		ID HUMAN SERVICES MEDICAID SERVICES		And the second s	FOF	ED: 12/22/2011 RM APPROVED IO. 0938-0391
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION ING JAN 0 (2012)	(X8) DATE S	URVEY
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	OVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP COD 2575 W 5TH ST GREENVILLE, NC 27834	E	
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F 279 SS=B	to develop, review ar comprehensive plan The facility must develop and for each resident objectives and timetal medical, nursing, and needs that are identificated assessment. The care plan must of the facility processed and seem of the required under \$483.25; and any seem of the required under \$483.10, including the under \$483.10, including the under \$483.10(b)(4) This REQUIREMENT by: Based on observation interviews and record develop a care plan residents (Resident failed to develop a desire and failed to develop of 4 sampled reside experienced weight 1. A. Resident # 61	e results of the assessment of revise the resident's of care. elop a comprehensive care that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive describe the services that are ain or maintain the resident's hysical, mental, and ing as required under revices that would otherwise 483.25 but are not provided exercise of rights under the right to refuse treatment T is not met as evidenced ons, staff and resident direview, the facility failed to for falls for 1 of 3 sampled # 61) that experienced a fall, ischarge care plan for 1 of 1	F 27	1. A discharge care falls care plan we developed for reson 12-15-11. A care plan was defor resident #35-11. 2. All residents can be audited by a member by 1-12 identify resident at a high risk for on the most reconstruction above equals high those residents fallen in the past The Falls Risk Ast completed upor and quarterly or resident. Identify residents will haplan for falls devented.	ere esident #61 nutritional eveloped on 12-15- re plans will MDS staff 2-12 to ts who are falls based ent Fall Risk re (10 or gh risk) and who have t 6 months. sessment is a admission n each fied ove a care veloped.	1-12-12 (X6) DATE
LABORATOR	A DIRECTORS ON AKOAIDE	VOULLELY VELVEOEMININE O DIGINALO		Administration	. (4.	1106-06

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.

If continuation sheet Page 1 of 46

CENTERS	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO				
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Γ΄ ΄		LE CONSTRUCTION	(X3) DATE SUI		
AND PLAN OF	CORRECTION	PERTITION TOWNS IN	A. BUI	LDING				
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F 279	her left heel, hyperte vascular disease, str vascular dementia, a muscle weakness. A Fall Risk Assessm scored Resident # 6 equaled high risk). I staff if the person we prevention protocol simmediately and doc Review of the care por interventions to prove the care por intervention with lenses. Resident # 6 extensive assistance and locomotion. Am not occur. She was extensive assistance hygiene. The reside impairment in function lower extremities. In identified as used by was not identified as used by was not identified as the care por interventions. In the care por interventions to prove the care por	ent completed on 08/02/11, as a 14 (10 or above the assessment directed the as identified as high risk, a should be initiated cumented on plan for falls revent falls. In Data Set (MDS), dated Resident # 61 was usually ally able to understand entified as having moderately but the use of corrective 61 was identified as sely impaired (11/15). She was ing behaviors or rejection of the was identified as requiring the with bed mobility, transfer abulation was coded as did identified as requiring the for toilet use and personal the mass of motion of both the mobility device was the transfer as the property of the selection of the content of the code of	F	279	All residents care plate audited by the Sor Worker by 1-12-12 to identify residents who not have a discharge plan developed. All residents identified whave a care plan for discharge developed. All residents care plate audited by the Registered Dietitian, Manager by 1-12-12 identify residents who have had a weight lead to 65% x 1 month or 1 months will have a nutritional care plandeveloped. All residentified will have a plan for nutrition developed.	cial o do care villns will /Dietary to no need ts who ess/gain L0% x 6	1-12-12	
	The resident's care 10/28/11, did not ac	plan, last reviewed on Idress falls.						

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 12/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 279	at 8:25 AM indicated the floor. Staff docun she had hit her head, the resident was place services was called a to the hospital for evanote indicated Reside facility. The facility Incident/A 12/01/11, indicated Resided the floor. The nurse stated she hit her head comments and/or ste recurrence, the facility contacted to discuss offer services. Reviet the 12/01/11 fall or in falls were not added. An interview was held 12/15/11 at 8:50 AM, the high position. The left side of the bed. On interview, the resident what had made her fishe had been asleep. An interview was held 12/15/11. Nurse # 2:8 Resident # 61's fall of entered the room, the	ress Notes, dated 12/01/11 the resident was found on mented Resident # 61 stated Vital signs were taken and ed back to bed. Emergency and transported the resident aluation. At 10:30 AM, the ent # 61 returned to the accident Report, dated tesident # 61 was found on documented the resident ad. Under additional ps taken to prevent y indicted therapy would be the resident's fall and would w of the care plan indicated terventions to prevent future to the care plan. d with the resident on The bed was observed in ne side rail was raised on the On the right side, the rail was ed table placed against the alarms or floor mats seen. ident stated she but was unable to recall all. She stated she guessed and rolled out of bed.	F	279	3. All new admission chawill be audited weekly the MDS Coordinator and/or MDS Nurse to ensure that those residuith a fall risk assessm score of 10 or greater a falls risk care plan developed. All falls wireviewed daily in the morning interdisciplinicare management meand residents reported having a fall based on 24 hour report sheets have a falls risk care produced. All new admission chawill be audited weekly the Social Worker to eathat a discharge care has been developed.	dents ent have II be ary eting d as the will lan arts y by ensure	1-12-12

pages Replaced.

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

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SU COMPLE	
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F 279	head of the bed. Bot bed was in the low pot bed raised 30 to 45 conot have a history of was not aware of any placed to prevent from referring to therapy for the nurse she had fliphead. No immediate the time of the fall to further falls. Nurse # discussed in morning meeting. Morning meeting. Morning meeting. Morning meeting. Morning meeting to be partment Heads, in Coordinator. Nurse is facility as to involve the interventions to prevent the control of the pool of the po	propped on the wall near the h side rails were up. The position with the head of the legrees. The resident did falls and the nurse stated he previous falls. Measures in further falls included or review. The resident told oped out the bed and hit her interventions were placed at protect the resident from 2 stated falls were meeting and a weekly fall meeting was attended by including the MDS and talls. If a with the Director of Nursing it 2:13 PM. Falls were meeting that was attended and including the MDS nurse. Expectation was for all falls is they occurred. Even if it dent, the DON stated the fall meet since at the time it would if Resident # 61's fall had did with the Administrator on. Accidents and incidents and up meeting everying was attended by all	F	279	will be aud the Regist Dietitian/I to ensure residents on utritional past history nutrition, resident/I have a nutrition developed identified weight lose month or will have a plan developed audits and determine	Dietary Manager that those who are at a I risk based on ry of poor diagnosis and amily interview tritional care pland. Those residents as having a ss/gain of 5% in 1 10% in 6 months a nutritional care loped. Ey Assurance & ht (QA&A) e will review I findings to trends and corrective action	1-12-12

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO. 0938					
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	OVIDER OR SUPPLIER	345377		2	REET ADDRESS, CITY, STATE, ZIP CODE 575 W 5TH ST GREENVILLE, NC 27834	1	0.2017	
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F 279	An interview was heli on 12/15/11 at 2:53 f stated the purpose o problems or potentia and interventions to plan also helped give order to take care of about residents was This would include in falls. The MDS Cooreceived a weekly fawhich listed resident The MDS Coordinate plan for falls was not a fall care plan was i stated she was awar and stated the resider review of the resider	d with the MDS Coordinator PM. The MDS Coordinator f a care plan was to identify I problems, formulate a goal reach that goal. The care the staff information in residents. The information shared in morning meetings. Iformation such as resident redinator stated she also all sheet after the fall meeting that had sustained falls. It is place and a resident fell, initiated. The MDS nurse re Resident # 61 had fallen ent had a fall care plan. After int's care plan, the MDS nurse realized Resident # 61 did not	F	279				
	B. Resident # 61 was cumulative diagnose left heel, hypertensid vascular disease, struscular dementia, a muscle weakness. Social Work (SW) P 08/09/11, indicated discharge plans. The that indicated the reinvolved in the discumpled in the discumpl	falls or the potential for falls. as admitted on 08/02/11 with es of pressure ulcer on her on, diabetes, peripheral roke with left hemiparesis, anxiety, and generalized rogress Notes, dated Resident # 61 had no pending here was no documentation sident and/or family had been ussion regarding discharge. mum Data Set (MDS), dated both the resident and family						

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMD 14C	7. 0330-0331
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI		PLE CONSTRUCTION	(X3) DATE SUP COMPLET	
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F 279	resident expectation remain in the facility. that discharge to the The most current SW 10/21/11, indicated the for long term care. No plans was seen. The that indicated the resinvolved in the discussion A Quarterly MDS, da Resident # 61 was usually was able to usually was identified as impaired (11/15). The resident participated The MDS also indicated was not feasible. The that indicated the resinvolved in the discussion of the di	sessment. The overall of Resident # 61 was to A determination was made community was not feasible. If Progress note, dated he resident was appropriate to mention of discharge was no documentation ident and/or family had been sion regarding discharge. Ited 10/27/11, indicated sually understood and inderstand others. Resident is moderately cognitively he MDS indicated the in the assessment process. Ited return to the community was no documentation ident and/or family had been sion regarding discharge. Islan, last reviewed on dress community discharge. Islan, last reviewed on gistered Dietician iponsible Party stated old him she was not going to		279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	9:54 AM. The SW st started when a note or regarding the process resident/family intervalued on the resident expressed their desire to the resident expressed then she, the SW con SW stated conversating family was document Progress Notes. The were formulated on tresidents. The SW smoderately cognitive make decisions regastated she had talked and her Responsible discharge and both a take care of the resident # 61 had not home discharge, the referrals had been mind an odocumentation stated on facility adminformed her, Resident # 61, stated that he was unsure it to care for her if she stated with the resident extensive/total care in the stated with the state	d with the SW on 12/15/11 at ated discharge plans were was received from therapy s. On admission, during the iew, questions were asked s. An assessment was also ent. The resident was asked go back to the community. If ed a desire to return home, ntacted local agencies. The ions with the resident and/or led in the Social Work e SW stated discharge plans both long and short term stay stated residents that were ly impaired were able to rding discharge. The SW di with both Resident # 61 Party about potential agreed there was no one to	F 279			

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	D. 0938-0391
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AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLET	160
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NAME OF PR	OVIDER OR SUPPLIER			1	575 W 5TH ST		
GREENFIE	ELD PLACE			i	REENVILLE, NC 27834		
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	An interview was held 1:29 PM. She identified the November 2011 reparty informed her Repeause she wanted she could not rememinformation to another stated a care plan she since the resident stated are plan indicated near plan indicated near end interview was held (DON) on 12/15/11 and discharge planning since the resident seemed to relay wants and near the expectation was residents/Responsible in the appropriate seem Information/communication/comm	d with RD on 12/15/11 at ed herself as the author of note where the Responsible esident #61 would not eat to go home. The RD stated ber if she provided that r staff member. The RD ould have been developed ted she was not eating to go home. Review of the or care plan for the behaviors lans seen. The RD stated to be alert, oriented and able seeds. If with the Director of Nursing to 2:16 PM. The DON stated thould start on admission. for interviews with e Party's to be documented	TAG	1	CROSS-REFERENCED TO THE A		
	meeting. He stated l	dent needs during morning ne would have expected to esident # 61's behavior and rn to the community.					
	on 12/15/11 at 3:01 I stated the SW was re discharges. The disc when there was a po	d with the MDS Coordinator PM. The MDS Coordinator esponsible for care planning charge plan was initiated tential discharge. The SW for care planning behaviors.					
FORM CMS-256	1 37(02-99) Previous Versions Ob	solete Event ID: GTZK	11	Fa	clity ID: 923145	If continuation sf	neet Page 8 of 46

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE	R:	MULTIPL JILDING	E CONSTRUCTION		FE SURVEY MPLETED
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F 279	resident had verbalized MDS nurse stated should be cause she wanted Coordinator stated a physical, mental and resident should be cashould be in place to desire to go home an home was not feasiblistated she was not stand the feasibility iss. 2. Resident # 35 was most recently readmicumulative diagnoses hypertension, vascula debility, edema and leffusion, pulmonary ochronic renal failure, cardiomegaly. Review of the Monthl Weights indicated no for Resident # 35 for October 2011. In the was the word "hospic The Nutritional Progrindicated an annual refor Resident # 35. Tidocumented the resident was not facility since she was the word should be the resident was not facility since she was the resident was not facility since she was the resident was not facility since she was the was	d she was not aware the ed a desire to go home. e was not aware the was not going to eat to go home. The MDS behavior that impacted emotional well being of are planned. A care plan deal with the resident's did the fact that returning le. The MDS nurse there are the desire to go home we should be care planned admitted on 07/20/09 atted on 02/28/11 with sof spinal stenosis, are dementia, atria fibrillated varicosity, pleural collapse, anemia, Stage adult failure to thrive and by Record of Vital Signs weight had been record a January 2011 throughed blank reserved for weight he Registered Dietician dent's diet was regular vand dinner. Current body 107.4 pounds. She addonger being weighed by	the the a n need. and tion, III d and ded and led pht fled (RD) vith	F 279			
FORM CMS-256	37(02-99) Previous Versions Ob	solete E	vent ID; GTZK11	Fac	cility ID: 923145	If continuat	ion sheet Page 9 of 46

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-0391
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F 279	centimeters (cc's) of documented the resist after set up and would meals. She docume indicated the resident normal limit. There with the resident was at in the resident was at in the Nutritional Progrindicated the last we 2010 at 107.4 pound (RD) added the weigh being obtained due to protocol. The RD do staff that reported the from 25% to 75% with chewing or swallowing indicated Resident # lunch and dinner. To indicating nutritional prevent nutritional document in the resident # 35 usual usually understand, moderately impaired lenses. Resident # 35 usual usually understand, moderately impaired condecision making. No Resident # 35. She with eating. Review of the care produced the resident # 35. She with eating.	reprotein and 1220 cubic water per day. The RD dent was able to feed herself ld at times consume 100% of inted labs from 04/01/11 the labs from 04/01/11, indicating the labs from 10/25/11, indicated the labs from 10/27/11 the labs from 10/27/11, indicated labs from	F	279			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	·				0938-0391
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F 279	A Care Conference Signature Sheet indicated the care plan was reviewed on 11/16/11. The determination was made to continue the care plan through the next review. There was no care plan added to address nutritional risk. On 11/19/11 at 10:00 PM, a nurse documented the resident ate in her room. Resident # 35's appetite was described as fair with a usual intake of 50%. There was no care plan that indicated decreased intake or nutritional risk.		F	279			
					i.		
	Resident # 35 receiv also included ice cre halt weight loss. Rev indicate a nutritional	Physician's orders indicated ed a regular diet. Orders am at lunch and dinner to view of the care plan did not care plan had been devised intions to identify potential				And Advanced to the Advanced t	
	was recorded as 103 6.8 pound weight los than 5% (indicated s significant weight los planned. There was	weight for Resident # 35 3.7 pounds. This reflected a is in one month or greater ignificant weight loss). The is had not been care no care plan that identified otential for weight loss.				-	
•	as Unit Manager, on nurse stated if a resi were not weighed m expected. Measured dictated by Hospice. 35's appetite varied he thought the resid	Id with Nurse # 2, who acted 12/15/11 at 1:08 PM. The dent was on Hospice, they onthly since weight loss was ments of weights were Nurse # 2 stated Resident # from day to day. He stated ent received supervision and to be supervision because					
FORM CMS-25	67(02-99) Previous Versions O	bsolete Event ID: GTZ	K11	Fa	acility ID: 923145	continuation shee	tPage 11 of 46

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			The state of the s	OMB	NO. 0938	-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		SURVEY PLETED	
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	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODI 2575 W 5TH ST GREENVILLE, NC 27834	E		
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F 279	eating. An interview was held 1:38 PM. The RD stated on a daily basis Monor Nutritional issues were up meeting every more Wound and Weight Mover estopped on those The RD stated the form instructed her to stop residents on Hospice expected. The RD a residents discharged stated she was unsufor Nov & Dec came new nutritional interview and approprimally implemented. She attracking weights becommended to do so, care plan nutritional interview was held (DON) on 12/15/11 attracked. An interview was held (DON) on 12/15/11 attracked.	d in her food rather than d with the RD on 12/15/11 at lated she was in the building day through Friday. Fre discussed during stand rning and weekly at the fleeting. Routine weights be residents on Hospice. From administrator had tracking weight for because weight loss was dided that she had seen from hospice. The RD from hospice. The RD from the remaining the residents on the remaining the resident from the remaining the r	F	279				
FORM CMS-25	I 67(02-99) Previous Versions Ob	solete Event ID; GTZK	11	F	Facility ID: 923145	If continuation	sheet Page	12 of 46

PRINTED: 12/22/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO	DDE		
GREENFIELD PLACE		i	75 W 5TH ST REENVILLE, NC 27834			
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care planned. The D weight reflected a sig added the November obtained at the reque DON's review of the plan to address nutrit An interview was helt 12/15/11 at 2:31 PM. a resident had signif loss should be care p not to be weighed the documentation in the notes should be foun F 280 483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or other incapacitated under the participate in plannin changes in care and A comprehensive ca within 7 days after th comprehensive asse interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent pra the resident, the resi legal representative;	ctual weight loss should be ON stated the December inificant weight loss. She weight was probably est of Hospice. On the resident's care plan, no care ional issues was found. If with the Administrator on The Administrator stated if icant weight loss the weight blanned. If the resident was en either a care plan or dietary notes or nurse's d. (k)(2) RIGHT TO INING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. The December of the State of	F 280	control edem developed fo on 12-15-11. for resident # updated to re discontinuati for contractu	rt hose to help na was r resident #48 The care plan f80 was eflect the on of splinting	1-12-12	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER		28	EET ADDRESS, CITY, STATE, ZIP CODE 675 W 5TH ST GREENVILLE, NC 27834			
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F 280	by: Based on observation review the facility falls of 21 sampled reside whose care plans we care plan was not upout support hose to help #80's care plan was rediscontinuation of splimanagement. Findin 1. Resident #48 was 03/25/11 and readmit 11/26/11. The reside included history of fer August 2011), periphileg edema and celluli amputation, left below diabetes. A 11/11/11 consult do "elevate leg & (and control swelling (of right and coumented, "Thigh imeasurements = thig calf 14". Apply while at his (night)." Resident #48's Nurse documented, "Thigh imeasuremented, "Thigh imeasuremented," Thigh imeasuremented, "T	is not met as evidenced n, staff interview, and record ed to update care plans for 2 ents (Resident #48 and #80) re reviewed. Resident #48's dated to reflect the use of control edema. Resident not updated to reflect the inting for contracture gs include: admitted to the facility on ted on 10/28/11 and nt's documented diagnoses moral/popliteal bypass (in eral vascular disease, right tis, right great toe v the knee amputation, and becumented for Resident #48 d) daily support stockings to ght lower leg)." order for Resident #48 high Ted hose h 23 " (inches), length 26", OOB (out of bed). Remove e Aide's Information Sheet high ted on OOB, off HS." 448's December 2011	F 280	2. All residents charts audited by the MDS Coordinator and/or Nurse by 1-9-12 to it residents who have physician orders for support hose to contedema. Identified rewill have their care pupdate to include the support hose to contedema. The MDS Coordinated and/or MDS Nurse wobtain a list of resident from the Rehab Dire and Restorative Nursidentify all residents are currently using sto ensure that the identified residents or plans have been upd regarding the use of Of the residents identified by the MDS Coordinator/MDS Nurse that the care plans will be audited by the MDS Coordinator/MDS Nurse that those residents listed a care plan implement for the use of splints.	MDS dentify trol esidents blan e use of trol or vill ents ctor se to who polints tare ated splints. tified, trol irse by tonly I have nted	1-12-12	

PRINTED: 12/22/2011 FORM APPROVED OMB NO. 0938-0391

SATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 1345377 NAME OF PROMOBER OR SUPPLIER GREENFIELD PLACE PARTY TYPE PRETIX PROMOBERS OR SUPPLIER GREENFIELD PLACE PROMOBERS FLAN OF CORRECTION GREENFIELD PLACE PRESIDENT OF DEFICICACIONS (EACH DEFICIENCY MUST) SEP PROCEDED BY TRULL REGULATORY OR I.SC DETHINYMO BROOMATION) F 280 Continued From page 14 revealed beginning on 12010/11 the application or the tack of application of support hose for the resident was being documented. Resident #48's care plan, last updated on 1200/11, identified "Resident is at risk for complications due to edoma site cellulitis (right) legifoci" as a problem. However, the use of support hose were ordered from the pharmacy for Resident #48's support hose were received in the facility, from the pharmacy for Resident #48's support hose were received in the facility from the pharmacy, during the first week of December 2011. This nurse reported the nursing assistants (NAs) applied the support hose to residents. At 4:30 PM on 12/15/11 Nurse #5 (a MDS nurse) stated resident care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose were received in their mall boxes. Nurse #6 reported that care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose and the analysing review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose word these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose word these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose word and any the part of	CENTER:	S FOR MEDICARE &	MEDICAID SERVICES			A STATE OF THE STA	1	D. 0938-0391	
A BUDDING STREET ADDRESS, CITY, STATE, 2P CODE 275 W STH ST GREEN/ILLE, NO. 2783.44 GREEN/I	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION				
At 1:22 PM on 12/15/11 Nurse #4 stated support hose were ordered from the pharmacy during the first least quarterly. However, she explained the MDS personnel received the pink copies of physician orders in morning meetings or in their mall boxes. Nurse #6 reported that care plans were updated following review of the score support hose to residents. At 1:20 PM on 12/15/11 Nurse #5 (a MDS nurse) stated resident care plans were updated following review of the search of the support hose of the thing the support hose of the support hose of the support hose was not documented as an intervention to the problem. At 1:22 PM on 12/15/11 Nurse #4 stated support hose were roceived in the facility, from the pharmacy for Resident #48 because of swelling in his right leg. She commented Resident #48 because of swelling in his right leg. She commented the pink copies of physician orders in morning meetings or in their mall boxes. Nurse #6 reported that care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose would be captured as a new intervention in the care plan for a resident who experienced deems and had a history of leg and	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING				
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F 280 Continued From page 14 reveated beginning on 12/01/11 the application or the lack of application of support hose for the resident was being documented. Resident #46's care plan, last updated on 12/05/11, identified "Resident is at risk for complications due to edema site cellulitis (right) leg/foot" as a problem. However, the use of support hose was not documented as an intervention to the problem. At 1:22 PM on 12/15/11 Nurse #4 stated support hose were ordered from the pharmacy, during the first week of December 2011. This nurse reported the nursing assistants (NAs) applied the support hose to residents. At 4:30 PM on 12/15/11 Nurse #5 (a MDS nurse) stated resident care plans were updated at least quarterly. However, she explained the MDS personnel received the pink copies of physician orders in morning meetings or in their mail boxes. Nurse #5 reported that care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose would be captured as a new intervention in the care plan for a resident who experienced edema and had a history of leg and	GKEENFIE	ELU FLAGE			G	REENVILLE, NC 27834			
revealed beginning on 12/01/11 the application or the lack of application of support hose for the resident was being documented. Resident #48's care plan, last updated on 12/05/11, identified "Resident is at risk for complications due to edema site cellulitis (right) leg/foot" as a problem. However, the use of support hose was not documented as an intervention to the problem. At 1:22 PM on 12/15/11 Nurse #4 stated support hose were ordered from the pharmacy for Resident #48's support hose were received in the facility, from the pharmacy, during the first week of December 2011. This nurse reported the nursing assistants (NAs) applied the support hose to residents. At 4:30 PM on 12/15/11 Nurse #5 (a MDS nurse) stated resident care plans were updated at least quarterly. However, she sexplained the MDS personnel received the pink copies of physician orders in morning meetings or in their mail boxes. Nurse #5 reported that care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose would be captured as a new intervention in the care plan for a resident who experienced edema and had a history of leg and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION	
toe amputation. Nurse #5 returned to report that the MDS Coordinator stated that initiation of support hose under such conditions should have been added to the resident care plan as a new intervention for management of edema and cellulitis.	F 280	revealed beginning of the lack of application resident was being do Resident #48's care 12/05/11, identified "complications due to leg/foot" as a probler support hose was not intervention to the property of	n 12/01/11 the application or n of support hose for the ocumented. plan, last updated on Resident is at risk for edema site cellulitis (right) m. However, the use of it documented as an oblem. //11 Nurse #4 stated support rom the pharmacy for se of swelling in his right leg. sident #48's support hose facility, from the pharmacy, of December 2011. This ursing assistants (NAs) nose to residents. //11 Nurse #5 (a MDS nurse) plans were updated at least she explained the MDS he pink copies of physician eetings or in their mail boxes. This nurse ald need to check with the make sure the use of be captured as a new are plan for a resident who and had a history of leg and rese #5 returned to report that or stated that initiation of such conditions should have estident care plan as a new	F	280	the previous day will be reviewed in the daily morning interdisciplin care management me to identify residents we new orders for support hose. Identified reside will have their care play updated and/or a new plan implemented to the use of support hose. The Rehab Director we the MDS Coordinator, Nurse will give a copy Rehab Instruction Record identifies those reside who utilize splints. The record will be used to identify residents who to have a new care play implemented or an experience.	ary eting vith t ents an v care reflect se. ill give /MDS of the cord ents ais	1-12-12	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345377	B. WIN	G		12/1	5/2011
	OVIDER OR SUPPLIER			257	ET ADDRESS, CITY, STATE, ZIP CODE 75 W 5TH ST REENVILLE, NC 27834		
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F 280	O2/19/08 with diagnory vascular accident with contractures. An annual Minimum I completed on 11/24/#111 as having mode and functional limitation one side of his up Review of Resident Rehabilitation/Restor Record, under the sudocumented the left I discontinued due to rof participation. Review of Resident # reviews had been do and 12/05/11. Under was documented; "renon-compliance behasplint, removing hand were to encourage repraise resident when counsel resident on twearing hand splint.	admitted to the facility on see of hypertension, cerebral helft hemiplegia, and joint Data Set assessment 11 documented Resident erate cognitive impairment for range of motion present per and lower extremities. #111's December 2010 ative Service Delivery immary note section; mand splint had been refusals, removals, and lack #111's Care Plan reflected ne on 06/21/11, 09/08/11 resident is exhibiting avior :application of hand displint." Approaches listed resident to wear hand splint; and medical complications of not	Ţ.	280	Audits of the care plathe identified resident with who utilize supphose and splints will be done weekly x 4 weekmonthly x 4 months trassure compliance. 4. The Quality Assurance Assessment (QA&A) Committee will review audits and to determine trends and establish corrective action base findings.	ts ort oe cs then o e & v ne	1-12-12
	at 2:05 PM and at 3: #111 sitting in a geri	of Resident #111 on 12/13/11 40 PM revealed Resident chair in his room holding his nd no splint present. When	MATERIAL PROPERTY OF THE PARTY				

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
a# delete in note kh Conho 4 con lise de su con E1 h an Fili	an interview with R and last three fines thumb and forefines an interview with R and her said Resider eft hand but it had not been sure who been sure with and clenched and no been sure with and clenched and no been sure with a splint in his room with no splint present. In an interview with N PM, she said Resident can be placed in the MDS nurses and the MDS nurses and physician orders as morning clinical meet. During an interview with N in placed a splint in the passion of the passion of the last times and the last times an	nt for his hand, Resident id not want it on and was able to open up his gers and partially open his ger. esident #111's family at 2:05 PM, the family at 2:05 PM, the family at 111 had a splint for his olonger been used as he family member said she ten she saw the splint last. In 12/14/11 at 9:05 AM 11 lying in bed with his left to splint present. Additional in 12/14/11 at 11:30 AM and sident #111 sitting in a geri his left hand clenched and urse #1 on 12/14/11 at 5:00 at #111's splint had been ept taking it off. Nurse #1 were responsible for e plans and received copies is well as updates in the lings. In the Nurse Aide (NA) #1 on NA #1 said Resident #111 st for his left hand but he la #1 said she could not the she saw the splint in in.	F 28	30			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 281 SS=D	intervention had beer expectation was the of the interventions rem In an interview with the 12/15/11 at 2:55 PM, reviewed quarterly ar. The MDS Coordinato shared at the daily clip review of new physicic Coordinator said the should have been uphad been discontinues aid all interventions each review and upda 483.20(k)(3)(i) SERV PROFESSIONAL ST. The services provided must meet profession. This REQUIREMENT by: Based on observation interviews, the facility orders for applying a incontinent care for 2 (Resident #24 and Rewas observed. Finding 1. The facility's policy Care/Incontinent Care 11/10/09, noted that pafter urination and bootntment was to be applying a sincontinent was to be applying a sincontinent Care 11/10/09, noted that pafter urination and bootntment was to be applying a sincontinent care for 2 (Resident #24 and Rewas observed. Finding 1.	a discontinued, his care plan was updated and oved. The MDS Coordinator on she said care plans were ad updated as necessary. The MDS coordinator was nical meetings as well as an orders. The MDS Resident #111's care plan dated when the arm splint d. The MDS Coordinator should be reviewed with ated as appropriate. THE MDS COORDINGTON MEET ANDARDS The MDS Coordinator should be reviewed with ated as appropriate. THE MDS COORDINGTON MEET ANDARDS The MDS Coordinator should be reviewed with ated as appropriate. THE MDS COORDINGTON MEET ANDARDS THE MDS COORDINGTON MEET ANDARDS	F 281	Employee counseling individual inservices v	were ing s #86) n (who dent ne ortance n barrier ed. im 12-29- Nursing	

PRINTED: 12/22/2011 FORM APPROVED OMB NO. 0938-0391

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F 281	O7/07/11. Cumulative hypertension, atrial fit gastroesophageal relation According to the nurse for Resident #24, who name barrier cream] incontinent episode. The Admission Minit O7/14/11 1/0/2 indicates assistance for hygier Assessment (CAA) deally living and urinate urinary incontinence incontinent of bowel of daily living CAA in dependent on staff for application of [a but the perineum and but each incontinent epistense the cream could be a laides to apply. Resident #24's care identified problems we development of present bladder incontinual approach section was protect and prevent be provided after each incontinual provided after each provided each provided after each provided after each provided eac	mitted to the facility on e diagnoses included brillation, anemia and flux disease. See aide's information sheet ich was undated, the [brand was to be applied after each mum Data Set (MDS) of sted she required moderate for toilet use and total ne. The Care Area letail included activities of ry incontinence. The CAA for indicated she was and bladder. The activities dicated she was totally or all activities of daily living. Sember 2011 order sheet an original date of 11/07/11 orand name barrier cream] to stocks of Resident #24 after sode. The order specified cept at bedside for the nurse plan, last reviewed 10/13/11,		281	2. An audit was completed all resident medical resident medical residentify those reside with barrier cream orders rewritten on all residents assure consistency withow the barrier cream physician orders were written. All barrier cream orders were written. All barrier cream orders were written. Cardexes. Nursing Stwere inserviced 12-21 thru 12-29-11 and on 12 regarding the importance of follow physician orders and applying barrier cream ordered and as specified the resident's plan of Skills validations were conducted by Nursin Administration on all nursing assistants from 23-11 thru 1-12-12 thrus assure compliance we applying barrier cream applying barrier cr	cords ents ders. were ents to th n e eam on the e aff 7-11 1-3- ing m as fied in f care. e g om 12- orith	1-12-12	

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F 281	was observed using Resident #24 into be she was in bed, NA#. When NA#2 was fini brief. She did not as cream. NA #2 was interview 4:59 PM on 12/14/20 trained to wash all a asked about use of [she reached into Redrawer for a containstated she should hashe would clean Resident was always a nurse #4 added the resident's nurse aide informati She stated aides we follow that sheet as residents. She state order for aides to ap were expected in ame cream) cream	a mechanical lift to place ad for incontinent care. Once f2 provided incontinent care. shed, she placed a clean oply any type of barrier red after the observation at O11. She stated she was reas front to back. When fa brand name barrier cream] sident #24's nightstand er of barrier cream. NA#2 ave applied the cream and sident #24 again and apply with Nurse #4, on 12/15/11 at d the nurse aides were frand name barrier cream] Interpretation of the evailable and kept at bedside. Interpretation sheet. with the Director of Nurses at 4:15 PM, she stated the for sheet was their "bible". For instructed in orientation to at directed their care for the evailable ream then the aides oply it. The DON remarked furse aides to apply [brand for after each incontinent for the cream was used as	F 28	3. Skillsl validations we completed on a min of 6 Nursing Assistathe application of be cream weekly x 4 we then monthly x 4 me Nursing Administrate assure compliance we application of barries creams. New admission to assure barrier cream order written consistently correctly. All new porders will be reviewed ally in the interdisce team meeting to idea residents with new cream orders and the Nursing Assistant Cardex will be updata appropriately.	imum ints on arrier eeks onths by ion to vith er sion ed on all s are and hysician ved ciplinary entify carrier ie

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Care/incontiner 11/10/09, noted after urination a procedure section ointment was to physician's order According to the for Resident #8 name barrier or buttocks and perisode. Resident #86 w 09/14/08. Cum respiratory failurabove the knee The Annual Mir 07/25/11 indica moderate to ex and hygiene. In Assessment (Concontinence. The most recer indicated Resident #86's identified a propressure utcers incontinence. I was to apply [b	policy for Perineal at Care for a female, last revised that perineal care would be done and bowel movements. In the on, it was noted that cream or be applied according to ers and a clean brief placed. e nurse aide's information sheet 6, which was undated, the [brand eam] was to be applied to the erineum after each incontinent ras admitted the the facility on sulative diagnoses included acute are with a tracheostomy, bilateral amputations and hypertension. Inimum Data Set (MDS) of sted Resident #86 needed tensive assistance with toileting included in the Care Area (AA)detail was urinary Int quarterly MDS of 10/10/11 Ident # 86 was incontinent of both ider and needed extensive in hygiene and toilet use. care plan, last reviewed 10/14/11, blem with being at risk for is related to bowel and bladder included in the approach section areand name barrier cream] after int episode to protect the skin and	F 281	4. The skills validation application of barricream, any deficient found and the resunew admission chawill be taken to the QA&A committee. QA&A committee verecommendations the findings of the validations and chaudits.	er Its of the Its of the It audits If facility The Vill make based on	1-12-12	

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		345377	B. WIN	IG		12/	15/2011	
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1575 W 5TH ST GREENVILLE, NC 27834			
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F 281	order sheet found in name barrier cream] buttocks and perineu episode. It also indicat bedside. During an observation 12/14/11 at 3:456 PM cleansed Resident # she had removed the brief. She did not aphis perineum or button Resident #86 had whom the sacral region fulcers. NA#3 was interviewed She stated barrier or and usually in the retremarked the [brand she had taken from the beused after incontine explanation as to who cream. During an interview of 10:20 AM, she stated expected to apply (blue after each incontiner cream was always a Nurse #4 added that resident's nurse aided.	ember 2011 physician's Resident #86 's chart, [brand was to be applied to the mafter each incontinent rated the cream could be left on of incontinent care on M, Nurse Aide #3 (NA#3) 86 to remove stool. Once estool, she placed a clean oply [brand name cream] to ocks area. It was noted nitish healed areas to his skin from previous pressure of on 12/14/11 at 4:15 PM. eams were available for use sident's rooms. She name barrier cream] which his night stand drawer could nent episodes. She had no y she did not apply the with nurse #4, on 12/15/11 at d the nurse aides were rand name barrier cream] in tepisode. She stated the vailable and kept at bedside. It was also written on the	F	281				
FORM CMS-25	67/02-99) Previous Versions Ol	osolete Event ID: GTZI		F	Facility ID: 923145	If continuation st	eet Page 22 of 46	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
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F 281 F 309 SS=D	aide information sh stated aides were in follow that sheet as residents. She state order for aides to a were expected to a that she expected in name cream cream cream episode. She added breakdown in the pused as prevention 483.25 PROVIDE CHIGHEST WELL BEACH resident mus provide the necessor maintain the higmental, and psychological solutions.	eet was their "bible". She instructed in orientation to it directed their care for the ed if a physician wrote an oply cream then the aides pply it. The DON remarked nurse aides to apply [brand in after each incontinent ed that Resident #86 had skin ast and the cream was being CARE/SERVICES FOR	F2	1. The staff caring #48 was inserv 11 regarding th importance of physician order following the replan of care to Hose as ordere	riced 12-27- ne following rs and esident's apply Ted	1-12-12
	by: Based on observative facility of 1 sampled resident physician orders for hose. Findings incomplete facility in the resident #48 was 03/25/11 and read 11/26/11. The resincluded history of August 2011), per leg edema and ce	NT is not met as evidenced ation, staff interview, and record ailed to apply support hose to 1 ents (Resident #48) with or the application of support clude: admitted to the facility on mitted on 10/28/11 and ident's documented diagnoses femoral/popliteal bypass (in ipheral vascular disease, right llulitis, right great toe elow the knee amputation, and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WNG		12/15/2011	
	OVIDER OR SUPPLIER		25	EET ADDRESS, CITY, STATE, ZIP CODE 575 W 5TH ST SREENVILLE, NC 27834		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 309	diabetes. A 11/11/11 consult do to "elevate leg & (and control swelling (of right of the control swelling (of right)." Resident #48's 11/26 set (MDS) documented (MDS) documen	ocumented for Resident #48 d) daily support stockings to ght lower leg)." order for Resident #48 nigh Ted hose h 23 " (inches), length 26", OOB (out of bed). Remove /// Quarterly minimum data ed his cognition was intact. e Aide's Information Sheet high ted on OOB, off HS." mber 2011 Medication d (MAR) documented the se were applied on 12/02/11 olan, last updated on Resident is at risk for edema site cellulitis (right) n. Interventions to this ovide treatments/meds as other 2011 MAR documented t hose were applied 12/06/11 2/11 Resident #48 was ning room. The resident was	F 309	2. An audit of the medic records on the other residents in the facility conducted on 12-26-1 identify other resident utilizing Ted Hose to a compliance with physorders. All Ted Hose of have been written on Nursing Assistants Ca Cardexs. The nursing was inserviced 12-27-thru 12-29-11 and 1-3 regarding the importational following physician's to apply Ted Hose as ordered.	y was .1 to ts assure ician orders the re staff .11 3-12 ance of	

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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				1). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		345377	B, WIN	IG		12/1	5/2011
	OVIDER OR SUPPLIER			25	EET ADDRESS, CITY, STATE, ZIP CODE 76 W 5TH ST REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	in the hallway in his word have support hose At 11:47 AM on 12/13 sitting outside the direction of the resident did not right leg. At 4:29 PM on 12/13 television room in his did not have support At 11:34 AM on 12/13 sitting outside the direction of the resident did not right leg. At 4:11 PM on 12/14 television room in his did not have support At 9:39 AM on 12/15 room. The resident his right leg. At 11:19 AM on 12/15 room. The resident his right leg. At 11:19 AM on 12/15 room about a week ago. I member had attempt to his right leg yet. Support hose were in basket on top of his had not been opene. At 1:22 PM on 12/15 hose were ordered for the support hose were support hose were ordered for the support hose were ordered for the support hose were supp	111 Resident #48 was sitting wheelchair. The resident did e on his right leg. 3/11 Resident #48 was ing room in his wheelchair. have support hose on his wheelchair. The resident hose on his right leg. 4/11 Resident #48 was in the wheelchair. The resident hose on his right leg. 4/11 Resident #48 was in the support hose on his wheelchair. The resident hose on his right leg. //11 Resident #48 was in the support hose on his right leg. //11 Resident #48 was in his did not have support hose on 5/11 Resident #48 stated he hose from the pharmacy However, he stated no staff ted to apply the support hose The resident stated the na bag which was stored in a chest of drawers. The bag	F	309	3. Audits will be condu Nursing Administrati the residents identif with Ted Hose order be done weekly x 4 we then monthly x 4 mo Nursing Administrat assure compliance we application of the Te New admission char be audited on admis assure that all Ted Horders are written of Nursing Assistant Ca Cardex. All new phy orders will be review daily in the interdisc team meeting to ide residents with Ted I and the Nursing Ass Care Cardex will be appropriately. 4. The results of these will be taken to the QA&A committee for review. The comm make recommendat based on the findin these audits	ion of ied s will weeks onths by ion to with ed Hose. Its will ssion to lose on the ciplinary entify Hose sistant updated e audits facility or ittee will ittons	1-12-12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	
		345377	B. WING		12	15/2011
	OVIDER OR SUPPLIER		257	ET ADDRESS, CITY, STATE, ZIP CODE 15 W 5TH ST REENVILLE, NC 27834		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	were received in the during the first weel nurse reported the applied the support to Nurse #4, Reside support hose some resident would occa hose and apply his stated Resident #4 and interviewable. At 1:30 PM on 12/1 did not apply anyth right leg/foot, and the regular sock on his the staff attempted resident's right leg swelling in it. The legetting support hose the resident was furthem. However, shoever refused to we took a lot of encount them on. NA #2 alsometimes remove applied them. According was alert, oriented. At 1:40 PM on 12/2 support hose had the pharmacy. She state extra support hose At 2:04 PM on 12/2 (DON) stated a factor measurements who	ge 25 sident #48's support hose e facility, from the pharmacy, k of December 2011. This nursing assistants (NAs) hose to residents. According ent #48 refused to wear the times. She explained the asionally remove the support regular socks. The nurse 8 was alert, oriented, reliable, 5/11 NA #2 initially stated she ing special to Resident #48's nat he wore shorts and a right foot. Later, she reported to apply support hose to the because he could experience NA commented the staff was e from the supply room, but ssing about having to wear he reported Resident #48 had hear the support hose; it just regement to get him to put so stated the resident would the hose himself after staff ording to the NA, Resident #48 reliable, and interviewable. 15/11 NA #3 stated thigh high to be ordered through the lated the facility did not keep in the general supply room. 15/11 the director of nursing illity treatment nurse obtained en a physician's order for ordered. She explained the	F 309			
EODM CNS 35	67(02-00) Previous Versions	Obsolete Event ID: GTZI	(11 Fac	cility ID: 923145	if continuation s	heet Page 26 of 46

out so the resident accounts could be charged. The supply clerk pulled Resident #48's account up on the computer, and reported the resident had never been charged for any support hose which were removed from central supply. F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal (assigned to care for Resident #24) was counseled and an individual inservice was conducted on 12-29-11 regarding the importance of following the policy and procedure for proper incontinent, care correctly. A skills validation		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SUF COMPLET	
PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY BUST BE PRECEDED BY FULL TAGE) PREFIX TAGE			345377	B. WNG_		12/1	5/2011
F 309 Continued From page 26 hose were ordered through the pharmacy/supply, and after they were received in the facility, NAs placed the hose on residents, and nurses observed to make sure they were applied correctly. According to the DON, she thought some support hose were also stocked in the supply room, although certain sizes might not be available at all times. At 2:38 PM on 12/15/11 treatment nurse (TN) #1 stated she measured Resident #48 for support hose, and ordered them through the pharmacy. She reported she did not think that thigh high support hose were kept in the supply room. At 3:15 PM on 12/15/11 the facility's supply clerk stated she was not aware that Resident #48 wore support hose. She reported that the facility did keep extra support hose. However, she stated any supplies which were removed by staff to use in the care of residents had to be signed out so the resident accounts could be charged. The supply clerk pulled Resident #48's account up on the computer, and reported the resident had never been charged for any support hose which were removed from central supply. F 312 SS=D DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal				S	2575 W 5TH ST		
hose were ordered through the pharmacy/supply, and after they were received in the facility, NAs placed the hose on residents, and nurses observed to make sure they were applied correctly. According to the DON, she thought some support hose were also stocked in the supply room, although certain sizes might not be available at all times. At 2:38 PM on 12/15/11 treatment nurse (TN) #1 stated she measured Resident #48 for support hose, and ordered them through the pharmacy. She reported she did not think that thigh high support hose were kept in the supply room. At 3:15 PM on 12/15/11 the facility's supply clerk stated she was not aware that Resident #48 wore support hose. She reported that the facility did keep extra support hose only in the central supply room, including thigh high hose. However, she stated any supplies which were removed by staff to use in the care of residents had to be signed out so the resident accounts could be charged. The supply clerk pulled Resident #48's account up on the computer, and reported the resident had never been charged for any support hose which were removed from central supply. 483.25(a)(3) ADL CARE PROVIDED FOR which were removed from central supply. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION
and oral hygiene. was completed on 12-30-11 to assure compliance with proper incontinent care. This REQUIREMENT is not met as evidenced	F 312	hose were ordered the and after they were replaced the hose on reobserved to make surcorrectly. According some support hose we supply room, although available at all times. At 2:38 PM on 12/15/stated she measured hose, and ordered the She reported she did support hose were keep extra support hose. She rekeep extra support hose, including thigh stated any supplies were use in the care of rout so the resident at The supply clerk pullicup on the computer, had never been chare which were removed 483.25(a)(3) ADL CADEPENDENT RESIDE A resident who is una daily living receives to maintain good nutriticand oral hygiene.	rough the pharmacy/supply, eceived in the facility, NAs esidents, and nurses are they were applied to the DON, she thought were also stocked in the certain sizes might not be support the through the pharmacy. The facility's supply clerk ware that Resident #48 wore experted that the facility did cose only in the central supply high hose. However, she which were removed by staff residents had to be signed eccounts could be charged. The central supply and reported the resident ged for any support hose from central supply. The central supply the central supply. The central supply the central supply the central supply the central supply. The central supply the central		1. Nursing Assistant #2 (assigned to care fo Resident #24) was counseled and an ir inservice was conditional importance of follo policy and procedu proper incontinent correctly. A skills was completed on to assure complian	r adividual ucted on the wing the re for care alidation 12-30-11 ce with	1-12-12

DELIMA		MEDICAID CERVICES				OMB N	O. 0938-0391
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	CORRECTION	IDENTIFICATION NUMBER:	A BUILE	DING		JOINI EL	· · ·
		345377	B. WING	3		12/	15/2011
NAME OF PR	OVIDER OR SUPPLIER	}			ET ADDRESS, CITY, STATE, ZIP CODE 5 W 5TH ST		
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F 312	by: Based on observation interviews, the facility incontinent care for residents (Resident observed. Findings The facility's policy of Care for a female, let that perineal care we and bowel movement was noted that the removed and placed washcloth with soap should be separated with the other. Gencleanse front to back organisms from convagina. A clean set used for each down be removed, hands donned. The resides side. The anal area to back manner. Goleansing, hands we donned. Cream or according to physic placed. Resident #24 was a 07/07/11. Cumulate hypertension, atrial gastroesophageal. According to the number of Resident #24, we see the part of the number of Resident #24, we see the procession of the number of Resident #24, we see the part of the number of Resident #24, we see the part of the number of Resident #24, we see the part of the number of Resident #24, we see the part of the number of th	on, record review and staff y failed to provide proper 1 of 2 sampled dependent #24) whose care was include: or Perineal Care/Incontinent ast revised 11/10/09, noted ould be done after urination ands. In the procedure section, a soiled brief should be d in a plastic bag. A wet o should be used. The labia d with one hand and washed the downward strokes to k to prevent intestinal attaminating the urethra or cition of the cloth should be award stroke. Gloves should washed and fresh gloves ent was to be cleansed in a front loves should be removed after awas to be cleansed in a front loves should be removed after ashed and clean gloves ointment was to be applied citian's orders and a clean brief admitted to the facility on citive diagnoses included I fibrillation, anemia and reflux disease. urse aide's information sheet which was undated, the [brand n] was to be applied after each	F	312	 Skills validations were conducted by Nursing Administration on all nursing assistants from 23-11 thru 1-12-12 to assure compliance with Care/Incontinent Care Policy and to assure compliance with propincontinent care. The nursing staff was inserved on 12-27-11 thru 12-2 and on 1-3-12 regardi importance of proper incontinent care. Skills validations will be completed on a minimor of 6 Nursing Assistant completing proper incontinent care weeks then monthly months by Nursing Administration to assecompliance with propincontinent care. 	n 12- h the er rviced 19-11 ng the ts on kly x 4 x 4	1-12-12

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F 312	or/14/11 1/0/2 indica assistance from staff assistance for hygien Assessment (CAA) didally living and urinary incontinence incontinent of bowel of daily living CAA independent on staff for the physician's Decented an order with a for application of [a by the perineum and but each incontinent epist the cream could be aides to apply. Resident #24's care identified problems with the direction of pressing and bladder incontinate approach section was protect and prevent be provided after each on 12/14/2011 at 4: was observed using Resident #24 into be she was in bed, NA# and pushed it down onto her left side, and underneath the dirty stated she was placing Resident #24 from we seed the seed of the provided after each control of the left side, and underneath the dirty stated she was placing Resident #24 from we seed the seed of the left side, and underneath the dirty stated she was placing Resident #24 from we seed the seed of the left side, and underneath the dirty stated she was placing Resident #24 from we seed the seed of the left side, and underneath #24 from we seed the left side of the left s	num Data Set (MDS) of ted she required moderate for toilet use and total inc. The Care Area retail included activities of ry incontinence. The CAA for indicated she was and bladder. The activities diciated she was totally or all activities of daily living. The Care Area retail included activities of remove and bladder. The activities diciated she was totally or all activities of daily living. The order sheet an original date of 11/07/11 orand name barrier cream to stock of Resident #24 after sode. The order specified tept at bedside for the nurse of the nu	F	312	4. The skills validations of proper incontinent can any deficiencies found be taken to the facility QA&A committee. The QA&A committee will recommendations bast the findings of the skill validations.	e and will e make ed on	1-12-12
		t#24 usually voided during					

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	OVIDER OR SUPPLIER	345377		2	REET ADDRESS, CITY, STATE, ZIP CODE 1675 W 5TH ST GREENVILLE, NC 27834	1 10	
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F 312	stool from the anal as she wiped, it was not a large amount of uribetween her legs on brief. NA #2 did not urine from the perine rolled her onto her belegs together. NA#2 push down into her godown the middle of the ask Resident #24 to to open them to rempooled between her flowed over and rand thighs. NA #2 did not from her upper thigh perineal area to remove the roll Resident #24 belief to the clean bried underneath her at the between her legs are not apply any type of the clean bried underneath her at the between her legs are not apply any type of the clean bried underneath her at the between her legs are not apply any type of the clean bried underneath her at the between her legs are not apply any type of the clean bried to wash all a questioned about he always placed a dia Resident #24 alway washed. She stated behind first due to the washed. She stated behind first due to the washed washed and did not be stated to the put of the commented she was observed and did not be stated to the put of the	posable wipes to remove rea wiping front to back. As led that Resident #24 voided ne which seeped down to her buttocks and the soiled use any wipes to remove the bum or the left buttock. She ack. Resident #24 held her used disposable wipes to groin areas to cleanse and he vaginal area. She did not open her legs nor did she try ove the urine that had visibly legs. The urine also had down the upper left and right of wash to remove the urine is nor did she cleanse the ove the urine. NA #2 did not ck onto her side to clean the al area after she voided. She if that she had placed the beginning of care up and taped it in place. She did	F	312			

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		345377	B. WIN	IG		12/1	5/2011
	OVIDER OR SUPPLIER			25	EET ADDRESS, CITY, STATE, ZIP CODE 575 W 5TH ST REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	into Resident #24's in container of barrier of have applied it after sin NA#2 stated she wou NA#2 commented the Resident #24's legs to She stated when an it the urine went everyor cleaned her better. During an interview vince 10:20 AM, she stated expected to apply (but after each incontinent cream was always and Nurse #4 added that resident's nurse aided. During an interview vince (DON), on 12/15/11 aide information she stated aides were instelled for aides to apply were expected to apply were expected to apply that she expected nuname cream] cream episode. The DON significant she expected the care she expected the and cleanse the residents in the residents of the point of the perine with the entire perineum as with the state of the perineum as with the	barrier cream] she reached ightstand drawer for a ream and stated she should she cleansed Resident #24. It clean Resident #24 again. It is was difficult to open o wash her inner thighs. Incontinent resident voided, where and she should have with nurse #4, on 12/15/11 at I the nurse aides were rand name barrier cream] It episode. She stated the vailable and kept at bedside. It was also written on the	Į.	312			

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F 312 F 364 \$S=D	remarked the cream preventative measur 483.35(d)(1)-(2) NUT PALATABLE/PREFE Each resident receiv food prepared by me value, flavor, and ap palatable, attractive, temperature. This REQUIREMEN by: Based on observatificatility failed to press green vegetable by on the stove and stemperature at 9:28 AM green pestove in the kitchen. At 9:48 AM on 12/14 heat of the stove but but they continued to 10:30 AM. At 10:30 AM on 12/2 green peas from the in a tray pan which we steam table which we have to 10:34 AM on 12/2 at 10:34 A	was being used as a e to prevent skin breakdown. FRITIVE VALUE/APPEAR, ER TEMP es and the facility provides whods that conserve nutritive pearance; and food that is and at the proper T is not met as evidenced on and staff interview the erve the nutrient content of a exposing it to prolonged heat am table. Findings include: tion observation on 12/14/11 as were at a full boil on the 14/11 the cook reduced the erner under the green peas, to cook at a light boil until 14/11 the cook removed the stove, and transferred them was placed into a well of the eras set on high.		312	2.	The cook on duty on 11 was inserviced or 11 on the important not exposing green vegetables to prolor heat due to the possioss of nutrient contithe vegetable. All dietary employe be inserviced by 1-1 the importance of covegetable to ensure they are not expose prolonged heat to entitional value. The nutritional value. The Registered Dietitian Manager will audit to vegetable Cooking to ensure that green vegetables are not be exposed to prolong	n 12-16- ce of nged sible cent of e will 2-12 on ooking c that d to nsure ir he /Dietary the Sheets n being	1-12-12
	green peas were the	e alternate for the lunch meal.						Į

He reported tray line temperatures were taken on foods served for lunch around 11:45 AM, and the tray line began operation at approximately 11:50

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 364 F 371 SS=E	stated when she had she placed her veget the steam table arour beginning operation to AM. She commented on the steam table lo register at least 165 cochecked using a calibitrary line started up. It important not to over they became mushy. At 10:12 AM on 12/15 dietitian (RD) and act stated green, orange should not be placed than fifteen minutes to operation. The acting these vegetables were greater the chance so mineral content would 483.35(i) FOOD PROSTORE/PREPARE/S	11 a dietary employee cooking duties in the kitchen ables for the lunch meal on ad 10:45 AM with tray line between 11:45 AM and 11:50 at she wanted the vegetables are enough that they would degrees Fahrenheit when wrated thermometer as the dowever, she reported it was cook vegetables because 6/11 the facility's registered ing dietary manager (DM), red, and yellow vegetables on the steam table more before the tray line began as DM explained the longer exposed to heat, the come of their vitamin and the destroyed. 6/URE, ERVE - SANITARY	F 364	 The cook on duty we responsible for ensithat vegetables are exposed to prolong and that they retain nutritional value. The dietary department provided with a Boi Times For Vegetable to assure compliant cooking vegetables appropriately. The Registered Dietitian Manager will audit Vegetable Cooking weekly x 4 weeks the monthly x 4 months ensure that the vegure are not being exposion prolonged heat. The results of these and any deficiencies will be taken to the QA&A committee. QA&A committee we recommendations be the findings of these 	uring 1-12-12 not ged heat in their line is was silling less sheet ice with in the store letables sed to seaudits is found facility. The vill make pased on

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	ILTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	
		345377	B. WING	3	12/	15/2011
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH ST GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
F 371	by: Based on observate facility failed to sai machine, failed to kitchenware run the sink system was so carts which were the failed to keep hot at or greater than operation of the traclean the faces of machine area and food preparations dented cans from and failed to label Findings include: 1. At 9:10 AM on a was spraying off of kitchenware into a scrubbing dirty kith wearing gloves with the wearing gloves with the wearing gloves with the wachine, removed machine, and placed machine, and placed with the wearing gloves which had be machine, and placed with the wearing gloves where the gloves with the wearing gloves with the gloves with the wearing gloves with the gloves with the gloves at this time of the gloves at this time of the gloves at this time of the gloves at this time.	And the staff interview the shitize kitchenware at the dish follow procedures to assure the staff interview the shitize kitchenware at the dish follow procedures to assure the staff interview to assure the staff interview to assure the staff interview to a staff interview the staff interview to the staff interview the staff	F3	1. The dishmachine repaired by Ecolal 14-11 to ensure the sanitizing solution reaching the dishmachine properly test the quaternary sanitizes of solution in the 3 compartment sind immediately give dietary staff on 1 make sure the solution adequate. The don duty were instantized using compartment sind importance of ledishes air dry between again. The dietary staff were inserviced 11 on the proper clean/sanitize the carts that are selected.	o on 12- nat the nis es in the erly. g strips to zing k were n to the 2-14-11 to lution was letary staff erviced on oroper way the 3 lk and the string the fore using on duty on 12-16- way to e feeding	1-12-12

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The distance stoff on duty.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SU COMPLET		
CX4) ID PREPIX TAGE SUMMARY STATEMENT OF DEFICIENCIES GREENVILLE, NC 27834			345377	B. Wik	IG		12/1	5/2011	
F 371 Continued From page 34 racks, and one removed sanitized kitchenware from the racks and placed it into storage. As kitchenware was run through the low temperature dish machine from 9:48 AM though 9:58 AM on 12/14/11 the final rinse gauge registered from 113 to 115 degrees Fahrenheit. At 10:00 AM on 12/14/11 strips, used to check the strength of the bleach-based sanitizing solution feeding into the dish machine, did not change color at all, then the sanitizing solution must not PREFIX TAG PREFIX T					25	575 W 5TH ST			
racks, and one removed sanitized kitchenware from the racks and placed it into storage. As kitchenware was run through the low temperature dish machine from 9:48 AM though 9:58 AM on 12/14/11 the final rinse gauge registered from 113 to 115 degrees Fahrenheit. At 10:00 AM on 12/14/11 strips, used to check the strength of the bleach-based sanitizing solution feeding into the dish machine, did not change color. At 10:06 AM on 12/14/11 the maintenance manager (MM) stated if the strips did not change color at all, then the sanitizing solution must not F 371 were inserviced on 12-16- 11 regarding how to ensure that soups are kept at 135 degrees or greater during the operation of the tray line. The fans in the dietary department were deep cleaned on 12-14-11 to make sure that all dust and debris were off of the fan blades and grills of the fan.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION	
immediately removed from the underted cans on 12- that solution never advanced into the dispenser. At 10:20 AM on 12/14/11 a dietary employee stated she used a strip to check the sanitizing system of the dish machine when she first came into work that morning at approximately 7:00 AM. She reported the strip she used registered 50 parts per million (PPM) hypochlorite. However, she commented no strips were used to check the sanitizing system after 7:00 AM on 12/14/11. At 4:05 PM on 12/14/11 the dish machine service representative reported air in the lines was preventing the sanitizer dispensing system. The representative reported he repaired the dish machine, and also adjusted the digital cycle timing on the dish machine. He commented that immediately removed from the undented cans on 12- 14-11 and placed on the bottom shelf in dry storage area so that the cans could be returned to the vendor. The unlabeled food items were discarded to ensure that no out of date items would be served. The dietary staff on duty were inserviced on 12-16-11 on the importance of labeling and dating all opened food items before placing those items back into storage.	F 371	racks, and one remove from the racks and please from the strength of the blease from 113 to the strength of the blease from 12/14 the strength of the blease from the strength of the dispensing system that solution never act at 10:20 AM on 12/14 stated she used a strength of the stripparts per million (PPI she commented no sanitizing system after the stripparts per million (PPI she commented no sanitizing system after the stripparts per sentative report preventing the sanitize representative report machine, and also act the stripparts from the sanitize representative report machine, and also act the stripparts from the sanitize representative report machine, and also act the stripparts from the sanitize representative report machine, and also act the stripparts from the sanitize representative report machine, and also act the stripparts from the sanitize representative report machine, and also act the stripparts from the stripp	ved sanitized kitchenware aced it into storage. un through the low chine from 9:48 AM though the final rinse gauge to 115 degrees Fahrenheit. 4/11 strips, used to check each-based sanitizing the dish machine, did not 4/11 the maintenance of the dish machine was esent in the tubing leading to mof the dish machine, but divanced into the dispenser. 4/11 a dietary employee ip to check the sanitizing achine when she first came g at approximately 7:00 AM. To she used registered 50 M) hypochlorite. However, trips were used to check the er 7:00 AM on 12/14/11. 4/11 the dish machine service ed air in the lines was sing solution in tubing from r dispensing system. The ed he repaired the dish djusted the digital cycle	F	371	were inserviced on 1 11 regarding how to that soups are kept a degrees or greater du the operation of the line. The fans in the dietar department were de cleaned on 12-14-11 make sure that all du debris were off of the blades and grills of th The dented cans were immediately removed t the undented cans on 1 14-11 and placed on th bottom shelf in dry sto area so that the cans co be returned to the vene The unlabeled food iter were discarded to ensu that no out of date iter would be served. The dietary staff on duty we inserviced on 12-16-11 the importance of labe and dating all opened f items before placing th	2-16- ensure t 135 uring tray 'Y ep to ist and e fan ne fan. from 12- e rage ould dor. ms ire ns ere on ling ood ose	1-12-12	

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURV COMPLETER	
		345377	B. WING		12/15/	/2011
	ROVIDER OR SUPPLIER		25	EET ADDRESS, CITY, STATE, ZIP CODE 75 W 5TH ST REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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	(X5) COMPLETION DATE
F 371	should register betwee Fahrenheit on the gastemperatures above degrees did not optir capabilities of the sa At 9:42 AM on 12/15 stated the staff was to the sanitizing solution machine just before kitchenware through She reported the emmachine were also so to make sure the ten recommended tempor commented strips of PPM hypochlorite. At 10:12 AM on 12/16 dietitian (RD) and act stated dietary staff we check the strength of solution as they start through and periodic the process was constaff should make sure of the dish machine degrees on the gauge of sanitizing kitchenware stacked three-compartment sanitizing solution in sanitizing solution in	ratures of the dish machine een 120 and 140 degrees uge. He explained 140 degrees and below 120 nize the sanitizing nitizing solution. //11 a dietary employee rained to use a strip to check in feeding into the dish beginning to run breakfast at approximately 9:00 AM. ployees running the dish upposed to watch the gauge inperatures were in the erature range. This employee sould register at least 50 5/11 the facility's registered ting dietary manager (DM) ras supposed to use strips to f the dish machine sanitizing ted running dirty kitchenware sally during the process until impleted. She reported the irre the final rinse temperature registered at least 150 ge during the entire process ware used during a meal.	F 371	2. All dietary staff will linserviced by 1-12-12 how to ensure that the dishmachine is proper sanitizing dishes, how properly test the quaternary sanitizing solution in the 3 compartment sink and importance of letting dishes air dry before next use, the proper sanitize the feeding that are sent to the how to ensure that are kept at 135 degrigeater during the operation of the travethe cleaning scheduling fans to ensure dust debris are removed, removal and placem dented cans, and late and dating all opened items in storage.	on he erly w to d the g the their way to carts halls, soups ees or y line, le of the and the peling	1-12-12
EODM C149.25	67/02-99) Previous Versions O	bsolete Event ID: GTZI	K11 Fa	cility ID: 923145 If	continuation shee	t Page 36 of 40

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID IN	0.0930-0331
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPE LDING	E CONSTRUCTION	(X3) DATE S COMPLE	
		345377	B. Will	1G		12/	15/2011
	ROVIDER OR SUPPLIER			25	EET ADDRESS, CITY, STATE, ZIP CODE 75 W 57H ST		
				G	REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΙX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	tray pan stacked in the water from the faucet in. At 9:28 AM on 12/14/tray pan stacked in the water from the faucet in. The cook reported staff was leaving kitch overnight. At 9:44 AM on 12/14/check the strength of sanitizing solution in system. The cook recompatible only with systems. According strips the staff were a sanitizing solutions in or four months. At 9:42 AM on 12/15/stated the dietary stakitchenware before some reported leaving wet overnight was not accomployee, after kitch sanitizing system at the it was to be stacked acriss-crossing pattern to air day. She complete using white stripshades of blue to che the kitchen sink since manager went out or explained that she not strip the stripshades of the stripshades	11 the cook obtained the top le sink, rinsed it under hot le and used it to place food 11 the cook obtained the top le sink, rinsed it under hot le sink, rinsed it under hot le and used it to place food dat this time that the PM lenware in the sink 11 the cook was asked to lenwly made up quaternary lithe three-compartment sink larieved strips which were leleach-based sanitizing lithe took, these were the lesing to check the quaternary lithe kitchen for the last three 11 a dietary employee lift was trained to air dry lacking it into storage. She likitchenware in a sink leptable. According to the lenware was run through the lenware was run through the len three-compartment sink, lusing an alternating le on the sink draining board lenented that the staff had los that changed different leck all sanitizing solutions in	F	371	3. Audits will be conductive Registered Dietitian/Dietary Moweekly x 4 weeks the monthly x 4 months assure proper sanitative dishmachine, couse of the quaternal sanitizing solution for compartment sink, sanitizing and clean dietary carts, proper temperatures, clean of fans, removal of cans, and the labelidating of opened for items to assure conwith policy and process and any deficiencies will be taken to the QA&A committee. QA&A committee was recommendations the findings of these	anager ten to to ation of orrect try or the 3 ting of or soup tiliness dented ting and tiliness dented tiliness dented tiliness dented tiliness til	1-12-12

Facility ID: 923145

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		345377	B. WIN	IG		12/1	5/2011
	OVIDER OR SUPPLIER			2!	EET ADDRESS, CITY, STATE, ZIP CODE 575 W 5TH ST BREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	dietitian (RD) and act stated the PM dietary be leaving kitchenwa. The DM stated she wastaff did not have the check the strength of 3. At 10:20 AM on 12 who had been taking she did not use any suraying the carts do near the compactor a meal carts were take onto resident halls. At 10:37 AM on 12/1 manager (MM) stated hosed down by the different an outside faucusually registered 15 when checked with a thermometer. At 2:10 PM on 12/15 thermometer system water coming from the carts were hosed do ranged from 96 to 12 MM stated he though be be at least 130 de bacteria. He explain outside water varied water was being use	y-based solutions. 5/11 the facility's registered ing dietary manager (DM) a staff was not supposed to re sitting in sinks overnight. It was unaware that the dietary correct strips with which to quaternary-based solutions. 5/14/11 a dietary employee meal carts outside stated sanitizing solution when with hot water outside area. She reported these in into the dining room and 4/11 the maintenance of that the meal carts were iterary staff with hot water et. He reported this water to to 155 degrees Fahrenheit in digital or calibrated 7/11 the MM used a digital to check the temperature of the outside faucet where meal with the temperature needed to egrees to kill germs and ed the temperature of this depending on how much	F	371			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SU COMPLE	
		345377	B. WIN	3		12/	15/2011
	COVIDER OR SUPPLIER			257	ET ADDRESS, CITY, STATE, ZIP CODE 75 W 5TH ST REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	reported, because the germs when taken the used a sanitizing solutioutside, and then spremployee commente other employees clear. At 10:12 AM on 12/14 dietitian (RD) and act stated all dietary employees and then using them down with. She that the carts be clear. 4. On 12/14/11 the luat 12:06 PM. At 12:15 PM on 12/14 used the microwave soup bowls. One bottray, and the other thof the steam table. At 12:24 PM on 12/14 employee placed the water bath on the burner of the steam table. At 12:26 PM on 12/14 removed from the horesident eating in the At 12:28 PM on 12/14 thermometer was used the soup remaining stove. The thermometer from the formometer state of the soup remaining stove. The thermometer was used the soup remaining stove.	e meal carts might pick up roughout the building, she ution to wipe down the carts ayed them with a hose. The d she was not sure how aned the meal carts. 5/11 the facility's registered ting dietary manager (DM) ployees should be hosing out a sanitizing solution to wipe reported it was important ned and sanitized. anch trayline began operation 4/11 a dietary employee to heat soup in four plastic will was placed on a resident ree were placed on the ledge 4/11 another dietary three bowls of soup in a hot riner of the stove. 4/11 a bowl of soup was t water bath and taken to a clining room.	F	371			

Facility ID: 923145

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	
		345377	B. WIN	G		12/1	5/2011
	ROVIDER OR SUPPLIER		•	2575	r Address, City, State, ZIP CODE W 5TH ST ENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	water bath on the sto microwaving soup, ar soup on the ledge of keep it hot enough. At the facility liked all hot degrees during the operation of the stated hot foods, inclust at least 135 degree entire operation of the 5. During initial tour obeginning at 10:43 Alfan had dirt and dust fan faces. There wer the back sides of both was turned toward the was not turned on du was turned toward for was not running during the floor fan in the kith blowing into the dish kitchenware was being were encrusted on the and wall fan faces. The and dirt on the back sides of the story of	rained to keep soup hot in a ve burners. She reported had then keeping bowls of the the steam table would not according to the employee, at foods to remain at 165 peration of the trayline. 5/11 the facility's registered ing dietary manager (DM) ading soups, should be kept as Fahrenheit during the extrayline. of the kitchen on 12/12/11, M, the floor fan and the wall encrusted on the grids of the extrands of dust and dirt on a fan faces. The floor fan are dish machine area, but ring initial tour. The wall fan od preparation tables, but ag initial tour. 11, during observation of the dish machine process, chen was turned on and machine area where ag cleaned. Dirt and dust agrids of the both the floor there were strands of dust sides of both fan faces.	F	371			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I.4 A. BUII		E CONSTRUCTION	(X3) DATE SU COMPLET	
		345377	B. WIN	G		12/1	5/2011
	OVIDER OR SUPPLIER			25	EET ADDRESS, CITY, STATE, ZIP CODE 75 W 5TH ST REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	stated the kitchen fan cleaned once to twice dietary staff notified the when the fans needed hosed the fans down sanitizing solution on commented is was imfaces clean so dirt an onto food and kitchen. At 10:12 AM on 12/15 dietitian (RD) and act stated dietary employ clean the kitchen fans. However, after lookin reported it appeared wiped down with a clean down and scrubbed, and dust we encruste faces, there was the kitchenware could be 6. During initial tour obeginning at 10:43 Al 10-ounce cans of madented 6-pound 11-ounce mixed in with the canned goods. At 9:42 AM on 12/15/stated dented cans we on the bottom shelf in separated from undare explained the dietary the food vendor with the food vendor with the tendor would pick up	11 a dietary employee s were supposed to be a week. She explained he maintenance department dicleaning, and maintenance outside, and used a them. The employee aportant to keep the fan digerms did not get blown aware. 5/11 the facility's registered ing dietary manager (DM) yees were supposed to sonce to twice a week. If a the fan faces were just both rather than being hosed the fan faces were just both rather than being hosed the DM commented if dirt don the grids of the fans chance that the food and contaminated. 6/ 16 the kitchen on 12/12/11, M, two dented 6-pound and arin oranges and one unce can of cheese sauce e stock of undamaged 11 a dietary employee ere supposed to be placed at the dry storage room, maged stock. She manager (DM) then notified the number of damaged ould get credit for and the the damaged goods.		371			
ORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: GTZK	.11	Fac	ility ID: 923145	If continuation she	etPage 41 of 46

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			and the second s	OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) IAI A. BUIL		E CONSTRUCTION	(X3) DATE SURV	
		345377	B. WIN			12/15	/2011
	ROVIDER OR SUPPLIER	1 010011		25	EET ADDRESS, CITY, STATE, ZIP CODE 175 W 5TH ST REENVILLE, NC 27834	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROPRIED TO THE APPROPRIED OF THE	JLD BE	(X5) COMPLETION DATE
· F371	dietitian (RD) and act stated there was a systorage room where stock was supposed reported the facility do cans because it pose residents sick from beacting to the DM measure to separate undamaged ones. 7. During initial tour beginning at 10:43 A turkey in the reach-ir label and date on it. brown bag of steak for chocolate chip cookic container of sliced stopened did not have the walk-in freezer a and a bag of breader been opened, did not them. In the dry stor waters in a plastic stopasta noodles, and a which had been opedates on them. During a follow-up to 12/14/11, beginning chicken in the walk-in pened did not have walk-in refrigerator a pickles which had belabel or date on it.	5/11 the facility's registered ting dietary manager (DM) becial section in the dry the employee putting away to place dented cans. She lid not use the food in dented at the risk of making acterial contamination. It was a good precautionary damaged food items from of the kitchen on 12/12/11, M, a plastic bag of sliced a refrigerator did not have a ln the reach-in freezer a ries, a plastic bag of e dough, and a 6.5-pound rawberries which had been labels or dates on them. In bag of diced green pepper d chicken patties which had at have labels or dates on rage room a bag of vanilla orage container, a bag of a bottle of condiment sauce ned did not have labels or	F	371			

Facility ID: 923145

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					VO. 0936-0391
STATEMENT (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE S COMPL	
		,	B, WIN				4510014
		345377	B, 7111			12	115/2011
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GREENFIE	ELD PLACE			i	675 W 5TH ST BREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	Continued From page container of brown state-ounce container of vanilla wafers in a play were opened did not them. At 9:42 AM on 12/15 stated all opened fooitems removed from supposed to have laid reported the dietary storage areas daily the following its labeling. At 10:12 AM on 12/1 dietitian (RD) and accorded the food items, pareas, or removed for packaging was respedates on the foods. The storage areas sure there were label explained the labeling important to help present to make sure the fact principle of first in-first 483.70(c)(2) ESSEN OPERATING COND. The facility must mat mechanical, electrice equipment in safe of the storage of the storage areas areas and the labeling important to help present the fact of the storage areas areas areas and the labeling important to help present the fact of the storage areas areas areas and the labeling important to help present the fact of the storage areas areas areas areas and the labeling important to help present the fact of the storage areas areas areas and the labeling important to help present the fact of the storage areas areas areas and the storage areas ar	gar in a plastic bag, a of quick oats, and a bag of astic storage container which have labels or dates on //11 a dietary employee of items, leftovers, and food their original packaging were bels and dates on them. She manager (DM) checked all o make sure the facility was policy. 5/11 the facility's registered ting DM stated whoever blaced leftovers in storage bood items from their original consible for placing labels and The DM reported she tried to as every morning to make els and dates in place. She ang/dating system was event foods from spoiling and cility was following the est out (FIFO). ITIAL EQUIPMENT, SAFE DITION intain all essential al, and patient care perating condition.		371		ng oil	1-12-12
Participants Annual	by: Based on observat	IT is not met as evidenced ion and staff interview the ntain and operate kitchen					

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES				1	0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUII	LDING			
		345377	B. WIN	G		12/1	5/2011
NAME OF PR	OVIDER OR SUPPLIER			ī	EET ADDRESS, CITY, STATE, ZIP CODE		
GREENFIF	LD PLACE			1	575 W 5TH ST REENVILLE, NC 27834		
OTCESTI IE				6	PROVIDER'S PLAN OF CORRECT	TON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR - DEFICIENCY)	JLD BE OPRIATE	COMPLETION DATE
F 456	Continued From pa equipment in a ma from harm and inju	nge 43 nner which protected the staff ry. Findings include:	F	456	the fryer cleaning sch and frying oil changin	·12 on edule	1-12-12
	1. During initial tou beginning at 10:43 was a very deep do the oil, along the si ledge/lip of the frye. At 11:44 AM on 12 deep fryer to cook haze in the kitchen the kitchen, and the open. The fumes and throats of the	ir of the kitchen on 12/12/11, AM, the oil in the deep fryer ark brown with food debris in des of the fryer, and on the			schedule. The cooks cleaning schedule was retyped so that the frequency of changing out the frye was reviewed with the to ensure that the frye would be changed ou each use to ensure the frying oil is in usable condition.	yer s r oil e staff ing oil t after	
	stated most of the department cleans the oil. However, sometimes change deep fryer if maint was too busy. The sure when the deet the oil changed. Sometimes the cook has been department of th	15/11 a dietary employee time the maintenance ad the deep fryer and changed she commented the cooks ed the 100% vegetable oil in the enance was not available or e employee could not say for ep fryer was last cleaned and she reported she thought ad the temperature of the deep when he was frying chicken on			3. The Registered Dietitian/Dietary Mar will monitor the clear of the frying machine frying oiled changed facility policy on a we basis x 4 weeks then monthly x 4 months. 4. The results of these a	nliness and per eekly	
	At 10:12 AM on 12 dietitian (RD) and stated the side do opened when the deep fryer on 12/1	2/15/11 the facility's registered acting dietary manager (DM) or to the kitchen had to be cook was frying chicken in the 4/11 because several staff ned that the smoke and odor			and any deficiencies will be taken to the fa QA&A committee. The QA&A committee will recommendations bathe findings of these	found acility ne Il make ised on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		CONSTRUCTION	(X3) DATE SU COMPLE	
		345377	B. WIN	G		12/	15/2011
	OVIDER OR SUPPLIER			2576	T ADDRESS, CITY, STATE, ZIP CODE 5 W 5TH ST EENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 456	expectation was for to deep fryer after each was not sure how oft specified the deep fry oil changed because handling that responsive was out on leave. At she was also suspicition too hot when frying on the cleaning and chafryer was not address. At 2:10 PM on 12/15 manager (MM) states not responsible for changing the oil in it. At 3:47 PM on 12/15 guidance for maintain when copies of the cobecause original pages the copying process, copy of the cleaning deep fryer was to be "as used". The adminterpret this to mear equipment was to be food debris built up in fryer, and the oil was became cloudy or the trapped in the oil counter foods cooked in 2. During observation on 12/14/14	The DM reported her the oil to be changed in the use. She commented she en the cleaning schedule yer was to be cleaned and its the administrator was sibility while the full time DM coording to the acting DM, ous that the cook had the oil hicken on 12/14/11. In cleaning schedule revealed niging of the oil in the deep sed. If the maintenance did the maintenance at the maintenance staff was eaning the deep fryer or If the administrator stated hing the deep fryer was lost leaning schedule were made es got folded under during. He reported the master schedule documented the cleaned and the oil changed inistrator stated he would in this piece of kitchen ecleaned as needed when in and along the sides of the to be changed when it ere was a chance odors ald contaminate the taste of in the fryer. In of the dish machine 1, between 9:12 AM and		456	4.1D: 0224/5		
FORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: GTZ	KH	racili	ty ID: 923145	ii continuation sh	eet Page 45 of 46

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	
		345377	B, WING		12	/15/2011
	ROVIDER OR SUPPLIER		257	ET ADDRESS, CITY, STATE, ZIP CO 5 W 5TH ST EENVILLE, NC 27834	ODE	AND
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 456	machine between the the water leaving the the drain and flooded kitchen floor. Staff m water between the di dish machine deposi used to hold the kitch. At 9:32 AM on 12/14, intervention, dietary the maintenance madrain at the dish machine drainage sy operate. At 9:40 AM on 12/14, place a drain decloge kitchen/dish machine from backing up onto At 9:42 AM on 12/15, stated there had bee kitchen/dish machine and off over the last the staff was trained backing up into the k dish machine and im At 10:12 AM the faciliand acting dietary mastaff made her aware any problems with the However, she reporte kitchen floor posed at	drained from the dish wash and final rinse cycles, dish machine backed up in a lout about four feet onto the loved back and forth in this rty and sanitized sides of the ting and retrieving racks nenware. In after surveyor staff stated they would call mager (MM) because the thine must be stopped up. Is was not the way the dish stem was supposed to In the MM stated he could ging product down the drain to keep the water of the kitchen floor.	F 456			

IEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES	vvv.	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD NG 01	COMPLEACED
	345377	B. WING	01/05/2012
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 67H ST	
GREENFIELD PLACE		GREENVILLE, NC 27:34	

(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 AN OF CORRECTION (EACH CORREC TIVE ACTION SHOULD BE CROSS-REFEREN HID TO THE APPROPRIATE D TCIENCY)	COMPLETION DATE
K 011 SS≌D	NFPA 101 LIFE SAFETY CODE STANDARD	K 011	K011 A. Fire Docr not opening properly with panic bar.	2-9-12
	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2		The Maintenance Department was informed of door 'o't opening properly with panic bar and they immediately repaired the doo so that it would open will an panic bar was pressed	· Parket and Company of the Company
K 038	l e e e e e e e e e e e e e e e e e e e	K 038	2. All door : with panic bars in facility there checked to make stire that they all opened properly when the panic but was pressed in.	
SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1		3. All door with panic bars will be crecked weekly x 4 weeks trensure they open by presting in on the panic bars. Following 1st 4 weeks the doors will be checked	
	This STANDARD is not met as evidenced by: A. Based on observation on 01/05.2012 the facility's exit doors have NC Special Locking installed on them and they all falled to release upon activation of the fire alarm and falled to release with the master switch located at the nurses station. This situation had been present for at least two (2) week according the staff. B. The staff interviewed did not know about the master door release switch located at the nurses station.		monthly ongoing. 4. The results of these audits will be knought to the facility (wellty Assurance & Assessment Committee (QA&A) to ensure that doors with panic bars open properly when panic bar is pressed in.	(xe) DATE

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

VUTA

(X2) MULTIPLE CONSTRUCTION

A, BUILDING

8. WING __

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
GREENFIELD PLACE

(X4) ID
PREFIX
TAG

REGULATORY OR LSC IDENTIFYING INFORMATION)

PRINTED: 01/08/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

01/05/2012

STREET ADDRESS, CITY, ST - FE, ZIP CODE

01 - MAIN BUILD MG 01

2575 W 5TH ST

GREENVILLE, NC 27 34

GREENFIELD PLACE				REENVILLE, NC 27 -34
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECISOR BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID Pilief TAG		PROVIDER'S F. AN OF CORRECTION (EACH CORREC' THE ACTION SHOULD BE CROSS-REPERENT FOR TO THE APPROPRIATE DI HICIENCY)
•	Continued From page 1 C. Based on observation on 01/05/2012 there were doors that required more than one (1) motion of the hand in order to exit the room; a. kitchen dry storage b, kitchen exit into corridor c. rest home dining supply room 400B 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD		038	releasing properly. Finally, the fire a arm will be activated on its regular schedule as set up by the Environn antal Services Director. The mast ar switches will be
K 051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K		tested 1 Ime per week x 1 month to ensure that when pressed: Il doors release properly. Then the master switches will be activated 1 time per month x 3 months to ensure that all doors release properly. 4. The results of these audits will be bipught to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that fire alarm an amster switches release chors when activated.
	This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 the	The second secon	The second secon	B. The Sta! Interviewed Did Not Knr w About The Master Door Release Switch Locater At The Nurses Station
			l	If continuation sheet Page 2

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(XX) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BUILDI 40 01 (X3) DATE GURVEY COMPLETED

346377

B. WING __

01/05/2012

NAME OF PROVIDER OR SUPPLIER

GREENFIELD PLACE

STREET ADDRESS, CITY, ST. 1E, ZIP CODF 2576 W 5TH ST

GREENVILLE, NC 27: 34

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUBIT HE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)	CH PRLITX BAT	PROVIDER'S F. AN OF CORRECTION (EACH CORRECT VE ACTION SHOULD BE CROSS-REFIRENC FO TO THE APPROPRIATE DE : CIENCY)	COMPLETION (XI)
К 076 s\$=D	Continued From page 2 battery back-up for the FACP would not operate the alarm and had been so for two (2) weeks according to the staff interviewed, (a)There was no audible signal at the FACP when the AC Power was disconnected. 42 CFR 483.70 (a) 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	K 051	 K076 A. Medical G as Storage 1. The oxyg in tanks in the storage room were immediat ily placed in their appropriste storage racks. 2. All areas in the facility where ox igen is in use or being stored was audited by Maint mance and Nursing S affito ensure correct si trage. 	2-9-12
	This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 there were unsecured 02 cylinders in the 400 hall storage room. 42 CFR 483.70 (a)		3. All staff vere inserviced on the proper storage of oxygen tenks by the Quality Assurance: Director. We will nonitor at least 1 times per day for the first 4 weeks at a after that we will mone or 1 times a week for the next 4 weeks to ensure tenks are being stored properly.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.

(XX) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

345377

A, BUILIDING

B. WING _

01 - MAIN BUILDING 01

01/05/2012

NAME OF PROVIDER OR SUPPLIER

GREENFIELD PLACE

STREET ADURESS, CITY, ST. FE, ZIP CODE 2576 W 5TH ST

GREENVILLE, NC 271 34

K 011 NFP/ SS=D If the nonc barrier addit corriself- This A. E door pani 42 C NFF SS=F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PA 101 LIFE SAFETY CODE STANDARD The building has a common wall with a succenforming building, the common wall is a fire prier having at least a two-hour fire resistance ing constructed of materials as required for the dition. Communicating openings occur only in critical and are protected by approved in-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 Its STANDARD is not met as evidenced by: Based on observation on01/05/2012 the fire for at room 315 could not be opened with the anic bar.	ID PREPIX TAGS	PROVIDER'S F AN OF CORRECTION (EACH CORRECT AN OF CORRECTION SHOULD BE GROSS-REFEREN(TO TO THE APPROPRIATE DE CIENCY)	COMPLETION DATE
SS=D If the nonc barrie rating addit corriself-	the building has a common wall with a inconforming building, the common wall is a fire prier having at least a two-hour fire resistance ling constructed of materials as required for the dition. Communicating openings occur only in the pridors and are protected by approvad inclosing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation on01/05/2012 the fire prior at room 315 could not be opened with the	K 011		
K 038 NFF	. Based on observation on01/05/2012 the file for at room 315 could not be opened with the			
7.1.	CFR 483,70 (a) FPA 101 LIFE SAFETY CODE STANDARD kit access is arranged so that exits are readily coessible at all times in accordance with section	K 038	KO3B A. Facility's citit doors falled to release upon activation of fire alarm and falled to release with the master switch located at nurses station.	2-9-12
A. facinst upo release nur for B. ma	his STANDARD is not met as evidenced by: A. Based on observation on 01/05.2012 the acility's exit doors have NC Special Locking installed on them and they all falled to release pon activation of the fire alarm and failed to elease with the master switch located at the jurses station. This situation had been present or at least two (2) week according the staff. B. The staff interviewed did not know about the naster door release switch located at the nurses station.		2. We immidiately contacted Solar Creations, Incland made arrangements for them to opine out to the facility of 1-5-12 to fix the circuit beard that was causing the doors to not release viten fire alarm was activated and causing the master's vitches to not	(X8) DATE

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

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Any deticiency statement ending with an exterisk (*) denotes a deticiency which the institution may be excused if an correcting providing it is determined that other sefeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the finding is added above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above finding is 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 00 program participation.

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	4-01					0900-0091
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CI IA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURV	
AND PLAN O	F CORRECTION	IDEA ILLEXTION ROSSESS	A. BU	LDING	01 - MAIN BUILD	NG 01		
		345377	B. WI	NG		•	<u> </u>	5/2012
NAME OF P	ROVIDER OR SUPPLIER	A (A parising A (A) p			ET ADDRESS, CITY, ST S W 5TH ST	· I'E, ZIP CODE		
GREENF	IELD PLACE				EENVILLE, NC 27	.34		
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.,	Continued From p. C. Based on obselwere doors that remotion of the handa. kitchen dry store b. kitchen exit into c. rest home dining 42 CFR 483.70 (a NFPA 101 LIFE S A fire alarm systematical fire alarm extinguishing syste	age 1 rvation on 01/05/2012 there quired more than one (1) i in order to exit the room; age corridor g supply room 400B	K	038	release the pressed. system we turned of members the doors no reside. The staff doors underlived at they fixed. After the fixed the activated released master so located a station we individual they released properly. 2. We have entire is once Sol replaced board. 3. The fire	doors when he door look is immediate and staff were placed to make sure its left the facility at the circuit board ire alarm was land all door properly. The itches that a sech nurse is checked by to make sech all door when pressed lidentified the lie and it was a Creations the faulty clither will be larm will be	cing city at e that cility. the ions nd coard, was as s e are s cure s d. e s fixed	2-9-12
					1 month doors at properh	 1 time per the consure the consure the consult of the con	at all re	
	This STANDARD	o is not met as evidenced by: servation on 01/05/2012 the	-		time pe	ı month x 3 n r ± that əli doo	nonths ors are	sheet Page 2 of

PRINTED; 01/08/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION				CONSTRUCTION		ŞŲRVEY LETED	
		345377	A. BUILDING B. WING	O.IIVE NIAM - 1:0		/05/2012	
	PROVIDER OR SUPPLIER	340077	2576	FAODRESS, CITY, \$1 W 5TH ST ENVILLE, NC 27	. re, zip code		
(X4) ID PREFIX TAG	#EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUS'I BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REPEREN	AN OF CORRECTION HE ACTION BHOULD BE HD TO THE APPROPRIATE CHENCY)	TUVG HOUSTHWOSE (Ax)	
K 076 \$8=D	the alarm and had according to the stace (a) There was no a when the AC Power 42 CFR 483.70 (a) NFPA 101 LIFE SA Medical gas storage protected in accord Standards for Health (a) Oxygen storage 3,000 cu.ft. are enseparation. (b) Locations for stage 3,000 cu.ft. are very 4,3.1.1.2, 19.3.2.4	the FACP would not operate been so for two (2) weeks aff interviewed. Indible signal at the FACP or was disconnected. AFETY CODE STANDARD Ite and administration areas are dance with NFPA 99. Ith Care Facilities. Ith Care Facilities. Ith consolor of greater than closed by a one-hour Imply systems of greater than one of the outside. NFPA 99 Is not met as evidenced by: Italian on 01/05/2012 there Ith consolor on 1/05/2012 there	K 076	residents 3. The FACP time per vinen 1 time months to battery be would opened that 1 would also power was 4. The resu will be be facility Q Assessment (QA&A) to doors with the contract of	es affecting this tag. Will be tested 1. Rek x 4 weeks E per month x 3 Ensure that the Rkup for the FACP rate the alarm the audible signal the when the AC I disconnected. Ts of these audits pught to the Hallty Assurance & Tt Committee Censure that The panic bars open When panic bar is	2-9-12	

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

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILD IG 01 B WING 346377 01/05/2012 STREET ADDRESS, CITY, STILTE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2575 W 5TH ST **GREENFIELD PLACE** GREENVILLE, NC 27!34 PROVIDER'S I LAN OF CORRECTION ASSE PONDO SUMMARY STATEMENT OF DEFICIENCIES ID (X4) [D (EACH CORREC VE ACTION SHOULD BE ROSS-REFEREN TO TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN YAG (CIENCY) n K 038 The staff that were on duty. 2-9-12 K 038 Continued From page 1 for 1-5-1; were inserviced C. Based on observation on 01/05/2012 there on the Mister Door Release were doors that required more than one (1) motion of the hand in order to exit the room: Switches :hat are located at a, kitchen dry storage each nurs as station. b. kitchen exit into corridor c, rest home dining supply room 400B 2. All staff in the facility were 42 CFR 483.70 (a) inservice: on the Master K 051 NFPA 101 LIFE SAFETY CODE STANDARD K 051 Door Release Switches that SS≃F A fire alarm system with approved components. are located at each nurses devices or equipment is installed according to station.. NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. 3. Audits will be performed Activation of the complete fire alarm system is by weekly x I weeks then manual fire alarm initiation, automatic detection or monthly 3 months in extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided which the staff are asked that manual pull stations are within 200 feet of about the location and nurse's stations. Pull stations are located in the purpose : I the Master Door path of egress. Electronic or written records of Release Sivitches. tests are available. A reliable second source of power is provided. Fire alarm systems are 4. The resul 3 of these audits maintained in accordance with NFPA 72 and records of maintenance are kept readily available. will be br :ught to the There is remote annunciation of the fire alarm facility Quality Assurance & system to an approved central station. Assessment Committee 9.6 (QA&A) t) ensure that fire alarm and master switches release diprs when activated This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 the

STATEMEN'	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION 01 - MAIN BUILD	J.	(3) OA'TE SURVEY COMPLETED
		345377	B. WING			01/05/2012
	PROVIDER OR SUPPLIER	### THE TENT OF TH	257	ET ADDRESS, CITY, ST 5 W 5TH ST EENVILLE, NC 27		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAGH CORRECT CROSS-REFERENT	AN OF CORRECTION AN ACTION BHOULE OF THE APPROPRICE OF T	D.BE COMMITTION
K 051	the alarm and had according to the sta (a) There was no a when the AC Powe 42 CFR 483.70 (a)	the FACP would not operate been so for two (2) weeks	K 051			2-9-12
\$S=D	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			will be b facility C Assessm (QA&A) alarm ar :	Is of these auditionality Assurance and Committee on ensure that find master switches when	its .
	A. Based on obser	s not met as evidenced by: vation on 01/05/2012 there cylinders in the 400 hall				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IULTIPI ILDING		TRUCTION MAIN BUILD	⊌G 01	COMPL	
		345377	8. 1/1	νς <u>.</u>			1 m th + + +	01/0	05/2012
	ROVIDER OR SUPPLIER			267	5 W 5TF		TE, ZIP CODE		•
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K 038	were doors that red motion of the hand a. kitchen dry stora b. kitchen exit into c. rest home dining 42 GFR 483,70 (a) NFPA 101 LIFE SA A fire alarm system devices or equipmed NFPA 72, National effective warning of Activation of the comanual fire alarm is extinguishing system patient sleeping are that manual pull stanurse's stations. Pour of egress, Elets are available, power is provided, maintained in accords of maintained and the cords of the cords of maintained and the cords of th	vation on 01/05/2012 there quired more than one (1) In order to exit the room; ge corridor supply room 400B		038	2.	All doors to exit round this required door han: All doors to exit round this required door han: All doors to exit round this required door han: be monit: basis to contain the resistant monites the resistant monites the resistant han the resistant has the resistant han the resistant has the resist	n the facility pensure that ofion was ned im. Any door did not mee ement had a	t only eded were t only eded r et new will nthly ly 1 d to k ore	2-9-12
	This STANDARD A. Based on obse	ls not met as evidenced by: vation on 01/05/2012 the		AMARIA AMARIAN	4.	will be b a facility C a Assessman (QA&A) a alarm ar d	is of these at ought to the pality Assurar nt Committe o ensure that I master swit pors when	nce & e t fire	

PRINTED: 01/08/2012 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES SYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING 01 - MAIN BUILD #G 01 p, WING_ 345377 01/05/2012

NAME OF PROVIDER OR SUPPLIER

GREENFIELD PLACE

STREET ADDRESS, CITY, ST . FF., XIP CODE 2575 W 5TH ST

GREENWILE NO 27 94

GIVERIAL.	ICLD PLAGE	GREENVILLE, NC 27 94					
(X4) ID PREFIX YAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREHIX TAG	PROVIDER'S F AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENT FD TO THE APPROPRIATE O) FICIENCY)	IX5; RUMIT THIN HAG			
K 038	C. Based on observation on 01/05/2012 there were doors that required more than one (1) motion of the hand in order to exit the room; a. kitchen dry storage b. kitchen exit into corridor c. rest home dining supply room 400B 42 CFR 483,70 (a)	K 038	KO51 A. The Batte y Back-up For The FACP Would Not Operate he Alarm. No Audible Signal At The FACP When The AC Power Was Disconne led. 1. The Mair tenance Department immediately called the vendor who supplies the backup batteries and they stated that the lighteries we had ordered the instock and they were brought out to the facility on 1-5-12 to replace the batteries that were death. Once the new batteries were installed the system was checked to make suilt that the battery backup for the FACP would operate he alarm and that there would be an audible signal at the FACP when the AC Power was	2-9-12			
	A. Based on observation on 01/05/2012 the		disconnerted.	<u></u>			