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	12/19/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an evaluation for level II Preadmission Screening and Resident Review (PASRR) determination for a resident with serious mental health diagnoses. This deficient practice was for 1 of 1 resident reviewed for PASRR (Resident #6).The findings included:The PASRR history detail reported dated 5/16/11, provided by the facility, revealed Resident #6 had a PASRR Level 1 review only completed on 5/16/11 and the review did not meet level II criteria. The PASRR review revealed Resident #6 was noted to have no mental health diagnosis at the time of the review.Resident #6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder. A review of the active diagnosis list revealed Resident #6 had a diagnosis of bipolar disorder unspecified noted as active on 4/18/19 and a diagnosis of schizophrenia unspecified noted as active on 7/20/24. Review of Resident #6's electronic and paper medical record revealed no evidence a request was submitted for an evaluation for level II PASRR determination. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #6 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.A telephone interview was conducted with Social Worker #2 on 12/18/25 12:44 pm who confirmed she was responsible for requests for PASRR evaluations for the facility at the time of Resident #6's new serious mental health diagnoses. Social Worker #2 stated that she typically would only review a PASRR for new admissions or those residents that had an expiration date on a PASSR level I. Social Worker #2 confirmed that Resident #6's new serious mental health diagnoses of bipolar disorder and schizophrenia would be a significant change in her mental health but it was not her normal practice to submit a request for evaluation of PASRR level II. Social Worker #2 stated she understood the process of PASRR evaluations, but it was not something that was normally needed for the resident population at the facility and not part of her normal practice. An interview was conducted with the Administrator on 12/19/25 at 3:38 pm who revealed the facility received Resident #6's PASRR level I information from the hospital and she was unsure who was responsible to resubmit when new mental health diagnoses were identified at the facility. The Administrator stated it was not the facility's normal practice to resubmit PASRR information after a resident was admitted to the facility and it was not something the facility was doing.

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

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	12/19/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Consultant Pharmacist, and Physician interviews the facility failed to have clinical documentation to support a diagnosis of schizophrenia for 1of 5 residents reviewed for unnecessary medications (Resident #6). The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder. Resident #6 was readmitted to the facility from a short-term hospital stay on 7/20/24. The hospital Discharge summary dated [DATE] did not list a diagnosis of schizophrenia for Resident #6.The provider progress note dated 5/06/25 revealed Resident #6 was seen by Physician #2 related to reported visual hallucinations by the nursing staff. The provider's progress note did not list schizophrenia as a diagnosis for Resident #6. The assessment and plan for Resident #6, as noted by Physician #2, was to add haloperidol (an antipsychotic medication primary used to treat psychotic disorders like schizophrenia) one (1) milligram tablet by mouth every 6 hours as needed for the continued hallucinations.The active diagnosis list revealed Resident #6 had a diagnosis of schizophrenia, unspecified which was noted as an admitting diagnosis that was active as of 7/20/24 with no onset date listed, and with the clinical category of medical management. The diagnosis list further revealed Resident #6's schizophrenia diagnosis was added by Nurse #1 on 5/06/25.An interview was conducted with Nurse #1 on 12/19/25 at 11:11 am who added Resident #6's schizophrenia diagnosis to the medical record. Nurse #1 stated she recalled adding the schizophrenia diagnosis based on a medication that Resident #6 was taking that did not have a correct diagnosis. Nurse #1 stated she believed the diagnosis was given to her by a physician at the facility but she could not recall exactly who gave the information. Resident #6's care plan which was last revised on 11/04/25 revealed no care plan was in place for the diagnosis of schizophrenia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #6 was coded for the following psychiatric/mood disorders: anxiety, depression, and bipolar disorder. Resident #6 was not coded for a diagnosis of schizophrenia. Review of Resident #6's electronic and paper medical records revealed no clinical documentation supporting the schizophrenia diagnosis. Multiple attempts to conduct a telephone interview with the MDS Nurse on 12/19/25 were unsuccessful. A telephone interview was conducted on 12/19/25 at 11:16 am with the Consultant Pharmacist who revealed the pharmacy had not requested that the facility add a diagnosis of schizophrenia for Resident #6. A telephone interview was conducted on 12/19/25 at 3:09 pm with Physician #1 who revealed he had not written or given the facility a diagnosis of schizophrenia for Resident #6. Physician #1 stated to the best of his knowledge Resident #6 did not have a diagnosis of schizophrenia.An attempt to conduct a telephone interview with Physician #2 on 12/19/25 at 3:19 pm was unsuccessful. An interview was conducted with the Director of Nursing (DON) on 12/19/25 at 3:29 pm who revealed she was unable to locate documentation from either Physician #1 or Physician #2 that noted Resident #6 to have a schizophrenia diagnosis. The DON stated she believed Physician #2 had reported that Resident #6 had a significant history of schizophrenia but she was not able to say why there was no clinical documentation regarding the diagnosis. The Administrator was interviewed on 12/19/25 at 3:42 pm. The Administrator revealed she was unable to recall if Resident #6 had a schizophrenia diagnosis but she stated she would discuss the diagnosis with the clinical team to confirm the diagnosis was correct.

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	12/19/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to provide tracheostomy (a hole surgeons make through the front of the neck and into the wind pipe, also known as the trachea) care consistent with professional standards of practice for 1 of 1 resident observed for tracheostomy care (Resident #2).The findings included:Resident #2 was admitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy and respiratory failure.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was severely impaired cognitively. The MDS further revealed the Resident #2 was coded for oxygen therapy, suctioning, respiratory services, and tracheostomy care.Resident #2 had a care plan with effective date of 12/12/25 that indicated a goal he would have no abnormal drainage around his tracheostomy site through the next review date. The care plan had interventions that included instructing the resident/caregiver in providing tracheostomy care/suctioning and signs/symptoms to report. An observation was conducted of tracheostomy care on 12/17/25 at 9:15am with Respiratory Therapist (RT) #1. RT #1 was observed performing hand hygiene and applying two pairs of clean disposable gloves. RT #1 opened the tracheostomy care tray on Resident #2's overbed table. RT #1 did not clean the overbed table before opening and setting up tracheostomy care supplies. RT #1 was observed pouring normal saline into the tracheostomy care tray and removing a clean gauze saturated with normal saline from the tracheostomy care tray. She then cleaned around Resident #2's tracheostomy site and placed the dirty gauze on a dressing package on Resident #2's overbed table. RT #1 was then observed removing another clean gauze from the tracheostomy care tray and cleaning around Resident #2's tracheostomy site and placing the soiled gauze in the clean tracheostomy care tray on top of the remaining clean gauze. RT #1 removed two cotton tip applicators saturated with normal saline from the tracheostomy care tray and cleaned around Resident #2's tracheostomy site. RT #1 was observed removing a clean gauze from under a used gauze to clean around the resident's tracheostomy site and placing the used gauze in the tracheostomy care tray. RT #1 removed the top pair of disposable gloves before opening the dressing to apply around Resident #2's tracheostomy site. RT #1 did not perform hand hygiene before applying the clean dressing to Resident #2's tracheostomy site.During an interview on 12/17/25 at 2:40pm RT #1 stated she was trained to work from the tracheostomy care tray, and she was not aware she needed to clean her work surface before setting up supplies. RT #1 confirmed she doubled gloved during the procedure and stated a third shift supervisor instructed her to use double gloves during tracheostomy care the morning of the observation. The RT #1 stated she normally wears the same gloves throughout tracheostomy care. She stated she was not aware she place the dirty gauze on top of the clean gauze.An interview was conducted over the phone on 12/18/25 at 11:41am with the Third Shift Supervisor who revealed he did not instruct RT #1 to double glove during tracheotomy care. The Third Shift Supervisor stated there was a discussion RT #1 on how care was performed in the past. He stated RT #1 must have misunderstood the conversation, because he never gave any directives for double gloving during tracheostomy care. The Third Shift Supervisor stated if he were performing tracheotomy care, he would perform hand hygiene and apply a clean pair of disposable gloves before applying a clean dressing.An interview was conducted on 12/18/25 at 10:10am with the Director of Respiratory Therapy who revealed they follow Lippincott's (digital resource) guidance for hand hygiene, which included removing gloves and performing hand hygiene between touching clean and dirty items during tracheostomy care. She stated that the Respiratory Department did not have an actual policy for tracheostomy care and that was a policy that may need to be added. She stated tracheostomy care was taught at the beside once the trainee was on the floor. The Director of Respiratory Therapy stated staff were not trained to (continued on next page)

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	12/19/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	double glove during tracheostomy care. She stated dirty items used should be disposed of to prevent cross contamination during tracheostomy care. She also stated she would expect staff to clean the work surface before setup, place wastebasket close by for disposal of dirty items, and she would expect hand hygiene to be performed before and after the procedure. When asked could there have been a negative outcome to Resident #2, the Director of Respiratory Therapy's response was anything is possible.An interview was conducted on 12/18/25 at 3:30pm with the Infection Preventionist (IP) who revealed she was not responsible for training staff from the Respiratory Department. The IP stated tracheostomy care was taught by Respiratory Department. She also stated they follow Lippincott's guidance. When the IP was asked what the expectation of staff was working on the unit, she stated the expectation would be not to contaminate a clean area. When asked what the outcome could have been from Rt #1's actions, the IP stated it could have put Resident #2 at risk for infection. An interview was conducted on 12/18/25 at 2:55pm with the Director of Nursing (DON) who revealed she was not aware of any training for staff that involved wearing double gloves. The DON stated her expectation during tracheostomy care would be for staff to perform hand hygiene and apply clean gloves, before applying a clean dressing. She also stated she would not expect staff to go from dirty to clean when providing care and she would expect staff to clean their work surface before and after performing care. When the DON was asked if she thought RT #1's actions could have had a negative impact on Resident #2, she stated it was possible.An interview was conducted on 12/19/25 at 3:00pm with Physician #2 who revealed he would expect RT #1 to apply clean gloves between dirty and clean when providing care. He also stated double gloves were not the appropriate Personal Protective Equipment (PPE) and staff should not take short cuts with hand hygiene. When asked if the actions of RT #1 could have had an negative effect on Resident #2, he indicated it could have caused additional problems.

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	12/19/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, and physician interviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents reviewed for unnecessary medications (Resident #6). The findings included:Resident #6 was admitted to the facility on [DATE]. Resident #6 was noted with diagnoses which included major depressive disorder, bipolar disorder, general anxiety disorder, and schizophrenia.The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that Resident #6 was cognitively intact and was not coded for hallucinations or behavioral symptoms during the assessment reference period. The MDS further indicated that Resident #6 reported feeling down, depressed, or hopeless for 2-6 days (several days) during the assessment reference period. The MDS quarterly assessment noted that Resident #6 was coded for the following psychiatric/mood disorders: anxiety, depression, and bipolar disorder. Resident #6 was coded for the use of antipsychotic and antidepressant medications. Review of the active physician orders dated December 2025 revealed that Resident #6 was prescribed the following medications: venlafaxine (antidepressant medication) 75 milligram (mg) capsule extended release 24-hour one capsule every day for bipolar disorder, unspecified; cariprazine (antipsychotic medication) 4.5 mg capsule daily for bipolar disorder unspecified; and fluoxetine (antidepressant medication) 20 mg capsule every day for major depressive disorder recurrent. The facility was unable to provide any documentation regarding mental health provider visits for Resident #6 since the last recertification survey of 9/18/24. The Facility Assessment that was last revised on 11/26/25, revealed the facility did not have behavioral or mental health providers which included psychiatrist, psychologist, or licensed counselors. The Facility Assessment further noted that the facility provided mental health and behavior services which were performed by the attending physician and the Social Worker. The Facility Matrix for Providers (a tool used to track resident's specific medical conditions and services needed) provided by the Administrator was reviewed and revealed that 16 of the 20 residents that resided at the facility were prescribed psychotropic (medications used to treat mental health conditions) medications which included antianxiety, antidepressants, and antipsychotic medications. An interview was conducted with Resident #6 on 12/19/25 at 11:16 am. Resident #6 reported that she was unable to recall the last time she was able to talk to a doctor about her mental health issues. The resident stated she used to see a mental health provider in the past before living at the facility. Resident #6 stated that she does talk to the staff, but she would like to be able to talk to a doctor when she begins to feel down. An interview was conducted with Nurse Aide (NA) #1 on 12/19/25 at 11:06 am who revealed she provided care to Resident #6 frequently. NA #1 reported that Resident #6 often had hallucinations which included seeing cats, dogs, rats, and people that were not there, as well as episodes of crying. NA #1 stated that when these things happened, she attempted to calm Resident #6 by trying to convince the resident that what she was seeing was not there. NA #1 stated she also would also spend time with Resident #6 until the resident was calm. During an interview on 12/19/25 at 11:11 am with Nurse #1 she revealed that Resident #6 had a history of hallucinations but reported the resident was easily settled by talking with the resident. The Social Worker was interviewed on 12/18/25 at 11:43 am who confirmed that the facility did not have a mental health provider that met with the residents. The Social Worker reported that Resident #6 had periods of hallucinations that were worsening and she was not sure how to engage with the resident when that happened. The Social Worker stated the nursing staff was very engaged with Resident #6 and talked with the resident often to help support Resident #6 when the hallucinations were occurring. (continued on next page)

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	12/19/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker stated she was able to provide Resident #6 with emotional and psychosocial support but stated that Resident #6 would benefit from talking to a mental health provider. The Social Worker reported that she had attempted to obtain a mental health provider for the facility by reaching out to providers and community organizations but she had not been successful. The Social Worker stated the need for a mental health provider had been discussed during the facility's IDT (interdisciplinary team) meetings but the facility was still without the services. A telephone interview was conducted with Physician #1 on 12/19/25 at 3:29 pm who was the provider for the residents of the facility along with Physician #2. Physician #1 stated that he and Physician #2 were Internists (physicians specialized in adult care) which afforded them the ability to manage all areas of care needed by the residents. Physician #1 reported that he and Physician #2 manage the mental health medications and immediate needs of the residents. He stated that the facility had a mental health provider in the past but they have not had anyone recently to provide those services. Physician #1 stated that the discussion regarding the need for a mental health provider in the facility has been discussed with Administration during the IDT meetings. An attempt to conduct a telephone interview with Physician #2 on 12/19/25 was unsuccessful.The Director of Nursing (DON) was interviewed on 12/18/25 at 2:57 pm who revealed the facility did not have a mental health provider but the facility relied on the physicians to mange the mental health care. The DON stated that Resident #6 did have periods of hallucinations but she was not able to say when she was last seen by a mental health provider.An interview was conducted on 12/19/25 at 3:09 pm with the Administrator who revealed the facility had a mental health provider that would come to the facility in the past, but they no longer came to see the residents. The Administrator stated the attending physicians were responsible for managing the mental health needs and medications of the residents. The Administrator confirmed the need for a mental health provider had been discussed during the quarterly IDT meetings but she had not been able to secure a mental health provider for the facility.

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	12/19/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Consultant Pharmacist, and Physician interviews, the facility failed to monitor a TSH (thyroid stimulating hormone) level for a resident prescribed amiodarone (a medication used to treat life-threatening irregular heartbeats). This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #19). The findings included: Resident #19 was admitted to the facility on [DATE] with diagnoses which included paroxysmal atrial fibrillation (an irregular heartbeat). Resident #19 had a physician order dated 10/14/25 for amiodarone 200 milligram tablet once a day for paroxysmal atrial fibrillation.The Consultant Pharmacist Recommendation to Physician report dated 10/27/25 revealed Resident #19 received the medication amiodarone but did not have a TSH blood test documented in the medical record for the last six months. The Consultant Pharmacist recommendation was to please monitor TSH on the next convenient laboratory day and every six months thereafter.Resident #19 was noted to have a physician order dated 11/06/25 for a TSH level blood test. The order was discontinued on 11/07/25. Resident #19's electronic and paper medical records were reviewed and revealed no TSH laboratory results from the 11/06/25 physician order.A telephone interview was conducted on 12/18/25 at 2:13 pm with the Consultant Pharmacist who revealed he reviewed Resident #19's medications upon admission and identified that a TSH level was not in the record. The Consultant Pharmacist stated that it was important to monitor TSH when taking the medication amiodarone because the medication had large amounts of iodine which can interfere with the normal thyroid function. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 3:00 pm who revealed the order for Resident #19's TSH level was entered as a one-time order (completed once) in the electronic record to be performed on 11/06/25 but it was not drawn by the lab. The DON stated that when an order was entered as a one-time order, the order automatically discontinued 24 hours after the order was entered because it was expected to be completed within the 24-hour period. The DON stated she did not know why the TSH lab was not obtained as ordered for Resident #19 and stated that when the TSH level was not drawn on 11/06/25 it should have been re-ordered to be drawn on the next day. The DON stated that she did not follow up to confirm that the TSH level was drawn as ordered on 11/06/25 and she was unable to locate any previous TSH results from the hospital discharge record. A telephone interview was conducted with the Physician on 12/19/25 at 3:09 pm who confirmed he was notified by the facility on 12/18/25 that Resident #19's TSH order was not completed as ordered. The Physician stated he did not have a concern that Resident #19's TSH level was not drawn when first ordered because it was just for monitoring purposes.

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	12/19/2025

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure the medical record was accurate related to pressure ulcer documentation and pressure ulcer treatment orders for 1 of 8 residents reviewed for accuracy of resident records (Resident #14).The findings included:Resident #14 was admitted to the facility on [DATE]. Review of Resident #14's Weekly Wound Assessments dated 11/03/25, 11/11/25, 11/18/25, and 11/25/25, and 12/02/25 revealed documentation of Resident #14's multiple wounds including a pressure ulcer to the right buttock, but there was no documentation for a wound to the left buttock. The assessments were completed by Nurse #3.Review of the December Treatment Administration Record (TAR) for Resident #14 revealed the following order for treatment to the right buttock wound, for the period of 12/2/25 through 12/10/25, to clean the right buttock wound with the wound cleanser, apply collagenase to the wound bed, pack the wound with saline soaked gauze, and apply foam dressing once daily and if soiled. This treatment was signed off as administered from 12/2/25 through 12/10/25. Nurse #3 signed off as administering the treatment on 12/9/25 and 12/10/25. For the period of 12/11/25 through 12/17/25 the treatment ordered was to clean the right buttock wound with wound cleanser, pack calcium alginate to wound bed, apply foam dressing once daily and as needed. Nurse #3 signed off the treatments as administered on 12/11/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, and 1217/25. There was no documentation for wound treatment provided to the left buttock.During an observation on 12/17/25 at 8:46 am Nurse #3 provided treatment to a wound on Resident #14's left buttock and there was no wound observed on the resident's right buttock.An interview was conducted on 12/17/25 at 1:51 pm with Nurse #3. During the interview Nurse #3 identified he had been documenting the location of Residents #14's left buttock wound incorrectly on his weekly wound assessments and Treatment Medication Record since the resident was admitted on [DATE]. He stated when Resident #14 was admitted to the facility he had conducted a wound assessment, then obtained an order for treatment for the wound from the physician and entered the order in the medical record. Nurse #3 stated he should have put the order in for the left buttock and not the right buttock. He also stated he should have documented the wound location as the left buttock not the right buttock on the weekly wound assessment sheet. Nurse #3 indicated he never noticed he was signing off the TAR for treatment to a right buttock wound after he provided the treatment to the left buttock.An interview was conducted on 12/17/25 at 2:55 pm with the Director of Nursing (DON). The DON stated Nurse #3 had informed her about Resident #14's wound documentation and wound orders being incorrect.During a follow up interview on 12/19/25 the DON stated she had not done rounds with Nurse #3, but a process needed to be put in place.

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	12/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review and staff interviews, the facility failed to implement infection control policy and procedures when Nurse #3 failed to perform wound cleansing and treatments for several wounds separately and failed to remove gloves and perform hand hygiene between cleansing each wound and providing the treatment for each wound. Nurse #3 also touched a new wound observed on the resident's right leg wearing a soiled glove (Resident #14). In addition, Nurse #2 failed to wear a gown when entering the room for a resident on contact precautions (Resident #13). The deficient practice occurred for 2 of 2 staff members observed for infection control practices (Nurse #3 and Nurse #2).The findings included: 1. The facility's Hand Hygiene policy last released in November 2022, stated to practice good hygiene to prevent the spread of disease or cross-contamination between patients, staff and food. The policy indicated hand hygiene should be performed: before having direct contact with patient/patients, before a clean/aseptic procedure, after touching a patient, after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled, after touching a patient's surroundings/environment, with additional opportunities being: before donning and after removal of gloves. The facility's Clean Dressing Change policy last released in October 2022, stated to perform clean aseptic technique while performing dressing changes to open wounds to protect from contamination and absorb drainage. The policy indicated to place plastic bag near foot of bed to receive soiled dressing, perform hand hygiene, create clean field with paper towels or drape, put on first pair of gloves, remove old adhesive, remove soiled dressing and discard one layer at a time, remove gloves and dispose, perform hand hygiene and put on second pair of gloves, clean wound with prescribed solution, remove gloves and perform hand hygiene, open dressing pack, and put on gloves. The Clean Dressing Change policy further noted if patient has multiple wounds to wash hands in between wounds and cleanse the least contaminated to the most contaminated wound. During an observation of wound care on 12/17/25 at 8:46am Nurse #3 was observed with supplies placed on a drape on top of Resident #14's overbed table. Nurse Aide #2 was also present to help position Resident #14 during wound care. Once Resident #14's was placed on his right side Nurse #3 loosened the edges of the dressings dated 12/16/25 from a wound to the sacrum (triangular bone at the base of the spine), a wound to the right ischium (curved bone that forms the lower and back portion of the pelvis), and wound to the left buttock. Nurse #3 performed hand hygiene and applied a clean pair of gloves. Nurse #3 was then observed removing the old dressing from the wound to the sacrum and rolling the old dressing down to the right ischial wound and rolling both old dressings from both wounds together and discarded both old dressings into a wastebasket at the bedside. Nurse #3 then removed the old dressing from the wound to the left buttock and discarded the old dressing into the wastebasket at the beside. Nurse #3 performed hand hygiene and applied a clean pair of gloves. Nurse #3 then began cleaning the wound to the sacrum, the wound at the right ischium and the wound at the left buttock. He used multiple gauze to clean all three wounds. Nurse #3 did not perform hand hygiene or apply clean gloves between each wound. While wearing the same pair of gloves Nurse #3 began packing an absorbent dressing in the wound to the sacrum, the wound to the right ischium and the wound to the left buttock. Nurse #3 did not perform hand hygiene or apply clean gloves between packing each wound or after she had packed the wounds. Nurse #3 opened three separate dressings onto the overbed table and proceeded to apply clean dressings to the wound to the sacrum, right ischium, and the left buttock. Nurse #3 was then observed performing hand hygiene and applying clean gloves before starting treatment to Resident #14's left heel. Nurse #3 applied the wipe that forms a protective barrier to the (continued on next page)

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	12/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	left heel. Nurse #3 then cut the soiled bandage from the right foot and placed the scissors onto the overbed table and applied the wipe that forms a protective barrier to Resident #14's right heel. Nurse #3 did not perform hand hygiene or apply clean gloves between performing the treatment between the wound on the left heel and the right heel. While still wearing the same pair of gloves Nurse #3 wrapped the right heel with a clean bandage. During the observation Nurse Aide #2 identified a new wound on Resident #14's outer right leg and Nurse #3 touched the new wound with his right index finger wearing the soiled gloves. Resident #14 was repositioned by Nurse #3 and Nurse #3 removed his gloves and performed hand hygiene. Nurse #3 did not remove his gloves or perform hand hygiene before repositioning Resident #14. Nurse #3 then discarded his supplies, removed his gloves and performed hand hygiene. Nurse #3 did not clean the overbed table that was used during Resident #14's treatment before leaving the room. During an interview on 12/17/25 at 1:51pm Nurse #3 stated he was not aware that he had touched the newly identified wound on Resident #14's outer right lower leg with soiled gloves he wore during the treatment for the left and right heel. Nurse #3 confirmed he did not perform hand hygiene or apply clean gloves between each wound. He confirmed he did not follow the dressing change policy, nor did he complete the dressing changes as he was trained. Nurse #3 stated he felt like he could have done better. An interview was conducted on 12/18/25 at 3:30pm with the Infection Preventionist (IP) who revealed she was responsible for training Nurse #3. The IP stated that the policy for dressing change does indicate staff should change gloves in between wounds during a dressing change. She then stated the expectation for staff would be to not cross contaminate between wounds and perform wound care for one wound before moving on to the next wound. When the IP was asked what the outcome could have been from Nurse #3's actions, the IP stated Resident #14 could have been put at risk for cross contamination if there was infection in any of the wounds. She also indicated she did not believe any of Resident 14's wounds were infected at that time. An interview was conducted on 12/18/25 at 2:55pm with the Director of Nursing (DON) revealed she would expect staff to perform hand hygiene and apply cleans gloves in between dressing changes for each wound. The DON also stated she would expect staff to clean the work surface before and after performing a treatment. When the DON was asked if she thought the actions of Nurse #3 could have had a negative impact on Resident #14, she stated it was possible. An interview was conducted on 12/19/25 at 3:00pm with Physician #2 who revealed he would expect staff to perform hand hygiene and apply clean gloves between wounds. Physician #2 stated that the actions of Nurse #3 were not appropriate and could have moved microbes (microorganism) from one area to another. 2. The facility's Personal Protective Equipment (PPE) policy last released in October 2022 revealed that PPE will be utilized to reduce the risk of transmission and prevent the transmission of pathogenic organisms from patient to health care worker and from health care worker to patient. The policy further noted that contact precautions were intended to prevent the transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. The policy stated that contact precautions required the use of gown and gloves on every entry into a patient's room or the patient's environment. On 12/17/25 at 9:33 am Resident #13 had signage posted at the entrance of the room that alerted staff that Resident #13 was on contact precautions. The signage noted that all healthcare personnel (continued on next page)

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	12/19/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	must wear gloves and gown when entering the room. A supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves. A continuous observation was conducted on 12/17/25 at 9:33 am through 9:35 am of Nurse #2 who was observed in Resident #13's room without a gown in place. Nurse #2 was observed to pick up enteral feeding supplies from the overbed table and walk towards the sink before returning the supplies to the overbed table. Nurse #2 was then observed to remove the disposable gloves, perform hand hygiene and exit the room. An immediate interview was conducted with Nurse #2 on 12/17/25 at 9:35 am. Nurse #2 confirmed that Resident #13 was on contact isolation for multiple drug-resistant organism (MDRO) related to pneumonia and she should have donned a disposable gown before entering the room, but it slipped her mind. An interview was conducted with the Infection Preventionist on 12/18/25 at 3:27 pm who revealed Nurse #2 was required to wear PPE, which included a disposable gown, for the entire time she was in a resident room that was on contact precaution isolation.