DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

SEP 17 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to schedule follow-up eye appointments for 2 of 4 sampled residents (Resident #72 and #73) reviewed for vision impairment. Findings included: 1. Resident #73 was admitted to the facility on 06/04/08 and readmitted on 12/29/12. The resident's documented diagnoses included blindness (left eye), prosthesis (left eye), neurotropic keratitis (inflammation of the cornea), leucoma (white opaque scarring of the cornea), and cerebrovascular accident with hemiplegia. A 04/25/12 eye exam performed by the facility's on-site doctor of optometry (OD) documented Resident #73 was seen due to diabetes and dry eyes. The assessment documented "neurotropic keratitis" and "diabetes-fundus not visible". The OD recommended the use of Lacrilube ophthalmic ointment four times daily and a return visit in six months.	F 313	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles D. Hale Jr.	ADMINISTRATOR	9-11-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 1 Record review revealed Resident #73 was next sent for an eye exam to a hospital-associated satellite clinic on 03/29/13. A Report of Consultation which was returned with the resident documented, "There is no capability in this satellite office to examine a patient on a stretcher. This patient needs to follow up with their ophthalmologist on site or eye care provider at (the main campus of the hospital-based eye clinic)." Record review revealed the resident was not sent out for further eye exams until after surveyor intervention. Resident #73's 04/12/13 annual minimum data set (MDS) documented the resident's cognition and vision were severely impaired, and corrective lenses were not used to help address the resident's vision problems. Visual Function triggered on the resident's 04/12/13 Care Area Assessment (CAA) Summary. The Visual Function CAA Worksheet documented Resident #73 was blind on interview, had peripheral vision or other visual problems that impeded his ability to eat/walk/interact with others, had difficulty negotiating the environment due to vision problems, and had difficulty seeing television/reading material of interest/participating in activities of interest because of vision problems. It was decided that visual function would be carried forward to the resident's care plan. Resident #73's 07/12/13 quarterly MDS documented the resident's cognition and vision were severely impaired, and corrective lenses	F 313	F313 Resident # 73 was seen by the ophalmologist on 8-28-13 for a follow up eye appointment with no new orders received or concerns identified. A follow up eye appointment for 9-13-2013 was made on 8-28-13 by the DON for resident #72. A 100% audit was made by DON and administrative nurses on 8-27-13 on all active residents to ensure that follow up on eye doctor recommendations have been scheduleded for follow up appointments with follow up appointments made as necessary. To prevent a re-occurrence, the DON or Administrative Nurses will review the eye doctor recommendations to ensure that follow–up appointments are made. They will be recorded in the "In House Eye Doctor Visits" logbook maintained in the DON/Administrative Nurse office. The DON will audit the logbook utilizing a QI tool weekly x4 weeks, then monthly x 4 months and then quarterly on an ongoing basis to ensure follow up eye appointments to include those for Residents # 73 and Resident # 72 are made timely. The DON will take the necessary action upon the identification of any potential follow up appointment concerns as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 2 were not used to help address the resident's vision problems. The resident's 07/25/13 care plan identified "Inability to focus on objects, discriminate color, adjust to changes in light and dark characterized by pain, decreased/impaired vision related to blindness" as a problem. The goal was to keep the resident free from injuries and keep him safe and in a secure environment through his next evaluation. Approaches to this problem included adapting the resident's environment to the resident's individual needs to ensure resident was able to recognize objects/his own environment, having staff announce themselves when entering the room and explaining all procedures to the resident, and keeping the resident's environment free of small objects and clutter. Review of Resident #73's August 2013 medication administration record (MAR) revealed the resident was still receiving Lacrilube ophthalmic ointment, applied to his right eye, four times daily. At 2:25 PM on 08/28/13 Nurse #1, who cared for Resident #73 on first shift, stated the paperwork from consulting physicians was usually sent back to the facility with returning residents. She explained it was the responsibility of the hall nurses to fax any consult recommendations to the primary physician for approval and to schedule any follow-up appointments and arrange the transportation to them. She reported each hall had a black book to record these appointments in. The nurse commented the facility's on-site OD examined residents in the facility quarterly, and the facility could also send resident's to his office. She was unable to explain	F 313	F313 To ensure that follow up appointments are made on an ongoing basis, the results of the eye appointment audits will be forwarded by the DON to the Executive QI Committee monthly x3 then quarterly for review, necessary follow up as deemed necessary, and to determine the need and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 3 why Resident #73 was not seen by this on-site OD after the hospital-based satellite clinic was unable to see him on 03/29/13. According to Nurse #1, Resident #73 experienced intermittent drainage from the prosthetic eye, but received eye drops for this. She stated the resident's family had no recent concerns about his vision, and the resident did not read or watch television. At 3:55 PM on 08/28/13 Nurse #3, who cared for Resident #73 on second shift, stated unless residents had a procedure or labs drawn which did not produce immediate results, they came back to the facility with their consult recommendations. She reported the hall nurses checked these recommendations to write any new orders (with primary physician approval) and to set up any follow-up appointments. She commented the hall nurses recorded the appointment in hall notebooks, and arranged for the transportation. Nurse #3 was unable to explain why Resident #73 was not seen by the on-site OD after the hospital-based satellite clinic was unable to see him on 03/29/13. According to Nurse #3, Resident #73 experienced intermittent drainage from the prosthetic eye, but received eye drops for this. At 4:03 PM on 08/28/13 the director of nursing (DON) stated the facility's on-site OD was last in the facility on 06/19/13. She was unable to explain why this OD did not see Resident #73 on this date to assess his vision. According to the DON, the on-site OD saw residents in the facility quarterly, and in acute situations the facility could send residents to his office. She explained that the OD kept his own records as to which residents in the facility were in need of follow-up vision appointments. The DON reported currently	F 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 4 there was no audit or back-up system utilized by the facility to make sure residents actually received the follow-up appointments recommended by the on-site OD. She stated her expectation was when Resident #73 was unable to be seen by the satellite vision center on 03/29/13, the resident should have been scheduled to see the on-site OD on his next visit to the facility. 2. Resident #72 was admitted to the facility on 4/13/12 with cumulative diagnoses of hypertension, vascular dementia and aphasia. Resident #72 had short and long term memory problems and was moderately cognitively impaired in daily decision making. Resident #72's Quarterly Minimum Data Set (MDS), dated 06/24/13, showed Resident #72 had impaired vision and no corrective lenses were being used. Review of Resident #72's Eye Evaluation, dated 10/24/12, showed an assessment of Asteroid Hyalosis and Nuclear Cataract. The plan was for a six month follow-up. Review of Resident #72's Nursing Progress Notes from 02/28/13-08/28/13 did not show any record of Resident #72 receiving a six month follow-up. In an interview on 08/28/13 at 2:25 PM, Nurse #1 stated the procedure for consults consisted of the transport personnel bringing the paperwork to the hall nurse if the resident were at an appointment	F 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 5	F 313		

outside the facility. Any consult (done inside or outside the facility) should then be faxed to the primary physician for their signature. The hall nurse should then schedule the follow-up appointment if one is required, arrange for transport and notify the resident's family. The nurse should note on the consult that it was faxed to the physician and add the date and time. She indicated there was no specific person responsible for scheduling follow-up appointments. Nurse #1 indicated that each nurse needed to schedule appointments for her assigned residents. Nurse #1 indicated that the Doctor of Optometry (OD) used by the facility came into the facility and also saw the residents in his office. She indicated the OD came to the facility on a quarterly basis.

A review of the 400 hall appointment book on 8/28/13 at 2:45 PM did not show any appointments for eye care follow-ups for Resident #72.

In an interview on 08/28/13 at 3:20 PM, Nurse #2 indicated the hall nurse who received the consult would make the follow-up appointment and place it in the appointment book. Transport would be arranged and the consult would be faxed to the physician. She stated that if a follow-up was scheduled for six months but the OD would not be in the facility at that time the resident should be sent out to the OD's office.

In an interview on 08/28/13 at 4:05 PM, the Director of Nursing (DON) stated the OD came to the facility quarterly. She indicated he kept a log of who he needed to see when he came in. The DON indicated that she provided a current census but did not track who needed to be seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 6 for follow-ups. She stated she relied on the OD to keep track of who needed to be seen. She indicated it was the responsibility of the facility to make sure follow-ups were completed. The DON stated there was no system in place so the facility would know who needed to be seen for follow-up appointments. She indicated it was her expectation that resident follow-ups were completed and that she expected the facility to keep up with which residents needed to be scheduled for follow-up examinations.	F 313		

FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY

- [x] Life Safety Code (405.1134a)
- [ ] Physical Environment
- [ ] 7-Day R.N. Requirement
- [ ] Patient Room Size (405.1134c)
- [ ] Medical Director (405.1911b)
- [ ] Beds Per Room (405.1134e)

1. Name of Facility Green Dale Forest

   Address 13041 SE Second St. Snow Hill, NC. 28580

2. Type Facility: SNF

   Program: XVIII/XIX [x] XIX [ ]

3. Vendor No. _____

   Provider No. 34-5366

4. Date of Survey: Life Safety Code 9-17-13

   General _____

5. Expiration Date of Current Agreement: 10-25-13

6. State Agency recommendation: [x] Approved [ ] Not Approved

   [x] Waiver/Variance Previously Approved

7. Reason for Recommendation: K-67 annual waiver for using Corridir as Return air plennum

8. Period for which Waiver/Variance is Recommended: 1 year

9. 10/28/13
   Date

10. _____
    Authorizing Signature of State Agency

TO BE COMPLETED BY REGIONAL OFFICE

11. Waivers/Variance Approved

    (a) _____
    (b) _____
    (c) _____
    (d) _____

12. Waivers/Variance Not Approved

    (a) _____
    (b) _____
    (c) _____
    (d) _____

3. _____
   Program Reviewer Signature

   _____
   Date

4. _____
   Discipline Reviewer Signature

   _____
   Date

5. _____
   Authorizing Signature
   Acting Director, Survey & Certification

   _____
   Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A. Based on observatio on 03/17/2013 the facility is a type V protected, fully sprinkled with (132) one-hundred and thirty two total beds.	K 000	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	10-25-13
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 09/17/2013 there were no dampers in the ceiling diffusers in the house keeping office and the scheduler office. 42 CFR 483.70 (a).	K 012		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: A. Based on observation on 09/127/2013 the smoke door near room 302 failed to close upon activation of the fire alarm.	K 027		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Charles J. Hall | ADMINISTRATOR | 10-10-13

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.

CD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 1 42 CFr 483.70 (a)	K 027	K 012 Dampers have been installed in the ceiling diffusers in the house-keeping supervisor's and scheduler's offices. There are no other ceiling diffusers in the facility that require a radiation damper. The ceiling diffusers in the house-keeper's and scheduler's offices will be inspected monthly by maintenance for three consecutive months to ensure that they are functioning properly. K 027 The smoke door on the 300 hall has been repaired to close and latch properly. The maintenance supervisor or designee will inspect all doors in the facility on a monthly basis to ensure that all doors close and latch properly. The results of the monthly maintenance inspection of all doors in the facility will be included for review in the facility safety program to ensure continued compliance.	10-25-13
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: A. Based on obsevation on 09/17/2013 the corridor is being used as a return air plenum. If a waiver is requested the following is required a. (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm system must shut down all air handling units when activated. 42 CFR 483.70(a)	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 02 - BUILDING 02 B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A. Based on observatio on 03/17/2013 the facility is a type V protected, fully sprinkled with (132) one-hundred and thirty two total beds.	K 000	K 067 A waiver request is attached to the Plan of Correction. The provider certifies that the following condition: are met: 1. Air handling units are equipp with smoke detectors. 2. There is a complete corridor smoke detection system. 3. Smoke detectors are wired t(the fire alarm system. 4. The fire alarm system will sh(down all air handling units when activated.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 09/17/2013 there were 02 cylinders both full and empty mixed in the 02 storage at the nusres station. 42 CFR 483.70 (a)	K 076		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Charles D Hall | ADMINISTRATOR | 10-10-13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ;her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ıllowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ·ogram participation.

cD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 03 - BUILDING 03 B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND ST SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A. Based on observatio on 03/17/2013 the facility is a type V protected, fully sprinkled with (132) one-hundred and thirty two total beds. B. Based on observation on 09/17/2013 there were no LSC deficiencies noted in buillding #3.	K 000	K 076 Oxygen storage has been corrected so that full and empty cylinders are not mixed at the 500 and 600 hall nurses' station. Maintenance or designee will inspect the the oxygen racks daily for five days to ensure that empty and unsused oxygen cylinders are stored in the appropriate, labeled rack, then inspect weekly on a regular basis. The results of the weekly inspections will be included for review in the facility safety program to ensure ongoing compliance.	10-25-13

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles D. Hall Jr.	ADMINISTRATOR	10-10-13

.ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days)llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

CD