PRINTED: 12/28/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				ATE SURVEY DMPLETED	
		345014	B. WING _			l	C / 19/2016	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>		FREET ADDRESS, CITY, STATE, ZIP CODE	10/	19/2016	
	10 113 211 011 001 1 21211				201 CAROLINA STREET			
GOLDEN	LIVINGCENTER - GREEN	NSBORO			REENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 241 SS=D	The facility must pron manner and in an env enhances each reside	note care for residents in a vironment that maintains or ent's dignity and respect in	F2	241			11/16/16	
	full recognition of his This REQUIREMENT by: Based on observatio interviews and record provide care in a man resident's dignity by r timely for residents no activities of daily living 3 sampled residents in (Resident # 2, and Re Findings Included: 1. Resident #2 was a 9/16/2016 with currer depressive disorder, with diabetic nephrop Resident #2 Minimum 10/3/2016 revealed R cognitively impaired. extensive assistance toilet use and persona The resident was free bladder and always in	or her individuality. I is not met as evidenced In, resident, family and staff I reviews the facility failed to mer to maintain the not answering call bells eeding assistance with Ig. This was evident for 2 of reviewed for dignity. esident #4) I dmitted to the facility on not diagnoses of major and type 2 diabetes mellitus athy. In Data Set (MDS) dated tesident #2 was moderately The resident required with bed mobility, dressing, all hygiene. I quently incontinent of incontinent of bowels.			Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provided the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state law. F 241 Resident #4 was discharged on 11/12/7 Resident #2 had call light answered at 2:40pm on 10/17/16 with incontinence care provided. Barrier cream applied to buttocks. Resident #4 received addition incontinence care on 10/18/16. Housekeeping cleaned the room and wheelchair on 10/18/16. NA #4 received education on 10/18/16 regarding proper incontinence care and changing of glow Beginning 11/8/16, 100% of residents were considered.	er of of se 16. hal ed r ves.		
	on 10/17/2016, she re waiting 30 minutes fo her. Resident #2 state Resident #2 indicated	with Resident #2 at 2:00PM evealed that she had been r staff to come and change ed her " butt was burning " . I that it ' s like this all the nat I have to wait so long,			be interviewed if they have a Brief Interview of Mental Status (BIMS) score 8 or higher to determine if resident feels their call lights are being answered time and there are no additional concerns wincontinence care. Beginning 11/8/16,	s ely		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/09/2016

Electronically Signed

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION (X3) DATE SU COMPLE		TE SURVEY MPLETED	
		345014	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343014	5:	CTDI	EET ADDRESS, CITY, STATE, ZIP CODE	1	0/19/2016
NAME OF F	ROVIDER OR SUFFLIER						
GOLDEN	LIVINGCENTER - GREE	NSBORO		1201 CAROLINA STREET			
				GRE	EENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	Continued From page	e 1	F 2	241			
	that this made her fe	e " . Resident #2 indicated el bad. e Resident #2 room on]	Director of Nursing Services, Assistar Director of Nursing Services, or desig will educate all facility staff on their no scheduled shift related to timeliness of	nee ext	
		M a clock on the wall in front		- 1	answering call lights. All staff membe are to respond to call lights. If the sta		
		dicated that was how she			member is unable to complete the	-	
		k staff to answer her call bell			resident request, the employee will no	otify	
	and provide care				appropriate personnel who will respon		
	for her.			t	timely to the request.		
		ation of Resident #2 's room		- 1	Beginning 11/8/16, all Department		
		016 at 2:00PM through t's call bell was activated.			Managers will randomly audit call ligh response times 5 times weekly for 8	ı	
		oved the blanket from her			weeks, then 3 times weekly for 8 week	ks	
		ne resident had a brief on.		- 1	with daily zone rounds. Audits will be		
	Observation of the br			- 1	presented in morning meeting 5 times	3	
		seen through the brief.			weekly for 8 weeks and reviewed.		
	There was a foul odo	_			·		
				-	The results of these audits will be		
	Observations on 10/1	17/2016 at around 2:40 PM		r	reviewed by the Director of Nursing		
	revealing Nursing As	sistant (NA) #2 walked into			Services or Executive Director and		
	the Resident #2 room	n's		- 1	brought to the Quality Assessment		
					Performance Improvement Committe	е	
		g Assistant (NA) #2 on			meeting by the Director of Nursing		
		M revealed that the reason			Services or the Executive Director. A	ny	
		ng to change and answer			ssues or trends identified will be	.	
		ell was because the facility			addressed by the Quality Assessmen		
		ich made it hard to get to nely manner. NA #2 revealed			Performance Improvement Committe they arise and the plan will be revised		
		two nursing assistants for the		- 1	needed to ensure continued compliar		
		edule this morning. NA#2			Audits will be reviewed monthly x 4	.50.	
		d 30 residents to provide		- 1	months at Quality Assessment		
	care for this morning.			F	Performance Improvement Committe beginning 11/8/16.	е	
		vith the interim Director of					
		0/19/2016 at 11:30AM she on was that staff would					
		call bell within 5 to 15					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345014	B. WING		C 10/19/2016
	ROVIDER OR SUPPLIER	NSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401	10/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 241	provided for the residence expectation that with respect and digration on 10/19/2016 at 1:0 expectation for staff timely manner and president. Administrate should not have to ward and the staff treatwould be all staff treatworks.	e and treatment were dent. ADON indicated that staff would treat all resident nity. with the interim Administrator	F 24	11	
	10/12/2016 with cumincluded major deprepain due to trauma. Record review reveal Data Set (MDS) assocare. Interview with the MI 11:00 AM revealed Foriented and able to The MDS Nurse indivextensive to total assexcept for eating. For Resident#4 was alway bladder. Observation of incom Nursing Assistant #4	admitted to the facility on aulative diagnoses which ression disorder and chronic led no available Minimum ressment or written plan of lessident #4 was alert, make her needs known. Cated Resident #4 required required required sistance from staff for all adls wither interview revealed rays incontinent of bowel and linence care provided by (NA) on 10/18/16 at 10:25 M was conducted. Resident an episode of bowel			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345014	B. WING		C 10/19/2016
	ROVIDER OR SUPPLIER	ENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 241	observed stool was the brief, in between and buttocks. Conti NA #4 wet the ends wash cloths with wa NA #4 removed stood #4 then wet several water and shampood Additional stool was resident 's skin. Ag and the ends of a closhampoo/body wash groin was cleansed wiped with end of the outer labia was not a clean brief and cloth Interview on 10/18/1 revealed this was he incontinence care. Interview on 10/18/1 Director of Nurses (I expectations were the body, mouth car and feet and hands Interview with Resid 10:30AM revealed Nower instead of we (referring to the incontinence care and treatments he was embarrassed and treatment. Cont Resident #4 stated the answering her call be desired.	removed the soiled brief and on the outside top portion of a the resident 's thighs, legs nuous observations revealed of a white cloth towel and ter at the bathroom sink and of from the resident's skin. NA more cloth washcloths with /body wash at the sink. then removed from the ain, NA #4 wet 3 washcloths oth towel with water and the n at the sink. The resident 's with the wash cloth then e wet towel. The resident 's cleansed. NA #4 placed a ing on the resident. 6 at 11:30 AM with NA #4 er routine for providing 6 at 1:12 PM with the Interim DON) revealed her ne body wash be rinsed off e and hair care be performed be washed during care. ent #4 on 10/19/2016 at IA #4 should have given her a letting wash cloths at the sink on tinence care observed on #4 stated she felt bad about ent. Resident #4 revealed that and upset about her care inuous interview with that staff was very slow with	F 24		

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345014	B. WING _		C 10/19	9/2016
	OVIDER OR SUPPLIER VINGCENTER - GREEN	ISBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401		0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242 4 SS=D M I iii iii ii	answer a resident's minutes and that care provided for the resident respectation that swith respect and dign. During an interview word 10/19/2016 at 1:00 expectation for staff to expect to the staff treat would be all staff treat dignity. Zero tolerance residents here. 483.15(b) SELF-DET MAKE CHOICES The resident has the expectation and outside the expectation of the staff treat with members and and outside the expectation of the staff treat with members and the expectation of the choice of Reget out of bed and ho expected to the transferred between the transferred by the transferred	n was that staff would call bell within 5 to 15 and treatment were ent. ADON indicated that taff would treat all resident ity. ith the interim Administrator DPM revealed her answer call bells within a povide care and treatment for or revealed that resident ait for care and treatment. It is that her expectation to tresidents with respect and it for disrespect for our ERMINATION - RIGHT TO right to choose activities, in care consistent with his or ments, and plans of care; is of the community both a facility; and make choices or her life in the facility that	F2		an ion ith	11/16/16

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O E I TI E I T	C . C	· · · · · · · · · · · · · · · · · · ·					, , , , , , , , , , , , , , , , , , ,
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						(c
		345014	B. WING				19/2016
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	10.2010
				12	201 CAROLINA STREET		
GOLDEN	LIVINGCENTER - GREE	NSBORO		G	REENSBORO, NC 27401		
(V4) ID	SI IMMADV ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL	PREF	Χ	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	DATE
					DEFICIENCY)		
F 242	Continued From page	e 5	F	242			
	Finding included:				the provision of federal and stat law.		
		s admitted to the facility on					
		ulative diagnoses which			F 242		
		major depression disorder			Resident #4 was discharged on 11/12/	16.	
	and chronic pain due				Resident #7 was discharged on Resident #4 and Resident #7 had their		
		ess Note dated 10/13/2016 I preferred to get up on a			choices reviewed related to the times t		
	daily basis during the				would like to go to bed and get up daily	-	
	Record review revea				10/19/16. Certified Nursing Assistants		
	assessment of Resid	·			were notified with the residents care ca		
		nimum data set (MDS) Nurse			and care plan being updated with the		
		AM revealed Resident #4 was			information.		
	alert and oriented an	d able to make her needs					
	known to staff. The N	IDS Nurse indicated the			Beginning 11/8/16, 100% of residents	will	
	resident needed exte	ensive to total assistance			be interviewed if they have a Brief		
		pletion of activities of daily			Interview of Mental Status (BIMS) scor	e of	
		ng. Continued interview with			8 or higher to determine the residents		
		aled Resident #4 was always			preference on time of getting out of be	d	
	incontinent of bowel				and going to bed. Preferences will be		
	Resident #4 was in s	n on 10/17/2016 at 12 Noon,			updated on the care plan for		
		till in bea. cted with Resident #4 on			communication to the Certified Nursing Assistants. Beginning 11/8/16, the)	
		M. The resident stated on			Director of Nursing Services or the		
		not able to get out of bed			Assistant Director of Nursing Services	or	
		dent #4 revealed that she			Designee will educate all nursing staff		
		ferred to get up during the			their next scheduled shift related to		
		ne liked eating all her meals			resident preferences related to getting	out	
		esident #4 stated she felt			of bed and going to bed.		
	bad "upset" the en	tire day, because most of					
	the day was gone.				Beginning 11/8/16, all Department		
		ed on 10/18/2016 at 9AM			Managers will randomly audit residents		
		amiliar with Resident #4 's			preferences related to the time they pr	efer	
		ed early. Further interview			to get out of bed or go back to bed to		
		the third shift was assigned			ensure these preferences are being m		
	_	ut of bed. NA #4 revealed "			These audits will occur during zone rol		
		Monday " (10/17/16).			5 times weekly x 8 weeks then 3 times		
	_	vith the Interim Administrator 0PM, she revealed each			weekly x 8 weeks with results reviewed morning meeting.	. III	
	On 10/13/2010 at 1.0	or ivi, site revealed each	1		moning meeting.		1

resident choices should be honored.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 ti 5 G1251			(
		345014	B. WING			10/	19/2016
	ROVIDER OR SUPPLIER	ISBORO		12	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA STREET REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 342 SS=D	7/22/2016 with currer infraction, hemiplegia hypertension, and and The Minimum Data S indicated resident#7 whearing and vision was required extensive as persons 'physical asstoilet use. During an observation Resident #7 was in st During an interview whole 10/19/2016 at 10:30 A preferred to go back to dinner. Resident #7 in she had to wait two her back to bed after revealed she hurt so long to be put back to Resident #7 indicated staff put her back to be preferred to have lunce Resident #7 also state 17, 2016 it was almost bed. During an interview of 11:45 AM, a nursing stanonymity indicated only had three NAs aresidents up and back During an interview with the sidents with th	s admitted to the facility on at diagnoses of cerebral and hemiparesis, kiety disorder et (MDS) dated 10/9/2016 was cognitively intact, as adequate. Resident #7 sistance of one to two sistance for bed mobility and on 10/17/2016 at 12 Noon, ill in bed. iith Resident #7 on M, Resident #7 on M, Resident #7 on evealed that last weekend ours or longer for staff to put dinner. Resident #7 bad because of waiting so bed "she cried." It was almost 9PM before ed. The resident stated she ch out of bed in her room. ed that on Monday, October et 2PM before she got out of an interview on 10/19/2016 at taff member who requested "yes during the weekend we not it took a long time to get of the interview of the long time to get in the Interim Administrator of the provided each all the behaviored. RE PROVIDED FOR		312	The results of these audits will be reviewed by the Director of Nursing Services or the Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee they arise and the plan will be revised a needed to ensure continued compliance. Audits will be reviewed monthly x 4 months at Quality Assessment Performance Improvement Committee beginning 11/8/16.	as as	11/16/16
	A resident who is una	ble to carry out activities of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345014	B. WING		C 10/19/2016
	ROVIDER OR SUPPLIER	ENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401	10/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 312	daily living receives	ge 7 the necessary services to tion, grooming, and personal	F 31	12	
	by: Based on observat resident interviews thorough and comp Resident #4. The fa provide oral care, a during morning care failed to cleanse the during bathing. Res 2 of 4 residents in tl activities of daily livi Resident #5) 1. Resident #4 was 10/12/2016 with cur included major depi pain due to trauma. Record review reve	aled no available Minimum		Preparation and/or execution of this pof correction does not constitute admission or agreement by the provious the truth of facts alleged or the conclusions set forth in the statement deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provisions of fede and state law. F312 Resident #4 had additional incontinent care provided on 10/18/16. NA #4 was educated on proper incontinence care 10/18/16. Resident #5 had her hair combed, oral care provided, and hand and feet washed on 10/18/16. NA #5 educated on the proper way to complete.	der of of use ral ce s e on
	Data Set (MDS) ass care. Interview with the M 11AM revealed Res and able to make he Nurse indicated Res to total assistance f eating. Further intervas always incontin	IDS Nurse on 10/19/2016 at ident #4 was alert, oriented er needs known. The MDS sident #4 required extensive from staff for all adls except for rview revealed Resident#4 tent of bowel and bladder. Intinence care provided by 4 (NA) on 10/18/16 at 10:25		ADL care on 10/18/16. Beginning 11/8/16, 100% of residents be interviewed if they have a Brief Interview of Mental Status (BIMS) scotting and they are receiving adequate adl care. Beginning 11/8/16, the Director of Nursing Services, Assistant Director of Nursing Services, or designee will educate all nursing staff on their next scheduled strelated to proper incontinence care ar proper care related to activities of dail	will ore of els rsing g shift

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
							С
		345014	B. WING _			10/	19/2016
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - GREE	NSBORO			REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					·		
F 312	Continued From page	e 8	F 3	312			
	AM through 11:15 AM	M was conducted. Resident			living (ADL). Beginning 11/8/16, all		
	#4 had experienced	an episode of bowel			Certified Nursing Assistants will have		
	incontinence. NA #4	removed the soiled brief and			incontinence care and ADL care		
	observed stool was o	on the outside top portion of			competencies performed by the Direct		
	the brief, in between	the resident 's thighs, legs			of Nursing or Assistant Director of Nurs	ing	
		nuous observations revealed			on their next scheduled shift.		
		of a white cloth towel and					
		er at the bathroom sink and			Beginning 11/10/16, audits will be		
	NA #4 removed stool			performed by the Director of Nursing			
	NA #4 then wet seve			Services or the Assistant Director of			
		poo/body wash at the sink.			Nursing Services to verify Certified		
		then removed from the			Nursing Assistants continue to perform		
	_	ain, NA #4 wet 3 washcloths			ADL care and incontinence care	:64	
		th towel with water and the			appropriately. 2 audits will occur per sh	IIΤ	
		at the sink. The resident 's			per week for 12 weeks.		
	•	vith the wash cloth then			The results of these audits will be		
		e wet towel. The resident 's			reviewed by the Director of Nursing		
	clean brief and clothi	leansed. NA #4 placed a			Services or Executive Director and		
		at 11:30 AM with NA #4			brought to the Quality Assessment		
		r routine for providing			Performance Improvement Committee		
	incontinence care.	reduite for providing			meeting by the Director of Nursing		
		PM an inquiry was made with			Services or the Executive Director. An	V	
		of Nurses (DON) about the			issues or trends identified will be	,	
		served. The DON indicated			addressed by the Quality Assessment		
	the resident should h	ave been provided a shower			Performance Improvement Committee	as	
		er to cleanse the resident 's			they arise and the plan will be revised	as	
	skin. Further intervie	w revealed			needed to ensure continued compliance	e.	
	Interview with Reside	ent #4 on 10/19/2016 at			Audits will be reviewed monthly7 x 4		
		A #4 should have given her a			months at Quality Assessment		
	shower instead of we	etting wash cloths at the sink			Performance Improvement Committee		
	(referring to the incor 10/18/16).	ntinence care observed on			beginning 11/8/16.		
		admitted to the facility on					
	7/17/15 with cumulat dementia.	ive diagnoses which included					
		rly Minimum Data Set (MDS) 22/16 revealed the resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	' '	COMPLETED
		345014	B. WING _			C 10/19/2016
	ROVIDER OR SUPPLIER	INSBORO	•	STREET ADDRESS, CITY, STATE, ZIP 1201 CAROLINA STREET GREENSBORO, NC 27401	CODE	10.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From pag	ne 9	F3	312		
		on and required extensive to staff for personal hygiene				
	revealed physical fu	n care plan updated 9/28/16 nctioning deficit. Some of the oral care and personal from staff.				
	body and shampoo	facturer 's instruction for the cleanser used by the facility rinse product off of the skin.				
	bath provided to Res #5 (NA) was conduct appeared to be tang head. NA #5 used a with Kiwi and Mango The resident's face water. The resident and feet were cleans body and shampoor resident's body. N cloth and cleansed to the rectum upwards Continued observati and socks were place # 5 was repositioned #5 left the resident'	8/16 at 11:45 AM of a bed sident #5 by Nursing Assistant ted. The resident 's hair led in the back portion of her a sudsy basin of water mixed bobdy and shampoo wash. was cleansed with plain 's body except for her hands sed with the sudsy water. The wash was not rinsed off the IA #5 used another wash he resident 's genitals from in a back to front motion. ons revealed a clean gown sed on the resident. Resident I in bed with pillows and NA is room. Mouth care and hair led. Nor were the feet ever				
	revealed she was no needed to be thorou body. NA #5 indicat	6 at 12:30 PM with NA #5 at aware that the body wash ghly rinsed off the resident 's ed she should have brushed and comb the resident 's				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED
			7 50.25.			С
		345014	B. WING			10/19/2016
	ROVIDER OR SUPPLIER	NSBORO	·	STREET ADDRESS, CITY, STATE, ZIP COD 1201 CAROLINA STREET GREENSBORO, NC 27401	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	
F 312	who indicated the res should have been con	e 10 S at 12:30 PM with Nurse #5 sident 's teeth and hair mpleted. NA #5 indicated neets to know how to provide	F	312		
F 353 SS=F	Director of Nurses (D expectations were the the body, mouth care and feet and hands b	6 at 1:12 PM with the Interim ON) revealed her e body wash be rinsed off and hair care be performed e washed during care. NT 24-HR NURSING STAFF	F	353		11/16/16
	provide nursing and r maintain the highest p					
	numbers of each of the personnel on a 24-ho	ride services by sufficient ne following types of our basis to provide nursing n accordance with resident				
	Except when waived section, licensed nurs personnel.	under paragraph (c) of this ses and other nursing				
	section, the facility me	under paragraph (c) of this ust designate a licensed harge nurse on each tour of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
		345014	B. WING		1	C 0/19/2016
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2010
				1201 CAROLINA STREET		
GOLDEN	LIVINGCENTER - GREE	NSBORO		GREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From pag	e 11	F 35	3		
		Γ is not met as evidenced				
	by:	i la fiat mat de evidenced				
		on, resident, family and staff		Preparation and/or execution	of this plan	
		d reviews the facility failed to		of correction does not constitute	•	
	provide care in a mai	_		admission or agreement by the		
	·	not answering call bells		the truth of facts alleged or the	•	
		eeding assistance with		conclusions set forth in the sta		
	activities of daily livin	g. This was evident for 2 of		deficiencies. The plan o correc	tion is	
	3 sampled residents	reviewed for dignity.		prepared and/or executed sole	ly because	
	(Resident # 2, and R	esident #4)		it is required by the provisions	of federal	
	Findings Included:			and state law.		
	1. Resident #2 was a	idmitted to the facility on		F 353		
		nt diagnoses of major		F 241: Resident #2 had call lig	ht	
	depressive disorder,	and type 2 diabetes mellitus		answered at 2:40pm on 10/17/	16 with	
	with diabetic nephrop	pathy.		incontinence care provided. Ba applied to buttocks. Resident #		
		n Data Set (MDS) dated		additional incontinence care or	า 10/18/16.	
	10/3/2016 revealed F	Resident #2 was moderately		NA #4 received education on 1	0/18/16	
	cognitively impaired.	The resident required		regarding proper incontinence	care and	
	extensive assistance toilet use and person	with bed mobility, dressing, al hygiene.		changing of gloves.		
	The resident was free	quently incontinent of		Beginning 11/8/16, 100% of re-	sidents will	
	bladder and always i	ncontinent of bowels.		be interviewed if they have a B	Brief	
				Interview of Mental Status (BIN		
		with Resident #2 at 2:00PM		8 or higher to determine if resid	dent feels	
		evealed that she had been		their call lights are being answ	ered timely	
	_	or staff to come and change		and there are no additional cor		
		ed her " butt was burning " .		incontinence care. Beginning 1		
		d that it 's like this all the		Nursing Management and exe		
		hat I have to wait so long,		Director evaluated the staffing	•	
		e " . Resident #2 indicated		establish patient acuity and sta		
	that this made her fe	el bad.		required. DNS evaluated the n	•	
	An abs	- Desident #0		schedule to accommodate the		
		e Resident #2 room on		the residents. Review of daily s	•	
		M a clock on the wall in front		schedule to ensure adequate r		
		d was within view of the		is available to accommodate the	•	
		dicated that was how she k staff to answer her call bell		level and provide quality care. advertising on internet job site.	-	
	I KLIEW HOW IOHU II 1001	N SIGH IU GHSWEI HEI CAH DEH	1	- auverising on interner ion site.	. มบอเอ ปH	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
	345014 B. WING		10/	19/2016			
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVINGCENTER - GREENSBORO				1201 CAROLINA STREET			
				GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
F 353	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 and provide care for her. A continuous observation of Resident #2 's room was done on 10/17/2016 at 2:00PM through 2:40PM. The resident 's call bell was activated. Resident #2 had removed the blanket from her body exposing that the resident had a brief on. Observation of the brief revealed brown substance could be seen through the brief. There was a foul odor in the room. Observations on 10/17/2016 at around 2:40 PM revealing Nursing Assistant (NA) #2 walked into the Resident #2 room 's Interview with Nursing Assistant (NA) #2 on 10/17/2016 at 2:52PM revealed that the reason why it took her so long to change and answer Resident #2's call bell was because the facility was short of staff which made it hard to get to each resident in a timely manner. NA #2 revealed that there were only two nursing assistants for the South hall on the schedule this morning. NA#2 revealed that she had 30 residents to provide care for this morning. During an interview with the interim Director of Nursing (DON) on 10/19/2016 at 11:30AM she stated her expectation was that staff would		F 353		social media, plan for pay raises, contacting advertising agency, and is networking with Agency pools for staffing, recruitment, and retention. Beginning 10/19/16, Executive Director will review staffing patterns with the DNS weekly for 3 months. The results of these audits will be reviewed by the Director of Nursing Services and Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as need to ensure continued compliance. Audits will be reviewed monthly x 4 months at Quality Assessment Performance Improvement Committee beginning 11/8/16.		
	minutes and that care provided for the resid her expectation that s with respect and dign During an interview w on 10/19/2016 at 1:00	ent. ADON indicated that staff would treat all resident ity.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345014	B. WING _			C	
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401	<u> </u>	10/19/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 353	resident. Administration should not have to we Administrator indicate would be all staff treatments.	e 13 rovide care and treatment for or revealed that resident rait for care and treatment. ed that her expectation at residents with respect and the for disrespect for our	F3	53			
	10/12/2016 with cum included major depre pain due to trauma. Record review revea	admitted to the facility on admitted to the facility on aulative diagnoses which ession disorder and chronic alled no available Minimum essment or written plan of					
	11:00 AM revealed F oriented and able to The MDS Nurse indi extensive to total assexcept for eating. For	OS Nurse on 10/19/2016 at Resident #4 was alert, make her needs known. cated Resident #4 required sistance from staff for all adls urther interview revealed ays incontinent of bowel and					
	Nursing Assistant #4 AM through 11:15 Al #4 had experienced incontinence. NA #4 observed stool was of the brief, in between and buttocks. Contin NA #4 wet the ends wash cloths with wat NA #4 removed stool	tinence care provided by (NA) on 10/18/16 at 10:25 M was conducted. Resident an episode of bowel removed the soiled brief and on the outside top portion of the resident 's thighs, legs nuous observations revealed of a white cloth towel and er at the bathroom sink and I from the resident's skin. NA more cloth washcloths with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345014	B. WING _			C 0/19/2016	
	ROVIDER OR SUPPLIER	EENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA STREET GREENSBORO, NC 27401		10/19/2016	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 353	Additional stool was resident 's skin. A and the ends of a shampoo/body was groin was cleanse wiped with end of outer labia was not clean brief and cloud Interview on 10/18 revealed this was incontinence care. Interview on 10/18 Director of Nurses expectations were the body, mouth cand feet and hand Interview with Res 10:30AM revealed shower instead of (referring to the interview and treatment. Con Resident #4 stated answering her call During an interview Nursing (DON) on stated her expectation that coprovided for the reher expectation the with respect and definition of the respectation the with respectation the with respectation the respectation of the respectation the with respectation the respectation of the respectation the res	co/body wash at the sink. as then removed from the Again, NA #4 wet 3 washcloths cloth towel with water and the ish at the sink. The resident 's id with the wash cloth then the wet towel. The resident 's id cleansed. NA #4 placed a sthing on the resident. 3/16 at 11:30 AM with NA #4 her routine for providing in the body wash be rinsed off are and hair care be performed is be washed during care. 3/16 at 1:12 PM with the Interim is (DON) revealed her is the body wash be rinsed off are and hair care be performed is be washed during care. 3/16 at 1:44 on 10/19/2016 at Inva #4 should have given her a wetting wash cloths at the sink continence care observed on the stated she felt bad about ment. Resident #4 revealed that issed and upset about her care intinuous interview with that staff was very slow with the bell on Monday. 3/16 at 1:12 PM with the Interim Director of 10/19/2016 at 11:30AM she atton was that staff would 's call bell within 5 to 15 care and treatment were esident. ADON indicated that at staff would treat all resident	F3	353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345014	B. WING			C	9/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	CODE	10/13	9/2010
GOLDEN LIVINGCENTER - GREENSBORO				1201 CAROLINA STREET GREENSBORO, NC 27401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 353 F 441 SS=D	timely manner and procesident. Administrator indicates would be all staff treat dignity. Zero tolerance residents here. 483.65 INFECTION CONTROLOR SPREAD, LINENS The facility must estal Infection Control Processes, sanitary and cort to help prevent the destroy of disease and infection (a) Infection Control Formulation The facility must estal Program under which (1) Investigates, contribute facility; (2) Decides what processould be applied to a (3) Maintains a record actions related to infection determines that a resiprevent the spread of isolate the resident. (2) The facility must processould be disease and infection determines that a resiprevent the spread of isolate the resident.	DPM revealed her or answer call bells within a covide care and treatment for or revealed that resident ait for care and treatment. The determinant residents with respect and the for disrespect for our control, PREVENT Delish and maintain an approximate the environment and transmission con. Description of the environment and evelopment and transmission con. Description of the environment in the envit in the environment in the environment in the environment in the	F 3			1	1/14/16
	(3) The facility must re	equire staff to wash their					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345014	B. WING _		1	C 0/19/2016	
NAME OF PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP COL		0/13/2010	
				1201 CAROLINA STREET			
GOLDEN	LIVINGCENTER - GR	EENSBORO		GREENSBORO, NC 27401			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From p	age 16	F 4	141			
	hands after each of	direct resident contact for which adicated by accepted					
		andle, store, process and as to prevent the spread of					
	by: Based on staff int standard infection followed by staff to soiled gloves used for 1 of 3 residents activities of daily li (Resident #4) Findings included: A continuous obserom 10:25 AM through care for Resident observed to donne hands, removed a bowel incontinence brief on the reside gloved hands (use #4 went into and commate 's closs attempting to local requested to wear bedside cabinet di			Preparation and/or execution of correction does not constit admission or agreement by the truth of facts alleged or the conclusions set forth in the state deficiencies. The plan of corresponding and/or executed so it is required by the provision and state law. F 441 Resident #4 had additional in care provided on 10/18/16. It educated on proper inconting infection control on 10/18/16. Beginning 11/18/16, the Direction Nursing Services or Assistan Nursing Services or designer all nursing staff on their next shift related to proper infection include when to change glover.	tute the provider of the provider of the tatement of rection is olely because of federal accontinence NA #4 was tence care and to the control of the will educate scheduled on control to		
	#4 's personal clo Interview on 10/18			Beginning 11/9/16, audits will performed by the Director of Services, Assistant Director of	Nursing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DELITICIO ATIONI NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345014	B. WING _			10/	19/2016	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
COLDEN	LIVINGCENTER - GREEN	JERORO		12	201 CAROLINA STREET			
GOLDEN	LIVINGCENTER - GREET	NSBORO		G	REENSBORO, NC 27401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 441	staff was to change s hands before comple Interview on 10/18/16	oiled gloves and wash ting another task. 5 at 2 PM with NA #4 she had changed her	F4	141	Services and RN Supervisor to monitor hand hygiene to include proper change of gloves with 2 staff members per shift days weekly x 4 weeks, then 1 staff member per shift 3 days weekly x 4 weeks. The results of these audits will be reviewed by the Director of Nursing Services and Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee they arise an the plan will be revised as needed to ensure continued compliance. Audits will be reviewed monthly x 4 months as Quality Assessment Performance Improvement Committee beginning 11/8/16.	d : 5		