DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	APPROVED			
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		O	<u>MB NO.</u>	0938-0391		
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED		
		345377	B. WING				C 23/2015		
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
GREENF	IELD PLACE			2575 W 5TH STREET GREENVILLE, NC 27834					
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 157 SS=D	consult with the resknown, notify the resonant interested fam accident involving the injury and has the printervention; a significantly and has the printervention; a significantly of the clinical complication in heat status in either life to clinical complication of treat consequences, or the treatment); or a decent the resident from the §483.12(a). The facility must also and, if known, the resident rights under regulations as specified in §483.1 resident rights under regulations as specified in the section. The facility must reat the address and philegal representative the address and philegal representative the address and philegal representative the section.		F 1	157	1. Nurse #1, that was assigned to		2/20/15		
	resident interviews, physician as to the	the facility failed to notify the discovery of blisters to the ER/SUPPLIER REPRESENTATIVE'S SIGN			Resident #6, was counseled and disciplined on 2-3-15 regarding the		(X6) DATE		
LADUKAIUKI		LIVOULFLIER REPRESENTATIVE S SIGI	NALUKE		IIILE		(AU) DATE		

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

02/13/2015

PRINTED: 03/02/2015

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
		345377	B. WING		C 01/23/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZI	
GREENF	IELD PLACE			2575 W 5TH STREET GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE
F 157	Continued From pa	age 1	F 1	57	
	right inner and oute	er knee for 1 of 3 residents were reviewed for notification.		importance of timely physical in regards to changes in the second	
	Resident #6 was ac 08/11/14. Cumulat	dmitted to the facility on ive diagnoses included , prostate cancer and history		2. All Nurses were inserving regarding the importance physician notification in rechanges in skin integrity. the facility will have a "Sk	of timely egards to All residents in in Integrity Audit"
	The most recent Quarterly Minimum Data Set (MDS) of 11/05/14 noted Resident #6 had no problems with cognition. He required extensive to total assistance with all activities of daily living.			egrity had timely an. tegrity Flowchart"	
	was completed by the Resident #6 had op and right inner knew that Resident #6 was that Resident #6 was the	nt Report of 01/17/15 which treatment nurse #1 noted ben blisters to the right outer e. It was noted on the report as his own responsible party vas notified at 12:00 PM on		A. Resident identified B. Area identified C. Area assessment D. Physician notification E. Responsible party r F. Treatment initiated	ollowing areas:
	A treatment progress note of 01/17/15 written by treatment nurse #1 noted that Resident #6 had a stage 2 to the right inner knee that measured 0.5 centimeters by 1 centimeter and a stage 2 to the right outer knee that measured 2 centimeters by			<ul> <li>G. Incident report com</li> <li>H. Skin referral form of</li> <li>I. Medical record docu</li> <li>J. 24 hour report docu</li> </ul>	ompletion mentation
		he wounds were cleaned with a [brand name dressing] was		Once an area of change identified and reported to assigned to the resident a Skin Integrity Flowchart	the Nurse a "Change in
	to clean Resident # normal saline and a every 3 days. It wa	none order of 01/17/15 noted 6's right inner knee with apply a [brand name dressing] is also noted to clean the right mal saline and apply a [brand ery 3 days.		and completed by the end The "Change in Skin Inte will be signed by the Nurs form and attached to the for review by the manage	d of the shift. grity Flowchart" se completing the 24 hour report ment team.
	During an observat	ion of personal care on		4. The "Change in Skin I Flowchart" will be monitor	

Facility ID: 923145

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WING			( 01/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENF	IELD PLACE				575 W 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	have an undated [b to the inner right kn knee. During an interview at 12:00 PM, he sta exactly which day h right knee but it was didn't remember wh reported the blisters An interview was co therapist that was ic Resident #6 last we she stated she word strengthening exerce mobility. She repor his knees every day to his request. She seeing blisters to hi document anything she wasn't sure if it Thursday of last we not notify the nursin During a telephone nurse (treatment nu PM, she stated Nur to Resident #6's kn January 16, 2015 a stated Nurse #1 ha forgotten to tell her nurse #1 reported t that she would asse She reported that s right knee on Satur blisters had erupted	M, Resident #6 was noted to rand name dressing] in place ee as well as the outer right with Resident #6 on 01/22/15 ted he didn't remember e noticed the blisters to his s last week. He also stated he nich staff person he had	F 1	157	using the 24 hour report and direct observation 5 days a week during the daily Interdisciplinary Team Meeting audit of a minimum of 3 resident che will be audited weekly x 4 weeks the monthly x 2 months by Nursing Management to assure compliance the procedures listed on the "Chang Skin Integrity Flowchart". The resu these audits will be taken to the fac QA&A Committee meetings. Recommendations will be made ba these audits.	gs. An larts en with ges in Its of ility	

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		AND HUMAN SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345377	B. WING				23/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENF	IELD PLACE				575 W 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	treatments of [brand days. She reported nurse who discover to start a monitoring and once the blister started using [brand nurse #1 stated the issue should have r Treatment nurse #1 hours to assess the skin referral. Nurse Aide #1 (NA with Resident #6 or 2015), Thursday (Ja (January 16, 2015), telephone interview She stated she was 2015) and Tuesday week but when she Wednesday (Janua blisters to Resident care. NA #1 stated blisters to the outer that had erupted no She commented the to the area of the ere knee. NA #1 stated Nurse #1 that day. Treatment nurse #2 wound care to Resi AM. She stated she yet and the treatme saline and apply [br stated treatment nu blisters. She remov from both wounds.	age 3 d name dressing] every 3 d that the protocol was for the red the change in skin integrity g sheet to monitor the blisters rs erupted, treatments were d name dressings]. Treatment e nurse who discovered the reported it to the physician. 1 commented that she had 24 e resident once she received a #1) was identified as working n Wednesday (January 14, anuary 15, 2015), and Friday. On 01/23/15 at 10:00 AM, a was conducted with NA #1. s off on Monday (January 12, r (January 13, 2015) of last e came back to work on ary 14, 2015) she noticed the s #6's knee during personal he had 2 small fluid filled right knee and another blister oted to his inner right knee. ere was red open skin noted rupted blister on the inner right d she reported the blisters to 2 was observed providing ident #6 on 01/23/15 at 10:10 e had not seen his wounds as ent was to clean with normal rand name dressing]. She urse #1 had told her about the ved the undated dressings Treatment nurse #1 cleaned mal saline and applied a	F 1	57			

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	OM	FORM APPRO IB NO. 0938-	
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	
345377 B. WING		C 01/23/201	5
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GREENFIELD PLACE 2575 W 5TH STREET GREENVILLE, NC 27834			
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF COLPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD E	BE COMPL	ETION
<ul> <li>F 157</li> <li>Continued From page 4</li> <li>[brand name dressing] to both. Resident #6 had no complaints during the procedure.</li> <li>During a telephone interview with Nurse #4, on 01/23/15 at 10:50 AM, she stated she had worked with Resident #6 last week. She stated she remembered NA #1 coming to her on Wednesday (January 14, 2015) and reported 2 bilsers to the outer right leg. Nurse #4 reported that she totally forgot to report the bilsters to the treatment nurse that day. She stated she was busy with other residents and had planned to make a late entry into the nurse's notes but had forgotten about the bilsters since she was assigned to work on a different hall the next day. She commented that she was supposed to notify the physician of any new skin issues when discovered and complete a skin referral form for the treatment nurse. Nurse #4 also stated she was also supposed to complete an incident report. Nurse #4 stated she dif orgotten about the bilsters.</li> <li>During an interview with the Director of Nurses (DON) and the Assistant DON (ADON), on 01/23/15 at 1:45 PM, the DON stated the nurse who discovered or received report of a change in a resident's skin was responsible for notifying the physician as well as the responsible party. She commented that Resident #6 was alser and oriented and his own responsible party. The DON stated staff members should complete an incident report if needed and initiate a skin referral to the treatment nurse. She stated this notification should be done upon discovered are change in a resident's skin should be reporting</li> </ul>			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	X3) DATE SURVEY		
NU PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		
		345377	B. WING		C 01/23/2015	
NAME OF I	PROVIDER OR SUPPLIER		1			
GREENF	FIELD PLACE			2575 W 5TH STREET GREENVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 157 F 309 SS=D	it. She stated she department to repo skin integrity upon department so they begin treatment. T didn't report the blis building on 01/16/1 483.25 PROVIDE 0 HIGHEST WELL B	expected the therapy rt any changes in a resident's discovery to the nursing could assess the area and he ADON stated Nurse #4 sters until she was leaving the 5. CARE/SERVICES FOR	F 15			2/20/15
	provide the necess or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment				
	by: Based on observa resident interviews changes in a reside evidenced by the d inner and outer righ assess and monito sampled residents reviewed for impair Resident #6 was ac 08/11/14. Cumulat paraplegia, anemia of a hip fracture. The facility's Augus orders for skin/wou	NT is not met as evidenced tions, record review, staff and the facility failed to report ent's skin integrity as evelopment of blisters to the the knee and also failed to r the blisters for 1 of 2 (Resident #6) who were red skin. Findings included: dmitted to the facility on ive diagnoses included the prostate cancer and history at 2014 standard physician's unds noted that any new or unds should be reported to the		<ol> <li>Nurse #1, that was assigned to Resident #6, was counseled and disciplined on 2-3-15 regarding the importance of timely physician notif timely assessment and timely initia treatment in regards to changes in integrity. The Physical Therapist as to work with Resident #6 was coun and inserviced on 2-5-15 regarding importance of timely reporting of ch in skin integrity.</li> <li>All facility staff, including the The Department, were inserviced on 2- 2-5-15, and 2-9-15 regarding the importance of timely reporting of ch in skin integrity. All Nurses were</li> </ol>	ication, tion of skin ssigned seled the hanges erapy 4-15,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM							03/02/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C	
		345377	B. WING				) 23/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREENFIELD PLACE					575 W 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	assessment of 08/1 cognitively intact wi making. He require assistance with all a Care Area Assessm assessment indicat including pressure of addressed in his ca Resident #6's care as being at risk for The most recent Qu (MDS) of 11/05/14 of problems with cogn to total assistance of An Incident/Accider was completed by t Resident #6 had op and right inner knee that Resident #6 wa and the physician w A treatment progress treatment nurse #1 stage 2 to the right centimeters by 1 cer right outer knee that 0.6 centimeters. Th normal saline and a applied. A physician's teleph	imum Data Set (MDS) 18/14 noted Resident #6 was th no problems in decision ed extensive to total activities of daily living. The nent (CAA) detail for this ed he triggered in 8 areas ulcers and all were to be the plan. plan of 11/17/14 identified him impaired skin integrity. uarterly Minimum Data Set noted Resident #6 had no ition. He required extensive with all activities of daily living. In Report of 01/17/15 which reatment nurse #1 noted be blisters to the right outer a his own responsible party vas notified at 12:00 PM. Ses note of 01/17/15 written by noted that Resident #6 had a inner knee that measured 0.5 entimeter and a stage 2 to the the measured 2 centimeters by the wounds were cleaned with a [brand name dressing] was	F	809	inserviced on 2-9-15 regarding the importance of timely reporting of ch in skin condition, timely notification of physician and timely initiation of trea- in regards to changes in skin integrit "Skin Integrity Audit" will be complet all residents in the facility by 2-20-19 newly found areas of impaired skin integrity Will have a "Changes in Ski Integrity Flow Chart" initiated and completed by the end of the shift. T will include timely notification of the physician and responsible party, tre initiated, completion of incident repo- skin referral form and documentation the medical record and 24 hour repo- skin referral form and documentation the medical record and 24 hour repo- 3. A "Changes in Skin Integrity Flow was put into place on 2-9-15. The flowchart addresses the following at A. Resident identified B. Area identified C. Area assessment D. Physician notification F. Treatment initiated G. Incident report completion H. Skin referral form completion H. Skin referral form completion J. 24 hour report documentation J. 24 hour report documentation J. 24 hour report documentation Skin Integrity Flowchart" will be initia and completed by the end of the shi The "Change in Skin Integrity Flow The "Change in Skin Integrity Flow D. Skin Integrity Flowchart" will be initia	of the atment ity. A ted on 5. Any in This atment ort and on in ort. wchart" reas: egrity is in ated ift.	
	to clean Resident #	one order of 01/17/15 noted 6's right inner knee with apply a [brand name dressing]			The "Change in Skin Integrity Flowd will be signed by the Nurse complet	chart"	

Facility ID: 923145

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WING			C 01/23/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENF	IELD PLACE				575 W 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 7	FS	309			
		s also noted to clean the right mal saline and apply a [brand ery 3 days.			form and attached to the 24 hour reformed to the bulk the management team		
		ed care plan of 01/19/15 noted the right inner and outer knee.			4. The "Change in Skin Integrity Flowchart" will be monitored and re using the 24 hour report and direct observation 5 days a week during t		
	01/21/15. He state	oserved in bed at 2:50 PM on d he came here for physical which resulted in a broken hip.			daily Interdisciplinary Team Meeting audit of a minimum of 3 resident ch will be audited weekly x 4 weeks th	gs. An larts	
	During an observation of personal care on 01/22/15 at 10:15 AM, Resident #6 was noted to have an undated [brand name dressing] in place to the inner right knee as well as the outer right knee.				monthly x 2 months by Nursing Management to assure compliance the procedures listed on the "Chang Skin Integrity Flowchart". The resu these audits will be taken to the fac QA&A Committee meetings. Recommendations will be made ba	ges in Its of ility	
	at 12:00 PM, he sta exactly which day h right knee but it was	with Resident #6 on 01/22/15 ted he didn't remember e noticed the blisters to his s last week. He also stated he hich staff person he had s to.			these audits.		
	working with Reside interviewed on 01/2 she worked with Re- strengthening exerce mobility. She repor- his knees every day to his request. She seeing blisters to hi document anything she wasn't sure if it Thursday of last we	bist that was identified as ent #6 last week was 12/15 at 3:00 PM. She stated esident #6 daily on cises, gait training and ted she had been measuring y that she worked with him due e stated she remembered s right knee but she didn't about them. She commented was on Wednesday or eek. She also stated she did ng staff about the blisters.					
	During a telephone	interview with the treatment					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345377	B. WING _				23/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENF	FIELD PLACE				575 W 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	nurse (treatment nu PM, she stated Nur to Resident #6's kn January 16, 2015 a stated Nurse #4 ha forgotten to tell her nurse #1 reported t that she would asse She commented the right knee on Satur blisters had erupted was notified and sh name dressing] eve the protocol was for change in skin integ to monitor the bliste erupted, treatments [brand name dressi commented that sh skin referrals on an stated the nurse wh have reported it to the nurse #1 commented assess the resident referral. Nurse Aide #1 (NA with Resident #6 or 2015), Thursday (Ja (January 16, 2015), telephone interview She stated she was 2015) and Tuesday week but when she Wednesday (Januar blisters to Resident care. NA #1 stated blisters to the outer	age 8 urse #1), on 01/22/15 at 4:15 rse #1 had reported the blisters bee late on Friday afternoon as she was leaving. She also ad commented that she had about the blisters. Treatment that she informed Nurse #1 ess the blisters the next day. at she assessed Resident #6's rday, January 17, 2015 but the d. She stated the physician be started treatments of [brand ery 3 days. She reported that if the nurse who discovered the grity to start a monitoring sheet ers and once the blisters is were to be started using ings]. Treatment nurse #1 he was supposed to receive by skin integrity issue. She no discovered the issue should the physician. Treatment ed that she had 24 hours to t once she received a skin #1) was identified as working in Wednesday (January 14, anuary 15, 2015), and Friday . On 01/23/15 at 10:00 AM, a was conducted with NA #1. s off on Monday (January 12, (January 13, 2015) of last e came back to work on ary 14, 2015) she noticed the t #6's knee during personal I he had 2 small fluid filled right knee and another blister oted to his inner right knee.	F 30	09			

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		AND HUMAN SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	INCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WING	;			C 23/2015
NAME OF PROVIDER C	OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREENFIELD PLA	CE				2575 W 5TH STREET GREENVILLE, NC 27834		
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
She com to the an she report Treatme wound of AM. She yet and to saline an removed wounds. areas of and app reddish a centimet size of a cleaned normal s had yelld wound th round in edges at centimet approxim tissue. With a [b no comp During a 01/23/15 with Res rememb (January outer rig forgot to that day.	ea of the e bried the bl ent nurse #2 care to Resise e stated shithe treatment ind apply [bither of the undate She clear the right o lied a [brandareas were the open a caline. Initia by slough b he center w shape, slig nd was app ters. The content of rand name blaints durin telephone of at 10:50 A sident #6 la ered NA #7 / 14, 2015) ht leg. Nur report the s and had p nurse's not	ere was red open skin noted rupted blister. NA #1 stated isters to Nurse #1 that day. 2 was observed providing ident #6 on 01/23/15 at 10:10 e had not seen his wounds as ent was to clean with normal rand name dressing]. She ed dressings from both ned the 2 small dark reddish uter knee with normal saline id name dressing]. The approximately 0.5 centimeters each or about the ser. Treatment nurse #2 rea to the inner right knee with ally the center of the wound but after she cleaned the vas dark pink. The wound was ghtly sunken with raised pink proximately 2 centimeters by 2 open area was surrounded by centimeters of darker red nurse #2 covered the stage 2 e dressing]. Resident #6 had ng the procedure. interview with Nurse #4, on AM, she stated she had worked st week. She stated she 1 coming to her on Wednesday and reported 2 blisters to the rse #4 reported that she totally blisters to the treatment nurse ed she was busy with other olanned to make a late entry es but had forgotten to do that.	F	309			

Facility ID: 923145

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		AND HUMAN SERVICES				FORM	03/02/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345377	B. WING	;		C 01/23/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENF	IELD PLACE				2575 W 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	different hall the ne she was supposed new skin issues wh skin referral form fo #4 also stated she complete an incider did not do any of th forgotten about the During an interview (DON) and the Assi 01/23/15 at 1:45 PM who discovered or na resident's skin was physician as well as commented that Re oriented and his ow DON stated staff m incident report if ne referral to the treatm notification should to change in skin integ DON also stated ar discipline who discover she expected the th change in a resident department so they begin treatment. The	he was assigned to work on a xt day. She commented that to notify the physician of any en discovered and complete a or the treatment nurse. Nurse was also supposed to int report. Nurse #4 stated she ose things as she had blisters. with the Director of Nurses istant DON (ADON), on <i>M</i> , the DON stated the nurse received report of a change in as responsible for notifying the s the responsible party. She esident #6 was alert and on responsible party. The embers should complete an eded and initiate a skin ment nurse. She stated this be done upon discovery of the grity and not 4 days later. The hy staff person regardless of overed a change in a uld be reporting it. She stated herapy department to report a ti's skin integrity to the nursing could assess the area and he ADON stated Nurse #1 eters until she was leaving the	F	309			

Facility ID: 923145

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