PRINTED: 12/07/2012 FORM APPROVED OMB NO. 0938-0391

,	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION (UZ)	(X3):DATE SU COMPLET	
·		345014	B. WIN	G		11/3	0/2012
	ROVIDER OR SUPPLIER	NSBORO		12	EET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	PRIVACY/CONFIDER The resident has the confidentiality of his or records. Personal privacy inclumedical treatment, we communications, personal privacy inclumedical treatment, we communications, personal record for each resident release of personal are individual outside the section, the resident release of personal are individual outside the The resident's right to and clinical records do resident is transferred institution; or record resident is transferred institution; or record resident is required by healthcare institution; contract, or the resident form or storage merelease is required by healthcare institution; contract, or the resident form of	right to personal privacy and repersonal and clinical ades accommodations, itten and telephone sonal care, visits, and desident groups, but this acility to provide a private at. paragraph (e)(3) of this may approve or refuse the ad clinical records to any facility. refuse release of personal mes not apply when the to another health care alease is required by law. confidential all information and records, regardless of another aw; third party payment aw; third party payment and the facility failed to treat assident with dignity and generally if she could ttorney. This was evident	F	164	Preparation and/or execution of this correction does not constitute admiss agreement by the provider of the true alleged or the conclusions set forth is statement of deficiencies. The plan of correction is prepared and/or execut because it is required by the provision federal and state law. F164 Resident #102 received mail delive her on 11/23/12. Resident #102 me the administrator on 11/26/12 regiment concerns regarding mail delive mail delivery preferences for resident and the delivery preferences for resident preferences was conducted by the Services Director. An audit of all resident mail delivery preferences was conducted by the Services Director and the Director Nursing on 11/30/12 to ensure all residents in the facility had a listed preference. Any residents found in have a listed preference had their information updated. The mail prelist was verified by the Social Services Director on 12/3/12 to ensure that and oriented residents were listed.	sion or th of facts in the of ted solely ons of vered to tet with the tery Social of d to to teference vices all alert	12/21/12
30RATORY DI	rector's or provider/sl	PPLIER REPRESENTATIVE'S SIGNATURE	84	La	utive Breitor	12	(6) DATE .//4/12

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.

Event ID: JFIJ11

FORM CMS-2567(02-99) Previous Versions Obsolete र ध्रीतिक (प्यूड़ा

Facility ID: 953201

If continuation sheet Page 1 of 17

No the Ha 5-04134 १८ विश्व

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3):DATE S	
	· 客間的	345014	B. WIN	IG		, 11/	30/2012
	ROVIDER OR SUPPLIER	ISBORO	·	1:	REET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST BREENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
	11/1/12. A review of the dated 11/6/12 revealed and oriented and able. An interview with Resi 2:42 PM revealed she facility had someone or make sure she was all her attorney. She state did not want my (family something from my att was waiting for the writing attorney. When I vimember) on Saturday the facility called her to me (resident) have this "Why would they call he Why did not they just or resident indicated she and was told they (facility check on these kind residents involved were mail from attorneys. She furious and was very assaff member in how dark correspondence from a aware of all my senses. An interview with Residmember on 11/27/12 at was surprised the facilities.	dmitted to the facility on the Minimum Data Set (MDS) d Resident #102 was alert to make her needs known. Ident #102 on 11/27/12 at was very upset that the all her (family member) to owed to receive mail from the d'It burned me, what if I y member) to know I got orney." She continued, "I tten correspondence from sited with my (family she told me someone from to ask if it was okay to let to mail from the attorney". The spoke with a staff member lity staff) sometimes have of things to make sure the to competent to receive the continued she still was energy. She stated to the the you question me getting enyone, I am alert and the really burned me." It really burned me."	F		Facility staff were inserviced by Director of Nursing Services and of Clinical Education regarding prand confidentiality with specific eon mail delivery. Staff were also inserviced on printing the mail prolist from the facility electronic merecord system. The Admissions stinserviced by the Director of Nurs Services on completing this information admission. The Director of Nursing Services, Services Director, Director of Cline Education and/or the Unit Manage audit all newly all new admissions ensure that there is a mil delivery preference in the electronic medicarecord system. This audit will be conducted daily, five days per wee four weeks, then three times per we four weeks, then once weekly for tweeks. The results of this audit will be rev by and brought to the Quality Asse Performance Improvement Commit Meeting by the Director of Nursing Services. Any issues or trends iden will be addressed by the Quality Assurance Performance Improvem Committee as they arise and the ple be revised as needed to ensure conformance.	Director rivacy emphasis eference edical aff were sing mation Social nical ers will to al ek for eek for four iewed ssment ttee Stiffed ent an will	

PRINTED: 12/07/2012 FORM APPROVED

CENT	ERS FOR MEDICARE &	MEDICAID SERVICES					FORM APPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE	E CONSTRUCTION	(X3) DAT	B NO. 0938-039 E SURVEY IPLETED
	4 入程	345014	B. Wil	NG			11/20/2012
NAME OF	PROVIDER OR SUPPLIER		L	STREE	TADDRESS, CITY, STATE, ZIP CODE		11/30/2012
GOLDE	N LIVINGCENTER - GREE	NSBORO		1201	I CAROLINA ST EENSBORO, NC 27401		
(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 SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	4 cour		1	į			1
F 164	4 Continued From page		F	164			
	stated "when I spoke was very upset they h	with her that afternoon she ad called me."					: !
	An interview with the	Administrator on 11/29/12 at	:	1			i I
	11:07 AM revealed sh	e was called by the MOD	:	:			
	(manager on duty) wh	o was concerned the					į
	attorney and wanted to	a large package from an	!	į			i
	give it to the resident	o make sure it was okay to She indicated she told her		-			j
	(MOD), Resident # 102	2 was new to the facility	i i	i			!
	and she was unsure of	her cognition or situation.	:				:
	She instructed the MO	D to call the family to	1	1			
	check to see if it was o	kay with them that she					
	received mail from an a	attorney. She further					!
	have wanted the family	ought the resident may not to know she contacted an		j			ļ
	attorney. She stated "	I spoke with the resident to		ļ			
	apologize for upsetting	her. "	!				
!	An Interview Male 41-		1	İ			:
	An interview with the se	ocretary on 11/29/12 at O on the day the package		1			
	was received), indicated	I she was concerned		İ			
:	when this large package	from an attorney was					
	sent to a resident. She i	ndicated she called the					
İ	Administrator to make s	ure the resident was alert					
	and able to receive a pa	ckage. She was unsure		!			
į.	now to check herself if the	his resident was alert and					
İ	able to receive mail. She directions from her Admi	was following the		1			
	483.15(a) DIGNITY AND		E 044	!			1
	INDIVIDUALITY	, , , , , , , , , , , , , , , , , , , ,	F 241	11			!
; -	The facility must promote	Care for residents in a		!			
	manner and in an enviror	nment that maintains or		!			
•	enhances each resident's	s dignity and respect in		1			
f	ull recognition of his or h	er individuality,		1		:	
	() ()	-					
	V 14					1	1
						1	1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION	(X3)*DATE SURVEY COMPLETED	
· · · · · · · · · · · · · · · · · · ·	•		A. BUILDING	<u></u>	,	
		345014	B. WING		11/30/2012	
	ROVIDER OR SUPPLIER LIVINGCENTER - GREEN	ISBORO	1	REET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST GREENSBORO, NC 27401	:	
(X4) ID PREFIX TAG	(ÉACH DEFICIENC REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	ON
	by: Based on observation interviews, and record provide privacy bag of drainage bags. This we residents with externa 174). The facility falled oriented resident with if she could receive me was evident for 1 of 1 Findings included: 1. A review of the (min 11/02/12 Resident # 1 facility on 11/10/12 due abdominal surgery. Reoriented and able to me A review of the Care Prevealed the resident in non pressure related to (external drainage bag tube. There were no in for the covering of the An observation on 11/2 Nurse # mentered the reliquid stool from two ex Both bags were not constool. One of the bags side of the resident on other bag was hanging on the right side of the	is not met as evidenced as, staff, family and resident beta review, the facility failed to overs for two external as evident for 1 of 2 Il drainage bags (Resident # d to treat an alert and dignity by asking her family ail from her attorney. This resident. (Resident #102) Immum data set) MDS dated 74 was admitted to the et to complication following esident # 174 was alert and ake needs known. Ilan dated 11/02/12 and altered skin integrity or Abdominal fistulas/ Eakin b), pouch place, and gastric terventions documented external drainage bags. 17/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags. 18/7/12 at 2:00 PM revealed esident's room to empty sternal drainage bags.	F 241	A dignity bag was provided for #174 on 11/30/12. Resident #174 longer a resident in the facility. Resident #102 received mail deliher on 11/23/12. Resident #102 rethe administrator on 11/26/12 rether concerns regarding mail delimail delivery preferences for resi #102 was updated on 11/30/12 by Social Services Director. An audit of all residents in the fact who had drainage bags was conducted by the Director of Nursing Services 11/29/12 to ensure dignity covers place for drainage bags. No other residents were found to be affected. An audit of all resident mail delive preferences was conducted by the Services Director and the Director Nursing on 11/30/12 to ensure all residents in the facility had a listed preference. Any residents found in have a listed preference had their information updated. The mail prelist was verified by the Social Services Director on 12/3/12 to ensure that and oriented residents were listed.	ivered to met with garding very. The ident y the cility pacted by on were in d. ery Social of to ference vices	2

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STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3)*DATE SURVEY COMPLETED	
		;	A. BUIL	טווועט		,	
	STATE OF THE STATE	345014	B. WINC	3		11/3	0/2012
	ROVIDER OR SUPPLIER LIVINGCENTER - GREEN	ISBORO		12	EET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	An observation on 11/Nurse #1 entered the liquid stool from two d were not covered and of the bags was hanging on the intrave of the resident. Both the staff, residents, and vicentering the resident the two bags and exite drainage bags uncovered and was hangthe left of the resident on the right side of the uncovered drainage bags uncovered and was hangthe left of the resident.	and exited the room leaving covered. 28/12 at 12 noon revealed resident's room to empty rainage bags. Both bags contained liquid stool. One ng on the left side of the e table. The other bag was nous pole on the right side bags were in full view of sitors passing by or s room. Nurse #1 emptied of the room leaving the red. 28/12 at 3:20 PM revealed sing approximately 300 cc sinage. The bag was not ing on the bedside table to On the intravenous pole resident's bed another ig was noted to contain of dark brown liquid. Both of staff, residents, and	F 2	241	Facility nursing staff were inserthe Director of Clinical Education Director of Nursing on ensuring drainage bags were covered to expected the dignity. Facility staff were inserviced by Director of Nursing Services and of Clinical Education regarding and confidentiality with specific on mail delivery. Staff were also inserviced on printing the mail plist from the facility electronic in record system. The Admissions inserviced by the Director of Nu Services on completing this infoon admission. The Director of Clinical Education Unit Managers will audit resident have drainage bags to ensure that covered. This audit will be conducted ally, five days per week for four then once weekly for four weeks.	on and the all insure of the dispersion of the d	
	An interview with the re PM revealed he hid the had company or went of want anyone to see the drained from them. He them, and they do not of drained, when thirst can to put them in, but now	drainage bags when he out of the room. He did not drainage bags or what stated "the nurses empty cover them after they are the staff just hang them d the other pole. I prefer			The Director of Nursing Services Services Director, Director of Cli Education and/or the Unit Managaudit all newly all new admission ensure that there is a mil delivery preference in the electronic media record system. This audit will be conducted daily, five days per we four weeks, then three times per value four weeks, then once weekly for weeks.	nical pers will s to cal ek for veek for	

Facility ID: 953201

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	PLE CONSTRUCTION	(X3) DATE SU	
7.11.57.5.11.0	OOMEDITOR	DENTING AND AND AND AND AND AND AND AND AND AND	A. BUI	LDING	3	""" ==	
	Reserve	345014	B. WIN	G		11/3	0/2012
	ROVIDER OR SUPPLIER	: Ispôno			EET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST		
GOLDEN	LIVINGCENTER - GREEN	ISBURU		G	REENSBORO, NC 27401		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
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		_					
F 241	Continued From page	5	F:	241	The results of this audit will be re		
		200/40 - 4.7.40 444 - 111 11	1	i	by and brought to the Quality Ass Performance Improvement Comm	nittee	
		29/12 at 7:10 AM with the	:		Meeting by the Director of Nursi	ng	
		2 uncovered drainage bags. h milky brown drainage was	!	1	Services. Any issues or trends ide	entified	į (
	_	le table to the left of the		1	will be addressed by the Quality		!
		covered bag with dark			Assurance Performance Improve	ment	
		ling on the intravenous pole		:	Committee as they arise and the p	olan will	!
	on the right side of the	• •			be revised as needed to ensure co	ntinued	
					compliance.		!
		MDS Nurse on 11/29/12 at	1		Comp		¹
	7:45 AM revealed the						
1	drainage bags should			i			
	(gastro intestinal altera			1			
!		its with external drainage is on the care plan which	1	į		:	
:		s for the drainage bags at	1	l			
!	all times.	3 for the dramage bags at	i				
	1.772		!				
į	An interview with the (staff development	i	1		!	1
-		the Unit Charge Nurse on		1			
1	11/29/12 at 7:35 AM re		,				
:	expectation was that a	ll external drainage		1		1	
		be covered with a dignity				į	
		nt was in their room or in a		i			
	public area. The Unit C	harge Nurse agreed.	:	!			
ar.	An interview with (nurs	ing assistant) NA #1 on				1	
		vealed all drainage bags	; r	1		:	Í
		vers on them. She stated		į		<u> </u>	
	" Resident # 174 had d			!		1	
The state of the s		She continued, she was		;		į	
i	unsure if they had priva	acy bags on them. "	,	Ì		!	
j :	Interview with NA #2 or	11/29/12 at 7:40 AM		ļ			
		n a drainage bag should		İ			1
		nem and they should not					İ
		icated she was unsure if	:	İ			
: 1	Resident # 174 had priv	acy bags since the					
	* *			- 1			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
		345014	B. WING		11	/30/2012
	ROVIDER OR SUPPLIER	ENSBORO	1201	ADDRESS, CITY, STATE, ZIP CODE CAROLINA ST ENSBORO, NC 27401		
(X4) ID PREFIX TAG	. (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
			!			
F 241	Continued From pag	ge 6	F 241			;
	nurses took care of	them.				
	Interview with the Do 11/29/12 at 8:09 AM was that all drainage bag and kept off the supposed to be putti drainage bags and the make sure they were drainage bags were place them back in the should be making sure. She stated Resmoom and no one conwould not matter excanyone walking by control they really should be interview with Admin AM indicated her experience of the bags where seen the bags with the presence of the drainage with Nui AM indicated the resimplements.	ON (director of nursing) on revealed her expectation a bags were kept in privacy floor. The NAs were ing the privacy bags on the he nurses follow behind to be covered. After the external emptied the nurses should the privacy bags. All staff ire the privacy bags were in ident # 174 was in a private all see them (the bags), so it teept if the door was open an see they are uncovered so in privacy bags at all times. " instrator on 11/29/12 at 8:11 bectation was that all the dible covered. The staff was sure it was covered. The nade rounds and they should were uncovered. The see #1 on 11/29/12 at 8:48 dent got up by himself so he is bags from the privacy				
	should make sure the times: She indicated place them back in th drained them the other	staff that went into his room bags were covered at all she must have forgotten to e privacy bags after she er day.				
	11/1/12. A review of the	s admitted to the facility on ne Minimum Data Set (MDS) ad Resident #102 was alert				

4. 10 g

The second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a second section in the second section in the second section is a section section in the section is a section section in the section section in the section section is a section	TO OTT WILLDION IL G	MICDIONID OCITATOCO	The state of the s	out, satisfying all all a set		UIVID I	NO. 0936-039 I
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i	: 1643 } E		7. 80	LUING			
	1 M.S.A.	345014	B. WIN	1G	****	11	/30/2012
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - GREEN	ISBORO			CAROLINA ST		
				GRE	EENSBORO, NC 27401		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID .		PROVIDER'S PLAN OF CORRECT		(X5)
TAG		SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETION DATE
					DEFICIENCY)		
E 0.44	i			!			
F 241	Continued From page		F	241			i
	and oriented and able	to make her needs known.					!
	: An interview with Resi	dent # 102 on 11/27/12 at		i !			1
		was very upset that the					!
		all her (family member) to	1				
		owed to receive mail from		:			1
	her attorney. She state	ed "It burned me, what if I	1				
;		y member) to know I got		į			
i	something from my att	orney." She continued, "I		1			ļ [
	was waiting for the writ	ten correspondence from					
i	my attorney. When I vi		1				
į	the facility called her to	she told me someone from ask if it was okay to let					
	me (resident) have this	mail from the attorney ".	į				
	"Why would they call he	er, I am not incompetent.					
		ome to talk to me?" The					
		spoke with a staff member					
i	and was told they (facil	ity staff) sometimes have	1				
	to check on these kind	of things to make sure the					
	residents involved were	competent to receive		i			
		e continued she still was	i	!			
	furious and was very an		İ			i i	
		you question me getting		!			
	correspondence from a	•	1	j			
	aware of all my senses.	it really burned me."	1	j			
	An interview with Reside	ent # 102 's family	:				
	member on 11/27/12 at	•		ļ		i	
	was surprised the facility			1			
r	esident getting mail. Sh	e indicated the resident	i	i			
	vas aware of her rights.						1
		h her that afternoon she		i			1
; v	vas very upset they had	called me."					1
i	teat 1 t		,			!	1
		ministrator on 11/29/12 at					
	1:07 AM revealed she v						
	manager on duty) who v						
. re	esident received such a	rarge package from an		į			1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	G. Marine	345014	B. WIN	G			1/30/2012	
	ROVIDER OR SÚPPLIER	NSBORO		1201	ADDRESS, CITY, STATE, ZIP CODE CAROLINA ST ENSBORO, NC 27401			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	give it to the resident. (MOD), Resident # 10 and she was unsure of She instructed the MC check to see if it was received mail from an indicated she never the have wanted the familiattorney. She stated apologize for upsettin. An interview with the state of the familiattorney and the familiattorney in the state of the familiattorney. She stated apologize for upsettin. An interview with the state of the familiation of the familia	to make sure it was okay to She indicated she told her 12 was new to the facility of her cognition or situation. 2D to call the family to okay with them that she attorney. She further rought the resident may not by to know she contacted an 1 spoke with the resident to g her. 1 spoke with the resident to g her. 1 spoke with the resident to g her. 1 secretary on 11/29/12 at 2D on the day the package ed she was concerned ge from an attorney was a indicated she called the sure the resident was alert package. She was unsure if this resident was alert and he was following the ministrator. SW (social Worker) on revealed resident 's mail ties coordinator to distribute the manager on duty the weekends. If a resident ey should automatically get them. ctivity coordinator on vealed an alert resident heir own mail, but if they opening the mail, or	F2	241				
	concluded. 483.25(c) TREATMEN	T/SVCS TO	F 31	4			:	

1 5 kg = 1.

12.13 13.14 15 172.44 15 182.5 15.8

STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3):OATE SURVEY COMPLETED	
		345014	B. WING	W-417-4-1	11/30/2012	
	ROVIDER OR SUPPLIER	NSBORO	1:	EET ADDRESS, CITY, STATE, ZIP CODE 201 CAROLINA ST REENSBORO, NC 27401		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	TION
	PREVENT/HEAL PR Based on the compreresident, the facility nowho enters the facility does not develop preindividual's clinical conthey were unavoidably pressure sores receives ervices to promote hyperentinew sores from the preventinew ore in the preventine sore and the preventine sore in the preventine sore and the preventine sore in the preventine sore in the preventine sore in the prevention of the prevention in the prevention of the prevention in the prevention of the prevention in the prevention of	chensive assessment of a nust ensure that a resident without pressure sores soure sores unless the ndition demonstrates that e; and a resident having res necessary treatment and realing, prevent infection and reduced ms, record reviews, and staff failed to provide a medically ein supplement and an oral at to assist in the healing of of 3 sampled residents.	F 314	The responsible party and atter physician were notified of the protein order and the date the protein was started for residennew orders were received. An medication administration recoprinted and placed on the mediadministration record of reside the Director of Nursing Service. An audit of all residents who hid dietary recommendations was by the Director of Nursing Service Director of Clinical Education. Managers, and Nursing Supervite the previous sixty days to ensure with needed follow up. No othwere found to be affected. The facility nurses were education Director of Clinical Education Director of Nursing Services of dietary recommendation proceensuring that dietary recommendation proceensuring the proceensuring that dietary recommendation proceensuring that dietary recommendation proceensuring the proceensuring	liquid iquid it #124. No ew ord was re- ication int #124 by es. ave had conducted vices, Unit visors for are that there indations er residents ted by the and in the ess and indations	2

PRINTED: 12/07/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3):DATE SURVEY COMPLETED		
	。 [2] [4] [3] [4] [4]	345014	B. WING		11/30/2	012
	ROVIDER OF SUPPLIER OF SUPPLIER LIVINGCENTER GREE	NSBORO	12	EET ADDRESS, CITY, STATE, ZIP CODE 01 CAROLINA ST REENSBORO, NC 27401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	The resident's care preadmission to the far planed for pressure untrient needs related Interventions listed in inspections, treatmer ordered, vitamin and monitor lab data, and changes. A review of the nursing 10/26/12 revealed a puttock that measure 2.5cm. The wound will pressure ulcer (partinvolving epidermis, of the resident was read 11/8/12. A review of the assessment revealed pressure ulcers. The documented to measure assessed as being untof wound bed by slow buttock area measure staged as a suspected. A dressing change to observed on 11/29/12 measured 1.6cm x 2.0 observed to be clean, surrounding skin had was no drainage. The A review of the dietary revealed an update by 11/16/12. The dieticia	lan was updated upon cility. The resident was care ilcers and for increased d to wound healing. Included: weekly skin has as ordered, diet as supplements as ordered, notify MD of weight and a session assessment on pressure ulcer on the right d 0.5 cm (centimeters) x has assessed to be a Stage had thickness skin loss dermis or both). Idmitted to the facility on the nursing admission documentation of bilateral right buttock area was used to coverage gh and/or eschar. The left d 5cm x 3cm and was deep tissue injury.	F 314	An audit of dietary recomme changes in will be reviewed Director of Nursing Services Clinical Education, or Unit I the morning meeting weekly months to ensure that recommend with changes that are needed medication administration reaction. The results of these audits we reviewed by and brought to the Assessment Performance Implementation Committee Meeting by the Director Nursing Services. Any issues identified will be addressed by Assessment and Assurance Countries and the plan will be needed to ensure continued continued to the services.	by the s, Director of Managers in for two mendations on the cord. ill be he Quality provement birector of or trends by the Quality ommittee as e revised as	

A. A.

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ATEMENT	OF DEFICIENCIES	WEDICAID SERVICES		****		OWR	NO. 0938-039
D PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE	CONSTRUCTION	(X3) DATE	
			A. BUIL	DING	-	СОМР	PLETED
	•	345014	B. WING	3		İ	
ME OF PI	ROVIDER OR SUPPLIER						1/30/2012
OI DEN	LIVINGCENTED				ADDRESS, CITY, STATE, ZIP CODE		
LDEN	LIVINGCENTER - GREEN	ISBORO	Ī		CAROLINA ST		
X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		GKE	ENSBORO, NC 27401		
REFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	! ID PREFIX		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	ORRECTION	(X5)
AG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE	E APPROPRIATE	COMPLETION DATE
	ST 478				DEFICIENCY)		
314	Continued From	44		:			
	Tom page		F 3	14			'
í	enhance healing of wo	ounds), large protein	1				i i
	portions for all 3 daily i	meals, a regular diet, and	'				
	as consuming 67% -	esident was documented		i			
	as consuming 67% of	meals.	:	!			
1	Resident #124 had had	seline Albumin levels drawn					
!	upon entry to the facilit	v Alhumin levels grawn	1	i			1
- !	monitored for wound he	ealing. Normal Albumin		į			
	levels are in the range	of 3.8 -5.3g/dl. Resident		į			
	#124 had an Albumin le	evel of 3.8a/dl on	:	[
1	10/31/12. Her hospital	discharge labs on 11/8/12					
	documented a level of 2	2.9g/dl. The physician had	!				
r	not ordered any further.	Albumin levels drawn.	i 1				
Δ	review of physician or	ders for Resident #124	: 				
re	evealed an order on 11	/16/12 for Pro Stat /a		İ			
р	rotein supplement) 30	ml 2 times a day and					
D	ecubi-Vite (a multi vita	min with the additives					
V	itamin C and Zinc) 2 ta	blets twice a day.					
1	\$ 100 P					!	
Α	review of the Medication	on Administration Record				Į į	- 1
_	MAR) for Resident #124	revealed no		!			I
do	ocumentation the reside	ent had received the		į			
or	dered supplements Pro	stat or Decubi-Vite.				į	
Ir	ne supplements were no	ot listed on the MAR for	!				1
ro	Iministration, Resident	#124 was receiving a					1
100	gular Multi Vitamin onci	e daily.					ı
An	interview was conduct	ed with the facility					
die	etician on 11/29/12 at 4	45 PM He stated he					
ha	d reviewed the labs and	documents from the				ļ	1
hos	spital discharge of Res	ident #124. He	1			1 1	}
rev	ealed he recommende	d the protein	i			1	ł
sup	oplement and specific v	itamin due to weight				į	1
los	s and the presence of a	n increasing decubitus				i	1
on	the right buttock.		1			!	ŀ

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345014	B. WING	11/30/2012				
	ROVIDER OR SUPPLIER	ENSBORO	1201	T ADDRESS, CITY, STATE, ZIP CODE I CAROLINA ST				
			GREENSBORO, NC 27401					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION			
E 044	0	40	F 314					
F 314	Continued From pa	▼	F 314					
		pm revealed she had seen						
		mmendations on 11/16/12 and						
		e Practitioner (PA). The DON						
		her a verbal order for Pro Stat /ite. The DON stated she put	;					
		the computer, made a MAR	1		:			
		ations, and filled out a dietary						
		etary changes on 11/16/12.			:			
		the dietary slip in the dietary						
		and gave the MAR and the						
		taff nurse on duty. The staff						
		put the physician order in his						
		nd to add the MAR page to the						
	current MAR for res	sident # 124.						
		out on sick leave and could ohone for an interview.						
	An interview was co	onducted with the Facility						
		cist on 11/29/12 at 5:45 PM.						
		rence between a regular multi						
		ered Decubi-Vite was the						
		Vitamin C which are believed						
	to assist with healin	g. The Pharmacist revealed						
		any research studies that	1					
		promoted healing. She						
		sicians order Pro Stat to			:			
		otein levels for healing. The						
	Pharmacist stated	she always defered to dietary						
		more about nutrtion and went						
	with their recommer	ndations.						
	A - total Wilmin American	nadvated with the North						
		ncducted with the North	1					
į	Carolina Departmen	it of Health Regulation's						
	Consulting Pharmac	sist on 11/29/12 at 6:00 pm. ite was multi vitamin tablet			:			
i		te was muiti vitamin tablet Omgs of Vitamin C and			:			
		stated due to the addtional						
,	ELUTINGS OF EITHO. THE	otatod dao to the additional						

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AND PLAN OF CORRECTION A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER GREENSBORO IDENTIFICATION NUMBER: A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA ST GREENSBORO, NC 27401	2012 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA ST 11/30/2	(X5) COMPLETION
GOLDEN LIVINGCENTER'S GREENSBORO	COMPLETION
\$40.103	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	D. 112
F 314 Continued From page 13 supplemental values Decubi-Vite was not interchangeable with the standard multi vitamin Resident # 124 was receiving. During her interview the DON stated it was her expectation staff would take off all medical orders, put all telephone or verbal orders in the MD box to be signed, and would insure all new orders were placed in the MAR for administration. She stated she expected residents to receive all medications, supplements, and treatments as the physician ordered. 483.26(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident's (1) Maintáins acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: ased o'n record review and interview with staff the facility failed to provide liquid nutritional supplement and protein supplement as recommended by the dietitian and ordered by the physician. This was evident 1 of 3 (Residént#124) Admittedf 40/28/12 Admittedf 40/28/12 F 325 F 325 The responsible party and attending physician were notified of the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein order and the date the liquid protein as started for resident #124. No new orders were received. A new medication administration record was reprinted and placed on the medication administration record of resident #124 by the Director of Nursing Services, Director of Clinical Education, Unit Managers, and Nursing Services, Director of Clinical Education, Unit Managers, and Nursing Services, Director of Clinical Education and the Director of Clinical Educa	12/21/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345014			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE		
		B. WING		11/3	0/2012		
NAME OF PI	ROVIDER OR SUPPLIER	NSBORO	12	EET ADDRESS, CITY, STATE, ZIP CO 101 CAROLINA ST REENSBORO, NC 27401	DE		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
	Based on record reviethe facility failed to prosupplement and protice recommended by the physician. This was etage (Resident#124) Admitted: 10/26/12 Dx: Acute kidney failuneck obstruction, hem HTN, cerebral artery of mouth, muscle spaweakness MDS Admission 11/18 BIMS 09 Bed Mobility - 3/3 Transfer 3/3 Locomotion 3/2, w/c Dsg 4/2 Eating 1/2 Toileting 4/2 Personal Hygiene 3/2 Bathing 4/2 Blanace - needs human ROM 1/1 Facility dietician 11/19 Last diet order 11/29/1 Prostat 30 ml BID Lrg protein portions x 3 Regular diet Last 14 days meal con	ew and interview with staff povide liquid nutritional en supplement as dietitian and ordered by the evident 1 of 3 re, dehydration, bladder laturia, vascular dementia, locculsuion, UTI, dandidiasis ms, GERD, muscle 5/12 an assist /12 3:49 2 3 meals	F 325	Director of Nursing Ser dietary recommendation ensuring that dietary record are processed entirely way. An audit of dietary record changes in will be revied Director of Nursing Ser Clinical Education, or Lethe morning meeting was months to ensure that rewith changes that are nemedication administration. The results of these audieviewed by and brough Assessment Performance Committee Meeting by Nursing Services. Any indentified will be address Assessment and Assurant they arise and the plan was needed to ensure continuation.	in process and commendations with needed follow simmendations for wed by the vices, Director of Unit Managers in eakly for two commendations edded on the on record. Its will be at to the Quality the Director of ssues or trends ested by the Quality once Committee as will be revised as		

Event ID: JFIJ11

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB 345014							APPROVI 0. 0938-03
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· .		CONSTRUCTION	(X3) DATE SUF	RVEY
	~ .,		A. BUI	LDING		COMPLET	ED
		345014	B. WIN	G		1	
NAME OF F	PROVIDER OR SUPPLIER			T		11/30	/2012
GOLDEN	LIVINGCENTER - GREE	NSBORO		1201	TADDRESS, CITY, STATE, ZIP CODE CAROLINA ST		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		GRE	ENSBORO, NC 27401		
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	< :	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETION DATE
F 325	Continued From page	15	F 3	25			
	MD ordono italia tata	•		-			
	MD orders dated 11/1 - Pro stat 30 ml 2	6/12					
	- Decubi-Vite (MVI w/r	minerals)					
	·	·					
,	Labs - Albumin 10/31/	12 3.8 (3.5-5.2)	1				
;	Albumin 11/5-11 2.9	1/8 from hospital stay was	1	:		,	
	Admission		i			:	
i	10/26/12 wt 140 lbs		0	ĺ			
1	11/8/12 wt 132 lbs		:	i		1 1	
1	11/26/12 - wt 127 lbs			:			
. (Care plan updated 11/1	5/10		1			
i -	Increased nutritional ne	o/ 12 Beds r/t wound healing		i		į	- 1
1	(potential wt changes r	t IV ffluids in hospital	:			1	
Г	enai insufficiency, kidni	ev failure, noor intake due	1	1			
- 1	o candidias in mounth,	dementia, depression	i				- 1
io	Cardiovascular status - ordered	monitor wts, diet as	į	į		1	
	Gastrointestinal distress	s r/t/ GERD	; 1	į			
-/	Alteration in elimination	of bowel & bladder -					1
Ca	atneter due to bladder d	bstruction	;			i	
:	Alteration in hydration r/	;t DM, kidney failure	<i>}</i>			1	1
R	eview of Nov. MAR rev	ealed no documentation	,			;	
of	ordered Pro stat and d	ecubi vite supplements.	i				
i	# 14 # W						
rev	terviews with Dietician1	1/29/12 at 4:45 PM				1	
fro	vealed he had reviewed im hospital discharge. I	He recommended by				:	- 1
su	pplements due to weigh	nt loss and presence of	' I				
inc	reasing decubius on R	buttocks.	}				
Inte	erview With DON 44	(00/40 t # 00 m;	1				1
rev	erview with DON on 11/ ealed she called the NF	29/12 at 5:00 PM	* 1			i	
rec	ommendations and rec	eived a verbal order to				1	1
put	the recommendations i	in place. The DON					

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ARTMENT OF HEALTH AND HUMAN SERVICES		FURMAPPROVE
ITERS FOR MEDICARE & MEDICAID SERVICES		OMB NO. 0938-039
TENT OF DEFICIENCIES AND PROMPTED OURSE LEGICIA	L/VOLMULTIDLE CONSTRUCTION	I/X3\ DATE SHRVEY

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
	- 10	345014	B. WIN	IG		11/30/2012		
	ROVIDER OR SUPPLIER	NSBORO		1201	ADDRESS, CITY, STATE, ZIP CODE Carolina St Ensboro, NC 27401			
(X4) ID PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 325	for the MD to sign, prand handed the MAR Rita Auff, RN. The Dislip and sent it to diet. Attempted to call Nursbronchitis. Unable to 11/29/12 5:45 PM Phone interview with pharmacist Charlotte decubi vite and prost drugs. She indicated regular mVI and the Dof Zinc and Vif. C which with healing. The phanot state it promoted heferred to dietary corabout the area. She with the dietary recom residents the best charman control of the company of	the computer, made a copy rinted the MAR for the order and the MD copy to nurse ON made out a dietary meal ary. See Auff who was out with reach her at home phone #. Facility Consulting Matheny. She stated the at were all over the counter the difference between a rebuti vite was the addition on the are believed to assist reacist stated she could realing but she always resultants who know more stated she always went mendations to give the nice of healing.	F	325				
		· ·						

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DHSR CONSTRUCTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fax:919-733-6592

Jan 5 2013 12:40pm P004/007

PRINTED: 12/20/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES JAN 2 5 2 63) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/18/2012 345014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 CAROLINA ST **GOLDEN LIVINGCENTER - GREENSBORO** GREENSBORO, NC 27401 PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY K 000 Preparation, submission and implementation of this Plan of Correction K 000 INITIAL COMMENTS do not constitute an admission of or agreement with the facts and conclusions Surveyor, 27871 set forth This Life Safety Code(LSC) survey was on the survey report. Our Plan of conducted as per The Code of Federal Register Correction is prepared and executed as a at 42 CFR 483.70(a); using the Existing Health means to continually improve the quality Care section of the LSC and its referenced of care and to comply with all applicable publications. This building is Type III construction, state and federal regulatory one story, with a complete automatic sprinkler requirements. system. The deficiencies determined during the survey K 012 Criteria 1 are as follows: 1/31/13 All areas identified as not meeting this NFPA 101 LIFE SAFETY CODE STANDARD K 012 K 012 standard have been sealed by SS-E Maintenance Director. Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 Criteria 2 The Maintenance Director assessed the facility -all areas not meeting this standard have been identified and corrected. This STANDARD is not met as evidenced by: Surveyor: 27871 Criteria 3 Based on observations and staff interview at Maintenance Director/designee will approximately 8:30 am onward, the following monitor facility monthly and after vendors work in the facility to ensure items were noncompliant, specific findings include: sprinkler pipe penetrating the fire wall on areas meet the building construction 100 hall in attic was not seal to maintain the rating are identified, sealed and building construction rating of building. maintained. 42 CFR 483.70(a) Criteria 4 K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 Maintenance Director will provide results from the monthly monitoring to the SS=E Exit access is arranged so that exits are readily **Ouality Assurance Process Improvement** accessible at all times in accordance with section committee for 3 months at which time the 7.1. 19.2.1 committee will determine the continued frequency of monitoring. (X8) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

All ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing lt/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 data 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 data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

<u>Gw</u>

twe

Fax:919-733-6592

Jan 5 2013 12:40pm P005/007

PRINTED: 12/20/2012 FORM APPROVED OMB NO. 0938-0391

_	DEP	ARTMENT OF HEALT	AND HUMAN SERVICES			OMB NO	D. 0938-0391
)	STATEM	TERS FOR MEDICARE IENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY
•			345014	B. WINC		12/18/2012	
NAME OF GOLDE (X4) ID PREFIX TAG K 052 SS=E	F PROVIDER OR SUPPLIER EN LIVINGCENTER - GF	REENSBORO	٤	TREET ADDRESS, CITY, STATE, ZIP CODE 1201 CAROLINA ST GREENSBORO, NC 27401			
	(X4) ii PREFI	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPR DEFICIENCY)	JUD BE	(XS) COMPLETION DATE
	K 03		!	K 03	K 038 Criteria 1 Maintenance Director installed sin motion locksets on all doors as indiso that exits are readily accessible at times.	Lateu	1/04/13
	•	Surveyor: 27871 Based on observatio approximately 8:30 a items were noncomp	not met as evidenced by: ns and staff interview at im onward, the following liant, specific findings are areas that at time of notions of hand to open		Vendor contracted, maglocks reconfigured to comply with specia locking according to NC Building Chapter 4. Criteria 2 Though all patients have the potent be affected by the alleged deficient	Jude,	
		Also, the delayed egn ends of each corridor	ess locking system at the did not function per NCSBC buld relock with use of ersible process of delayed		practice, none were. Maintenance Director/designee will monitor facil monthly and after vendors work in facility to ensure areas meet the bui construction rating are identified, sand maintained.	the Iding	
		Required automatic sp continuously maintaine condition and are inso	ed in reliable operating	K 062	Criteria 3 Maintenance Director/designee will inservice staff about the impact of the reconfiguration of the maglock. The Maintenance Director/designee will monitor facility weekly for the next months to ensure areas not meeting building construction rating are identified, sealed and maintained.	1e	1/31/13
		Surveyor: 27871 Based on observations approximately 8:30 am items were noncomplia	onward, the following		Criteria 4 Maintenance Director will provide refrom the weekly monitoring to the Q committee for 3 months at which time committee will determine the continufrequency of monitoring.	API e the	



FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 953201

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Jan 5 2013 12:40pm P006/007

PRINTED: 12/20/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 B. WING_ 12/18/2012 345014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1201 CAROLINA ST **GOLDEN LIVINGCENTER - GREENSBORO** GREENSBORO, NC 27401 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX" TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY K062 Criteria 1 K 062 K 062 Continued From page 2 1/19/13 Heater replaced and functioning in Riser system. Also, no spare heads for sprinkler Room and additional Spare Sprinker system in sprinkler box in riser room. Heads replaced and provided by vendor. 42 CFR 483.70(a) Criteria 2 Though all patients have the potential to be affected by the alleged deficient practice, none were. The Maintenance Director assessed the facility, no other areas found to be affected. Criteria 3 The Maintenance Director/designee will monitor the function of the heater in the Riser Room weekly for the next 3 months. Inventory and par level of spare Sprinkler Head replacements will be assessed and monitored by the Maintenance Director. Criteria 4 Maintenance Director will provide results from the weekly monitoring to the Quality Assurance Process Improvement committee for 3 months at which time the committee will determine the continued frequency of monitoring. /



FORM CMS-2587(02-99) Previous Versions Obsolete

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FORM APPROVED

CENTE	ERS FOR MEDICARI	E & MEDICAID SERVICES		OMB NO. 093			
STATEMEN	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	DENTIFICATION NO MOCIC	A. BUILDING 02 - BUILDING 02				
		345014	B. WING		12/	18/2012	
NAME OF	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP C	ODE		
GOLDE	N LIVINGCENTER - GI	REENSBORO	1	1 CAROLINA ST EENSBORO, NC 27401			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE	
K 000	INITIAL COMMENT	S :	K 000				
	at 42CFR 483.70(a);	e Code of Federal Register using the Existing Health SC and its referenced ilding is Type III - sy, with a complete					
	No LSC deficiencies	noted at time of survey.					
	42 CFR 483.70(a)	<u>;</u>					
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A inciency 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.