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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345273	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital East Greensboro	2401 South Side Boulevard Greensboro, NC 27406

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews, Pharmacy Nurse Consultant and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of narcotic medications (Hydrocodone and Oxycodone) prescribed to treat pain and an antianxiety medication (Lorazepam) prescribed to treat anxiety. This affected 6 of 6 residents reviewed for misappropriation of resident property (Residents #5, #17, #223, #224, #225 and #226). The findings included: A. Resident #5 was admitted to the facility on [DATE] with diagnoses of spinal stenosis and chronic pain. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact. A review of Resident #5's physician orders included the following: - An order dated [DATE] through [DATE] for Oxycodone 10 milligrams (mg) one tablet by mouth every six hours as needed for pain. - An order dated [DATE] for Oxycodone 10 mg one tablet by G-tube every six hours as needed for pain. A review of the Controlled Medication Utilization Record revealed Resident #5 was signed out as receiving Oxycodone 10 mg on [DATE], [DATE], [DATE], [DATE] and [DATE] by Nurse #1. A review of the Medication Administration Record (MAR) for [DATE], [DATE] and [DATE] did not reveal Resident #5 was signed out as receiving Oxycodone by Nurse #1 on [DATE], [DATE], [DATE], [DATE] or [DATE]. A review of Resident #5's medical record did not reveal any evidence of uncontrolled pain. B. Resident #17 was admitted to the facility on [DATE] with diagnoses that included spastic hemiplegia affecting the right dominant side and acute and chronic respiratory failure. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #17's physician orders included an order dated [DATE] for Oxycodone 5 mg one tablet by G-tube every eight hours as needed for pain. A quarterly MDS assessment dated [DATE] indicated Resident #17 had severely impaired cognition. A review of the Controlled Medication Utilization Record revealed Resident #17 was signed out as receiving Oxycodone 5 mg on [DATE] at 5:00 AM and [DATE] at 12:00 PM by Nurse #1. A review of the [DATE] MAR did not reveal Resident #17 was signed out as receiving Oxycodone on [DATE] at 5:00 AM or 12:00 PM by Nurse #1. A review of a time punch record for Nurse #1 on [DATE] showed she did not clock into work until 7:06 AM. A review of Resident #17's medical record did not reveal any evidence of uncontrolled pain. C. Resident #223 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure and muscle spasm. A review of Resident #223's physician orders included an order dated [DATE] for Oxycodone 5 mg one tablet via G-tube every six hours as needed for moderate pain manifested by grimacing/restlessness. A quarterly MDS assessment dated [DATE] indicated Resident #223 had severe cognitive impairment. A review of the Controlled Medication Utilization Record revealed Resident #223 was signed out as receiving Oxycodone 5 mg on [DATE] at 8:40 AM and [DATE] at 12:00 PM by Nurse #1. A review of the [DATE] MAR revealed Resident #223 was signed out as receiving Oxycodone 5 mg on [DATE] at 8:40 AM but not [DATE] at 12:00 PM by Nurse #1. A review of Resident #223's medical record did not reveal any evidence of uncontrolled pain. D. Resident #224 was admitted to the facility on [DATE] with diagnoses that included chronic pain and a stage 4 pressure ulcer of the sacral region. He was discharged to the hospital on [DATE]. A review of Resident #224's physician orders included an order dated [DATE] for Hydrocodone-Acetaminophen 5 mg-325 mg one tablet by G-tube every six hours as needed for pain. A review of the Controlled Medication Utilization Record revealed the following regarding Resident #224's Hydrocodone: - The medication was marked as popped out by accident by Nurse #1 and wasted on [DATE], [DATE] and [DATE]. The witness signature was marked as Nurse #2. - The medication was signed out as given to Resident #224 on [DATE], [DATE] at 9:00 AM, [DATE] at 2:00 PM, ,d+[DATE]//24 at 2:00 PM, [DATE] at 3:00 PM and [DATE] at 2:00 PM by Nurse #1. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the [DATE] MAR revealed Resident #224 was not signed out as receiving Hydrocodone by Nurse #1 on [DATE], [DATE] at 9:00 AM, [DATE] at 2:00 PM, ,d+[DATE]//24 at 2:00 PM, [DATE] at 3:00 PM and [DATE] at 2:00 PM. A review of the Master Signature Log for staff revealed the initials for Nurse #2 did not match the Controlled Medication Utilization Record for the witnessed wastes on [DATE], [DATE] and [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #224 had severely impaired cognition. A review of Resident #224's medical record did not reveal any evidence of uncontrolled pain. E. Resident #225 was admitted to the facility [DATE] with diagnoses that included chronic respiratory failure, ankylosing spondylitis and chronic pain. He expired on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #225 had severe cognitive impairment. A review of Resident #225's physician orders included the following: - An order dated [DATE] through [DATE] for Lorazepam 2 mg per milliliter (ml). Inject 0.25 ml intravenous every three hours as needed for anxiety/agitation/shortness of breath. - An order dated [DATE] for Lorazepam 2 mg per ml. Give 0.25 ml intravenously every two hours as needed for anxiety/agitation/shortness of breath. A review of the Controlled Medication Utilization Record revealed the automatic waste of 0.75 ml of Lorazepam was signed out by Nurse #1 on [DATE] at 11:00 AM, [DATE] at 6:20 PM, [DATE] at 10:25 AM and the waste of the 0.75 ml was witnessed by Nurse #2. In addition, Nurse #1 signed out Lorazepam on [DATE] at 8:00 AM, [DATE] at 2:00 PM, [DATE] at 5:30 PM and [DATE] at 6:34 PM and the waste of the 0.75 ml was witnessed by Nurse #3. A review of the Master Signature Log for staff revealed the initials for Nurses #2 and #3, did not match the Controlled Medication Utilization Record for the witnessed wastes of Lorazepam 0.75 ml. Review of an employee timecard for Nurse #3 indicated she clocked in to work on [DATE] at 7:00 PM. F. Resident #226 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure and chronic pain. He expired [DATE]. A review of Resident #226's physician orders included an order dated [DATE] for Hydrocodone-Acetaminophen 5 mg- 325 mg one tablet via G-tube every six hours as needed for pain. A quarterly MDS assessment dated [DATE] indicated Resident #226 had severe cognitive impairment. A review of the Controlled Medication Utilization Record revealed Nurse #1 had the following Hydrocodone-Acetaminophen 5 mg-325 mg marked as wasted by Nurse #1: - An entry on [DATE] as an error and waste witnessed by Nurse #2. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An entry on [DATE] as an error and waste witnessed by Nurse #4. - An entry on [DATE] at 5:37 PM with no reason for waste and witness signature unreadable. - An entry on [DATE] at 10:00 AM with no reason for waste and witness signature unreadable. - An entry on [DATE] with no time and waste witness signature Nurse #2. - An entry on [DATE] at 7:00 PM with no reason for waste and waste witness signature Nurse #5. - An entry on [DATE] at 9:00 PM with reason as dropped and no waste witness signature. - An entry on [DATE] at 7:16 AM with no reason for waste and waste witness signature Nurse #2. - An entry on [DATE] at 12:00 PM with reason as dropped and waste witness signature Nurse #4 - An entry on [DATE] at 1:00 PM with no reason for the waste and waste witness signature Nurse #2. - An entry on [DATE] at 12:00 PM with reason as dropped for the waste and waste witness signature #2. A review of the Master Signature Log for staff revealed the initials for Nurses #2, #4 and #5 did not match the Controlled Medication Utilization Record. An initial report was submitted to the North Carolina Department of Health Human Services Division of Health Service Regulation on [DATE] by the Administrator. The allegation of misappropriation of property was made on [DATE] when narcotic discrepancies were found on five residents narcotic records involving Nurse #1. A witness statement dated [DATE] from Nurse #2 read that the signatures for wastes with Nurse #1 were not hers. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation completed by the Director of Nursing on [DATE] revealed on [DATE] she was informed by the Unit Manager that there was a discrepancy on two Controlled Medication Utilization Records dated [DATE] by Nurse #1. Nurse #1 had signed out Oxycodone 5 mg for Resident #17 at 5:00 AM and 12:00 PM. Both administrations were not captured on the MAR and Nurse #1 did not clock into the facility to begin work on [DATE] until 7:06 AM. Therefore, she was not present in the facility at 5:00 AM. Nurse #1 also signed out Oxycodone 5 mg for Resident #223 at 12:00 PM on [DATE]. There was no documentation of this on the MAR. The previous administration was documented as 8:40 AM and the medication was ordered every six hours as needed for pain, thus it would have been too soon for the resident to have received the medication. A more thorough investigation began with all narcotic records being reviewed. It was found during the investigation that Nurse #1 signed out on the narcotic record providing Resident #5 with Oxycodone 10 mg five times with no record of the medication given on the MAR. Resident #226 had Hydrocodone-Acetaminophen ,d+[DATE] mg wasted seven times by Nurse #1 from [DATE] to [DATE] with signatures for witnessed wastes that did not match the Master Signature Log. Resident #225 was ordered Lorazepam 0.25 ml as needed with an automatic waste of 0.75 ml. There were eight witnessed wastes for this medication with questionable witness signatures. One that stood out the most was on [DATE] for a signature from Nurse #3 witnessed at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM. Nurse #3 did not clock in for work on [DATE] until 7:00 PM. A witness statement dated [DATE] from Nurse #4 read that she had not witnessed the wasting of narcotics with Nurse #1 on [DATE] or [DATE]. The statement further read the initials that were present were not hers. On [DATE] at 8:07 AM, an interview occurred with the Unit Manager who stated that on the morning of [DATE] she was approached by Nurse #6 to look at the Controlled Medication Utilization Record for Resident #223, because the administration times for his Hydrocodone didn't look right. The medication was to be given every six hours as needed but the times of administration were to close together and weren't marked out as given on the MAR. It was also noted that Resident #17's Oxycodone 5 mg was signed out on the Controlled Medication Utilization Record as given by Nurse #1 at 5:00 AM and 12:00 PM. This was odd since Nurse #1 worked 7:00 AM to 7:00 PM that day. This was reported to the DON, who began an investigation of all the narcotic records. An interview occurred with Nurse #4 on [DATE] at 2:11 PM. She reviewed the narcotic record for Resident #226's Hydrocodone and stated that the witnessed waste signature for [DATE] and [DATE] were not hers. I didn't witness any wastes of medications with Nurse #1. Nurse #6 was interviewed on [DATE] at 2:13 PM and stated she notified the Unit Manager on [DATE] that something didn't look right on Resident #223's Controlled Medication Utilization Record. She explained she noticed his medications were signed out by Nurse #1 as being given to close together and weren't captured on the MAR and for Resident #17 the Oxycodone was signed out by Nurse #1 at a time she wasn't at the facility. A phone interview occurred with Nurse #3 on [DATE] at 9:40AM. She had a witness signature for a waste of Lorazepam 0.75 ml for Resident #225 on [DATE] at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM on the Controlled Medication Utilization Record. Nurse #3 stated she worked 7:00 PM to 7:00 AM shift and wasn't present at the facility during those times on [DATE]. An interview occurred with Nurse #2 on [DATE] at 11:02 AM. After reviewing the narcotic records, she stated the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For Resident #224's Hydrocodone, that was not her signature for the witnessed wastes on [DATE], [DATE] and [DATE]. - For Resident #225's Lorazepam it was not her signature for the witnessed wastes on [DATE] and [DATE]. - For Resident #226's Hydrocodone it was not her signature for the witnessed wastes on [DATE], [DATE], [DATE], [DATE] or [DATE]. Nurse #2 further stated that she did not work on [DATE]. A phone interview occurred with the Pharmacy Nurse Consultant on [DATE] at 11:17 AM. She stated the facility had identified the misappropriation of narcotics by Nurse #1 and asked for her to come and audit narcotic records to ensure they had not missed anything. She stated the facility had captured all the concerns during her review and she provided education to all the nursing staff regarding procedure for wasting medications, and misappropriation of narcotics on [DATE]. The Director of Nursing (DON) was interviewed on [DATE] at 11:27 AM and explained that during a morning meeting on [DATE] she was notified by the Unit Manager there was a discrepancy found for two residents controlled medications by Nurse #1 on [DATE]. It was noted that Nurse #1 had signed the Controlled Medication Utilization Record as giving Resident #17 his Oxycodone on [DATE] at 5:00 AM and 12:00 PM. These were not captured on the MAR and Nurse #1 didn't arrive to work until 7:06 AM on [DATE], therefore she couldn't have administered the 5:00 AM dose. Resident #223's Oxycodone was signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 12:00 PM but was not captured on the MAR. This prompted the DON to do a more thorough investigation that revealed a lot of wastes with questionable signatures for the nurses that were to witness the wasting of the narcotic or no witness signatures, as well as entries on the Controlled Medication Utilization Record that were not captured on the MAR. The specific narcotic records were reviewed with the DON and revealed the following: - Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR. - Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 5:00 AM when she didn't clock in for work on that day until 7:06 AM. - Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 12:00 PM and was not captured on the MAR. - Resident #224 had a waste of Hydrocodone on [DATE] where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR. - Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR. The Administrator was interviewed on [DATE] at 2:01 PM and stated once the suspicion of misappropriation of narcotics was found the nurse was suspended pending the investigation. The police department, corporate, pharmacy, Drug Enforcement Agency and North Carolina Board of Nursing were notified. The investigation began with all the narcotic records being audited. The investigation showed that Nurse #1 was the nurse that marked waste for narcotics the most and most entries weren't reflected on the resident MAR's as being given to them. We never suspected her of taking medication prior to [DATE] as she was never visibly impaired. Once the investigation was completed Nurse #1 was terminated. Multiple unsuccessful attempts were made to contact Nurse #1. The facility provided the following corrective action plan: Corrective action for the involved residents: Resident records were reviewed as well as medications/narcotics for the residents affected. Interviews were conducted with the residents. Resident Council was completed. Pain assessments were completed. Pharmacy performed an audit of the narcotics on [DATE]. The nurse was suspended pending the investigation. On [DATE] the police department was notified. On [DATE] the Drug Enforcement Agency was notified. On [DATE] a 24 hour report was submitted, and the North Carolina Board of Nursing was notified. Corrective action for other potentially affected residents: All narcotic records as well as Medication Administration records were reviewed. A pharmacy audit was performed on [DATE] with no other concerns identified. Pain assessments were completed by the DON. Measures that were put in place or systemic changes: The Staff Development Coordinator (SDC) initiated education on [DATE] to all nurses on Controlled Substance Diversion Training and Drug Diversion Policy. How the facility plans to monitor: The DON and Unit Manager will continue their audits of the MAR, Narcotic Sheets and Medications weekly for six months then monthly for one year. The SDC will educate all new and active staff on a continued basis on Abuse, Neglect and Misappropriation. All nurses will continue, on a regular basis, to be educated by the SDC/DON on medication administration and drug diversion. The plan alleged compliance on [DATE]. As part of the validation process, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Review of the facility plan of correction revealed evidence of 100% auditing of medication concerns or misappropriation, including pain assessments. The facility provided evidence of 100% staff education on Controlled Substance Diversion Training and Drug Diversion Policy completed on [DATE]. The facility reported Nurse #1 to the North Carolina Board of Nursing on [DATE]. Reports were presented to the Quality Assurance committee by the DON to ensure corrective action was appropriate. Ongoing audits were reviewed. The validation process verified the facility's date of compliance of [DATE].

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40197 Based on record reviews and staff interview, the facility failed to submit an initial report to the state regulatory agency within 24 hours of a discovery of misappropriation of resident property. This was for 6 of 6 residents (Residents #5, #17. #223, #224, #225 and #226) reviewed. The findings included: A review of the facility's Reporting Reasonable Suspicion of Crime policy, last revised 10/2022, revealed the facility would report a 24-hour investigation for a reasonable suspicion of crime no later than 24 hours if the alleged violation does not result in serious bodily injury. An interview with the Director of Nursing (DON) was conducted on 9/17/24 at 11:27 AM and indicated she was notified on 8/9/24 by the Unit Manager that there was a discrepancy on the Controlled Medication Utilization Record for Residents #17 and #223 involving Nurse #1. The DON stated she notified the Administrator and began an audit of all resident Controlled Medication Utilization Records on 8/9/24 , finding the following: - Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR. - Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 5:00 AM when she didn't clock in for work on that day until 7:06 AM. - Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 12:00 PM and was not captured on the MAR. - Resident #224 had a waste of Hydrocodone on 6/6/24 where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR. - Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste. - Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 2:01 PM, an interview occurred with the Administrator. She explained that she didn't send an initial report to the state regulatory agency within 24 hours because they were not sure if this was a misappropriation of resident medications issue or not on 8/9/24. The Administrator stated once they suspected the misappropriation of narcotic medications, the corporate agency, pharmacy, law enforcement, Drug Enforcement Agency and North Carolina Board of Nursing were notified. She acknowledged the 24 hour report was not sent to the State Agency until 8/19/24, stating we were doing the investigation and wanted to make sure the problem was corrected.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, family, and staff interviews, the facility failed to provide the responsible party (RP) written notification of the reason for a hospital transfer for 1 of 1 resident reviewed for hospitalization (Resident #10). The findings included: Resident #10 was originally admitted to the facility on [DATE]. A review of Resident #10's medical record revealed the following transfers and discharges to the hospital: - Transferred to the hospital on 1/22/24 for hypotension and fever. He returned to the facility on [DATE]. - Transferred to the hospital on 2/6/24 for hypotension and returned to the facility on [DATE]. - Transferred to the hospital on 2/20/24 for altered mental status and returned to the facility on [DATE]. - Transferred to the hospital on 6/23/24 for altered mental status and returned to the facility on [DATE]. There was no documentation that a written notice of transfer was provided to the RP for any of the hospital transfers noted above. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 had severe cognitive impairment. During an interview with Resident #10's RP, he indicated he had not received anything in writing regarding Resident #10's hospital transfers but was notified by phone. The Administrator was interviewed on 9/17/24 at 9:00 AM and stated that when a resident was transferred to the hospital the RP was notified by phone. A transfer/discharge form was sent with the resident to the hospital, but nothing was mailed to the RP. The Administrator further stated it was her expectation for the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 20934 Based on observations, staff interviews and record review, the facility failed to post daily nurse staffing data at the beginning of two shifts, post accurate daily nurse staffing data for two shifts and maintain records of posted daily nurse staffing data for two shifts. This failure occurred for 6 of 45 days of daily nurse staffing data reviewed. The findings included: 1a. An observation of posted daily nurse staffing data occurred on 9/15/24 at 8:50 AM and 9/15/24 at 11:55 AM. Each observation revealed daily nurse staffing data was posted for the 7AM shift for 9/14/24. The daily nurse staffing data recorded the facility census of 21 residents, two registered nurses (RN) for a total of 24 hours worked, one licensed practical nurse (LPN) for a total of 12 hours worked and three nurse aides (NA) for a total of 36 hours worked. Actual staff observed for the 7AM shift on 9/15/24 included one RN, two LPNs and four NAs. 1b. A review of daily nurse staffing data records occurred with the Staffing Coordinator on 9/17/24 at 2:04 PM and revealed the following: - On Saturday, 8/3/24, there was no record of the daily nurse staffing data posting for the 7AM to 7PM shift. - On Monday, 8/12/24, the daily nurse staffing data posting for the 7AM shift did not record a RN who worked 8 hours. - On Saturday, 8/17/24, there was no record of the daily nurse staffing data posting for the 7AM to 7PM shift. - On Tuesday, 8/20/24 the daily nurse staffing data recorded two LPNs worked 12 hours on the 7PM to 7AM shift. The nursing assignment sheet recorded five LPNs, and one RN worked on 8/20/24, 7PM shift. An interview with the Staffing Coordinator occurred on 9/17/24 at 9:58 AM. The Staffing Coordinator stated she normally worked 9AM to 5:30PM Monday through Friday and weekends as needed. She stated that the nurse on each shift was responsible to post the daily nurse staffing data at the beginning of the shift, but that she checked when she arrived to work and if the correct daily nurse staffing data was not posted, she would post it. The Staffing Coordinator stated that she worked 9/14/24 7PM to 7AM and completed and posted the daily nurse staffing data for that shift but that she may have recorded the wrong shift on the posting. She stated she recorded that the data was for the 7AM to 7PM shift on 9/14/24, but that she meant to record that it was for 9/14/24, 7PM to 7AM shift. She stated that she always reminded the nurses that daily nurse staffing data should be posted at shift change, and currently the charge nurse was responsible to post daily nurse staffing data at the beginning of each shift. She stated she could not locate the daily nurse staffing postings for 8/3/24 or 8/17/24 and that the daily nurse staffing data postings on 8/12/24 and 8/20/24 did not include all the RNs or LPNs that worked in the facility on those dates. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kindred Hospital East Greensboro		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 South Side Boulevard Greensboro, NC 27406	

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with the charge nurse (Nurse #4) occurred on 9/18/24 at 9:32 AM. Nurse #4 stated that she worked the 7AM shift on 9/15/24 and that she trained a new nurse on that shift. Nurse #4 stated that when she arrived for work at 7AM on 9/15/24, she just forgot to post the daily nurse staffing data for the 9/15/24 7AM shift, but that she was aware of that responsibility. She stated, It was just an oversight. An interview with the Administrator occurred on 9/16/24 at 4:51 PM. The Administrator stated that she expected the nursing staff to work together to post the daily nurse staffing data at the beginning of each shift, ensure the records were accurate and that staffing data records should be maintained for 15 months.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 20934 Based on observations, record review and interviews with the Registered Dietitian (RD) and staff, the facility failed to provide a four-ounce portion of pureed beef taco meat per the approved menu and prepare pureed foods per the recipe (beef taco meat, bean and corn salsa and cilantro lime rice). This failure occurred for 1 of 1 resident with a diet order for pureed textured foods (Resident #4). The findings included: A continuous observation of the lunch meal tray line occurred on 9/17/24 from 11:40 AM to 11:50 AM. Review of the tray card revealed Resident #4 had a diet order for pureed textured foods. During the observation, the following foods were plated for Resident #4: -Cook #1 used a #10 scoop to plate a 3 1/5-ounce portion of pureed beef taco meat that had an applesauce consistency instead of a four-ounce portion, per the menu. -Cook #1 used a #8 scoop to plate a four-ounce portion of pureed bean and corn salsa with a thick consistency. -Cook #1 used a #8 scoop to plate a four-ounce portion of pureed cilantro lime rice with an applesauce consistency. Review of the approved menus and recipes revealed the following instructions: -Bean and Corn Salsa, Pureed, serve a 1/2 cup or four-ounce portion. For texture modification, remove the number of portions required from the regular recipe, process bean and corn salsa and 3 tablespoons of thickener per 10 servings, to achieve a smooth textured product, final product should be smooth, pudding like consistency but not runny. -Cilantro Lime Rice, Pureed, serve a 1/2 cup or four-ounce portion. For texture modification, remove the number of portions required from the regular recipe, blend until smooth adding 1 teaspoon margarine, melted, plus 1 tablespoon hot water or hot low sodium vegetable broth per serving to achieve a smooth textured product. Final product should be smooth pudding like but not runny. -Beef Taco Bowl, Pureed. Serve a four-ounce portion. Prepare beef taco meat and puree according to the recipe. There was no recipe available for review for the beef taco meat, pureed. Cook #1 was interviewed on 9/17/24 at 11:50 AM and stated that he did not have a recipe to refer to when he prepared the pureed foods, so he used 2 servings of a #10 scoop (3 1/5 ounce) of each food item, beef taco meat, cilantro lime rice and bean and corn salsa, added some water and thickener, but that he did not measure how much water or thickener he added to puree these foods. He stated that this was his routine practice when he prepared pureed foods. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Patient Ambassador, Dietary Aide #1 (DA #1) was interviewed on 9/18/24 at 11:18 AM and stated that she worked in the kitchen as a DA since April 2024. DA #1 stated that she put together the recipe binder when she started, sometime in April 2024 or May 2024. DA #1 stated that when she put together the recipe binder, she printed the recipes for regular textured foods and some of those recipes included instructions to modify the texture to prepare pureed foods, but not all of recipes for regular textured foods included instruction for texture modifications. She stated that she did not print or include recipes for pureed foods in the recipe binder, but that she would do so going forward. The Kitchen Supervisor was interviewed on 9/17/24 at 11:55 AM and stated that he provided oversight of the lunch meal tray line three days per week. During the interview he reviewed the recipe binder and stated that the binder included recipe instructions for preparing foods for a regular textured diet and some of the recipes included instructions for modifying textures. After reviewing the recipe binder, he stated that the recipe binder did not have a recipe in the binder for pureed beef taco meat that was served for lunch on 9/17/24. He stated that the pureed taco meat should be served in a four-ounce portion. The Food Service Director was interviewed on 9/17/24 at 12:02 PM and stated that he provided tray line and food production oversight to the dietary staff. The Food Service Director stated that he was relatively new to his role in the dietary department and that he had not observed [NAME] #1 prepare pureed foods, but that he expected recipes to be followed. The RD was interviewed on 9/18/24 at 10:23 AM and stated that she reviewed/approved the recipes in the recipe binder. The RD stated that when she reviewed the recipe binder, she usually looked for the recipes for regular textured foods, and that she did not always review the recipe binder to ensure there were recipes included for all texture modifications. The RD stated that she expected recipes to be followed for texture modified foods and for foods to be served to residents in portions per the menu. During the interview, the RD provided recipes for pureed textured cilantro lime rice, pureed bean and corn salsa and pureed beef taco bowl. A recipe for pureed beef taco meat was requested, but not provided. The RD stated DA #1 was responsible to ensure the recipe binder was kept up to date. The Administrator was interviewed on 9/18/24 at 11:00 AM. She stated that menus and recipes should be available and followed to serve residents the correct portions and texture modifications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observations, record review, and interviews with the Registered Dietitian (RD) and staff, the facility failed to remove expired foods from refrigerated storage, store dented canned goods separate from foods available for use, store potentially hazardous foods in sealed containers with a label that recorded the date of storage and the use by date. This failure had the potential to affect food served to 7 of 21 residents. The findings included: 1a. An observation on [DATE] at 11:17 AM of the walk-in refrigerator occurred with the Kitchen Supervisor and revealed a sign posted on the exterior that recorded Food Storage Chart - Refrigerated Foods, Label when product is opened, the time listed is added to today's date. Deli Meats, + (plus) 3 days. Inside the walk-in refrigerator, a plastic bag of sliced turkey meat was observed open to air with a use by date recorded as [DATE]. During the observation, the Kitchen Supervisor stated that all foods stored in refrigeration should be stored in sealed containers and discarded by the use by date. 1b. An observation on [DATE] at 11:20 AM of the walk-in freezer revealed the following opened foods were stored on a rack in plastic bins, not in the original packaging, and open to air with no label to record the date opened or a use by date: - Diced potatoes were stored in a plastic bag that was open to air, with no label to record the date opened or the use by date. - Hash browns were stored in a plastic bag that was open to air, with no label to record the date opened or the use by date. The hash browns were covered with ice and had a dried, white appearance. During the observation, the Kitchen Supervisor discarded the hash browns and stated the hash browns appeared freezer burned. - Breakfast sausage was stored in a plastic bag that was open to air with no label to record the date opened or the use by date. - Diced chicken was stored in a plastic bag that was open to air, with no label to record the date opened or the use by date. The diced chicken was covered with ice and had a dried white appearance. During the observation, the Kitchen Supervisor discarded the diced chicken and stated the diced chicken appeared freezer burned. - Tater tots were stored in a plastic bag that was open to air with no label to record the date opened or the use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. An observation of the dry storage room occurred with the Kitchen Supervisor on [DATE] at 11:30 AM. A canned product was observed with a dent along the seal and was stored with canned foods that were available for use. The Kitchen supervisor stated that I usually put the dented cans on the first row of the rack, but since that row is not labeled, for the storage of dented cans, that's why a dented can was stored with cans available for use. An interview on [DATE] at 11:24 AM with the Kitchen Supervisor revealed the facility received food delivery twice per week and on those days, staff monitored the storage of foods for proper packaging and labeling. He stated that foods should be stored in sealed containers to prevent freezer burn and include a label that recorded date opened/received and the use by or expiration date. The RD was interviewed on [DATE] at 3:23 PM. The RD stated that she conducted monthly sanitation rounds that included an observation of the dish room and cold, frozen and dry storage. The RD stated that when she identified concerns with food storage, she re-educated staff immediately. The RD stated that foods should be stored in sealed containers, with labels and discarded by the use by date. The Food Service Director stated in an interview on [DATE] at 12:02 PM that dietary services should be provided per regulatory requirements. The Administrator was interviewed on [DATE] at 11:00 AM. She stated that the dietary department should store foods per regulatory requirements.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 20934 Based on record review and staff interviews, the facility failed to include dementia management training and care for cognitively impaired residents as part of the required annual training for 3 of 6 nurse aide (NA)s reviewed for annual staff training (NA #4, NA #5 and NA #6). The findings included: 1a. NA #4 was hired on 9/14/20. Review of nursing assignment records revealed NA #4 worked the 7PM to 7AM shift on August 5, 6, 15, 22, and 29, 2024 and September 16, and 17, 2024. Attempts to interview NA #4 were unsuccessful. 1b. NA #5 was hired on 8/23/10. Review of nursing assignment records revealed NA #5 worked the 7PM to 7AM shift on August 10, 13, 19, and 23, 2024 and September 18, 2024. Attempts to interview NA #5 were unsuccessful. 1c. NA #6 was hired on 2/11/08. Review of nursing assignment records revealed NA #5 worked the 7PM to 7AM shift on August 2, 4, 9, 14, 24 and 31, 2024 and September 15, 2024. Attempts to interview NA #6 were unsuccessful. An interview with the Staff Development Coordinator (SDC) occurred on 9/17/24 at 2:00 PM. During the interview, a review of annual NA training revealed there was no documentation of annual dementia management training and care for cognitively impaired residents for NA #4, NA #5 or NA #6. The SDC stated that she was not aware that annual dementia management training and training to care for cognitively impaired residents was required. The SDC stated that the electronic training management system used by the facility allowed her to populate specific training for each NA to complete each month but stated I just have not populated the training yet, there is no specific reason why. The SDC further stated that NA #4, NA #5 and NA #6 each worked at the facility in the last 12 months. An interview with the Administrator occurred on 9/16/24 at 4:51 PM. The Administrator stated that she expected each NA to receive the required annual training. The Administrator stated she felt certain the required annual training for dementia management and care for cognitively impaired residents had been provided, but that she could not locate any documentation.