

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Blumenthal Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3724 Wireless Drive Greensboro, NC 27455	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and Wound Nurse Practitioner (NP) interviews, the facility failed to obtain a treatment order for a suspected deep tissue injury when it was first observed which resulted in a delay in the initiation of treatment for 1 of 3 residents reviewed for pressure ulcers (Resident #5).</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on [DATE] with diagnoses that included left total knee arthroplasty (surgical procedure to restore or repair a damaged joint) on 11/25/24, type 2 diabetes, chronic kidney disease, osteoarthritis, chronic pain, neuralgia (pain caused by damaged nerve), spondylosis with radiculopathy cervical region (spinal degeneration with nerve root compression of the bones and disks in the neck), hypertension, systemic inflammatory response syndrome (widespread inflammation in the body), hypothyroidism, neuromuscular disorder and obesity.</p> <p>The care plan dated 12/01/24 revealed the resident was at risk for pressure ulcers related to chronic health conditions, immobility, and incontinence. The goal was Resident #5 would not have any skin impairments. Interventions included assessing resident for risk of skin breakdown, keeping skin clean and dry as possible, and skin assessments as indicated.</p> <p>A review of the Wound Nurse Practitioner (NP) progress note dated 12/01/24 read in part, Preventative measures: continue with turning and repositioning schedule per protocol for pressure prevention, position patient side to side as tolerated, float heels while in bed with use of pillows. New recommendations as follows: schedule an appointment visit in 2 weeks with the surgeon. The patient has a surgical wound. There is no evidence of infection noted today upon assessment. If complications arise, staff understand to contact operating surgeon. The risk of complications and/or morbidity/mortality of the patient's management is moderate.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #5 was cognitively intact and required supervision/touching assistance to moderate assistance with activities of daily living. The MDS further revealed that Resident #5 was at risk for pressure ulcers.</p> <p>A review of the progress notes by the Advanced Practice Nurse (APN) dated 12/10/24 revealed Resident had a planned discharge to home on [DATE] and had 2 two falls at home and returned to the facility the same day. The Resident was evaluated via teleconference by the Advance Practice Nurse (APN) and indicated the left knee surgical wound initially was bleeding and had stopped, the surgical dressing was in place and was reinforced with ace bandage. Resident was to follow up with orthopedic on 12/11/24.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345006
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of physician orders revealed an order dated 12/10/24 to monitor left knee for changes and rewrap dressing every other day.</p> <p>A review of the NP's note dated 01/28/25 revealed Resident #5 was sent to neurology to evaluate her complaint of upper and lower extremity weakness as well as upper extremity tremors. The resident had labs done and an electromyography (EMG) (a diagnostic test that assesses the health of muscle and the nerves connected to them) for bilateral legs were ordered and awaiting scheduling. An evaluation of upper extremities deferred as it was considered less concerning to the provider and suspected pinched nerve. An electroencephalogram (EEG) (electrical activity of the brain) to rule out seizure disorder causing episodes of loss of cognitive abilities and flailing of arms and legs. Plan to follow up in office in 3 months.</p> <p>A review of the weekly skin observation tool form dated 01/30/25 revealed Resident #5 had a suspected deep tissue injury on the left heel.</p> <p>Review of Resident #5's Treatment Administration Record (TAR) dated January 2025 revealed no treatment for a left heel pressure ulcer.</p> <p>An interview was conducted on 05/30/25 at 3:52 pm with the Wound Nurse and she indicated she had conducted a skin assessment on Resident #5 on 01/30/25 and observed a suspected deep tissue injury on Resident #5's left heel. She indicated she thought she had received an order for the wound and had placed the order on the computer. The Wound Nurse stated, I'm not sure what happened.</p> <p>A review of Resident #5's care plan dated 02/04/25 revealed the Resident had a deep tissue injury to the left heel. The goal was the Resident would not develop any further skin impairment, and the wound will show signs and symptoms of healing. The interventions included treatment as ordered, assessing resident for risk of skin breakdown, keep skin clean and dry as possible, referral to wound physician as indicated, skin assessments as indicated, and wound reviews as indicated.</p> <p>An interview was conducted with the Wound NP on 05/30/25 at 4:10 pm and she indicated she was informed by the Wound Nurse on 02/04/25 during wound rounds that Resident # 5 had a deep tissue injury on the left heel. Wound NP stated she observed Resident # 5's left heel pressure ulcer on 02/04/25 and she placed orders to treat the wound with skin prep to left heel DTI and leave open to air daily and as needed. She indicated Resident #5 had something going on with her neurologically and did not think the facility did anything wrong in this case.</p> <p>A review of Resident #5's February TAR revealed a treatment had been initiated on 02/05/25 indicating the treatment had been started on 02/05/25 for skin prep to left heel deep tissue injury (DTI) and leave open to air daily and as needed.</p> <p>During an interview with the Nurse Practitioner (NP) on 05/30/25 at 4:04 pm it was indicated he did not recall if he received notification about Resident #5's left heel pressure ulcer. He stated sometimes the facility would notify him and sometimes they would notify the Wound NP. He indicated he observed Resident #5 offloading her heels during his visits with Resident. The NP indicated he would expect to have seen a treatment order for the left heel pressure ulcer.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed on 05/30/25 at 5:04 pm and she stated, I would expect that we notify the provider and get an order in place. She indicated she did not know why an order was not in place for Resident #5's left heel pressure ulcer.</p> <p>The Administrator was interviewed on 05/30/25 at 5:44 pm and she indicated the Nurse should have notified the physician immediately and receive an order for Resident #5' s left heel pressure ulcer.</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to: 1) Obtain a provider's order prior to requesting radiology testing (x-ray) be completed for a resident; and 2) Notify the Nurse Practitioner (NP) when the results of the x-ray revealing 4 rib fractures became available. This occurred for 1 of 3 residents (Resident #2) reviewed for accidents.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with cumulative diagnoses which included a history of stroke, generalized muscle weakness, and dementia.</p> <p>The resident's admission Minimum Data Set (MDS) dated [DATE] revealed she had severely impaired cognition. Resident #2 required set-up or clean-up assistance for eating, partial/moderate assistance for bed mobility and walking 10 feet; with substantial/maximum assistance for toileting, bathing, sit to stand, and chair to bed to chair transfers.</p> <p>Resident #2's electronic medical record (EMR) included a Fall Note dated 4/21/25 at 1:00 PM. This note reported Resident #2 had a fall to the floor after attempting to rise out of her wheelchair in the hall despite verbal redirection. She was witnessed by staff as she sat down on the floor. The resident denied having any pain at the time of the incident.</p> <p>On 4/21/25, the facility's Nurse Practitioner (NP) ordered x-rays be completed for Resident #2 due to staff reporting the resident complained of general achiness.</p> <p>A Radiology Results Report documented an x-ray of Resident #2's bilateral ribs (3 views) was completed on 4/22/25 at 2:57 AM and the x-ray results were reported on 4/22/25 at 7:00 AM. The findings of this report noted in part, There is no acute fracture or dislocation of ribs demonstrated in these projections. the visualized lungs are clear. The bony mineralization is mildly decreased. The Impression on the report noted mild osteopenia was demonstrated in the x-ray.</p> <p>A Progress Note dated 4/22/25 at 11:15 AM and authored by the NP reported Resident #2 was seen for a post-fall evaluation and follow-up review of her 4/22/25 x-ray results. No concerns related to the x-ray results were noted.</p> <p>No additional falls were documented in Resident #2's EMR after the fall she experienced on 4/21/25.</p> <p>On 5/7/25 at 12:39 PM, a Progress Note authored by the NP documented an interim visit was conducted with the resident for her acute and chronic issues. The note indicated Resident #2 had no pain at that time. The Assessment and Plan read in part: resting in bed at start of this encounter. easily awakened but wants to return to sleep.</p> <p>(continued on next page)</p>		

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the resident's EMR and Physician's Orders revealed no orders were obtained or documented for an x-ray to be conducted for this resident. However, a Radiology Results Report in the EMR indicated another x-ray of Resident #2's bilateral ribs (3 views) was completed on 5/7/25 at 12:37 PM with the x-ray results reported on 5/7/25 at 4:18 PM. The report noted that a comparison of Resident #2's 4/22/25 x-ray was conducted. The findings read: There is visualization of multiple right-sided rib fractures involving ribs five through eight. There is no obvious pneumothorax (collapsed lung). The results of the x-ray were sent electronically to the facility.</p> <p>An interview was conducted on 5/29/25 at 12:39 PM with Nurse #1. Nurse #1 was identified as the nurse who requested an x-ray for Resident #2 on 5/7/25 without obtaining and/or documenting a provider order for the testing. When asked what prompted her to request radiology testing for the resident on 5/7/25, the nurse stated on that date she herself had a cough and congestion. Nurse #1 stated it was going around and she thought the resident had the same type of signs/symptoms. The nurse reported that the resident did not complain of pain during her shift. When asked, Nurse #1 reiterated that pain was not the reason for obtaining the x-ray. Upon further inquiry, the nurse stated the facility's NP verbally ordered this x-ray, so she put the request in for it. She stated, That's the one I forget to put the order in for. Nurse #1 reported she was assigned to another hall when Resident #2's x-ray results came back. During the interview, Nurse #1 stated she was not sure if she told the oncoming nurse an x-ray was taken and that the results were still pending for this resident.</p> <p>An interview was conducted on 5/29/25 at 11:33 AM with the facility's NP. During the interview, the NP reported he received a call from the Unit 1 Manager on 5/8/25 informing him that Resident #2 was declining and that her oxygen saturation rate was low despite supplemental oxygen being provided. Therefore, he gave an order to send the resident out to the hospital Emergency Department (ED) for evaluation and treatment. The NP reported he then went into the resident's EMR to review the resident's past lab results. At that time, he noticed a chest x-ray was done on 5/7/25, adding that he did not order that x-ray. After seeing the results of the x-ray revealing Resident #2 had 4 rib fractures, he reported he called back to the facility's Unit 1 Manager to discuss concerns related to these results. The NP noted his discovery of the radiology report occurred after the resident had already been sent out to the ED due to a change in condition. When asked if he would have done anything differently if he had been notified of the x-ray results when they first became available to the facility on 5/7/25, the NP stated he would have wanted to assess Resident #2 fully to see if she had any other clinical findings of concern. He noted the resident did not have any respiratory problems until 5/8/25 (when she was sent out to the hospital ED).</p> <p>Resident #2's EMR documented she was sent out to the hospital Emergency Department (ED) due to altered mental status on 5/8/25. She arrived at the hospital on 5/8/25 at 10:32 AM. The ED records indicated a chest x-ray completed on 5/8/25 at 12:00 PM reported the resident had multiple subacute/healing right rib fractures noted. The term subacute refers to a post-injury period of time that may vary depending on individual factors. A subacute fracture typically falls within the 5-14 day range after the initial injury but may be as much as 6 weeks post-injury. The ED to Hospital admission (discharged) notes dated 5/8/25 reported Resident #2's primary hospital problem was determined to be sepsis (the body's extreme reaction to an infection).</p> <p>(continued on next page)</p>		

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