E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUIT		<u>MB NO.</u>	0938-0391
	(X2) MUIT			
	. ,	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING CON		
345377	B. WING		( 04/3	; 30/2015
3		STREET ADDRESS, CITY, STATE, ZIP CODE		
		2575 W 5TH STREET		
		GREENVILLE, NC 27834		
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	( EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
ANCES	F 1	66		5/31/15
prievances the resident may ose with respect to the behavior				
erview and record review the corporate a care concern alf of 1 of 10 sampled residents to its grievance system in order be reached. Findings included: vances and Complaint (revised 11/07/12) documented, her representative, family yee has the right to voice t discrimination or reprisal. The nvestigated and resolved in a ne resolution progress and the		<ul> <li>after supper and made comfortable 4-12-15. Staff will be inserviced or 18th thru May 31st regarding the importance of reporting any concer- grievances timely.</li> <li>2. The Facility Grievance and Con Resolution Policy was revised on 5 to include that the Administrator wi a log and log all grievances and co that he receives. Staff will be inser on May 18th thru May 31st regarding</li> </ul>	e on May ms or plaint -15-15 I create ncerns viced ng the	
tive, family member or admitted to the facility on lmitted on 01/27/14. The ented diagnoses included history ulcer, anorexia, malnutrition, ve, and Alzheimer's dementia. 15 interdisciplinary progress "Family upset that resident an 4 hours today." (name o stated resident was gotten up went to church in facility and		<ul> <li>of reporting grievances and complating timely as is identified in the policy. hour reports will be audited 5 times week to assure that all concerns/grievances are identified investigated.</li> <li>3. The Administrator and Social W will compare logs weekly x 4 then r x 2 to assure that all grievances ar investigated timely. Facility staff w inserviced monthly x 2 then quarte</li> </ul>	aints The 24 a and orker monthly e ill be rly x 2	
	R TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) HT TO PROMPT EFFORTS TO VANCES e right to prompt efforts by the grievances the resident may nose with respect to the behavior s. ENT is not met as evidenced aterview and record review the corporate a care concern half of 1 of 10 sampled residents no its grievance system in order o be reached. Findings included: vances and Complaint (revised 11/07/12) documented, vances and Complaint (revised 11/07/12) documented, vances and resolved in a The resolution progress and the communicated to the resident, ative, family member or " s admitted to the facility on dmitted on 01/27/14. The ented diagnoses included history e ulcer, anorexia, malnutrition, rive, and Alzheimer's dementia. (15 interdisciplinary progresss I, "Family upset that resident an 4 hours today." (name r) stated resident was gotten up d went to church in facility and he got back this PMresident	R       ID         ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)       ID         HT TO PROMPT EFFORTS TO VANCES       F 1         e right to prompt efforts by the grievances the resident may nose with respect to the behavior 5.       F 1         ENT is not met as evidenced       ID         iterview and record review the corporate a care concern half of 1 of 10 sampled residents no its grievance system in order o be reached. Findings included:         vances and Complaint (revised 11/07/12) documented, //her representative, family byee has the right to voice ut discrimination or reprisal. The investigated and resolved in a the resolution progress and the communicated to the resident, ative, family member or "         s admitted to the facility on dmitted on 01/27/14. The ented diagnoses included history e ulcer, anorexia, malnutrition, rive, and Alzheimer's dementia.         (15 interdisciplinary progress I, "Family upset that resident an 4 hours today." (name ) stated resident was gotten up d went to church in facility and he got back this PMresident	R       STREET ADDRESS, CITY, STATE, ZIP CODE         2575 W 5TH STREET       GREENVILLE, NC 27834         TATEMENT OF DEFICIENCIES       ID         PROVIDER'S PLAN OF CORRECTION SHOULD       PROVIDER'S PLAN OF CORRECTION SHOULD         COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PROVIDER'S PLAN OF CORRECTION SHOULD         ALL COMMUST BE PRECEDED BY FULL       PREFIX         ALL COMMUST BE PRECED TO THE APPROPHING INFORMATION       PREFIX         ALL COMMUST BE PRECED TO THE APPROPHING INFORMATION       Internation of COMMUST INFORMATION         VIEW STATE PRECED TO THE APPROPHING INFORMATION       Internation of COMMUST INFORMATION         VIEW	345377     B. WING     Odd?       R     STREET ADDRESS, CITY, STATE, ZIP CODE     2375 W STH STREET       INTERENT OF DEFICIENCIES     D     PREVIDER, NC 27834       INTERENT OF DEFICIENCIES     D     PREVIDE, NC 27834       INTO PROMPT EFFORTS TO VANCES     F 166     PREVIDE, NC 27834       ENT is not met as evidenced     1. Resident #66 was placed back in bed after supper and made comfortable on 4-12-15. Staff will be inserviced on May 18th thru May 31st regarding the importance of reporting any concerns or grievances timely.       Vances and Complaint (revised 11/07/12) documented, ther resolution progress and the investigated and resolved in a he resolution progress and the communicated to the resident, ative, anorexia, mainutrition, ive, and Alzheimer's dementia.     2. The Facility Grievance and Complaint timely as is identified in the policy. The 24 hour reports will be au

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

05/21/2015

PRINTED: 05/26/2015

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.

**Electronically Signed** 

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUITIP	LE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		3		COMPLETED	
					(	C	
		345377				30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GREENF	IELD 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 166	Continued From pa	ige 1	F 166	3			
	put back to bed and supper."	d made comfortable after		grievances/concerns timely.			
Review of the facility's grievance log revealed no grievance was filed on behalf of Resident #66 regarding the family's 04/12/15 concern that the resident was left sitting up too long.			4. The results of these comparisons will be taken to the facility QA&A committee. The committee will make recommendations based on the finding c				
	At 9:17 AM on 04/3 thought she had co capture the concern expressed on 04/12 was concerned bed was out of bed in h remained in this ch the afternoon betwo According to Nurse back to bed after sl meal, but the nurse what had transpired one position in her reported the purpos system was to allow problems, and deve them from occurrin complainant was al investigation outcom develop an atmosp service.	20/15 Nurse #1 stated she impleted a grievance form to ns Resident #66's family 2/15. She reported the family cause they stated the resident er geri-chair at 10:30 AM and air until they returned later in een 5:00 PM and 6:00 PM. #1, the resident was placed he finished eating her supper commented she was unsure d to cause the resident to be in chair for so long. The nurse se of the facility's grievance w the facility to investigate elop interventions to prevent g again. She commented the so informed of the me and plan of correction to here of good customer					
	(SW) stated she ne from the administra 04/12/15 concerns of care. She report completed it would the baskets at the r forwarded to the ac	0/15 the facility's social worker ever received a grievance form ator so she could log in the regarding Resident #66's lack ted if the form had been have been placed in one of nursing stations, collected, iministrator who verified that it the concern, discussed in					

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/26/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED	
		345377	B. WING				C 4/30/2015	
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 ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 166 F 314 SS=D	and assigned to sor nursing to investiga anytime a family me member expressed being, a grievance f situation could be in could be addressed improve. At 9:52 AM on 04/3 he did not maintain he reviewed and the stated a grievance f anytime a family me member had conce residents. Accordin concern expressed 04/12/15 should hav facility's grievance s 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat	laced on the grievance log, meone associated with te. According to the SW, ember, resident, or staff concerns about resident well form was completed so the nvestigated, and the problem I so that resident care would 0/15 the administrator stated a list of the grievance forms en forwarded to the SW. He form was to be completed ember, resident, or staff rns about the welfare of ng to the administrator, the by Resident #66's family on ve been run through the system. ENT/SVCS TO RESSURE SORES rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and	F 1		1. Resident #66 was returned to be physicians order was written for resident for re		5/31/15	

			()(0)	יחי -			0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	· · ·	SURVEY	
			A. BUILDIN	NG_		C		
		345377	B. WING				, 80/2015	
NAME OF I	PROVIDER OR SUPPLIER				I REET ADDRESS, CITY, STATE, ZIP CODE	04/3	0/2013	
					575 W 5TH STREET			
GREENF	IELD PLACE				REENVILLE, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 314	Continued From pa	ane 3	F 31	14				
1 014		(Resident #66) with current or	гэ	14	#66 stating "up for 2 hours daily the	'n		
		cers who remained in a			#66 stating, "up for 2 hours daily the return to bed" to assist with maintain			
		ut the day, and had a			skin integrity to prevent a new press			
		avoid sacral pressure.			ulcer from developing. Staff will be			
	Findings included:				inserviced May 18th thru May 31st			
					regarding the importance of turning			
		admitted to the facility on			repositioning residents in bed and w			
		nitted on 01/27/14. The nted diagnoses included history			up in chairs to maintain skin integrity promote healing and prevent pressu			
of sacral pressure ulcer, anore: adult failure to thrive, and Alzhe				ulcers from developing.	li e			
					alooio nom aorolopiligi			
		-,			2. Staff will be inserviced May 18th	thru		
	Review of physician orders, treatment progress	n orders, treatment progress			May 31st regarding the importance	of		
		consultation notes revealed an			turning and repositioning residents i			
		der, initiated on 04/21/14, to			and while up in chairs to maintain sl			
		ure. A 06/21/14 wound ocumented Resident #66's			integrity, promote healing and preve pressure ulcers from developing. A			
		er, which had been treated			Directed Inservice on Pressure Ulce			
		and required use of an			was conducted from May 18th thru I			
		to prevent contamination, was			31st. The Directed Inservice will be			
	0	progress notes documented			accomplished via a DVD obtained fr			
		ppened on 09/26/14, presenting			the Laupus Library at the Brody Sch			
	as a stage II wound	d, and healed on 12/12/14.			Medicine at Vidant Medical Center.			
	The regident's 01/1	1/15 annual minimum data set			DVD is titled Skin Integrity and Pres Ulcers. This DVD will be shown to N			
		d she had short and long term			and Nursing Assistants.	Nuises		
		nt, was severely impaired in			and Nursing Assistants.			
	<b>,</b>	equired extensive assistance			3. A list of resident requiring extens	ive		
		ers with transfers, was at risk			assist or who are total care was			
		sure ulcers, and had a stage II			generated. To assure compliance w	vith		
		sent on the previous MDS			turning and repositioning a Direct			
	assessment.				Observation worksheet was develop			
	The resident's 01/1	3/15 care area assessment			This worksheet will be used to direc observe residents over a 3 hour per			
		I she was bed/chair bound,			assure that they are turned and			
		had a stage II sacral ulcer			repositioned timely to maintain skin			
		2/12/14. Pressure ulcer risk			integrity, promote healing and preve	ent		
	was identified as a	problem to address in the			pressure ulcers from developing. T	hese		
	resident's care plar				direct observations will be complete	d on a		

Facility ID: 923145

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345377	B. WING			C 04/30/2015	
NAME OF I	PROVIDER OR SUPPLIER			S	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 ' 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 314	04/13/15, identified (in regard to) decre (bowel and bladder risk for weight loss" to this problem includ devices to bed/chai turn/reposition routi and limiting sitting t On 04/29/15 at 8:45 observed in her ger geri-chair had a cus remained in her ger removed. The resid dining room in her get removed. The resid dining room in her get taken back to her ro her geri-chair betwe was wheeled to the for a group event at until 3:15 PM, was remained in her get On 04/29/15 at 5:05 intervention, the co bottom was checke resident's bottom w imprint on the resid her brief and from t On 04/29/15 at 5:12 #1, assigned to car because the reside her bottom previous her chair more thar However, she repor	plan, last updated on "Skin breakdown at risk for r/t ased mobility, B & B incont incontinence), poor intake, as a problem. Interventions uded using pressure reducing r, assisting/encouraging to nely, turning every two hours,	F	314	minimum of 10 residents a week for weeks then monthly x 2 weeks. Our resident sample will be taken from generated list of residents requiring extensive assist or who are total ca 4. The results of these direct observations will be taken to the far QA&A committee. The committee make recommendations based on findings of these observations.	ur the re. cility will	

STATE MEAN OF CORRECTON       (X1) DENTIFICATION NUMBER:       A BUILDING			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/26/2015 APPROVED 0938-0391	
345377         B. WING         04/30/2015           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2575 W 51H STREET         GREENFIELD PLACE         STREET ADDRESS, CITY, STATE, ZIP CODE         2575 W 51H STREET         GREENVILLE, NC 27834         Continued From Page 5         PROVIDERS PLAN OF CORRECTION (PROVIDERS PLAN OF CORRECTION)         PROVIDERS PLAN OF CORRECTION (PROVIDERS PLAN OF CORRECTION)         CONTINUE (PROVIDERS PLAN OF CORRECTION)				. ,		COM	PLETED	
GREENFLED PLACE         2575 W 5TH STREET GREENVILLE, NC 27834           PMPERY TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Implement PREFX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Implement PREFX TAG         Continued From page 5 Resident #66 was up in her chair when she started her shift, but she did not realize that the resident had been up in the chair since breakfast. She stated the resident stayed in one position when up in her geri-chair with the cushion in the seat.         F 314         F 314           At 8:53 AM on 04/30/15 physical therapist (PT) #1 stated Resident #66 had a fost outshion explores the geri-chair. He reported if the resident stayed sitting in her geri-chair which wo hours she should be lifted of the cushion every 45 minutes to avoid "hot spots" which could eventually cause pressure problems to the bottom/sacrum (the staff was not observed doing this).         At 9:07 AM on 04/30/15 NA #2, assigned to care for Resident #66, stated the resident stayed up in her geri-chair for more than two hours at a time because she had a pressure ulcer on her bottom in the past. She reported she tried to get the resident up to the chair twice during first shift with some time in the bed in between. She commented there was no need to lift the resident of the cushion in ther geri-chair for more than two hours at a time.         At 12:18 PM on 04/30/15 the director of nursing stated Resident #66 was not supposed to be up in her gri-chair for more than a couple of hours at at time. She also reported she would expect         Implemented here was not supposed to be up in her geri-chair for more than a couple of hours at a time. She also reported she w			345377	B. WING	 			
GREENVILLE, NC 27834           (P4)ID TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PIO PARETX TAG         PROVINCE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         Comparison (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           F 314         Continued From page 5 Resident #66 was up in her chair store breakfast. She stated the resident tayed in one position when up in her geri-chair or more than two hours she should be lifted off the cushion in her geri-chair. He reported if the resident tayed in intures to avoid "hot spots" which could eventually cause pressure problems to the bottom: Action of Mass not observed doing this).         A 19:07 AM on 04/30/15 NA #2, assigned to care for Resident #66, stated the resident tayed up in her geri-chair for more than two hours at time because she had a pressure ulcer on her bottom in the past. She reported she tried to get the resident up to the chair twice during first shift with some time in the bed in between. She commented there was no resident if the resident of the cushion in her geri-chair for more than two hours at a time.         <	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CACORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       Comment DEFICIENCY)         F 314       Continued From page 5 Resident #66 was up in her chair when she started her shift, but she did not realize that the resident had been up in the chair since breakfast. She stated the resident stayed in one position when up in her geri-chair with the cushion in the seat.       F 314         At 8:53 AM on 04/30/15 physical therapist (PT) #1 stated Resident #66 had a foam cushion in her geri-chair. He reported if the resident stayed sitting in her geri-chair for more than two hours she should be lifted off the cushion every 45 minutes to avoid "hot spots" which could eventually cause pressure problems to the bottom/sacrum (the staff was not observed doing this).       At 9:07 AM on 04/30/15 NA#2, assigned to care for Resident #66, stated the resident stayed up in her geri-chair for more than two hours at a time because she had a pressure ulcer on her bottom in the past. She reported she tried to get the resident up to the chair for more than two hours at a time. She reported she tried to get the resident never stayed in the chair for more than two hours at a time. At 12:18 PM on 04/30/15 the director of nursing stated Resident #66 was not supposed to be up in her geri-chair for more than a couple of hours at a time. She also reported she would be expect	GREENF	IELD PLACE						
<ul> <li>Resident #66 was up in her chair when she started her shift, but she did not realize that the resident had been up in the chair since breakfast. She stated the resident stayed in one position when up in her geri-chair with the cushion in the seat.</li> <li>At 8:53 AM on 04/30/15 physical therapist (PT) #1 stated Resident #66 had a foam cushion in her geri-chair. He reported if the resident stayed sitting in her geri-chair for more than two hours she should be lifted off the cushion every 45 minutes to avoid "hot spots" which could eventually cause pressure problems to the bottom/sacrum (the staff was not observed doing this).</li> <li>At 9:07 AM on 04/30/15 NA #2, assigned to care for Resident #66, stated the resident stayed up in her geri-chair for no more than two hours at a time because she had a pressure locer on her bottom in the past. She reported she tried to get the resident up to the chair twice during first shift with some time in the bed in between. She commented there was no need to lift the resident off the cushion in her geri-chair for more than two hours at a time.</li> <li>At 12:18 PM on 04/30/15 the director of nursing stated Resident #66 was not supposed to be up in her geri-chair for more than a couple of hours at a time. She also reported she would expect</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION	
she was out of bed in her geri-chair.F 325483.25(i) MAINTAIN NUTRITION STATUSF 325SS=DUNLESS UNAVOIDABLE5/31/15	F 325	Resident #66 was u started her shift, bu resident had been u She stated the resid when up in her geri- seat. At 8:53 AM on 04/3 stated Resident #66 geri-chair. He report sitting in her geri-ch she should be lifted minutes to avoid "he eventually cause p bottom/sacrum (the this). At 9:07 AM on 04/3 for Resident # 66, s in her geri-chair for time because she h bottom in the past. the resident up to th with some time in th commented there w off the cushion in he resident never stays two hours at a time. At 12:18 PM on 04/ stated Resident #66 in her geri-chair for at a time. She also staff to reposition th she was out of bed 483.25(i) MAINTAIN	<ul> <li>up in her chair when she to she did not realize that the up in the chair since breakfast. Ident stayed in one position -chair with the cushion in the</li> <li>0/15 physical therapist (PT) #1</li> <li>b had a foam cushion in her ted if the resident stayed hair for more than two hours off the cushion every 45 of spots" which could ressure problems to the estaff was not observed doing</li> <li>0/15 NA #2, assigned to care that the resident stayed up no more than two hours at a had a pressure ulcer on her She reported she tried to get the chair twice during first shift he bed in between. She was no need to lift the resident er geri-chair because the ed in the chair for more than the cushing was not supposed to be up more than a couple of hours reported she would expect he resident occasionally when in her geri-chair. NUTRITION STATUS</li> </ul>				5/31/15	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/26/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		345377	B. WING		04	C / <b>30/2015</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Based on a residen assessment, the far resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t (2) Receives a ther nutritional problem.	t's comprehensive cility must ensure that a stable parameters of nutritional y weight and protein levels,	F 3	25		
	review the facility fa with all meals, as in dietitian (RD), for 1 (Resident #55) who loss. Findings inclu Resident #55 was a 02/19/08. The resid included cerebrovat hemiplegia, dyspha A 11/12/13 physicia on a finger food die The resident's Mon Weights documented documented) Resid pounds, weighed 14 and weighed 138.9 A 02/09/15 nutrition the facility's RD, do	ion, staff interview, and record illed to provide a sandwich pplemented by the registered of 1 sampled residents experienced gradual weight ided: admitted to the facility on dent's documented diagnoses scular accident with left gia, and contractures. In order placed Resident #55 t with nectar thick liquids. thly Record of Vital Signs and ed in November 2014 (no date lent #55 weighed 144.7 41.4 pounds in January 2015, pounds in February 2015. al progress note, written by cumented Resident #55 was h therapy and was picking up			<ol> <li>The Administrator immediately got a sandwich for Resident #55. The dietary staff were inserviced on 4-30-15 regarding the importance of putting a sandwich on the tray of Resident #55 at each meal.</li> <li>The Dietary staff will be inserviced on 5-22-15 regarding the importance of following tray cards appropriately. The nursing staff will be inserviced between May 18th thru May 31st on how to read the tray card and regarding the importance of checking tray cards at each meal to assure that the items on the tray match the tray cards. A list of residents with weight loss or that their weight is trending downward was generated to assure that there were dietary interventions in place.</li> <li>Audits will be completed to assure that all dietary interventions provided with meals are in place to prevent weight loss. These audits will be conducted on 10</li> </ol>	

Facility ID: 923145

If continuation sheet Page 7 of 11

		AND HUMAN SERVICES				FORM	05/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345377	B. WING				C 30/2015
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 / 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 325	RD recommended med pass nutritiona to drink it, and this y order. A 02/09/15 speech "Patient seen at lun w/o (without) being requested some sa Assisted patient in or divide sandwiches in The resident's Mon Weights documented documented) Resid pounds. A 03/20/15 nutrition the facility's RD, do continuing to lose w that he likes sandw eat sandwiches and therapydietary info The resident's Mon Weights documented documented) Resid pounds. A 04/02/15 nutrition the facility's RD, do receiving sandwiche A 04/02/15 quarterly documented the residential moderately impaire	mayonnaise sandwiches. The discontinuing the resident's al supplement due to refusals was carried out per physician therapy note documented, ich and interestingly enough asked patient verbally ndwiches as an alternate. using template cutter stamp to into small bite sized portions." thly Record of Vital Signs and ed in March 2015 (no date lent #55 weighed 135.7 hal progress note, written by cumented Resident #55 was veight. "Resident nods head ichesResident states he will d discussed with speech ormed and added to tray card." thly Record of Vital Signs and ed in April 2015 (no date lent #55 weighed 133.9 hal progress note, written by cumented Resident #55 was es with all meals. y minimum data set (MDS) sident's cognition of d, he required set up help only experienced no significant	F	325	residents weekly x 4 then monthly x Any deficient areas will be corrected immediately. 4. The results of these audits will be taken to the facility QA&A committee Recommendations will be made bat the findings of these audits.	d be be.	

If continuation sheet Page 8 of 11

		AND HUMAN SERVICES				FORM	05/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		345377	B. WING				C 30/2015
NAME OF F	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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	Continued From pa mechanically altere	d diet.	F 3	325			
	04/03/15, identified complications due t swallowing issues" this problem include	plan, last updated on "Resident is at risk for to history of chewing and as a problem. Interventions to ed speech therapy as needed, is ordered, and safe es.					
	his supper meal in l slip documented he	8/15 Resident #55 was eating his room. The resident's tray was to receive a sandwich at as no sandwich on his meal					
	his breakfast meal i tray slip documente	9/15 Resident #55 was eating in his room. The resident's ed he was to receive a but there was no sandwich on					
	operation was obse diet for each reside information such as likes/dislikes, and s employee placed be the meal trays. The plates, and the calle	29/15 the kitchen trayline erved. A caller called out the nt and other pertinent s adaptive utensils, supplements. A second everages and condiments on e cook placed the food on the er verified the food being sent ips before placing the trays in					
	his supper meal in l slip documented he	9/15 Resident #55 was eating his room. The resident's tray was to receive a sandwich at as no sandwich on his meal					

If continuation sheet Page 9 of 11

		AND HUMAN SERVICES				FORM	05/26/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345377	B. WING _				C 30/2015
NAME OF I	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 PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	At 6:07 PM on 04/2 stated as he set up checked tray slips t received the correc supplements, and li honored. At 6:12 PM on 04/2 the kitchen would b sandwich. At 6:25 PM on 04/2 cheese sandwich, w plastic wrap, was of The resident nodde staff member unwra cutting it up. At 9:07 AM on 04/3 supposed to check slips to make sure to diet, received their and dislikes were h At 10:12 AM on 04/4 the intervention of s place for Resident a experiencing gradu identified sandwich sandwiches fit into of finger foods. Ho expected the staff t the resident so he of At 10:15 AM on 04/ (ST) stated Residen sandwiches, but the	<ul> <li>19/15 nursing assistant (NA) #3</li> <li>resident meal trays he comake sure residents at diet and consistency, ikes and dislikes were</li> <li>19/15 the administrator stated be bringing the resident a</li> <li>19/15 a whole bologna and which was tightly wrapped in n Resident #55's meal tray. Each that he would appreciate a apping the sandwich and</li> <li>10/15 NA #2 stated NAs were the trays against the meal residents received the right supplements, and their likes onored.</li> <li>130/15 the RD stated she put sandwiches at all meals in #55 because he was al weight loss, the resident es as a food he liked, and the the resident's diet prescription wever, she stated she so cut up the sandwiches for could pick them up easier.</li> <li>130/15 the speech therapist nt #55 seemed to enjoy eating ey should be cut up smaller improved intake and safety in</li> </ul>	F 32	25			

Facility ID: 923145

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	·		PLETED	
		345377	B. WING	<u></u>			C 30/2015	
NAME OF	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GREENF	IELD PLACE				2575 W 5TH STREET			
					GREENVILLE, NC 27834			
(X4) ID PREFIX TAG	IFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE GREGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	

PRINTED: 05/26/2015