

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Greendale Forest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE Second Street Snow Hill, NC 28580	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49159</p> <p>Based on observations and staff interviews, the facility failed to provide a clean and sanitary environment by not removing a dark grey/black colored substance from 20 of 25 ceiling fans observed on 8 of 8 resident halls.</p> <p>Findings included:</p> <p>1a. During an observation of the 600-hall on 3/27/25 at 8:26 AM 2 ceiling fans were noted with a dark grey/black colored substance on all 5 of the blades.</p> <p>b. During an observation of the 600-hall on 3/27/25 at 8:26 AM the ceiling fan in front of the nurse's station for the 500-hall and 600-hall was noted with a dark grey/black colored substance on all 5 of the blades.</p> <p>c. An observation conducted on 3/27/25 at 8:28 AM of the 500-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades.</p> <p>d. An observation conducted on 3/27/25 at 8:30 AM of the 400-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades.</p> <p>e. An observation conducted on 3/27/25 at 8:32 AM of the 300-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades.</p> <p>f. An observation conducted on 3/27/25 at 8:33 AM of the ceiling fan in front of the nurse's station for the 100-hall and 200-hall revealed the ceiling fan was noted with a dark grey/black colored substance on all 5 of the blades.</p> <p>g. An observation conducted on 3/27/25 at 8:34 AM of the 100-hall revealed 3 ceiling fans had a dark grey/black colored substance on all 5 of the blades.</p> <p>h. An observation conducted on 3/27/25 at 8:37 AM of the 200-hall revealed 2 ceiling fans had a dark grey/black colored substance on all 5 of the blades.</p> <p>i. An observation conducted on 3/27/25 at 8:41 AM of the 700 hall and 800 hall nurse's station revealed 2 ceiling fans had a dark grey/black colored substance on all 5 of the blades.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>j. An observation conducted on 3/27/25 at 8:42 AM of the 800-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades.</p> <p>k. An observation conducted on 3/27/25 at 8:42 AM of the 700-hall revealed 1 ceiling fan had a dark grey/black colored substance on all 5 of the blades.</p> <p>On 3/27/25 at 8:46 AM an interview was conducted with Housekeeping Staff #1. She stated the housekeeping department was responsible for cleaning the ceiling fans within the facility. She further stated the ceiling fans were cleaned weekly and to her knowledge the fans were last cleaned one week ago. During visual inspection she indicated the fans required cleaning.</p> <p>An interview was conducted with the Housekeeping Manager on 3/27/25 at 8:49 AM. He stated the housekeeping department was responsible for cleaning the ceiling fans, and they were supposed to be cleaned weekly by the Floor Technician staff member who was responsible for this task.</p> <p>An interview was conducted with the Floor Technician on 3/27/25 at 8:52 AM. He stated he was responsible for cleaning the ceiling fans within the facility. He further stated the ceiling fans were usually cleaned weekly, however the ceiling fans were last cleaned 2 weeks ago, as he was on leave from the facility.</p> <p>An observation was conducted on halls 700 and 800 with the Housekeeping Manager and Floor Technician on 3/27/25 at 8:54 AM. Both the Housekeeping Manager and Floor Technician indicated the ceiling fans needed to be cleaned. They stated all ceiling fans in resident halls would be cleaned that day.</p> <p>On 3/27/25 at 10:50 AM an interview was conducted with the Director of Nursing (DON). She stated the housekeeping department was responsible for cleaning the ceiling fans. She further stated it was her expectation that housekeeping staff would clean the ceiling fans weekly and as needed.</p> <p>An interview was conducted with the Administrator on 3/27/25 at 1:37 PM. She stated housekeeping staff were responsible for cleaning the ceiling fans, and they followed a cleaning schedule. She further stated her expectation was that the ceiling fans were cleaned per the cleaning schedule (weekly).</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41387</p> <p>Based on record reviews and staff interviews, the facility failed to conduct and document care plan meetings after completion of quarterly and/or annual Minimum Data Set (MDS) assessments for 6 of 31 residents reviewed for care planning (Resident #27, Resident #100, Resident #91, Resident #45, Resident #18, and Resident #21).</p> <p>The findings included:</p> <p>1. Resident #27 was admitted to the facility on [DATE].</p> <p>The last care plan meeting documented in Resident #27's medical record was dated 7/9/2024.</p> <p>MDS assessments were completed for Resident #27 on the following dates: 9/16/2024 (quarterly), 11/11/2024 (quarterly), 1/10/2025 (quarterly) and 3/21/2025 (significant change).</p> <p>The significant change MDS dated [DATE] indicated Resident #27 was moderately cognitively impaired.</p> <p>On 3/27/2025 at 1:37 pm in an interview with the MDS Coordinator, she explained the Social Worker was sent the scheduled timeframe for completion of MDS assessments monthly to use for scheduling care plan meetings.</p> <p>On 3/26/2025 at 9:41 am in an interview with the Social Worker, she recalled Resident #27's Resident Representative changing the care plan meeting to 10/14/2024 at 3:00pm and talking with Resident #27's resident representative on the telephone while Resident #27's Resident Representative was driving home from work. The Social Worker stated she didn't know why she didn't document the care plan meeting held on 10/14/2024 in Resident #27's medical record. The Social Worker stated Resident #27 had not had a care plan meeting since 10/14/2024. She stated Resident #27 should have had a care plan meeting in January 2025 and was unable to provide a reason why a care plan meeting had not been held for Resident #27.</p> <p>On 3/27/2025 at 11:20 am in an interview with the Administrator, she stated the Social Worker was responsible for scheduling resident care plan meetings. In a follow up interview on 3/27/2025 at 2:48 pm, she stated care plan meetings were held quarterly and she was unaware quarterly care plan meetings had not been conducted for Resident #27.</p> <p>2. Resident #100 was admitted to the facility on [DATE].</p> <p>The last care plan meeting documented in Resident #100's medical record was dated 9/26/2024.</p> <p>Quarterly MDS assessments were completed for Resident #100 on 11/14/2024 and 2/12/2025.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #100 was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/27/2025 at 1:37 pm in an interview with the MDS Coordinator, she explained the Social Worker was sent the scheduled timeframe for completion of MDS assessments monthly to use for scheduling care plan meetings.</p> <p>On 3/26/2025 at 8:19 am in an interview with the Social Worker, she stated she was unable to find documentation Resident #100 had a care meeting since 9/26/2024. She explained she used the MDS schedule for completion of assessments and updating care plans to schedule the care plan meetings. She explained she had not been able to contact Resident #100's representative for a care plan meeting and stated Resident #100's representative not attending did not prevent the facility staff from having a care plan meeting for Resident #100. The Social Worker stated Resident #100 should have had a care plan meeting in November 2024 and did not know why a care plan meeting was not conducted.</p> <p>On 3/27/2025 at 11:20 am in an interview with the Administrator, she stated the Social Worker was responsible for scheduling resident care plan meetings. In a follow up interview on 3/27/2025 at 2:48 pm, she stated care plan meetings were held quarterly and she was unaware quarterly care plan meetings had not been conducted for Resident #100.</p> <p>39731</p> <p>3. Resident #45 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus and hypertension.</p> <p>Resident #45's electronic medical record revealed the last documented care plan meeting occurred on 8/20/24.</p> <p>Minimum Data Set (MDS) assessments were completed for Resident #45 on the following dates: 9/20/24 (quarterly), 12/2/24 (annual), 12/18/24 (quarterly), 1/20/25 (significant change in status), and 2/13/25 (quarterly).</p> <p>The quarterly MDS assessment dated [DATE] revealed Resident #45 had severely impaired cognition.</p> <p>An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #45 has not had a care plan meeting since 8/20/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.</p> <p>In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.</p> <p>4. Resident 91 was admitted to the facility on [DATE] with diagnoses that included heart disease and congestive heart failure.</p> <p>Minimum Data Set (MDS) assessments were completed for Resident #91 on the following dates: 10/11/24 (quarterly), 11/29/24 (quarterly), and 2/18/25 (quarterly).</p> <p>Resident #91's electronic medical record revealed the last documented care plan meeting occurred on 9/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The quarterly MDS assessment dated [DATE] revealed Resident #91 had moderate cognitive impairment.</p> <p>An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #91 had not had a care plan meeting since 9/17/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.</p> <p>In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.</p> <p>5. Resident #18 was admitted to the facility on [DATE] with diagnoses that included dementia and chronic kidney disease.</p> <p>Minimum Data Set (MDS) assessments were completed for Resident #18 on the following dates: 9/23/24 (quarterly), 10/22/24 (quarterly), 1/15/25 (quarterly), and 2/4/25 (quarterly).</p> <p>Resident #18's electronic medical record revealed the last documented care plan meeting occurred on 8/20/24.</p> <p>The quarterly MDS assessment dated [DATE] revealed Resident #18 had severe cognitive impairment.</p> <p>An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #18 has not had a care plan meeting since 8/20/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator.</p> <p>In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the care plan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.</p> <p>6. Resident #21 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus and hypertension.</p> <p>Minimum Data Set (MDS) assessments were completed for Resident #21 on the following dates: 9/2/24 (quarterly), 10/10/24 (quarterly), 1/6/25 (annual), and 2/6/25 (quarterly).</p> <p>Resident #21's electronic medical record revealed the last documented care plan meeting occurred on 8/26/24.</p> <p>The quarterly MDS assessment dated [DATE] revealed Resident #21 had moderate cognitive impairment.</p> <p>An interview was conducted with the facility Social Worker on 3/26/25 at 3:04 PM who stated Resident #21 has not had a care plan meeting since 8/26/24. She reported she was unsure why the care plan meetings had not been scheduled as she used the list of upcoming MDS assessments provided by the MDS Coordinator. The Social Worker stated she had a care plan meeting scheduled for 1/28/25 but Resident #21 was in the hospital. She stated she planned to schedule a care plan meeting for Resident #21 in April 2025.</p> <p>(continued on next page)</p>		

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F 0657  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	In an interview with the Administrator on 3/27/25 at 11:20 pm, she stated the Social Worker was responsible for scheduling the careplan meetings. She reported the care plan meetings should be scheduled according to the federal timeframes.		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387</b></p> <p>Based on record review and staff interviews, the facility failed to have effective systems in place for identifying the development of skin breakdown which delayed treatment and interventions. Resident #39's skin was intact on re-admission on 11/19/24. On 1/4/25 excoriation was noted on her buttocks. There were no further documented assessments until a wound assessment dated [DATE] recorded Resident #39 developed an unstageable (full thickness skin and tissue loss where the extent of tissue damage cannot be determined due to presence of slough, a yellow/white layer of dead skin tissue, or eschar, dry dead tissue, obscuring the wound bed) 5 centimeter (cm) by 5cm right buttocks pressure wound. Resident #39's right buttocks pressure wound deteriorated and required hospitalization for an infected right buttocks/sacral pressure wound on 2/17/2025. Resident #39 received intravenous antibiotic therapy and a debridement (a medical procedure to remove dead, damaged or infected tissue from a wound to promote healing and prevent infection) of the right buttocks pressure wound while in the hospital. Resident #39 was discharged back to the facility on [DATE] with orders for oral antibiotics for 5 days. The deficient practice occurred for 1 of 2 residents reviewed for pressure ulcer care (Resident #39).</p> <p>Findings included:</p> <p>Resident #39 was admitted to the facility on [DATE] with diagnoses including coronary artery disease and renal insufficiency. Resident #39 was discharged to the hospital and readmitted to the facility on [DATE].</p> <p>Resident #39's skin assessment dated [DATE] recorded there were no skin issues.</p> <p>There was no documentation observed in Resident #39's electronic medical record or on Resident #39's Medication Administration Record (MAR) to alert the nursing staff to conduct a weekly skin assessment.</p> <p>The care plan dated 11/19/2024 indicated Resident #39 was a potential risk for skin breakdown. Interventions included observing the skin weekly and notifying the nurse of any changes in the development of new skin impairments.</p> <p>Physician orders dated 11/19/2024 included a supplement that provided additional calories and protein 60 milliliters (mL) three times a day for weight management.</p> <p>Resident #39's recorded weight in the medical record on 11/20/2024 was 180.2 pounds (lbs).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #39 was cognitively intact with severely impaired hearing. Resident #39 was always incontinent of urine and stool and required total assistance with bed mobility and activities of daily living. There were no dental issues coded on the MDS for Resident #39. The MDS assessment further indicated Resident #39 was at risk for developing a pressure ulcer but was not marked as having a pressure ulcer or skin impairment.</p> <p>On 12/19/24 Resident #39 was ordered a high protein nutritional supplement 30mL daily for weight management.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #39's medical record documented skin assessments were conducted on 12/15/2024 with no skin issues recorded and on 1/4/2025 with skin excoriation (the act of abrading or wearing off the skin) recorded to the buttocks. There was no further documentation of the excoriation or assessment of Resident #39's skin until the Treatment Nurse's pressure wound assessment on 1/17/25.</p> <p>A review of nursing documentation from 11/19/2024 to 1/17/2025 in the electronic medical record recorded Resident #39 was turned and repositioned and provided incontinence care. There was no documentation of the development of a pressure wound for Resident #39.</p> <p>On 3/27/2025 at 1:36 pm in an interview with Nurse Aide (NA) #2, she stated Resident #39 required assistance in turning and incontinent care and Resident #39 was checked for incontinence and repositioned every two hours. She recalled Resident #39 not having any skin breakdown when admitted to the facility and stated she couldn't recall Resident #39's skin on her buttocks being red or irritated. She stated when she observed a quarter size red open area to Resident #39's buttocks while providing care, she informed the Treatment Nurse. NA #2 was unable to recall the date she informed the treatment nurse.</p> <p>Documentation of a wound assessment dated [DATE] by the Treatment Nurse recorded Resident #39 had an unstageable 5cm by 5cm right buttocks pressure wound. The right buttocks pressure wound assessment recorded the pressure wound was 90% dark eschar (dry dead tissue) and 10% pink tissue with moderate amount of serous exudate (drainage). There was no odor, tunnelling (narrow opening or passageway extending from a wound underneath the skin), or undermining (erosion that occurs under the edges of a wound) recorded. The Treatment Nurse recorded the physician and Resident #39's Representative were notified, and treatment was started with the application of silver alginate (highly absorbent, antimicrobial pad) and covered with a foam dressing.</p> <p>Physician orders dated 1/20/2025 included an order to cleanse the unstageable right buttock with normal saline, pat dry with gauze, apply skin prep to the periwound (skin around a wound) and allow to dry. Silver alginate was to be applied to the wound and the wound covered with a foam dressing every Monday, Wednesday and Friday.</p> <p>A review of Resident #39's January 2025 Medication Administration Record recorded Resident #39 received wound care as ordered.</p> <p>Resident #39's weight was recorded in the medical record on 1/24/2025 as 192.3 pounds that was a 12.1 lbs increase in weight.</p> <p>Dietary notes dated 1/30/2025 reported Resident #39 had an unstageable pressure wound to the right buttocks and Resident #39 was receiving a high protein nutritional supplement 30 milliliters daily and a supplement that provides additional calories and protein for persons at high risk for malnutrition 60 milliliters three times a day to aid in wound healing. The dietary note recorded Resident #39 consumed 50-100% of a regular mechanical soft diet and recommended ordering a Multivitamin (MVI) and Ascorbic Acid (Vitamin C) 500milligrams to further aid in wound healing.</p> <p>A review of Resident #39's January 2025 and February 2025 Medication Administration Record recorded Resident #39 was started on a Multivitamin (MVI) and Ascorbic Acid on 1/31/2025 and received the two dietary supplements, MVI and Ascorbic Acid as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Documentation of the wound assessment on 2/4/2025 by the Treatment Nurse recorded Resident #39's unstageable right buttocks pressure wound measured 5 cm by 5 cm with eschar. Moderate serous exudate was recorded with no tunneling, undermining, odor or signs of infection. The wound bed was described as 90% dry, dark eschar and 10% pink tissue. The Treatment Nurse recorded the physician and Resident #39's Representative was notified. The wound was cleansed with normal saline and pat dried with gauze. Skin prep (forms a protective film on the skin) was applied to the periwound and allowed to dry. Silver alginate was applied and covered with a foam dressing.</p> <p>Resident #39's weight was recorded in the medical record on 2/8/2025 as 177.3 lbs that was a 15 lbs weight loss.</p> <p>Physician progress notes dated 2/14/2025 recorded the nursing staff reported Resident #39 was refusing to eat and was unable to chew food due to pain. Resident #39's gum on the left upper canines was observed swollen and Nurse Practitioner #1 ordered Amoxicillin 500 milligrams three times a day for five days.</p> <p>Documentation of the wound assessment on 2/14/2025 recorded a stage IV (most severe form of pressure injury that extends through skin, underlying tissue, muscle and bone) right buttocks pressure wound measured 5cm by 5cm by 0.8 cm and there was 1 cm of undermining in the position of 6-11 o'clock of the wound and 0.7cm from the position of 2-5 o'clock. Heavy serous exudate was documented with no odor or sign of infection. The wound bed was recorded as 50% deep red tissue, 15% fascia (layer of connective tissue below the skin), 15% muscle and necrotic (dead tissue) with 15% stringy gray colored dead tissue and 5% adipose (fat) tissue. The wound assessment recorded the physician and Resident#39's Representative were notified. Treatment of the right buttocks pressure wound included cleaning with normal saline, patting the area dry, applying skin prep to the periwound and allowing it to dry. The wound was packed with saline-moistened polyurethane foam dressing impregnated with methylene blue and covered with a foam dressing. Resident #39's dressing was ordered to be changed every Monday, Wednesday and Friday.</p> <p>On 2/17/2025 a wound assessment note by the Treatment Nurse recorded Resident #39's right buttocks pressure wound was measuring 7cm by 11cm by 2cm and was recorded as a stage IV pressure ulcer with an opened area measuring 7cm by 4cm and a 7cm by 4cm patch of dark dry eschar beside the opened area. Documentation of the wound recorded the opened area was tunneling underneath the eschar area with a heavy serous exudate and 40% of the area was dark, dry eschar, 40% deep pink tissue, and 10 % fascia, 50% adipose tissue and 5% bone. The wound was cleansed with normal saline and packed with saline moistened polyurethane foam dressing impregnated with methylene blue and covered with a foam dressing. The physician and Resident #39's Representative was notified and Resident #39 was scheduled to attend an appointment at the wound clinic on 2/17/2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/2025 at 12:58 pm in an interview with the Treatment Nurse, she stated the nursing staff were to conduct and document skin assessments weekly and notify her when skin breakdown was identified. The Treatment Nurse stated she was aware of the excoriated skin to Resident #39's buttocks documented on the skin assessment dated [DATE] and it was treated with barrier cream. She stated NA #2 informed her on 1/17/2025 of an area to Resident #39 buttocks that was observed as black eschar and weekly assessments and treatments were started based on the skin protocol. She explained Resident #39 wound remained a stable eschar wound tissue until 2/14/2025 when an area of the dry dead tissue was observed opened with no odor or drainage. The Treatment Nurse explained she had called the wound clinic for a referral when the right buttocks pressure wound was identified and was scheduled to go to the Wound Clinic on 2/17/2025. She stated on 2/17/2025, Resident #39's wound was observed worsening due to increase in size, drainage and odor. She explained since Resident #39 was scheduled to attend her first initial visit to the wound clinic on 2/17/2025, she called and notified the wound clinic of the change in Resident #39's right buttocks pressure wound. She stated the wound clinic requested Resident #39 to attend the scheduled appointment at the wound clinic on 2/17/2024 and if needed, the wound clinic would send Resident #39 to the hospital for admission.</p> <p>The wound clinic notes dated 2/17/2025 recorded Resident #39 was presenting to the wound clinic for the first time with an existing stage IV pressure injury that had worsen. The wound clinic note recorded the right buttocks pressure wound was very foul smelling with a necrotizing (death of bodily tissue) appearance at the undermined areas that was very concerning for a necrotizing soft tissue infection (NSTI). The pressure wound located on the right buttock/sacral area was recorded measuring 3.5cm by 8cm by 2 cm with black, green, red and tan colored wound bed with moderate amount of green serous exudate. The periwound was recorded as blanchable erythema (redness) with no tunneling and 4.5 cm of undermining. The wound was cleansed and dressed, and the wound clinic consulted the hospitalist (physician that works at the hospital) to direct admit Resident #39 from the wound clinic to the hospital.</p> <p>A review of the hospital discharge summary dated 2/24/2025 recorded Resident #39 was admitted from the wound clinic due to foul smelling and worsening of right buttock/sacral pressure wound on 2/17/2025. During hospitalization , Resident #39 received debridement on 2/20/2025 of the right buttock/sacral pressure wound and intravenous (medical technique that involves administering fluids, medications and nutrients directly into a vein) antibiotics. Resident #39 was discharged from the hospital and readmitted to the facility on [DATE]. The discharge summary included physician orders for Amoxicillin-Potassium Clavulanate Tablet 875-125 milligram (mg) twice a day for wound infection for five days. There was no order for wound care on the discharge summary.</p> <p>Physician orders dated 2/24/2025 included the following orders: Amoxicillin-Potassium Clavulanate Tablet 875-125 milligram (mg) twice a day for wound infection for five days and cleansing the right buttock/sacrum with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze, pat dry with gauze and apply skin prep to periwound and allow to dry thoroughly. The application of an enzymatic debriding ointment was ordered to the areas of yellow/white dead skin tissue and the wound packed with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze and covered with a bordered foam dressing every day for a stage IV pressure ulcer.</p> <p>A review of Resident #39's February 2025 and March 2025 MAR recorded Resident #39 received the prescribed antibiotic and wound treatments.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/27/2025
NAME OF PROVIDER OR SUPPLIER  Greendale Forest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE Second Street Snow Hill, NC 28580	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Physician orders dated 3/25/2025 included cleansing the right buttock/sacral wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze, patting the area dry with gauze, applying a thin layer of zinc-oxide based ointment and then nystatin (antifungal medication) powder to the periwound, applying an ointment that removes dead tissue to the areas of yellow/white dead tissue and packing the wound with a topical super-oxidated solution formulated to combat bacteria and facilitate wound healing moistened gauze and covering with a bordered foam dressing every day and evening shift.</p> <p>On 3/25/2025 at 3:03pm, the Treatment Nurse was observed changing Resident #39's right buttock/sacral pressure wound. The Treatment Nurse stated that when Resident #39 attended a wound clinic visit on the morning of 3/25/2025, the right buttock/sacral pressure wound was measured and wound clinic notes recorded the pressure wound as 5.3cm by 10 cm by 1 cm and ordered wound care to be performed twice a day. Resident #39 right buttocks/sacral open wound was observed with black colored tissue to the lower left portion of the wound, the center of the wound with a small white patch tissue and the remaining tissue was red in color. There was no foul odor detected from the right buttocks/sacral wound. The Treatment Nurse cleansed the wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze, applied a zinc-oxide based ointment to the edges covered with nystatin powder, applied an ointment that removes dead tissue to the dark colored tissue inside the wound and packed the wound with a wound solution that contains pure hypochlorous acid that fights bacteria and infection moistened gauze and covered with a foam dressing as ordered by the physician.</p> <p>On 3/27/2025 at 1:25 pm in an interview with Nurse #4, she stated skin assessments were to be conducted by the nursing staff weekly and documented in Resident #39's medical record. Nurse #4 stated she did not know why Resident #39 skin assessments were not conducted weekly.</p> <p>On 3/27/2025 at 12:50 pm in an interview with the Director of Nursing (DON), she stated skin checks were performed daily on residents during baths, showers, incontinence care and with weekly nursing skin assessments. She stated nursing staff were to observe for any changes in resident's skin and report to the Treatment Nurse as needed. She stated skin assessments should have been conducted and documented by the nursing staff for Resident #39 and she was unable to provide a reason why Resident #39's skin assessment were not performed weekly. She stated Resident #39's right buttocks/sacral pressure wound was discussed in morning and evening meetings and Resident #39's wound worsened because Resident #39 stopped eating due to dental issues that were treated.</p> <p>On 3/27/2025 at 1:45 pm in a phone interview with the Medical Director, he stated the Treatment Nurse started providing wound care to Resident #39 when notified of the skin breakdown on 1/17/2025. He explained he reviewed the Treatment Nurse wound assessments weekly and was scheduled to be evaluated at the wound clinic on 2/17/2025. He stated there were no reports of infection to Resident #39's pressure wound until 2/17/2025 and Resident #39 was seen at the wound clinic as scheduled on 2/17/2025. He stated due to the Resident #39's comorbidities, Resident #39 was at risk for developing the pressure wound and the deterioration of the right buttock pressure wound was unavoidable.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502</b></p> <p>Based on record review, observations, and staff interviews the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 3 of 3 residents reviewed with urinary catheters (Resident # 8, Resident # 5 and Resident # 14).</p> <p>The findings included:</p> <p>1. Resident # 8 was admitted to the facility on [DATE] with diagnoses which included acute kidney failure, urinary retention, and acute cystitis without hematuria (a lower urinary tract infection without blood in the urine).</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 8 had severely impaired cognition. The assessment indicated Resident # 8 was dependent upon staff for all of his activities of daily living (ADL). Resident # 8 was coded for an indwelling urinary catheter.</p> <p>Resident #8's care plan dated 3/12/25 revealed Resident #8 was at the risk for infection due to the alteration pattern of urinary elimination with the use of an indwelling urinary catheter. Interventions included maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary collection bag below the level of the urinary bladder. Interventions did not include keeping the urinary collection bag and tubing off the floor.</p> <p>An initial observation was conducted on 3/24/25 at 12:39 pm of Resident # 8 as he was lying in his bed. A urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's left side of the bed (with a solid, blue-colored side of the bag facing the window). The entire bottom of the urinary catheter drainage bag was resting on the floor.</p> <p>An additional observation was conducted on 3/24/25 at 3:03 pm Resident # 8's urinary catheter drainage bag was observed to be hanging off the bedframe on the resident's left side of the bed. The entire bottom of the urinary catheter drainage bag was resting on the floor.</p> <p>During an interview on 3/26/25 at 6:19 am with Nurse Aide (NA) # 1, he stated the urinary catheter bags were not supposed to be touching the floor due to contamination and infection control. NA# 1 repositioned the urinary catheter drainage bag so that it was not resting on the floor.</p> <p>In an interview with Nurse # 1 on 3/26/25 at 6:45 am, she stated she was the hall nurse assigned to care for Resident #8. Nurse # 1 was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, It shouldn't touch the floor. The nurse stated she thought the urinary catheter drainage bag ended up touching the floor due to the low position of Resident # 8's bed.</p> <p>During a subsequent observation on 3/26/25 at 10:15 am, Resident # 8 was observed in his bed with his urinary catheter drainage bag hanging from the left side of the bed and again the catheter drainage bag was touching the floor.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Greendale Forest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1304 SE Second Street Snow Hill, NC 28580	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/2025 at 7:35 am in an interview with the Director of Nursing, she stated to prevent contamination urinary drainage bags were not to be touching or placed on the floor.</p> <p>41387</p> <p>2. Resident #14 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #14 was moderately cognitively impaired, was incontinent of stool and had a indwelling urinary catheter for urine elimination.</p> <p>Resident #14's care plan dated last reviewed 2/25/2025 listed Resident #14 at the risk for infection due to the alteration pattern of urinary elimination with the use of an indwelling urinary catheter. Interventions included maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary collection bag below the level of the urinary bladder. Interventions did not include keeping the urinary collection bag off the floor.</p> <p>Review of a hospital discharge summary dated 3/12/2025 reported Resident #14 was treated for a urinary tract infection with antibiotics during the hospitalization .</p> <p>On 3/26/2025 at 6:20 am, Resident #14's urinary collection bag was observed lying on the floor. Nurse Aide #1 was observed in Resident #14's room providing care to Resident #14's roommate.</p> <p>On 3/26/2025 at 6:29 am, NA #1 was observed exiting Resident #14's room and Resident #14's urinary collection bag was observed lying on the floor. NA #1 stated he had attached the urinary collection bag to the bed and Resident #14's urinary collection bag must have fallen to the floor. NA #1 stated Resident #14's urinary collection bag was not to touch the floor to prevent contamination. NA #1 was observed re-entering Resident #14's room to re-attach Resident #14's urinary collection bag to the bed frame. NA #1 was observed placing the urinary collection bag into a dark blue storage bag that was hanging on the bed frame and touching the floor and raising Resident #14's bed enough to prevent the dark blue storage bag from touching the floor.</p> <p>On 3/26/2025 at 7:35 am in an interview with the Director of Nursing, she stated to prevent contamination urinary collection bags were not to be touching or placed on the floor.</p> <p>3. Resident #5 was admitted to the facility on [DATE] with diagnoses including retention of urine.</p> <p>Resident #5's care plan included a focus dated last revised on 8/6/24 indicating Resident #5 was at risk for an infection due to an altered pattern of urinary elimination with the use of a indwelling catheter. Interventions included the use of a suprapubic catheter ( a thin, sterile tube that is inserted through a small cut in the lower belly used to drain urine from the urinary bladder) and maintaining a closed drainage system with an unobstructed urine flow and keeping the urinary catheter collection bag below the level of the bladder. There was no intervention for keeping the catheter collection bag off the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A quality assurance note dated 1/26/2025 recorded Resident #5 was admitted to the hospital from 12/10/2024 to 12/19/2024 for sepsis (a serious condition in which the body responds improperly to an infection) secondary to an urinary tract infection.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was severely cognitively impaired, was incontinent of stool and had an indwelling catheter for urine elimination.</p> <p>On 3/24/2025 at 11:01 am, Resident #5's bed was observed in the lowest position and the urinary collection bag was observed touching the floor.</p> <p>On 3/25/2025 at 9:08 am, a tube on the urinary collection bag that was used to empty the urinary collection bag was observed clamped and touching the floor. There were no staff observed in the hallway near Resident #5's room to address the concern.</p> <p>On 3/26/2025 at 7:35am in an interview with the Director of Nursing (DON), the DON was informed observing Resident #5's urinary collection bag and the tube used to empty the urinary collection bag touching the floor. The DON stated to prevent contamination the urinary collection bag and the tube used to empty the urinary collection bag should not be touching the floor.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387</b></p> <p>Based on record review, observations and staff interviews, the facility failed to administer supplemental oxygen as prescribed by the physician for 1 of 1 resident reviewed for oxygen use (Resident #27).</p> <p>Findings included:</p> <p>Resident #27 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD and congestive heart failure (CHF).</p> <p>Physician orders dated 3/20/2025 included an order for continuous oxygen at four liters per minute by nasal cannula every shift for respiratory disease.</p> <p>The significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #27 was moderately cognitively impaired and was receiving oxygen therapy.</p> <p>Resident #27's care plan dated 3/25/2025 included a focus for the potential or actual ineffective breathing pattern related to COPD and CHF. Interventions included oxygen at four liters per minute by nasal cannula.</p> <p>A review of Resident #27's March 2025 Medication Administration Record (MAR) recorded Resident #27 received four liters of oxygen via nasal cannula each shift on 3/20/2025 through 3/26/2025 and recorded oxygen saturations (measurement of how much oxygen present in the blood) ranged from 95% to 99%.</p> <p>On 3/25/2025 at 9:04 am, Resident #27 was observed lying in bed with the head of bed elevated and receiving oxygen by nasal cannula at two liters per minute. Resident #27 was observed with no signs or symptoms of respiratory distress.</p> <p>On 3/26/2025 at 6:20 am, Resident #27 was observed lying in the bed with her eyes closed and receiving oxygen at two liters per minute by nasal cannula. Resident #27 was observed with no signs or symptoms of respiratory distress.</p> <p>On 3/26/2025 at 7:05 am in an interview with Nurse #2, who worked the 11:00 pm to 7:00 am shift, she stated Resident #27 wore oxygen continuously at four liters per minute and Resident #27 was known to adjust the controller of the oxygen concentrator. Nurse #2 stated the oxygen concentrator was at four liters per minute when she checked it on the 11:00pm to 7:00am shift and was unable to recall specific time it was checked.</p> <p>On 3/26/2025 at 7:26 am, Nurse #2 checked the oxygen concentrator and stated Resident #27's oxygen concentrator was set at two liters per minute. Nurse #2 was observed verifying the physician order for oxygen and adjusted Resident #27's oxygen concentrator to four liters per minute.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/2025 at 7:28 am in an interview with Nurse #3, who worked the 7:00 am to 3:00 pm shift, she stated the nursing staff were to check Resident #27's oxygen concentrator every shift to ensure the oxygen concentrator was set at four liters per minute and stated Resident #27 had been on oxygen at four liters per minute for as long as she could remember.</p> <p>In a follow up interview with Nurse #3 on 3/26/2025 at 5:03pm, she stated she had charted Resident #27 on four liters of oxygen on the 3/25/26 for the 7:00 am to 3:00 pm shift because Resident #27 was supposed to receive four liters of oxygen. She stated she had not looked at the oxygen concentrator to verify the oxygen concentrator was set at four liters per minute. She stated Resident #27 had been observed turning the controller on the oxygen concentrator in the past.</p> <p>On 3/26/2025 at 7:40 am, in an interview with the Director of Nursing (DON) with the Administrator present, the DON stated Resident #27 had always received oxygen therapy at four liters per minute. After reviewing Resident #27's electronic medical record, the DON stated there was no order to titrate Resident #27's oxygen to two liters per minute and the nursing staff had been charting on the MAR Resident #27 was receiving oxygen at four liters per minute when checking the oxygen concentrator. The Administrator recalled the facility calling to verify Resident #27's oxygen order on 3/20/2025 for four liters per minute by nasal cannula after readmission to the facility.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>49502</p> <p>Based on record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing information for 16 of 114 days reviewed for posted nurse staffing (12/9/24, 12/16/24, 12/30/24, 1/4/25, 1/14/25, 1/22/25, 1/27/25, 1/28/25, 1/30/25, 2/7/25, 2/17/25, 2/21/25, 2/23/25, 2/28/25, 3/11/25, and 3/16/25).</p> <p>The findings included:</p> <p>The daily posted nurse staffing sheets were reviewed for the period of 12/1/24 through 3/24/25 and revealed the following:</p> <p>-December 2024 did not have any RN documented as working for all 3 shifts on the following days: 12/9/24, 12/16/24, and 12/30/24.</p> <p>-January 2025 did not have any RN documented as working for all 3 shifts on the following days: 1/4/25, 1/14/25, 1/22/25, 1/27/25, 1/28/25, and 1/30/25.</p> <p>-February 2025 did not have any RN documented as working for all 3 shifts on the following days: 2/7/25, 2/17/25, 2/21/25, 2/23/25, and 2/28/25.</p> <p>-March 2025, for the period of 3/1/25 through 3/24/25, did not have any RN documented as working for all 3 shifts on the following days: 3/11/25 and 3/16/25.</p> <p>Review of employee timecard punches provided by the Administrator verified there had been RN coverage in the building for all the above dates and the Registered Nurse (RN) staffing information posted was incorrect.</p> <p>During an interview on 3/26/25 at 3:28 pm with the Scheduler, she stated she was responsible for the staff posting and she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing.</p> <p>During an interview on 3/27/25 at 2:15 pm with the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being done, and the Scheduler did not know the posted staffing should be updated with the actual staff on each shift.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41387</p> <p>Based on record review, observation and staff interviews, the facility failed to maintain an accurate medical record in documenting the administration of oxygen for 1 of 31 residents whose medical records were reviewed (Resident #27).</p> <p>Findings included:</p> <p>Physician orders dated 3/20/2025 included an order for continuous oxygen at four liters per minute by nasal cannula every shift for respiratory disease.</p> <p>A review of Resident #27's March 2025 Medication Administration Record (MAR) recorded Resident #27 received four liters of oxygen via nasal cannula each shift on 3/20/2025 through 3/26/2025 and recorded oxygen saturations (measurement of how much oxygen present in the blood) ranged from 95% to 99%.</p> <p>On 3/25/2025 at 9:04 am, Resident #27 was observed lying in bed with the head of bed elevated and receiving oxygen by nasal cannula at two liters per minute. Resident #27 was observed with no signs or symptoms of respiratory distress.</p> <p>On 3/26/2025 at 6:20 am, Resident #27 was observed lying in the bed with her eyes closed and receiving oxygen at two liters per minute by nasal cannula. Resident #27 was observed with no signs or symptoms of respiratory distress.</p> <p>On 3/26/2025 at 7:28 am in an interview with Nurse #3, who worked the 7:00am to 3:00 pm shift, she stated the nursing staff were to check Resident #27's oxygen concentrator every shift to ensure the oxygen concentrator was set at four liters per minute and stated Resident #27 had been on oxygen at four liters per minute for as long as she could remember.</p> <p>In a follow up interview with Nurse #3 on 3/26/2025 at 5:03pm, she stated she had charted Resident #27 on four liters of oxygen on the 3/25/26 for the 7:00 am to 3:00 pm shift because Resident #27 was supposed to receive four liters of oxygen. She stated she had not looked at the oxygen concentrator to verify the oxygen concentrator was set at four liters per minute.</p> <p>On 3/26/2025 at 7:40 am, in an interview with the Director of Nursing (DON) with the Administrator present, the DON stated Resident #27 had always received oxygen therapy at four liters per minute. After reviewing Resident #27's electronic medical record, the DON stated there was no order to titrate Resident #27's oxygen to two liters per minute and the nursing staff had been charting on the MAR Resident #27 was receiving oxygen at four liters per minute.</p>		