STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Guardian, Nurse Practitioner, Infectious Disease Physician interviews, the facility failed to ensure Resident #24 attended a scheduled infectious disease clinic appointment as ordered, for 1 of 5 residents reviewed for professional standards of care (Resident #24). Findings included:Record review of a hospital Discharge summary dated [DATE] revealed Resident #24 was prescribed Biktarvy, an antiretroviral medication used to treat human immunodeficiency virus (HIV), filled by the hospital retail pharmacy prior to discharge, with instructions to closely follow up at the infectious disease clinic. The discharge summary further documented a follow-up appointment scheduled for 11/12/2025. Resident #24 was admitted to the facility on [DATE] with cumulative diagnoses including a mental health disorder and HIV infection. Physician's orders for Resident #24, dated 10/10/2025, directed administration of Biktarvy 50-200-25 milligrams, one tablet orally daily. Review of the care plan for Resident #24 initiated 10/14/2025 identified chronic disease management as a focus area with interventions to administer medications as ordered and monitor for complications related to HIV. The admission Minimum Data Set, dated [DATE] documented Resident #24 had moderate cognitive impairment.Interview with the Guardian for Resident #24 on 11/26/2025 at 11:03 AM revealed she was not notified of the 11/12/2025 infectious disease clinic appointment. The Guardian stated she did not receive a phone call or message regarding the appointment and reported that, prior to hospitalization from 10/4/2025 to 10/9/2025, a mental health service employee typically accompanied Resident #24 to appointments. The Guardian was uncertain when the 11/12/2025 appointment was cancelled.Interview with the facility Transportation Coordinator on 11/26/2025 at 11:57 AM revealed Resident #24's 11/12/2025 appointment required accompaniment per administrative policy. The Guardian was called several times the week prior, but no response was received, and no message could be left. The Transportation Coordinator cancelled the appointment one to two days prior and rescheduled it for 11/24/2025. During a follow-up interview on 12/1/2025 at 8:02 AM, the Transportation Coordinator acknowledged awareness of the importance of the 11/12/2025 appointment and stated she notified the Administrator, Unit Manager #1, and Nurse Practitioner #1 of the rescheduling.Interview with the Social Worker on 11/26/2025 at 1:19 PM revealed the Transportation Coordinator was responsible for arranging Resident #24's appointments. The Social Worker confirmed the Guardian was sometimes difficult to contact. Review of the November Medication Administration Record and notes written by Nurse #8 on 11/13/2025 at 1:23 PM revealed Biktarvy was not administered. Interview with Nurse #8 on 11/26/2025 at 12:40 PM confirmed the medication was unavailable on the medication cart beginning 11/13/2025. Nurse #8 reported contacting the physician, who indicated Resident #24 needed to be seen at the infectious disease clinic before the pharmacy would dispense additional medication.Review of a communication progress note dated 11/18/2025 at 9:36 AM by the Assistant Director of Nursing (ADON) documented the Guardian was updated regarding Resident #24's HIV medication. The note revealed the pharmacy would not dispense Biktarvy until Resident #24 was seen at the clinic, and an appointment was scheduled for the following week. Interview with the ADON on 11/25/2025 at 6:24 PM confirmed Resident #24 had run out of Biktarvy and required a clinic visit for refill authorization. The ADON stated the facility pharmacy ultimately obtained Biktarvy after insurance was willing to pay for it prior to the rescheduled clinic appointment.Review of a progress note dated 11/18/2025 at 10:19 PM by Nurse Practitioner #1 documented Resident #24 was not receiving Biktarvy due to lack of insurance coverage and refusal by the infectious disease provider to refill without a recent clinic visit.Interview with NP #1 on 11/26/2025 at 12:13 PM revealed the ADON informed him of the lapse in medication. NP #1 confirmed the infectious disease physician declined to refill until Resident #24 was seen. NP #1 acknowledged awareness of multiple cancellations and rescheduling of the clinic appointment. NP #1 stated the facility pharmacy ultimately obtained Biktarvy, and Resident #24 resumed therapy on 11/22/2025.Interview with the Guardian on 11/26/2025 at 11:03 AM revealed she was notified on 11/17/2025 that the 11/12/2025 appointment was cancelled and rescheduled for 11/24/2025. She was also informed Resident #24 was not receiving Biktarvy pending clinic evaluation. The Guardian arranged for a mental health service representative to accompany Resident #24 to the 11/24/2025 appointment.Interview with the Transportation Coordinator on 11/26/2025 at 11:57 AM revealed she believed the appointment was scheduled for 11/24/2025 and contacted the Guardian accordingly. The Guardian arranged accompaniment. However, the actual appointment was on 11/17/2025, which Resident #24 missed. The Transportation

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Interim Director of Nursing, Former Director of Nursing, Assistant Director of Nursing, Medical Director, Nurse Practitioner, Regional Director of Clinical Services, Director of Pharmacy Operations, Pharmacist, and Infectious Disease Physician, the facility failed to provide services to ensure the acquiring, dispensing, and administration of a medication for 3 of 7 sampled residents whose medications were reviewed (Resident #3, Resident #13, Resident #24). The facility failed to ensure uninterrupted access to prescribed antiretroviral medication for Resident #24. The facility failed to have a medication used to treat diabetes available for administration to Resident #3. The facility failed to have a nasal spray available on the correct medication cart for Resident #13.Findings included: 1. Documentation on a hospital Discharge summary dated [DATE] revealed Resident #24 had a prescription for Biktarvy filled by a local retail pharmacy before discharge and was to closely follow up with the infectious disease clinic. Biktarvy is an antiretroviral medication used to treat human immunodeficiency virus (HIV). The same discharge summary also documented Resident #24 had a follow-up appointment scheduled for the infectious disease clinic on 11/12/2025. Resident #24 was admitted to the facility on [DATE] with multiple diagnoses, including a mental health disorder and human immunodeficiency virus infection (HIV). Resident #24 had a physician's order initiated on 10/10/2025 for 50-200-25 milligrams of Biktarvy (Bictegravir-Emtricitabine-Tenofovir) oral tablets to be administered as one tablet by mouth one time a day for HIV. On 11/26/2025 at 11:57 AM, the Transportation Coordinator reported during an interview that she had been unable to contact Resident #24's Guardian prior to the scheduled infectious disease clinic appointment on 11/12/2025. The Transportation Coordinator further explained that she cancelled the appointment on 11/12/2025 and rescheduled it for 11/24/2025. Documentation on the November Medication Administration Record (MAR) for Resident #24 revealed that Biktarvy was not administered on 11/13/2025 by Nurse #8, with a chart code that referenced the progress notes. Documentation in a Medication Administration note dated 11/13/2025 at 1:23 PM written by Nurse #8 indicated the ordered dose of Biktarvy was not administered to Resident #24 and the Medical Doctor and Responsible Party were aware. Documentation on the November MAR for Resident #24 revealed that Biktarvy was not administered on 11/14/2025 by Nurse #8, with a chart code that referenced the progress notes. Documentation in a Medication Administration note dated 11/14/2025 at 10:49 AM, written by Nurse #8, explained that Resident #24 did not have the medication Biktarvy stocked on the medication cart. The Medical Doctor, Unit Manager, and Assistant Director of Nursing (ADON) were aware of the situation. Nurse #8 communicated information regarding the last prescriber, awaited further instruction, and documented that both the Responsible Party and emergency contact had been notified. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #8 was interviewed on 11/26/2025 at 12:40 PM. During the interview, Nurse #8 reported that Resident #24's supply of Biktarvy was depleted on 11/13/2025. Nurse #8 stated she contacted the facility's pharmacy; however, the pharmacy was unable to provide a refill. The pharmacy informed Nurse #8 that Resident #24 would require a new prescription from the original prescribing physician. Nurse #8 reported she provided the Medical Director with the prescriber's name and contact information obtained from the empty Biktarvy medication container. Nurse #8 stated she assumed the Medical Director would contact the prescriber to obtain a new prescription for Resident #24. Nurse #8 further stated she notified the Director of Nursing (DON), ADON, the Administrator, and the Transportation Coordinator that Resident #24 needed to secure another prescription from the Infectious Disease clinic, where the original prescription for Biktarvy was obtained. Documentation on the November MAR for Resident #24 revealed that Biktarvy was not administered on 11/16/2025 by Nurse #3, as indicated by a chart code that referenced the progress notes. Documentation in a Medication Administration note dated 11/16/2025 at 9:28 AM, written by Nurse #3, indicated the ordered dose of Biktarvy was not administered to Resident #24, and the Medical Doctor and Responsible Party were aware. Nurse #3 did not respond to a request for an interview. Documentation on the November MAR for Resident #24 revealed that Biktarvy was not administered on 11/17/2025, 11/18/2025, and 11/19/2025 by Nurse #8, as indicated by a chart code that referenced the progress notes. Documentation in a Medication Administration note dated 11/17/2025 at 10:09 AM written by Nurse #8 indicated Resident #24 was awaiting an appointment with the infectious disease clinic for a refill of Biktarvy. Documentation in the Medication Administration notes dated 11/18/2025 at 8:14 AM and 11/19/2025 at 11:03 AM written by Nurse #8 indicated Resident #24 did not have Biktarvy on the medication cart. The Medical Director, who was also the physician for Resident #24, was interviewed on 11/25/2025 at 7:11 PM. The Medical Director stated he was not involved with resolving the issue of Resident #24 running out of Biktarvy. Documentation in a communication progress note dated 11/18/2025 at 9:36 AM written by the Assistant Director of Nursing (ADON) revealed the following information. It was discussed with Resident #24's Guardian that his HIV medication needed to be obtained from the facility pharmacy and NP #1 was made aware Resident #24 was missing doses of Biktarvy. On 11/25/2025 at 6:24 PM, the ADON was interviewed and reported that Biktarvy had initially been obtained for Resident #24 through the hospital retail pharmacy. The ADON explained that the facility was unable to secure subsequent refills through the same pharmacy because the infectious disease clinic required Resident #24 to be seen to issue a new prescription. The ADON confirmed Resident #24 did not have Biktarvy available from 11/13/2025 until 11/22/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/2025 at 12:13 PM, NP #1 was interviewed and stated that he was not actively working to obtain Biktarvy for Resident #24 and was unaware of the lapse in administration until the ADON approached him. The ADON informed NP #1 that insurance would not cover the medication through the facility pharmacy. NP #1 emphasized that Biktarvy was essential, had no therapeutic alternatives, and should not be withheld. NP #1 believed a referral was made to the infectious disease clinic, later cancelled, and rescheduled, attributing the delays to transportation issues. NP #1 indicated the matter was ultimately resolved. On 12/1/2025 at 1:35 PM, the facility Pharmacist was interviewed and reported that Resident #24's initial prescription for Biktarvy had been filled at the hospital retail pharmacy upon admission on [DATE]. A refill request was denied by the infectious disease clinic provider because the resident had not been seen recently. The Pharmacist explained that it was uncommon for facility residents to obtain medications from outside pharmacies, as tracking was unreliable. The facility pharmacy could not dispense Biktarvy because insurance coverage was denied. The Pharmacist submitted three high-cost item forms to the (former) Director of Nursing requesting facility payment for the medication, but no response was received. On 11/25/2025 at 6:48 PM, the Director of Pharmacy Operations was interviewed and reported that the facility pharmacy could not fill Biktarvy because insurance had not approved coverage. The Director explained that Biktarvy was classified as a high-cost item requiring procurement from a specialty pharmacy, with an out-of-pocket cost exceeding $5,000 for a 30-day supply. There were no alternative medications available, and partial dispensing was not possible. On 11/18/2025, insurance approved coverage, and the facility received the medication on 11/19/2025 at 9:35 PM. Documentation on a packing slip for delivery of Biktarvy for Resident #24 confirmed it was delivered to the facility on [DATE] at 9:35 PM and signed for by Nurse #1. Nurse #1 was interviewed 12/1/2025 at 11:28 AM. Nurse #1 stated that she did not recall signing for the medication delivery from the pharmacy on 11/19/2025 at 9:35 PM. Nurse #1 said that usually she delivers the medications from the pharmacy to the medications carts for which the medication belongs so they can be put away by the nurse or the medication aide on that cart. Documentation on the November MAR revealed Medication Aide #1 administered an ordered dose of Biktarvy to Resident #24 on 11/20/2025. Medication Aide #1 was interviewed on 11/25/2025 at 6:02 PM. Medication Aide #1 stated that she documented the medication Biktarvy was administered to Resident #24 by mistake on 11/20/2025. Medication Aide #1 stated that everybody knew that the medication Biktarvy was not available on the medication cart that week. Documentation on the November MAR for Resident #24 revealed an ordered dose of Biktarvy was not administered on 11/21/2025 by Nurse #8. Documentation on the November MAR for Resident #24 revealed an ordered dose of Biktarvy was reinitiated and administered on 11/22/2025 by Nurse #8. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/2025 at 12:40 PM, Nurse #8 was interviewed and confirmed that she removed the seal from the Biktarvy bottle and administered the first ordered dose to Resident #24 on 11/22/2025. Nurse #8 reported that the Biktarvy bottle had not been present on the medication cart for several days prior to 11/22/2025 and stated that the bottle could not have been overlooked once placed on the cart. The Regional Director of Clinical Services was interviewed on 11/26/2025 at 1:03 PM and described the facility's process for receiving medications from the pharmacy. The pharmacy driver delivers medications to the charge nurse, who signs for the delivery and distributes the medications to the nurse or medication aide responsible for the appropriate cart. The Regional Director stated that Resident #24's Biktarvy should have been delivered to the correct cart on the evening of 11/19/2025. On 12/1/2025 at 11:18 AM the facility's Pharmacist was interviewed and stated that the expectation was for nurses to ensure medications delivered at night were placed on the correct cart to prevent missed doses. The Pharmacist confirmed that Resident #24's scheduled dose of Biktarvy should have been administered at 9:00 AM on 11/20/2025. The Former DON was interviewed on 11/25/2025 at 5:11 PM and stated that Resident #24 did not receive Biktarvy for approximately one week. The Former DON acknowledged that Biktarvy was costly but necessary and reported that NP #1 had indicated Resident #24 required the medication. The Former DON stated he discussed payment for Biktarvy with the Administrator, who allegedly informed the Former DON that the facility would not pay for the medication. The Administrator was interviewed on 12/1/2025 at 12:15 PM and reported awareness that Resident #24 had obtained Biktarvy from an outside source upon admission. The Administrator stated she was not notified when residents ran out of medications, as nursing staff managed that process. The Administrator denied ever refusing to pay for Biktarvy and denied telling the Former DON that the facility would not pay. On 12/1/2025 at 11:54 AM and again on 12/5/2025 at 12:32 PM the interim DON was interviewed. The DON stated that Resident #24 was expected to receive medications as prescribed. She explained that when Resident #24 was running low on Biktarvy, nurses submitted an electronic refill request to the pharmacy. The pharmacy then sent a high-cost item form to the Former DON, as Biktarvy could not have been dispensed without facility payment approval. The DON reported that the first high-cost item request for Resident #24's Biktarvy was submitted on 10/31/2025 and should have been addressed at that time. An infectious disease clinic physician was interviewed on 12/8/2025 at 1:03 PM and the following information was provided. The infectious disease clinic physician was not the prescribing physician for the Biktarvy while Resident #24 was in the hospital. The Infectious disease clinic physician had seen Resident #24 in the past, but the inpatient infectious disease team saw him in the hospital. A prescription for Biktarvy was sent to the hospital retail pharmacy by the hospitalist with a denial for a refill. The physician reported that there was no record of the long-term care facility contacting the infectious disease clinic for a refill or new prescription. The physician explained that typically the facility provider would write orders for Biktarvy, which would then be filled by the facility pharmacy. 2. Record review revealed Resident # 3 was admitted to the facility on [DATE] with a diagnosis of diabetes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders revealed Resident # 3 was ordered to receive Ozempic 1milligram subcutaneously weekly on Wednesdays for Diabetes. According to the order the Ozempic was supplied in a Subcutaneous Pen-Injector which had 4 mg (milligrams)/3 ml (milliliters). This order originated on 3/25/25 and remained as a current order. Review of Resident # 3's November MAR (Medication Administration record) revealed the resident was scheduled to receive the Ozempic on 11/5/25, 11/12/25, and 11/19/25. The doses of 11/12/25 and 11/19/25 were checked as administered and were the only documented doses in November as of the record review date on 11/25/25. The dose of 11/5/25 was not checked as administered by Nurse # 9 who signed a 9 rather than a check mark, which indicated the medication was not administered. Nurse # 9 was interviewed on 11/5/25 at 1:40 PM and reported the following information. Resident # 9's Ozempic was not available for administration on 11/5/25 when it was due. She had called the pharmacy that day, but it did not come in for administration while she was there. She had passed along the information in report. Interview with Resident # 3 on 11/25/25 at 1:50 PM revealed during one of the weeks in November the facility did not have the Ozempic to give him. He had missed one week's dose in November 2025. He did not recall the specific week. On 11/25/25 at 2:05 PM Nurse # 9 was accompanied as she looked in storage for Resident # 3's Ozempic medication to determine if it was currently available for the next dose the resident was scheduled to receive, which was due on 11/26/25 (Wednesday). After searching for the Ozempic, Nurse #9 reported she could not find Resident # 3's Ozempic supply for the next day's scheduled dose and she would call the pharmacy. During a follow up interview with Nurse #9 on 11/25/25 at 2:50 PM, Nurse # 9 reported she had called the pharmacy to request the Ozempic in order to ensure that it would be available for administration the next day and was told the pharmacy would send it but could not send it till the next day. According to Nurse # 9 the pharmacy had asked that the facility follow up with them the next day also to make sure it was sent. On 11/25/25 at 3:50 PM and again on 11/25/25 at 7:00 PM the Pharmacy's Director of Operations was interviewed via phone. Regarding the Ozempic dose not being available on 11/5/25, the Pharmacy Director reported the following information. Prior to 11/5/25 the facility had last requested a refill on 9/11/25 and it was sent. Prior to 9/11/25 the facility had been ordering Resident # 3's Ozempic consistently and may have had enough till 11/5/25. Prior to 11/5/25 the pharmacy had not received an electronic request for a refill since 9/11/25. Resident # 3's Ozempic was sent out on 11/5/25 on the late delivery which was at 10:29 PM on 11/5/25. That supply was for 28 days because one pen had 4 milligrams in each pen and the resident was ordered only to receive one milligram per week. Therefore, the facility should still have Resident # 3's Ozempic dose available for the next scheduled dose for the following day (11/26/25). Regarding why Nurse # 9 was told that the pharmacy could not fill the Ozempic on 11/25/25 for the missing 11/26/25 dose, the Pharmacy Director reported it was rejected in the pharmacy's system because it was too early to fill given the facility should have a dose available. On 11/26/26 the pharmacy would be able to refill it and would send it on 11/26/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident # 3's record revealed on 11/25/26 at 6:09 PM orders were obtained from Nurse Practitioner # 1 to hold Resident's Ozempic. There was a notation by the order which noted, awaiting pharmacy, RP (responsible party notified and NP notified. There was no time limit to hold the Ozempic. On the MAR a notation was placed by the Ozempic order to hold from 11/25/25 at 6:09 PM to 11/26/25 at 6:08 PM. On 11/26/25 there was no documentation that Resident # 3 received his Ozempic or any day following that as of a review of the MAR on 12/1/25. On 12/1/25 at 11:55 AM Nurse # 10 was interviewed via phone and reported the following information. She had cared for Resident # 3 on 11/26/26 (Wednesday) and she did not give Resident # 3 his Ozempic because it was not there. She called the pharmacy, and they said they had already sent it. She did not routinely work at the facility. She did not know who she had told but she was sure she passed along the problem to someone. During a follow up interview on 12/1/25 at 12:57 PM with the Pharmacy's Director of Operations the Pharmacy's Director reported the following. The pharmacy had sent Resident # 3's Ozempic on 11/26/25 at 8:20 AM and the pharmacy's records showed it was received by Nurse # 10 on 11/26/26 at 9:17 AM. Therefore, from their records, the medication should have been available to be given. The Corporate Clinical Consultant, who was working as the interim Director of Nursing, was interviewed via phone on 12/1/25 at 1:24 PM and again at 1:58 PM and reported the following information. The facility records showed that the Ozempic was delivered to them on 11/26/25 at 9:17 AM. She had located the medication that day and looked to see if a dose was administered from it. She was unable to tell from looking at the pen and needles which were supplied with the multidose pen. There was one missing needle but no documentation that it had been administered in the record since it had been received. She had talked to the resident that day and Resident # 3 reported he had not received his 11/26/25 dose of Ozempic. Nurse Practitioner # 1 was interviewed on 12/1/25 at 9:15 AM and reported the following information. He would not consider missing Ozempic a significant medication error. During the interview, NP # 1 reviewed the resident's blood sugars and reported that they appeared stable. In reviewing the record, he recalled that the facility had asked for a hold for the Ozempic. He also saw on 12/1/25 that it was never given. That to him was concerning. NP # 1 further reported Ozempic is a medication that is ramped up to avoid any gastrointestinal side effects. With missed doses there is sometimes a risk for gastrointestinal side effects, but he (NP# 1) was not aware of any harm or side effects to Resident # 3. 3. Record review revealed Resident # 13 was admitted to the facility on [DATE]. The resident had a diagnosis of allergic rhinitis. Review of current physician orders revealed an order, which was initiated on 9/27/24, for Fluticasone propionate nasal spray 50 micrograms/ACT (actuation) one spray in both nostrils two times per day. Review of Resident # 13's November MAR (Medication Administration Record) revealed the following information. 11/20/25 for the 9 PM dose-Nurse # 7 documented a check mark indicating the Fluticasone was given. 11/21/25 for the 9 AM dose-Nurse # 2 documented a check mark indicating the Fluticasone was given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/21/25 for the 9 PM dose-Nurse # 7 documented a check mark indicating the Fluticasone was given. 11/22/25 for the 9 AM dose-Nurse # 6 documented a check mark indicating the Fluticasone was given. 11/22/25 for the 9 PM dose-Nurse # 11 documented a check mark indicating the Fluticasone was given. 11/23/25 for the 9 AM dose-Nurse # 2 documented a check mark indicating the Fluticasone was given. 11/23/25 for the 9 PM dose-Nurse # 11 documented a check mark indicating the Fluticasone was given. 11/24/25 for the 9 AM dose-MA # 2 documented a check mark indicating the Fluticasone was given. During an interview with Resident # 13 on 11/24 25 at 10:16 AM the resident reported her nose would run especially in the morning and the facility did not have her prescribed Flonase (Fluticasone). She had complained of this for several weeks and was not given a reason. During a follow up interview on 11/25/25 at 3:15 PM Resident # 13 was interviewed regarding with whom she had discussed the problem of the missing Flonase (Fluticasone). Resident # 13 reported she had discussed it with Nurse 7, Medication Aide # 2, and Nurse # 3. Medication Aide (MA) # 2 was interviewed on 11/24/25 at 3:05 PM about Resident # 13 reporting not receiving the Fluticasone. MA # 2 reported he had not given the Fluticasone because he could not find it. He was observed to look through his medication cart and show the surveyor that it was not available on the cart. MA # 2 further reported the following information. He had called the pharmacy about the missing medication. He had not meant to sign that he had given it on the MAR. That had been an unintentional mistake. Interview with Nurse # 3 on 11/25/25 at 9:30 AM revealed she covered (fulfilled the responsibilities which a medication aide was not certified to do) on 11/24/25 for MA # 2. Resident # 13's Fluticasone had not been available from the pharmacy although it had been ordered from the pharmacy. Nurse # 7 was interviewed on 11/25/25 at 7:50 PM via phone and reported the following information. She had not administered the Fluticasone on 11/20/25 and 11/21/25 when she worked and the check mark indicating it was given was an inadvertent error. She had ordered the Fluticasone from the pharmacy and faxed them several times about the missing medication, but it had not been delivered. Nurse # 2 was interviewed on 11/25/25 at 9:40 AM and reported she did not recall any issues with Resident # 13 having a runny nose and her Fluticasone not being available. According to Nurse # 2 it had been a busy morning on 11/23/25 and she had gotten pulled to another floor, but she thought she would have taken care of it if it had been brought to her attention. Nurse # 6 was interviewed on 11/24/25 at 7:35 PM via phone and reported the following information. She had been a supervisor on 11/22/25 and was trying to help an agency nurse catch up on medications. She may have inadvertently clicked that the Fluticasone was administered on 11/22/25 while doing so but she had not given the Fluticasone and did not know about it missing from the pharmacy delivery. An attempt was made to interview Nurse # 11 on 11/24/25 at 7:47 PM and the nurse could not be reached for interview. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	3724 Wireless Drive Greensboro, NC 27455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Pharmacy Director of Operations was interviewed on 11/25/25 at 3:50 PM and reported the following information. The pharmacy records showed the facility staff had requested the Fluticasone on 11/14/25 and 11/20/25 for Resident # 13. They had already sent a 30-day supply of the Fluticasone on 11/1/25 and therefore it was too early to fill it. The facility should have had the medication available when they ordered it on 11/14/25 and 11/20/25. When the facility requests a medication too early then in the pharmacy system it will show as pending since the pharmacy cannot fill it. On 11/24/25 the time between refills was sufficient so that they did send it on 11/24/25. Therefore, their records showed they had sent it on 11/2/25 and 11/24/25. Unit Manager # 1 was interviewed on 11/25/25 at 1:30 PM and reported the following information. She had located a Fluticasone nasal spray for Resident # 13 in another unit's storage supply the previous day (11/24/25). It had not been stored on the unit where Resident # 13 resided. When nurses received medications from the pharmacy, they were told to take the medication to the proper nurse if it is not a medication for one of their residents. The Regional Director of Clinical Services, who was filling in for the interim Director of Nursing (DON), on 11/25/25 was interviewed on 11/25/25 at 12:40 PM and reported the following information. Resident # 13 was a credible resident in the things she reported. Their records showed that they had ordered the Fluticasone on 11/14/25 and it was sent on 11/20/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	3724 Wireless Drive Greensboro, NC 27455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Nurse Practitioner, Medical Director, Pharmacist, Interim Director of Nursing, Assistant Director of Nursing, Pharmacy Operations manager and Infectious Disease Clinic Physician, the facility failed to prevent a significant medication error for 1 of 5 residents whose medications were reviewed (Resident #24). The facility failed to administer prescribed antiretroviral medication to Resident #24 when the initial supply was exhausted and for two subsequent scheduled administration times following delivery from the pharmacy. Findings included:Record review of a hospital Discharge summary dated [DATE] revealed Resident #24 had not received prescribed antiretroviral medications, resulting in an uncontrolled viral load and a CD4 count of less than 200. An uncontrolled viral load with a CD4 count below 200 indicates active damage to the immune system, placing the resident at high risk for opportunistic infections and progression to Acquired Immune Deficiency Syndrome (AIDS), requiring urgent medical intervention. Resident #24 had a prescription for Biktarvy filled by the hospital retail pharmacy prior to discharge and was scheduled for close follow-up with the infectious disease clinic. Biktarvy is an antiretroviral medication used in the treatment of human immunodeficiency virus (HIV).Resident #24 was admitted to the facility on [DATE] with cumulative diagnoses which included a mental health disorder and human immunodeficiency virus infection (HIV).Resident #24 had a physician's order initiated on 10/10/2025 for 50-200-25 milligrams of Biktarvy (Bictegravir-Emtricitabine-Tenofovir) oral tablets to be administered as one tablet by mouth one time a day for HIV.Review of the November Medication Administration Record (MAR) revealed Biktarvy was not administered to Resident #24 on 11/13/2025 by Nurse #8, with documentation directing to see the progress notes.A Medication Administration note dated 11/13/2025 at 1:23 PM, written by Nurse #8, indicated the ordered dose of Biktarvy was not administered to Resident #24 and that the Medical Doctor and Responsible Party were aware.Review of the November MAR further revealed Biktarvy was not administered to Resident #24 on 11/14/2025 by Nurse #8, with documentation again directing to see the progress notes. A Medication Administration note dated 11/14/2025 at 10:49 AM, written by Nurse #8, indicated Biktarvy was not available on the medication cart. The Medical Doctor, Unit Manager (#1), and Assistant Director of Nursing (ADON) were aware. Nurse #8 documented communication with the prescriber, awaited further instruction, and notified the Responsible Party and emergency contact. During interview on 11/26/2025 at 12:40 PM, Nurse #8 stated Resident #24 ran out of Biktarvy on 11/13/2025. Nurse #8 reported contacting the facility pharmacy, which was unable to refill the medication, and notifying the Medical Director, Unit Manager (#1), and ADON. During interview on 11/25/2025 at 7:11 PM, the Medical Director, who was also Resident #24's physician, stated he was not involved in resolving the lapse in medication supply. The Medical Director stated interruption of antiretroviral therapy could result in mutation of the HIV virus and emphasized that only the infectious disease clinic could interpret blood tests to determine the consequences of the lapse in administration.Unit Manager #1 was interviewed on 11/25/2025 at 6:07 PM and revealed she was aware Resident #24 was admitted from the hospital with a bottle of Biktarvy but was unsure of the quantity of pills contained in the bottle. Unit Manager #1 further stated she was aware that once Resident #24 exhausted his supply, the hospital retail pharmacy was unable to refill the prescription, and the ADON subsequently addressed the issue of obtaining the medication.Review of the November MAR revealed documentation by Nurse #2 of an administered dose of Biktarvy to Resident #24 on 11/15/2025; however, during interview on 11/25/2025 at 6:13 PM, Nurse #2 stated she did not administer the medication and acknowledged she likely documented the dose for the sake of completion without actual administration.Documentation on the November MAR for Resident #24 revealed Biktarvy was not administered to Resident #24 on 11/16/2025 by Nurse #3, with a chart code to see the progress notes. Documentation in a Medication Administration note dated 11/16/2025 at 9:28 AM written by Nurse #3 indicated the ordered dose of Biktarvy was not administered to Resident #24 and the Medical Doctor and Responsible Party were aware.Nurse #3 did not respond to a request for an interview.Further review of the November MAR revealed Biktarvy was not administered on 11/17/2025, 11/18/2025, and 11/19/2025 by Nurse #8, with progress notes indicating the medication was unavailable on the cart and that Resident #24 was awaiting an infectious disease clinic appointment for a refill.A communication note dated 11/18/2025 written by the ADON revealed the Guardian and NP #1 were informed that Resident #24 was missing doses of Biktarvy.During interview on 11/25/2025 at 6:24 PM, the ADON confirmed the facility was unable to obtain