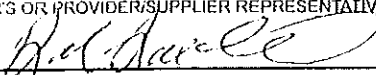


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 312 SS-D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide perineal care in a sanitary manner to 1 of 2 sampled dependent residents (Resident #92) whose care was observed. Findings included:</p> <p>Resident #92 was admitted to the facility on 03/30/06 and re-admitted on 08/30/12. Cumulative diagnoses included Alzheimer's disease, hypertension and depressive psychosis.</p> <p>The facility's procedure for providing perineal care, dated 2006, outlined to obtain the necessary supplies for providing care which included a basin of warm water, soap or perineal cleansing solution, wash cloths, gloves and towels. It was noted that if a resident was soiled with feces, the perineum and rectal area should be cleansed to remove the feces and the basin of water changed. The soiled linens were to be discarded. Staff were to change their gloves and wash their hands before continuing to provide care.</p> <p>The 04/10/13 Annual Minimum Data Set (MDS) assessment indicated Resident #92 was not cognitively intact. She needed extensive to total</p>	F 312	<p><i>Please accept this Plan of Correction as Golden Living Center's credible allegation of compliance. This Plan of Correction shall not be construed as an admission of fault nor agreement with the finding of non-compliance. The Plan of Correction is provided pursuant to Federal requirements which require an acceptable Plan of Correction as a condition of continued certification.</i></p> <p>F 312 Activities of Daily Living</p> <p>The facility will continue to provide necessary services to maintain good nutrition, grooming and personal and oral hygiene for residents who are unable to carry out activities of daily living.</p> <p>1.) On 6-10-13, the Director of Clinical Education , re-educated NA# 3 on proper procedures and expectations for providing incontinence care for all residents but specifically regarding resident #92 . NA #3 was also required to perform return demonstration for perineal care and a copy of competency was given to NA #3.</p>
DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 		TITLE Executive Director	(X6) DATE 6/24/13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/06/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 1 assistance with all activities of daily living. She was incontinent of both bowel and bladder. The Care Area Assessment (CAA) detail indicated she triggered in activities of daily living.  Resident #92's care plan, last reviewed on 04/11/13, identified a problem with alteration in elimination of bowel and bladder as Resident #92 was incontinent of both. Staff were to provide incontinence care as needed.  During an observation of personal hygiene care on 06/06/13 at 3:00 PM, Nurse Aide # 3 (NA #3) washed her hands, filled a bath basin with water, placed 2 wash cloths into the basin, closed the privacy curtain and told resident #92 what she was about to do. NA #3 untaped the corners of her soiled brief and pressed the brief down underneath her perineum. NA #3 picked up one of the wash cloths from the basin, squirted liquid soap on it and washed each groin. She rinsed the cloth in the water. Using different corners of the cloth, she washed her labial lips and perineum in a front to back motion. She rinsed the cloth out in the basin of water and rinsed the areas she had washed. She then dried her skin with a clean towel. NA #3 assisted Resident #92 to roll onto her right side to remove the soiled brief. As she removed the brief, she used it to remove a moderate amount of soft brown stool from the rectal area. There was still stool left in this area so she picked up one of the wash cloths from the basin of water and squirted liquid soap onto the cloth. NA #3 then used the cloth to remove the remainder of the stool. It was noted as she was wiping that there was soft brown stool on the cloth. NA #3 rinsed the cloth out in the basin of water contaminating the water with stool.	F 312	2.) All residents have the potential to be affected by alleged deficient practice therefore the Director of Clinical Education, Director of Nursing and or designees will randomly observe nursing assistance on each unit, over a period of 3 months for the provision of perineal care and basic bath techniques. Any concerns will be addressed and corrected immediately. The Director of Nursing will report findings of observations at the monthly Quality Assurance Meeting, recommendations will be made and corrected immediately. Compliance will be monitored for 3 months or until deemed unnecessary .  3.) The Director of Clinical Education will re in-service all nursing assistants on the proper technique for the provision of incontinence care. In-servicing is expected to be completed by 6-23-2013.	6-24-13  6-24-13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/06/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 2  She continued to use the same cloth to wash her anal area as well as her buttocks. Each time after she removed stool, NA #3 rinsed the stool soiled cloth in the dirty water. Once the stool had been removed, she used one of the wash cloths from the basin of dirty water to rinse her perineal area and buttocks. NA #3 then dried and applied barrier cream to her skin. NA #3 placed a clean brief and positioned Resident #92 for comfort. She bagged her linens, dumped the water and washed her hands.  NA #3 was interviewed immediately following the observation on 06/06/13 at 3:35 PM. NA #3 stated she was taught to cleanse a female resident wiping from front to back. She stated she was taught to use different corners of the cloth to wipe down each groin as well as the right and left labia. NA #3 reported there were disposable wipes available to remove stool prior to washing with soap and water. NA #3 reported that she had been taught to change the bath water if stool had been removed. When questioned about not changing the basin of water, she replied that she was supposed to have 4 wash cloths but she only had 2. NA #3 stated it was shift change and the linen carts had been taken off the hall to be refilled and there were no wash cloths available on her hall. NA #3 stated she would have had to go to another location to get the wash cloths she needed. NA #3 agreed that she had cleaned Resident #92's skin using stool contaminated water.  The Director of Nurses (DON) was interviewed on 06/06/13 at 4:35 PM about her expectations for providing personal care to the residents. The DON stated she expected staff to gather all the	F 312	<b>4.) A skills competency tool will be used by the Director of Clinical Education, Director of Nursing and designees to monitor results of random observations. This observation will be completed once a week times one month, then monthly times 3 months. Any concerns will be corrected immediately upon observation. The Director of Nursing will report findings of observations at the monthly Quality Assurance Meeting, recommendations will be made and corrected immediately .Compliance will be monitored for 3 months or until deemed unnecessary .</b>	6-24-13	

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 3 necessary supplies including enough wash cloths and towels before beginning to provide care. The DON stated staff should have at least 4 wash cloths. She stated staff should provide privacy and explain what procedure they were performing to the resident. The DON stated staff could use soap and water or disposable wipes to cleanse the residents wiping in a front to back manner. The DON commented staff should not contaminate the water with stool by placing soiled wash cloths into the water. She stated they should not use the water to continue providing care as it should be dumped and fresh water obtained.	F 312		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  345168	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 6/6/2013
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 156	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits</p>		

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345168</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>6/6/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2910 MACGREGOR DOWNS GREENVILLE, NC</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 156</b>	<p>Continued From Page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide a resident/responsible party with a Medicare provider non-coverage notification letter in a timely manner, for 2 of 3 residents (Residents #240 and #245) whose notifications were reviewed Findings included:</p> <ol style="list-style-type: none"> <li>1. A Medicare provider non-coverage letter reviewed for Resident #240 documented the last day of Medicare skilled nursing coverage was 12/23/12. Resident #240 was admitted for short-term rehabilitation on 12/6/12 and discharged on 12/24/12. She was her own responsible party and signed the letter on 12/24/2012.</li> <li>2. A Medicare provider non-coverage letter reviewed for Resident #245 documented the last day of Medicare skilled nursing coverage was 4/23/13. Resident #245 was admitted for short-term rehabilitation on 4/4/2013 and discharged on 4/24/2013. He was his own responsible party and signed the letter on 4/24/2013.</li> </ol> <p>In an interview with the facility's social services director on 6/6/13 at 3:20 PM, she stated that she usually discussed financial coverage of services ending during the discharge planning meeting that she had with residents approximately a week before they discharge, but that she did not keep documentation specifically regarding this discussion. She also stated that she did not have residents or responsible parties sign the notification letter until the day of discharge and was not aware that she should have gotten the resident or responsible party to sign the letter at least 48 hours prior to the expiration of coverage for services</p> <p>In an interview with the facility's administrator on 6/6/13 at 5:55 PM, he stated that he was not aware that notices were not being administered correctly, but that he would expect that residents be provided notice as required.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NEW 152 BED FACILITY - NEW SITE LOCATION B. WING	<div style="border: 2px solid black; padding: 5px; display: inline-block;">                 RECEIVED                  JUL 24 2013                  07/09/2013             </div> (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834
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K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.  The deficiencies determined during the survey are as follows:	K 000	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of Federal and State law requires it.</i>	8/1/2013
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3  This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 7/9/13 at approximately noon the following corridor door was non-compliant, specific findings include, door to pantry #3 did not close and latch tightly in it's frame.	K 018	K 018 The pantry door in question was fixed on 7/10/2013. The Director of Maintenance, Assistant Director of Maintenance, Director of Dining, Dining Staff, and Executive Director will monitor daily all doors which enter into all Pantries to assure compliance. Any issues with any door closings will be reported to the Maintenance Director for immediate correction. The Maintenance Director will report any compliance issues in the monthly QAA Committee for a period of 3 months, to identify trends and implement additional action plans to assure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Quake TITLE: Executive Director (X6) DATE: 7/21/2013

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SRW