STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Place Center for Nursing and Rehabilitation	1201 Carolina Street Greensboro, NC 27401

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review, observation, and resident and staff interviews, the facility failed to honor a residents' request to have medications administered at a time that was desired for 1 of 4 residents (Resident #64) reviewed for choices. The findings included: Resident # 64 admitted to facility on 7/16/24 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #64 was cognitively intact. On 09/10/24 at 12:51 PM an interview was conducted with Resident #64 and he indicated he was concerned with the time he was getting his medications. He indicated he would sometimes receive his morning medications close to lunch time. Resident #64 stated, I have talked numerous times to someone here about my medications and getting them on time, and nothing has changed A review of Resident#64's September electronic medication administration record revealed morning medication times scheduled for 7:00 AM, 8:00 AM, and 9:00 AM. On 09/11/24 at 9:46 AM an interview was conducted with Resident #64 and he stated he had not received his medications yet. An interview was conducted with Nurse #4 on 09/11/24 at 11:46 AM and she indicated, Resident #64 went to the medication cart around 10:30 am and requested his medications. The Nurse indicated she was working her way to Resident #64's room, however she was running behind on the medication pass. She stated, I came in to help out and got here about 8:00 or 8:30 AM, so I'm running behind. Nurse #4 acknowledged Resident # 64's morning medications were administered late. At 11:57 AM on 09/11/24 another Interview was conducted with Resident #64 and he stated, they were making me late for bible study, so I went to ask for my medicines. He indicated he just wanted to get his medications a certain time every day without having to ask for them. (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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/24 at 12:00 pm and interview was conducted with the Director of Nursing (DON) and she indicated she would change Resident #64's medication times so he would get them as he preferred. An interview was conducted on 09/12/24 at 10:54 AM with the Administrator and he stated, he expected the Resident to get his medications timely. He indicated it was the Residents' right to get his medications when he wanted them, and we should honor his request.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interviews of the staff, physician, and nurse practitioner, the facility failed to notify the on-call nurse practitioner when a resident had a change in condition (Resident #95). This deficient practice affected 1 of 2 residents reviewed for hospitalization . Findings included: Resident #95 was admitted to the facility on [DATE] with diagnoses of diabetes, atrial fibrillation on anticoagulant, and end stage renal disease dependent on renal dialysis. On 6/12/24 at 7:30 pm Nurse #1 documented in the neurological assessment form Resident #95 had blood pressure (BP) 135/95, pulse (P) 91, respirations (R) 13, and temperature (T) 97.0. The resident was lethargic with both pupils reactive but sluggish. The resident had no motor function of all extremities and hand grasp. There was no headache, seizure, drainage from the ear or nose, or vomiting. On 9/11/24 at 2:49 pm Nurse #1 was interviewed. Nurse #1 stated she had not informed the on-call nurse practitioner (NP) on 6/12/24 at 11:30 pm when the resident had a change in her neurological status starting at 7:30 pm. Nurse #1 stated I do not think I included the pupils and lethargy information when I contacted the NP about the resident's sleepiness. The NP was informed the resident was too drowsy and sleepy to wake up for medication at 7:30 pm and 11:30 pm. Nurse #1 stated she had not thought to notify the NP about the sluggishness of the eyes, lethargy, diaphoresis, and that she had not moved her extremities. The NP directed Nurse #1 to hold the resident's evening medications. On 9/12/24 at 12:35 pm an interview was conducted with the day-shift Nurse Practitioner. The Nurse Practitioner stated she was not on call on 6/12/24. There was a high risk for bleeding when a resident was receiving anti-coagulant. The Nurse Practitioner stated she would want to be called at the time when there was a change in the resident's neurological status. The Nurse Practitioner stated the on-call service for after hours (after 5:00 pm and before 7:00 am) do not know the residents and would be solely reliant on what the nurse reported. The on-call service providers do not have access to the facility's records. On 9/12/24 at 11:30 am an interview was conducted with the Physician. The Physician stated any change in a resident's neurological status needs to be reported immediately to medical staff.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interviews of the staff, physician, and nurse practitioner, the facility failed to identify a resident's change in condition (Resident #95). This deficient practice affected 1 of 2 residents reviewed for hospitalization . Findings included: The resident had medical orders for scope of treatment (MOST) form dated 3/21/22 signed by a representative. Section A was for do not resuscitate. Section B was limited additional interventions: Do not intubate or mechanical ventilate but may consider less invasive airway support such as BiPAP or CPAP (oxygen mask with positive pressure), transfer to hospital if indicated, and avoid intensive care. Sections C and D were to provide antibiotics and intravenous fluids. Resident #95 was admitted to the facility on [DATE] with diagnoses of diabetes, atrial fibrillation on anticoagulant, and end stage renal disease dependent on renal dialysis. Resident #95's care plan dated 5/23/24 documented she had an impaired cognitive function and thought process, was at risk for falls, required hemodialysis, and was receiving anticoagulant for atrial fibrillation (dysrhythmia of the heart). Anticoagulant interventions were to monitor for changes in mental status, changes in vital signs, and lethargy. Resident #95 had an order dated 2/11/24 for Eliquis (anticoagulant) 2.5 mg twice a day. On 9/12/24 at 10:38 am an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #95 on 6/12/24 from 7:00 am to 7:00 pm. The resident was assessed by the Director of Nursing (DON) and me up to 5:00 pm. The resident was at her mentation baseline. The resident went to dialysis at approximately 10:30 am to 4:00 pm on 6/12/24. The resident had her dialysis as scheduled. Nurse #2 stated at dialysis the resident would have had heparin anticoagulant in the dialysis solution in addition to her twice a day facility provided anticoagulant. Resident #95 had no change on my shift 6/12/24 before dialysis. I last saw the resident about 5:30 pm sitting up in her bed with her meal. On 6/12/24 at 7:30 pm Nurse #1 documented in the neurological assessment form Resident #95 had blood pressure (BP) 135/95, pulse (P) 91, respirations (R) 13, and temperature (T) 97.0. The resident was lethargic with both pupils reactive but sluggish. The resident had no motor function of all extremities and hand grasp. There was no headache, seizure, drainage from the ear or nose, or vomiting. On 6/12/24 at 11:40 pm Nurse #1 documented in the neurological assessment form Resident #95 had BP 144/105, P 93, R 14, and T not documented. The resident was lethargic with both pupils reactive but sluggish. The resident had no motor function of all extremities and hand grasp. Nurse #1 was unable to assess headache, seizure, drainage from the ear or nose, or vomiting. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1's nurses' note dated 6/13/24 at 12:20 am of Resident #95. The resident was lying in bed, unlabored breathing, diaphoretic, lethargic, and unarousable. The resident's evening medications were placed on hold due to resident acute changes and inability to arouse to swallow. The nurse practitioner was notified (of the inability to arouse and swallow medication). On 6/13/24 at 3:20 am Nurse #1 documented in the neurological assessment form. Resident #95 was unresponsive with both pupils fixed. The resident had no motor function of all extremities and hand grasp. Nurse #1 was unable to assess whether the resident had a headache, seizure, drainage from the ear or nose, or vomiting. On 9/11/24 at 2:48 pm an interview was conducted with Nurse #1. Nurse #1 stated on 6/12/24 at 7:00 pm Resident #95 had a neurological assessment every 4 hours. The resident was barely responding with labored breathing and was diaphoretic. Nurse #1 stated she could not tell if the change was neurological because the resident had received dialysis earlier that day. Residents were usually worn out after dialysis. Nurse #1 stated she passed the medication to other residents and returned to Resident #95 to administer medications at 11:00 pm. The resident was too sleepy to wake up and swallow her evening medications. The resident's pupils were responsive but slow and she would only moan when attempted to wake. The resident was not moving her extremities and was diaphoretic. Nurse #1 decided she would wait for the resident to wake up and tried again at 11:30 pm. Nurse #1 assessed Resident #95, she was still very tired, not waking up and not moving. Nurse #1 believed the resident was tired from dialysis and had not refused medication before. The resident was not talking, just moaning at 7:30 pm and 11:30 pm assessments. Nurse #1 stated she called the on-call nurse practitioner and informed her the resident was very sleepy and could not swallow evening medication. The nurse practitioner directed Nurse #1 to hold the resident's evening medications. Interview continued: Nurse #1 stated she came back at approximately 3:20 am on 6/13/24 and Resident #95 was unable to wake up and was not moving. The resident had a large amount of saliva in her mouth and her tongue was stuck on the left side and she had extreme diaphoresis. Nurse #1 tried sternal rub and was unable to wake the resident. Nurse #1 called NA #1 into the resident's room and they both could not wake the resident. Nurse #1 stated she called another nurse into the resident's room and this nurse could not wake the resident. The resident was noted to not react to sternal rub, saliva was coming out of her mouth, and her pupils were not reactive and fixed. The resident was not responding at all, she had a weird gurgling noise in her mouth. Nurse #1 stated she called the DON to inform her of the resident's status and was directed to send the resident out. Nurse #1 stated she called 911 around 3:45 am on 6/13/24. Nurse #1 further stated that something was not right with the resident, she was very diaphoretic and needing her clothes changed, and her blood glucose check was 147, but the resident was not responding to anything. She had no muscle control and fixed pupils. Nurse #1 went on to state she thought the resident was sleepy from dialysis. Nurse #1 had not suspected a neurological change because I was not at the facility all day to see the resident. Nurse #1 was aware the prior shift nurse had not observed the resident's lethargy. Nurse #1 stated she received in report the resident was at neurological baseline when she came back from dialysis at 4:30 pm on 6/12/24. The resident's mental status was normal prior to the 7:00 pm to 7:00 am shift on 6/12/24. Everything changed on my shift. Nurse #1 stated the resident's blood pressure was elevated which was not normal for her. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:30 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated she was assigned to Resident #95 on 6/12/24 from 7:00 pm to 7:00 am. NA #1 stated the resident was talking to her but drowsy at 7:00 pm. NA #1 thought the resident was tired from dialysis. The resident was more quiet than normal and remained that way until the next check at 11:00 pm when the resident was not talking, and the NA thought the resident was sleeping and had not tried to wake her. NA #1 stated sometime after midnight the resident could not wake up, not sure the exact time. Around 3:00 am on 6/13/24 Nurse #1 called me into the resident's room to observe the resident. The resident was not able to wake up and not moving. Nurse #1 stated another nurse attempted to wake the resident unsuccessfully. The resident was sent out by EMS to the hospital.