PRINTED: 02/05/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		e) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
701012701	or contraction	IDENTIFICATION NOTICE.	A. BUILDING:		OOWII EETEB			
		HAL041074	B. WING		01/23/2018			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE				
SPRING A	SPRING ARBOR OF GREENSBORO  5125 MICHAUX ROAD  GREENSBORO, NC 27410							
(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		(X5) COMPLETE DATE		
D 000	0 Initial Comments		D 000					
		artment of Social Services survey on January 16, 2018						
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service		D 299					
	10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.							
		as evidenced by: ns and interviews, the facility nunces of pasteurized milk at						
	The findings are:							
	wall in locked unit #2	ule posted on the kitchen revealed "Milk must be ice daily - Breakfast and						
	facility's locked unit # am to 12:40 pm revea -Eleven residents were -Ten residents were s	nch on meal service in the 2 on 01/16/18 from 11:50 aled: re present for the meal. served the lunch meal in the resident received her meal						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED				
HAL041074		HAL041074	B. WING	01/23/2018					
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	,				
	5125 MICHAUX ROAD								
SPRING A	RBOR OF GREENSBOR	O GREENSE	BORO, NC 2741	10					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	RRECTIVE ACTION SHOULD BE COMPLÉTE ERENCED TO THE APPROPRIATE DATE				
D 299	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D 299						
	-The aides were resp beverages during the -He was not always ir entire meal, but staff:	onsible for serving							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041074	B. WING		01/23/2018	
	ROVIDER OR SUPPLIER	5125 MICH	RESS, CITY, STATE, ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETE DATE	
D 299	RBOR OF GREENSBORO  GREENSBOI  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		D 299			

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