She stated Resident of turning the controller in the past.  On 3/26/2025 at 7:40 Director of Nursing (Director of	at four liters per minute. #27 had been observed on the oxygen concentrator  am, in an interview with the DON) with the Administrator ted Resident #27 had en therapy at four liters per gg Resident #27's electronic ON stated there was no ent #27's oxygen to two liters ursing staff had been Resident #27 was receiving er minute when checking tor. The Administrator Illing to verify Resident #27's /2025 for four liters per ula after readmission to the g Information (4)  ffing Information. equirements. The facility gg information on a daily  and the actual hours worked pries of licensed and aff directly responsible for the state law).		732		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345366		B. WING		C 03/27/2025	
	NAME OF PROVIDER OR SUPPLIER  GREENDALE FOREST NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1304 SE SECOND STREET SNOW HILL, NC 28580	03/2//2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 732	Continued From page	32	F 732			
	specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readable (B) In a prominent pla residents and visitors §483.35(g)(3) Public staffing data. The fact written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fact posted daily nurse states 18 months, or as requising greater. This REQUIREMENT by:  Based on record revifacility failed to post at (RN) staffing informat reviewed for posted in 12/16/24, 12/30/24, 1 1/27/25, 1/28/25, 1/36 2/21/25, 2/23/25, 2/28  The findings included	pest the nurse staffing data in (g)(1) of this section on a sinning of each shift.  ed as follows: le format. Ince readily accessible to eaccess to posted nurse staffing data in for review at a cost not to y standard.  Independent of the following of the following:  Independent of the following of the following:  Independent of the following of the following:  Independent of the following:  Independent of the following of the following:  Independent of the following of the following of the following:  Independent of the following of t		F732 Posted Nurse Staffing Information On 4/14/25, the Administrator and Dire 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, 2/17/2/2/1/25, 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 accura	/25,	
		not have any RN ng for all 3 shifts on the		to include but not limited to accurate	leiy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  . BUILDING		(X3) DATE SURVEY COMPLETED	
		345366	B. WING	2		C	
		343366	B. WING_			3/27/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
GREENDA	ALE FOREST NURSIN	IG AND REHABILITATION CENTER		1304 SE SECOND STREET			
ORLEAD	tee i oiteo i itoitoii			SNOW HILL, NC 28580			
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 732	Continued From p	age 33	F 7	32			
	following days: 12	/9/24, 12/16/24, and 12/30/24.		Registered Nursing staffing in The Director of Nursing addre			
	as working for all	not have any RN documented 3 shifts on the following days: 22/25, 1/27/25, 1/28/25, and		concerns identified during the include updating the Daily Sta when indicated. The audit will completed by 4/17/2025.	audit to ffing sheet		
	-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.			On 4/11/2025, the Administrat an in-service with the Director (DON) and Scheduler regarding of Daily Staffing Sheet with con accurate information to include limited to the Registered Nurs	of Nursing ng Posting omplete and e but not		
				information. In-service will be by 4/11/2025. Newly hired DO scheduler will be in-serviced be during orientation.	completed N and		
				The Administrator will audit the Staffing sheets to include wee weekly x 4 weeks and monthly to ensure daily posting include	ekends y x 1 month		
	the Scheduler, she for the staff postin requirement to adj information to refle	w on 3/26/25 at 3:28 pm with estated she was responsible g and she was unaware of the ust the posted staffing ect the actual staff present. She		and accurate information to in not limited to the Registered N Staffing information. Retrainin immediately conducted by the Nursing for any identified area.	lurse g will be Director of as of		
	ahead of time bas She stated when s vacation, she com sheets ahead of ti	ted the posted staffing sheets ed on the staff work schedule. she was off on the weekend or pleted the posted staffing me and they were not adjusted ct the actual staffing.		concern. The Administrator wi Daily Staffing sheets weekly x then monthly x 1 month for co and to ensure all areas of con addressed.	4 weeks mpletion		
	During an intervier the Administrator, the requirement to accurately reflect	w on 3/27/25 at 2:15 pm with she stated she was aware of adjust the posted staffing to the actual staff present. She as unaware this was not being		The Administrator will forward of the Daily Staffing sheets to Assurance Performance Impre (QAPI) Committee monthly x 2 review to determine trends an that may need further interver	the Quality ovement 2 months for d/or issues		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345366	B. WING				27/ <b>2025</b>	
NAME OF P	ROVIDER OR SUPPLIER	0.000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	2112025	
					304 SE SECOND STREET			
GREENDA	ALE FOREST NURSING A	AND REHABILITATION CENTER			NOW HILL, NC 28580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 732	32 Continued From page 34		F	732				
		uler did not know the posted dated with the actual staff on			into place and to determine the need for further and/or frequency of monitoring.	r		
F 842 SS=D	Resident Records - Id CFR(s): 483.20(f)(5),		F	842			4/17/25	
	(i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or o	lease information that is						
		ordance with accepted als and practices, the facility all records on each resident ented; e; and						
	all information contain regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health	r their resident permitted by applicable law; yment, or health care ted by and in compliance						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED		
	345366	B. WING		C 03/27/2025		
ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE SECOND STREET  SNOW HILL, NC 28580	03/21/2023		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION		
activities, judicial and law enforcement purposes, research medical examiners, a serious threat to he by and in compliance §483.70(h)(3) The frecord information a unauthorized use.  §483.70(h)(4) Medicing for- (i) The period of time (ii) Five years from there is no requirem (iii) For a minor, 3 yelegal age under State §483.70(h)(5) The region of the	d administrative proceedings, rposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512.  acility must safeguard medical against loss, destruction, or cal records must be retained e required by State law; or the date of discharge when the in State law; or ears after a resident reaches te law.  Inedical record must containtion to identify the resident; esident's assessments; sive plan of care and services by preadmission screening evaluations and ducted by the State; te's, and other licensed tess notes; and ology and other diagnostic required under §483.50. It is not met as evidenced view, observation and staff ty failed to maintain an cord in documenting the ygen for 1 of 31 residents	F 84	F842 Resident Records-Identifiable Information On 4/11/25, the Director of Nursing (			
			educated Nurse # 3 and Nurse #2 or following physician orders for oxyger	1		
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From page activities, judicial and law enforcement pude purposes, research medical examiners, a serious threat to he by and in compliance  §483.70(h)(3) The farecord information and unauthorized use.  §483.70(h)(4) Medication formation and unauthorized use.  §483.70(h)(4) Medication formation and unauthorized use.  §483.70(h)(5) The farecord of the record information and resident information formation formation and resident review determinations concept (vi) The results of an and resident review determinations concept (vi) Physician's, nurse professional's progressional's progress	ALE FOREST NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	A BUILDIN  345366  ROVIDER OR SUPPLIER  LLE FOREST NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 35  activities, judicial and administrative proceedings, law enforcement 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.  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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.125			С	
		345366	B. WING		0:	03/27/2025	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	•	5/2//2020	
				1304 SE SECOND STREET			
GREENDALE FOREST NURSING AND REHABILITATION CENTER				SNOW HILL, NC 28580			
(X4) ID	SUMMARY ST	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
F 842	Continued From page 36		F 84	42			
				administration with accurate			
	Findings included:			documentation in the electron	nic record.		
		ed 3/20/2025 included an		On 3/28/2025, the Nurse clar			
		oxygen at four liters per		physician order for the use of			
	disease.	nula every shift for respiratory		supplemental oxygen for resi			
	uisease.			updated the electronic record	•		
	A review of Resident	#27's March 2025		apacioa ino diodionio rocore	4.		
	Medication Administr			On 4/10/2025, the Director of	f Nursing		
	recorded Resident #27 received four liters of			(DON) initiated an audit of all			
	oxygen via nasal cannula each shift on 3/20/2025			residents receiving suppleme	ental oxygen		
	through 3/26/2025 and recorded oxygen			compared to the flow rate of			
	saturations (measurement of how much oxygen			administered to ensure they	_		
	present in the blood)	ranged from 95% to 99%.		physician orders with accura			
	O 0/05/0005 -+ 0-0/	L D : + + + + + + + + + + + + + +		documentation in the electron			
		I am, Resident #27 was		The Director of Nursing address			
		d with the head of bed ng oxygen by nasal cannula		concerns identified during the include but not limited to clar			
		te. Resident #27 was		the physician of the resident'			
	observed with no sig			supplemental oxygen to inclu			
	respiratory distress.	c. cyp.cc c.		and monitoring parameters, e			
	, ,			oxygen was administered pe			
	On 3/26/2025 at 6:20	am, Resident #27 was		orders with documentation in	the		
	observed lying in the	bed with her eyes closed		electronic record. The audit v	vill be		
	and receiving oxyger	n at two liters per minute by		completed by 4/10/2025.			
	nasal cannula. Resident #27 was observed with						
	no signs or symptoms of respiratory distress.			On 4/11/2025, the Staff Facil			
				an in-service with all nurses i	•		
	On 3/26/2025 at 7:28 am in an interview with			Administration of Oxygen wit	•		
	Nurse #3, who worked the 7:00am to 3:00 pm			on (1) ensuring resident utiliz			
	shift, she stated the nursing staff were to check Resident #27's oxygen concentrator every shift to			supplement oxygen have a c physician order to include flo			
		oncentrator was set at four		monitoring parameters and (2			
		stated Resident #27 had		administered per physician o	,		
	-	our liters per minute for as		accurate documentation in th			
	long as she could rer			record. The in-service will be			
	3 - 1112 55 31 31 101			by 4/17/2025. After 4/17/202	•		
	In a follow up interview with Nurse #3 on			who has not worked or comp			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345366 B. WING			C 03/27/2025			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		03/	27/2025	
10 10 1	TO VIDER OR GOLF EIER				804 SE SECOND STREET			
GREENDALE FOREST NURSING AND REHABILITATION CENTER				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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 842				in-service will complete it at the ne scheduled work shift. All newly hir nurses will be in-serviced during orientation by SDC.  The Unit Managers will review all residents eMARs for residents reconsupplemental oxygen compared to flow rate of oxygen being administ ensure they are following physicial with accurate documentation in the electronic record weekly x 4 weeks monthly x 1 month utilizing Oxygen Tool. The Director of Nursing will a all concerns identified during the a include clarifying orders when indicadministering oxygen per physicial and/or re-training of staff. The Director of Nursing (DON) will review the Oxy Audit Tool weekly x 4 weeks then a x 1 month to ensure all concerns a addressed.  The DON will forward the findings Oxygen Audit Tool to the Quality Assurance Performance Committee (QAPI) monthly for 2 months for redetermine trends and/or issues that need further interventions put into and to determine the need for furth frequency of monitoring.		ing e ed to orders nen udit ress it to ed, orders or of n nthly  the		