DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			LETED
		345116	B. WING		08/	; 19/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	15/2022
	A PINES AT GREENSBO		1	09 S HOLDEN RD		
				SREENSBORO, NC 27407		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 08/19/22. The compliance with the r	ertification and complaint vas conducted on 08/15/22 e facility was found to equirement CPR 483.73, ness. Event ID #1MVN11.	F 000			
		complaint investigation d from 08/15/22 through IMVN11.				
		were investigated: 86751, NC00186933, 88710, NC00188828 and				
	2 of the 32 complaint substantiated resultin					
	Immediate Jeopardy	was identified at:				
	K	684 at a scope and severity 756 at a scope and severity				
	K	roo at a scope and seventy				
	Immediate Jeopardy was removed on 08/1	began on 04/21/2022 and 8/2022 for F684.				
	Immediate Jeopardy was removed on 08/1	began on 04/27/2022 and 9/2022 for F756.				
	An extended survey	vas conducted.				
F 600 SS=D	Free from Abuse and CFR(s): 483.12(a)(1)	-	F 600			9/14/22
	§483.12 Freedom fro	m Abuse, Neglect, and				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					09/08/2022

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11, FORM APF OMB NO. 093	ROVE		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED			
		345116	B. WING		C 08/19/20	08/19/2022		
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z	IP CODE			
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COM	(X5) IPLETION DATE		
F 600	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not us physical abuse, corpo- involuntary seclusion This REQUIREMENT by: Based on record rev staff interviews, the fa- resident's right to be staff member (Nursin "rough" while providir comments, and staff Assistants #2 and #4 to provide activities o while being resistive reviewed for mistreat The findings included Resident #3 was adm 04/28/22 with diagno- behavioral disturbanc disease. Resident #3 's admis (MDS) dated 05/04/2 cognitive impairment assistance with 2-per	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. and the symptom is the second of the second edical symptom is the second of the second is not met as evidenced iew, observation, family and acility, failed to protect a free from mistreatment by a g Assistant #1) due to being ing care, making disrespectful members (Nursing) were observed to continue f daily living on Resident #3 to care for 1 of 2 residents ment (Resident#3). I: nitted to the facility on ses of Dementia with	F 6	 When Administratic the allegation on 8/15/2 assistant #1 was remov building and suspended investigation, investigat and the Initial Report fo was submitted for resid assistant #1 was termin employment 8/19/2022. #2, #4 were re-educated for dealing with resident resistive to activities of 8/16/2022. Starting on 8/16/20 oriented residents (BIM interviewed to identify on have concerns regardin CNAs. Skin assessmen cognitively impaired ress Interviews and skin che completed 9/7/2022. Effective 8/15/2022 Development Coordinat 	022 the nursing ed from the I pending ion was initiated, r alleged abuse ent #3. Nursing ated from Nursing assistant d on procedures ts who are daily living care on 22, alert and S >8) were thers that may g treatment from ts were done for idents (BIMS <8). cks were			

Facility ID: 953473

	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY PLETED	
	CONTRECTION	BENTI IOATION NOMBER.	A. BUILDING	i		C	
		345116	B. WING			08/19/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From page	2	F 60	0			
		e, extensive assistance of		staff residents have the rig from abuse, neglect, misa resident property and expl	ppropriation of		
	revised on 7/15/22 re	dated 5/3/22 and last vealed Resident #3 was		includes but is not limited to corporal punishment, invol	untary		
		icking, punching at staff, and profanities. The goal was		seclusion, verbal, mental, physical abuse, and physic restraint not required to tre	cal or chemical		
	review. Interventions	erate with care through next included staff were to give Il care activities prior to an		resident's symptoms. Edu include how to recognize v has potentially been abuse	vhen a resident		
	as they occur during	each contact and make sure and reapproach resident		included when a resident included when a resid	s resistive to		
	once she is calm.			resident to calm down and provide care to the resider	nt. If resident		
	family member it was	n 8/15/22 at 4:36 pm with a indicated that she had ber an allegation of a staff		continues to remain resisti nursing aide will notify the representative party will be	nurse and the		
	member handling her	family member rough he indicated she reported to		Education will continue in new hire. In-person and/or	orientation with		
	on Sunday Aug 14, 20	e (Nurse #2) around 5:00pm 022, NA #1 was in Resident		4. Administrative team w staff members per unit pro	viding activities		
	very aggressive and t	care and "yanked her leg old Resident you better Resident had Dementia and		of daily living to a resident is not providing care to a re resistive care and listen to	esident that is		
	could be resistive at t care.	imes when staff provide		are not making disrespect towards residents' random weekends on random shift	days to include		
	at 5:03 pm read in pa	rogress Note dated 08/14/22 rt Resident #3 ' s family		weeks and weekly x 4 wee Administrative team will in	eks. terview 2		
	-	t the assigned NA other and stated he was evious task he performed.		residents per unit with BIN resident is not being abuse weeks. Nursing will perfor	ed weekly x 8		
	She stated that she d her mother. Both part	id not want him caring for ies were shouting at each		skin assessment on 2 residuation with BIMS <8 to ensure no	dents per unit signs of abuse		
	Family member state	proposed by them both. d that he had better not r again! Reported situation		weekly x 8 weeks. Results will be reviewed at Quarter Assurance Meeting X 3 for	rly Quality		

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				LE CONSTRUCTION		O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345116	B. WING			B/19/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		5/15/2022
				109 S HOLDEN RD		
CAROLIN	A PINES AT GREENSBO	RO, LLC		GREENSBORO, NC 27407		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From page	a 3	F 60	0		
1 000	Continued i forn page	5 0	F 00	of Nursing will review the re	culte of wookly	
	An interview was con	ducted with the Scheduler		audits to ensure any issues		
		n. She indicated she was		corrected.		
		n 8/14/22. She indicated she				
		lurse #2 on 8/14/22 and she				
		amily member and staff				
		g back and forth. She stated				
		send the staff member				
		e staff member also had				
	called her and inform	-				
		at him and making threats him to go home and come				
		d talk with management.				
		him home because she did				
		e. She indicated she was not				
		n of mistreatment with				
	Resident #3.					
	An interview was con	ducted on 8/15/22 at 5:49				
	pm with NA #1 and he	e indicated he was providing				
	care for Resident #3	on 8/14/22 while the family				
		. He indicated during care				
	he asked Resident #3					
		Ild provide care for her. He				
	-	tated he looked a little				
		mily member followed him ated he then called the				
		ause the family member was				
	-	t him, and he was told by the				
		b home and return to work				
	the next day. During					
		sent in the dining room at the				
	•	as told to come back to work				
	-	2 and was working on the				
		vay and around 4:00 pm he				
		ector of Nursing to write a ppened on Sunday. He				
	stated he was not bei					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2022 APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345116	B. WING		_		C 19/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBOI	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 274	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 600	it takes 2 people to he another NA was provi the other NA left the m soap. An interview was come 8/15/22 at 6:08 pm an asked by NA #1 to he #3. NA #5 indicated s the entire time with Na stated NA #1 had alres to asking her to help. During an interview w 10:01 am it was indica was caring for Reside evening the allegation she reported the allegation she reported the allegation she attempted to conf (DON) and was unsue On 8/19/22 at 10:46 at made of NA #2 and N to beginning care they activities of daily living wash Resident's face at staff cursing and m was holding Resident take clothing off and F and resist staff. Surve informed staff to go go desk with NA #2 and N Resident some Tylend would make the DON	care provided. He indicated elp with Resident and he and ding care for Resident, and oom briefly to get some ducted with NA #5 on nd it was indicated she was lp provide care for Resident he was not present during A #1 and the family. NA #5 eady been in the room prior with Nurse #2 on 8/17/22 at ated she was the Nurse that ent #3 on 8/14/2022 the n was made. She indicated gation to the Manager on-call 6:00 pm and NA was sent -call. She also indicated tact the Director of Nursing ccessful. Im an observation was A #4 inform Resident prior y were going to provide g care. NA #2 attempted to and Resident began to hit oving about in bed. NA #4 ' s hands and attempting to Resident continued to hit eyor intervened and et Nurse. Surveyor went to Nurse stated she had given ol and they stated they aware. h 8/19/22 at 10:54 am with	F 600				
	-	n 8/19/22 at 10:54 am with I Resident #3 is like that all					

Facility ID: 953473

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345116	B. WING				C 19/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			09 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	the time, fighting and her. NA #2 indicated t later, but we just try a On 8/19/22 at 11:41 a was made and she in would initially stop pro #3 became resistant t approach. DON indic staff would stop and r were being resistant of she would continue to dementia training for behaviors. During an interview w 8/19/2022 at 1:18 pm like staff sometimes s was resistant to care, stop when residents v reapproach later. Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The facilitit implement written pol §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95,	resisting to let us care for they sometime come back and get it done. Iman interview with DON dicated she believed staff oviding care when Resident to care and would re tated it was her expectation eapproach resident that during care. She indicated be educate staff and provide caring with residents with with the Administrator on it was indicated it sounded top care when Resident #3 and he expected staff to vere resistant to care and buse/Neglect Policies -(3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures		600			9/14/22

Facility ID: 953473

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	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MI II TI		STRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				MPLETED
							С
		345116	B. WING				08/19/2022
NAME OF P	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
				109 S H	IOLDEN RD		
CAROLIN	A PINES AT GREENSBO	KO, LEC		GREE	NSBORO, NC 27407		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 607	Continued From page	9.6	F 60	72			
	Based on record rev				When Administration was inform	med of	
		ailed to report the allegation			e allegation on 8/15/2022 the		
	-	n the specified timeframe of			vestigation was initiated and the li	nitial	
		ident for 1 of 3 alleged		Re	port for alleged abuse was subm		
		completed by the facility			mediately upon notification.		
	(Resident #3).				On 8/17/2022 the Administrator		
	The findings included				dited reported allegations of abus d/or neglect from last 60 days to		
					hour and 5-day reports were	verny	
	The facility abuse pol	icy 'Allegations of Abuse,			mpleted and submitted timely as		
		tion with the revised date of			quired by regulation and Elder Ju	stice	
	11/01/2020 included i	n part: "1. Reporting of all		Ac			
	-	he Administrator, state			On 8/16/2022 Regional Directo		
		ive services and to all other			nical Services educated the lead	•	
		g., law enforcement when			am, including the Administrator ar		
	applicable) within spe	later than 2 hours after the			rector of Nursing on the abuse po nich states, "Reporting of all allego	-	
		the events that cause the			plations to the Administrator, State		
	•	use or result in serious bodily			ency, Adult Protective Services a		
	injury., or b. Not later	r 24 hours if the events that		oth	ner required agencies (e.g., law		
	-	do not involve abuse and do			forcement when applicable) withi		
	not result in serious b	oodily injury,"			ecified timeframes: a. immediatel		
	During on interview o	n 8/15/22 at 4:36 pm with a			t later than 2 hours after the alleg made if the event that cause the	ation	
		indicated that she had			egation involved abuse or result i	n	
	-	ber an allegation of a staff			rious bodily injury., or b. Not later		
		family member rough			hours if the events that cause the		
	during patient care. S	he indicated she reported to			egation do not involve abuse and		
		(Nurse #2) around 5:00pm			sult in serious bodily injury".		
		022, NA #1 was in Resident			ective 8/15/2022, Staff Developm		
		are and "yanked her leg told Resident you better		-	ordinator educated all current sta	att	
		Resident had Dementia and			embers on reporting all alleged plations involving abuse, neglect,		
		imes when staff provide			ploitation, or mistreatment, includ	ing	
	care.	L			uries of unknown origin and	5	
				mi	sappropriation of resident proper		
		rogress Note dated 08/14/22			ported immediately to the Adminis		
		rt Resident #3's family			d/or Director of Nursing. Educatio		
	member reported tha	t the assigned NA		CO	ntinue in orientation with new hire) .	

Facility ID: 953473

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		MEDICAID SERVICES	(X2) MEILTI	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETE	
					С	
		345116	B. WING		08/19/2	022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM HE APPROPRIATE	(X5) IPLETIOI DATE
F 607	Continued From page 7 rough-handled her mother and stated he was frustrated from the previous task he performed. She stated that she did not want him caring for her mother. Both parties were shouting at each other & threats were proposed by them both. Family member stated that he had better not touch her mother ever again! Reported situation to manager on-call. An interview was conducted with the Scheduler on 8/15/22 at 5:33 pm. She indicated she was the Manger on call on 8/14/22. She indicated she		F 6	 In-person and/or via phone. Regional Director of Opmonitor 24 hour and 5-day nensure reports are sent in a the regulations weekly x 8 wof these audits will be review Quarterly Quality Assurance for further problem resolution The Administrator will review weekly audits to ensure any identified are corrected. 	verations will reports to ccording to veeks. Results wed at Meeting X 3 n if needed. v the results of	
	the Manger on call or received a call from N was informed that a f member was arguing she told Nurse #2 to home. She stated the called her and inform member was cursing to him, and she told h back the next day and She stated she sent h not want it to escalate					
	During an interview with Nurse #2 on 8/17/22 at 10:01 am it was indicated she was the Nurse that was caring for Resident #3 on 8/14/2022 the evening the allegation was made. She indicated she reported the allegation to the Manager on-call at after dinner around 6:00 pm and NA was sent home by Manager on-call. She also indicated she attempted to contact the Director of Nursing (DON) and was unsuccessful.					
	was sent to NC Depa	nitial report dated 8/15/22 Irtment of Health and Human Health Service Regulation				

Facility ID: 953473

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345116	B. WING				
NAME OF PR	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLINA	PINES AT GREENSBOI	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 610 SS=D	on 08/19/2022 at 11:4 expectation was for st compliance officer wh and/or herself of any a the investigation woul During an interview w 8/19/2022 at 1:18 pm appeared to a misund However, his expecta abuse had to be sent suspend the alleged p investigation. Investigate/Prevent/C CFR(s): 483.12(c)(2)- §483.12(c) In respons neglect, exploitation, o must: §483.12(c)(2) Have ev violations are thoroug §483.12(c)(3) Prevent neglect, exploitation, o investigation is in prog §483.12(c)(4) Report investigations to the a designated representa accordance with State Survey Agency, withir incident, and if the alla appropriate corrective	5:04 pm. ith the Director of Nursing 1 am, she indicated her iaff to notify the abuse o is the Administrator allegations of abuse, and d start within 2 hrs. ith the Administrator on and it was indicated it erstanding of the allegation. tion was any allegation of within 2 hours to the state, berpetrator pending orrect Alleged Violation (4) the to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated. it further potential abuse, or mistreatment while the gress.		607			9/14/22

Facility ID: 953473

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	: 11/09/2022 APPROVED . 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
		345116	B. WING			C 08/19/2022		
NAME OF PF	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLINA	A PINES AT GREENSBOI	RO, LLC		09 S HOLDEN RD IREENSBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 610	to residents after an a 1 of 3 residents review by allowing the allege to work the next day. The findings included Resident #3 was adm 04/28/22. Resident #3's admiss (MDS) dated 05/04/22 cognitive impairment assistance with 2-pers mobility, dependent w with transfer, toilet us one-person physical a During an interview of family member it was reported to staff mem member handling her during patient care. S Resident #3's Nurse (on Sunday Aug 14, 20 Resident #3's room pi her leg very aggressiv better stop." She indid Dementia and could to staff provide care. A review of Nurses Pr at 5:03 pm read in pa member reported that rough-handled her mo	ews, staff and family failed to provide protection illegation of mistreatment for wed for abuse (Resident #3) d perpetrator to come back itted to the facility on ion Minimum Date Set 2 indicated Resident #3 had and required extensive son physical assist with bed with 2-person physical assist e, extensive assistance of assist with eating. In 8/15/22 at 4:36 pm with a indicated that she had ber an allegation of a staff family member rough he indicated she reported to Nurse #2) around 5:00pm 022. NA #1 was in roviding care and "yanked /e and told Resident you cated Resident had be resistive at times when	F	610	 When Administration was infor the allegation on 8/15/2022 the nur assistant #1 was immediately remo- from the building and suspended p investigation, investigation was init and the Initial Report for alleged at was submitted for resident #3. Nur assistant #1 was terminated on 8/19/2022. Starting on 8/16/2022 alert and oriented residents (BIMS >8) were interviewed to identify others that in have concerns regarding treatment CNAs. Skin assessments were dor cognitively impaired residents (BIM Interviews and skin checks were completed 9/7/2022. Regional Director of Clinical S educated Administrator and Director Nursing to remove the staff member is identified in the allegation immed Completed on 8/16/2022. Employees involved in allegati be removed immediately upon kno of an investigation by the Administrator monitor weekly x 8 weeks. Results these audits will be reviewed at Qu Quality Assurance Meeting X 3 for problem resolution if needed. The Administrator will review the results weekly audits to ensure any issues identified are corrected. 	sing ved endii ated use sing d ay by le fo S <{ for that iatel ons wiled ator will of artel furth s of	ng I ses at y. will ge or	

Facility ID: 953473

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DEPARTMENT OF HEALTH					FORM	: 11/09/2022 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE : COMPI	SURVEY _ETED
	345116	B. WING		_	08/1	; 19/2022
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	TATE, ZIP CODE		
CAROLINA PINES AT GREENSE	BORO, LLC		9 S HOLDEN RD REENSBORO, NC 274	407		
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 her mother. Both protection of the states were Family member states touch her mother end to manager on-call. An interview was call from was informed that a member was arguing she told Nurse #2 th home. She stated called her and informember was cursing to him, and she told back the next day a She stated she sere not want it to escale aware of an allegate Resident #3. An interview was call for the stated she sere not want it to escale aware of an allegate Resident #3. An interview was created to the room, and the follow of the stated she sere not want it to escale aware of an allegate Resident #3. 	e did not want him caring for arties were shouting at each re proposed by them both. ted that he had better not ver again! Reported situation	F 610				

Facility ID: 953473

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION		LETED	
		345116	B. WING				C 19/2022	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CAROLIN	A PINES AT GREENSBOI	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 610	During this interview present in the dining r he was told to come to 8/15/22 and was work hallway and around 4 Director of Nursing to happened on Sunday being aggressive with resident was aggress care provided. He ind help with Resident an providing care for Res the room briefly to get An interview was come 08/15/22 at 6:10pm, s help provide care for 1 indicated she was not time with NA #1 and t #1 had already been in her to help. During an interview w 10:01 am it was indica was caring for Reside evening the allegation she reported the allegat at after dinner around home by Manager on- she attempted to cont (DON) and was unsue Review of the alleged revealed perpetrator f 2:11 pm and clocked of During an interview w on 08/19/2022 at 11:4	NA #1 indicated he was room at the facility because pack to work at 2:00 pm on king on the other side of the :00 pm he was asked by the write a statement of what . He stated he was not the resident and that the ive at times and yells when dicated it takes 2 people to d he and another NA was sident, and the other NA left t some soap. duct with the NA#5 on she was asked by NA #1 to Resident #3. NA #5 t present during the entire he family. NA #5 stated NA in the room prior to asking with Nurse #2 on 8/17/22 at ated she was the Nurse that ent #3 on 8/14/2022 the n was made. She indicated gation to the Manager on-call 6:00 pm and NA was sent -call. She also indicated tact the Director of Nursing ccessful.	F	610				

Facility ID: 953473

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				LE CONSTRUCTION		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · /	E SURVEY PLETED
					с	
		345116	B. WING		08	8/19/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO. LLC		109 S HOLDEN RD		
		,		GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 610	Continued From pag	e 12	F 61	0		
1 010		ho is the Administrator	FUI	0		
		allegations of abuse, and				
	-	or would be suspended until				
		completed to make sure all				
	residents are protect					
	During an interview y	vith the Administrator on				
		and it was indicated it				
		derstanding of the allegation.				
		ation was suspend the				
	alleged perpetrator p					
F 641	Accuracy of Assessn	nents	F 64	1		9/14/22
SS=D	CFR(s): 483.20(g)					
	§483.20(g) Accuracy	of Assessments.				
		st accurately reflect the				
	resident's status.					
		Γ is not met as evidenced				
	by:					
		riews and staff interviews, the		1. Resident #98 discharge des		
		ately code a discharge and a		was corrected in the discharge N		
		ata Set (MDS) assessment eviewed for facility discharge		8/18/2022. Mood and behavior for resident #3 MDS was corrected of		
		of 1 resident reviewed for		9/1/2022.		
	behaviors (Resident			2. Effective 8/24/2022 MDS nu	rses	
				reviewed 30 days of discharge s		
	The findings included	1:		to ensure accurate coding of disc status, mood and behavior was of		
	1. Resident #98 was	admitted to the facility		correctly. Completed on 9/9/202		
		oses to include hypertension		correction for discharge status a		
		esident #98 left against		corrections on mood and behavior	or.	
	medical advice (AMA	A) on 6/13/2022.		Corrections completed on 9/9/20		
	The discharge MDS	dated 6/13/2022		3. Effective 8/31/2022 & 9/1/20 Regional MDS Consultant educa		
	-	nt #98 had an unplanned		nurses on coding MDS assessme		
	discharge to the hos	-		accurately regarding discharged,	mood,	
	A nursing note deted	6/13/2022 documented		and behavior. The facility is in prohim		
	A nursing note dated			I mining a social service director, th		

Facility ID: 953473

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		<u>O. 0938-039</u> e survey
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · · ·	IPLETED
						С
		345116	B. WING			8/19/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 13	F 64	41		
	Resident #98 left the member.	facility AMA with a family		receive education from the ensure the deficient practice of the defici	tice will not recur.	
		ated 6/13/2022 documented I to go home, and she called I left AMA.		 Administrator and/or audit 3 discharge assess the proper discharge stat accurately weekly x 8 we Administrator and/or des 	ments to ensure tus is coded eeks.	
	on 8/18/2022 at 11:34	ducted with the MDS nurse 4 AM. The MDS nurse aware Resident #98 ' s hospital discharge.		MDS assessments to en- behaviors are coded acc 8 weeks. Results of thes reviewed at Quarterly Qu	sure the proper urately weekly x se audits will be uality Assurance	
	at 10:11 AM. The Adr	is interviewed on 8/19/2022 ministrator reported when facility, she had said she		Meeting X 3 for further pu if needed. The Administra- the results of weekly aud issues identified are corr	ator will review lits to ensure any	
	reported he thought t coded the assessme	e hospital. The Administrator hat was why the MDS nurse nt as Resident #98 was				
	reported it was his ex	spital. The Administrator pectation that MDS oded accurately, and errors				
	were corrected.					
	2. Resident #3 was a 04/28/22 with diagno behavioral disturband disease.					
	revised on 7/15/22 re resistive to care by e behaviors by biting, k	cicking, punching at staff, and				
	Resident would coop review. Interventions	g profanities. The goal was erate with care through next included staff were to give				
	clear explanation of a as they occur during	all care activities prior to an each contact and make sure e and reapproach resident				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING _				C 19/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			9 S HOLDEN RD REENSBORO, NC 27407		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	2 14	F 6	641			
F 684 SS=K	(MDS) dated 05/04/22 cognitive impairment assistance with 2-per- mobility, dependent w with transfer, toilet us one-person physical a or behaviors coded of On 8/19/22 at 10:46 a made of NA #2 and N activities of daily living was resistive to care. During an interview of NA#2 it was indicated the time, fighting and her. NA #2 indicated the time, fighting and her. NA #2 indicated the later, but we just try a Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe practice, the comprehencare plan, and the residents This REQUIREMENT by: Based on record revi Physician Assistant and facility failed to impler	are ndamental principle that and care provided to get it done.	F 6		 Resident #72 no longer resides in facility. Regional Director of Clinical Servic (RDCS) reviewed current residents with 	es	9/14/22

Facility ID: 953473

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ATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE C	ONSTRUCTION	· · ·	
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G			PLETED
		345116	B. WING				C
	ROVIDER OR SUPPLIER	343110			REET ADDRESS, CITY, STATE, ZIP CODE	08	8/19/2022
					S HOLDEN RD		
CAROLIN	A PINES AT GREENSBO	RO, LLC			EENSBORO, NC 27407		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 684	Continued From page	a 15	F 68	24			
1 001	twice daily for Reside		F 00		diabetic medication orders to ensure		
	administered injectab	•			residents are receiving blood sugar		
		nt #72 who was diagnosed			checks for 30 days (7/18/2022 -		
		monitoring the resident's			8/18/2022) of admissions to ensure		
		nission to the facility until			accuracy of orders on 8/18/2022.		
		pital. On 8/13/22, Resident			3. The Staff Development Coordinate	or.	
	#72's blood sugar reg	-			RDCS and Unit Managers educated th		
		nt #72 was sent to the			licensed nurses regarding the process		
	emergency departme	ent (ED) due to being			verifying new admission orders for		
	lethargic and staff we	re unable to obtain vital			residents admitted to the facility, ensur	ing	
	signs. At the hospita	l, Resident #72 ' s blood			a second nurse verifies orders for		
	sugar was recorded a				accuracy. New licensed nurses will		
		he Resident received insulin			receive this education in orientation. The		
		od to lower blood sugar			RDCS educated the Director of Nursin	g	
	levels. Resident #72	-			and nurse managers regarding the		
		s (a buildup of acids in your			validation of new admission orders dur	ing	
		o diabetic coma or even			the morning clinical meeting for		
	death) /Hyperosmola	sugar level). This deficient			admissions from the prior day. All	n	
		1 of 3 sampled residents			education was completed on 8/17/20234. Director of Nursing and/designee		
	-	s care (Resident #72).			review new admission orders on the ne		
					business day for accuracy daily x 8	571	
	Immediate ieopardy b	began on 4/21/22 when the			weeks. Director of Nursing will review	4	
		or blood sugars for Resident			residents per unit receiving antidiabetic		
	-	s and received injectable			medications to ensure residents are		
		dications. The hospital			receiving blood sugar checks as ordered	ed	
		ncluded orders to monitor			by medical physician weekly x 8 weeks		
	the resident 's blood	sugars twice a day. The			Results of these audits will be reviewed		
	-	ers did not include blood			Monthly Quality Assurance Meeting X		
		e daily. The immediate			for further problem resolution if needed		
		ed on 8/18/22 when the			The Director of Nursing will review the		
		cceptable credible allegation			results of weekly audits to ensure any		
		y removal. The facility will			issues identified are corrected.		
	-	ance at a scope and severity					
		h potential for more than					
		not immediate jeopardy) to					
	ensure monitoring an	o all statt nave been					

Facility ID: 953473

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345116	B. WING				C 19/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBOI	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	(d/c) summary dated to test blood sugar two Resident #72 was add 4/21/22 and had diago mellitus type 2, Parkin dementia. Physician orders date (an antihyperglycemic to control high blood s (mg)/0.5 milliliters (ml morning every Monda oral diabetes medicat by mouth one time a d the admission orders. A review of Physician through 8/13/2022 rev for blood sugar monite During an interview of Nurse #1 it was indicated sure if she had put the from the hospital d/c s however she indicated day. She indicated if discharge summary fo blood sugar checks d have been an order to	 #72 's hospital discharge 4/17/2022 revealed orders ice daily. mitted to the facility on noses including diabetes nson 's disease, and ed 4/21/22 included Trulicity cinjectable medication used sugar) 1.5 milligrams) subcutaneously in the ay and Metformin HCI (an ion) 1000 mg give 1 tablet day. Nurse # 1 documented orders from 4/21/2022 vealed no order documented oring. n 8/17/22 at 2:08 pm with ated she was not completely e orders in the computer summary on admission, d she was the nurse that it was documented on the or Resident #72 to have one that then there should o do so. m Data Set (MDS) dated dent had cognitive 	F	684			
	impairment received i	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			C	
		345116	B. WING				_ 19/2022	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
F 684	 4/27/22, 5/26/22, 6/23 (A blood test that measugar levels over the 6.6% (A level of 6.5% check blood sugars b A review of medical review of the Basic 5/16/22 revealed the mg/dl. A review of the Basic 5/16/22 revealed the mg/dl, reference rang A review of medical review of medical review of a Progress 8/13/22 read, in part, be severely lethargic, were unable to obtain registered "HI", which manufacture informat over 600 mg/dl. Spouwith nurse to transfer evaluation and treatmon-call Nurse Practitic A call was placed to 9 hospital and emergen and transferred reside An interview with Direve 8/17/22 at 3:05 pm wai indicated she was not orders on admission for stated the facility short 	progress notes dated 3/22 read, in part, recent A1c asures your average blood past three months.) was indicates diabetes.) and will efore meals and at bedtime. ecord revealed blood sugar fall on 4/29/22 and was 88 Metabolic Panel dated sugar result was high at 220 e is 70-99 mg/dl. ecord revealed a blood n 6/23/22 and was 155 s notes by Nurse #2 dated Resident #72 was found to skin cool to touch and staff o vital signs. Blood sugar e per the glucometer ion indicates a result of HI is use was present & agreed Resident to hospital ED for nent. Call was placed to oner and was made aware. 11 to transfer Resident to tocy medical service arrived ent to hospital. ector of Nursing (DON) as conducted and she t aware Resident #72 had for blood sugar checks. She uld have verified the orders	F	684				
	8/17/22 at 3:05 pm wa indicated she was not orders on admission f	as conducted and she t aware Resident #72 had for blood sugar checks. She uld have verified the orders						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345116	B. WING				19/2022	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAROLIN	A PINES AT GREENSBO	RO, LLC			09 S HOLDEN RD GREENSBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	9 18	F	684				
	On 8/17/22 at 3:19 pr Physician Assistant w blood sugar checks w Physician. She indica was on the orders fro blood sugar should ha ordered. During an interview w (MD) on 8/18/22 at 4: facility had issues with transcribed as ordere #72 the blood sugar of facility should have be they were ordered. H been doing the blood could ' ve seen his blo of time and modified I A review of the EMS of pm revealed upon arr was responsive to ver and blood sugar was "HI". According to the hosp dated 8/13/22, Reside 764 mg/dl in the ED a Diabetic Ketoacidosis hyperglycemia and re time of the survey. Th ED with altered menta for further managements insulin drip for severe	n an interview with the indicated an order for vas missed by her and the ted if blood sugar checking in the hospital, then the ave been checked as with the Medical Director 49 pm it was indicated the h orders that were not being d. He indicated for Resident checks were missed and the een doing the checks as le indicated if the facility had sugar checks, then staff bod sugar was rising ahead his medications. report dated 8/13/22 at 7:48 ival to facility Resident #72 rbal stimuli by name only obtained, and results read bital ED documentation ent #72 had a blood sugar of and was diagnosed with c/Hyperosmolar remained in the hospital at the he Resident presented to the al status and was admitted ent. He was started on an hyperglycemia. s notified of immediate						
	On 8/18/2022 the fac	ility provided the following						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345116	B. WING				C 19/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	are likely to suffer, a s a result of the noncom The facility failed to corresidents #72 medicat the need to monitor in anti-diabetic medication medication regimen re- inadequate monitoring and anti-diabetic medi- received weekly insul- medication without ble and experienced critici identified at the hospi pharmacy medication months of April, May, revealed no identifica monitoring of insulin a anti-diabetic medication On 8/17/2022 the Reg Services (RDCS), rev diabetic medication to receiving blood sugar RDCS notified the Nu- opportunities identifie explained their respon 8/17/2022. On 8/17/2 of Clinical Service (RI admissions to ensure Actions taken by the fiprocess or system fail	Immediate Jeopardy Its who have suffered, or serious adverse outcome as inpliance. Implete an evaluation of tion regimen that identified issulin administration and ons. Resident #72 eview did not identify the g of insulin administration ication. Resident #72 in and daily anti-diabetic bod sugar testing as ordered cally high blood sugars tal. A review of the regimen reviews for the June, and July of 2022 tion of inadequate administration and on. gional Director of Clinical iewed residents with o ensure residents are checks. On 8/17/22 the rse Managers of any d during this audit and nsibility to correct by 2022 the Regional Director DCS), reviewed 30 days of accuracy of orders. Facility to alter to alter the lure to prevent a serious n reoccurring and when the	F	684			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345116	B. WING				C 19/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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)	ЗE	(X5) COMPLETION DATE
F 684	Director of Clinical Se educated the License process for verifying r residents admitted to call the medical doctor to verify orders on the entering the orders in medical record. Whe entered into the electri second nurse is to ve when confirming. The ensure no licensed nur receiving this education agency staff will receind start of their shift. Eco by 8/17/2022 by the Si Coordinator, Regional Services, and Unit Ma The Regional Director educated the Director Managers regarding to admission orders durit meeting for admission education was comple Effective 8/17/2022 the ultimately responsible of this immediate jeop alleged non-complian Alleged Date of Imme 8/18/2022 On 8/19/22 the credib jeopardy was validate	nt Coordinator, Regional ervices, and Unit Managers d Nurses regarding the new admission orders for the facility. The nurse is to or and/or nurse practitioner e discharge summary prior to to the residents ' electronic in the admission orders are ronic medical record, a rify orders for accuracy e Director of Nursing will urse will work without on. Any new hires, including ve education prior to the ducation will be completed Staff Development I Director of Clinical anagers. r of Clinical Services r of Nursing and Nurse he validation of new ing the morning clinical ns from the prior day. This eted on 8/17/2022. he Administrator will be e to ensure implementation pardy removal for this ce ediate Jeopardy Removal:	F	684			

Facility ID: 953473

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMF	LETED
		345116	B. WING				C 19/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	19/2022
					109 S HOLDEN RD		
CAROLIN	A PINES AT GREENSBO	RU, LLC			GREENSBORO, NC 27407		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
E 604		04	_				
F 684	Continued From page		F	684	4		
	Interview with the Reg	when a new admission was					
		/, the nurse needed to call					
		or Nurse Practitioner to					
		mary orders prior to entering sident ' s medical record.					
		nen admission orders were					
		record, a second nurse was					
	•	confirming for accuracy,					
		it entered the facility, they narge summary from the					
		e orders that were in the					
	system for accuracy.						
	A review of the audits	revealed all residents '					
	orders were reviewed were corrected.	l and any discrepancies					
	A review of the educa	tion training revealed					
		ed to staff as stated in the					
	credible allegation.						
	Interview was conduc	ted with staff on 8/19/2022					
		cated knowledge of what to					
		residents and entering the					
	new orders.						
	Interview was conduc	ted with staff on 8/19/2022					
	at 11:00 am who indic	cated knowledge of what to					
		residents and entering the					
	new orders from the h	nospital.					
	Interview was conduc	ted with Unit Manager on					
	8/19/2022 at 11:45 ar	n who indicated knowledge					
		nented to verify orders from					
	the d/c summary from patients.	n the hospital for all new					
		ted with Staff Development					
		2022 at 11:58 am and it was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 11/09/202 1 APPROVE). 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345116	B. WING			」 19/2022
NAME OF PF	ROVIDER OR SUPPLIER	I	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
CAROLIN	A PINES AT GREENSBO	RO, LLC		09 S HOLDEN RD REENSBORO, NC 27407		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 684	Continued From page	e 22	F 684			
		knowledge of how to				
	complete the medicat	tion reconciliation for new				
	admissions, and she checklist that was im					
	completion of new ad					
	Interview with the DC	N on 8/19/2022 at 12:00 pm				
		nission audit will help the Il assessment of residents '				
		is and treatments will be				
	reviewed for the resid	lents during the admission				
	process.					
	Interviews with staff r provided.	evealed that education was				
	The immediate jeopa 8/18/2022 was valida	-				
F 727 SS=E	RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1)		F 727			9/14/22
	§483.35(b) Registere	d nurse				
	§483.35(b)(1) Except					
		f this section, the facility s of a registered nurse for at				
		ours a day, 7 days a week.				
	§483.35(b)(2) Except	when waived under				
	paragraph (e) or (f) o	f this section, the facility				
	must designate a reg director of nursing on	istered nurse to serve as the a full time basis.				
		ector of nursing may serve				
		ly when the facility has an ncy of 60 or fewer residents.				
		is not met as evidenced				
	by:					
		iews and the staff interviews ave a Registered Nurse		1. Staff schedules were adjusted immediately to ensure proper RN		
		and a registered mulse				

Facility ID: 953473

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TATEMENT (OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
			A. BUILDING		С
		345116	B. WING		08/19/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBC	PRO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 727	Continued From pag	e 23	F 727	7	
		ecutive hours a day for 1		coverage is in place. 2. Current residents are affected t current deficiency.	by this
A r thr Re no on	Findings included:			 Regional Director of Clinical Se educated the Director of Nursing an 	
	through 08/18/22 rev			Administrator on 8/31/2022 on provi Registered Nurse in the facility for 8	
	Registered Nurse on	07/25/22.		consecutive hours for a day, 7 days week.	а
		rds revealed the facility had		4. Director of Nursing and/or desig	-
		a RN present in the facility		will audit schedule to ensure a Regi	
		the requirement for an RN at nours per day on 07/25/22.		Nurse in the facility for 8 consecutiv hours for a day, 7 days a week wee weeks. Results of these audits will	kly x 8
		ed with the Scheduler on stated there should have		reviewed at Quarterly Quality Assur Meeting X 3 for further problem reso	ance
	The Scheduler stated	n a Registered Nurse scheduled on 07/25/22. Scheduler stated she worked with staff ncies to ensure RN coverage.		if needed. Director of Nursing will re the results of weekly audits to ensur issues identified are corrected.	
		ed with the Director of			
	Nursing on 08/18/22	at 11:30am stated she			
		to have a Registered Nurse egulation for 8 consecutive a week.			
	08/18/22 at 2:30pm s	ed with the Administrator on stated he expected the Registered Nurse for 8 hours ek.			
	Drug Regimen Revie CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F 756	3	9/14/22
		ug regimen of each resident least once a month by a			

Facility ID: 953473

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2022 APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345116	B. WING			C 08/19/2022		
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				10	99 S HOLDEN RD			
	A PINES AT GREENSBO			G	REENSBORO, NC 27407			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 756	Continued From page §483.45(c)(2) This re of the resident's media §483.45(c)(4) The phi irregularities to the at facility's medical direct and these reports mut (i) Irregularities included drug that meets the c (d) of this section for (ii) Any irregularities re during this review mut separate, written report attending physician a director and director of minimum, the resident and the irregularity th (iii) The attending phy resident's medical read irregularity has been action has been taken be no change in the r physician should doc the resident's medical §483.45(c)(5) The fac maintain policies and drug regimen review	e 24 view must include a review ical chart. armacist must report any tending physician and the ctor and director of nursing, ist be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a nt's name, the relevant drug, e pharmacist identified. /sician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		756				
	the process and step when he or she ident requires urgent action	ifies an irregularity that to protect the resident.						
	Based on record rev Medical Director and failed to complete an medication regimen t	iew, Consultant Pharmacist, staff interviews, the facility evaluation of Resident #72's hat identified the need to d oral diabetes medications			 Resident #72 no longer resides in facility. Regional Director of Clinical Serv (RDCS), reviewed residents with diab medication, pharmacy medication 	ices		

Facility ID: 953473

		MEDICAID SERVICES				0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE S COMPL	
					C	;
		345116	B. WING		08/1	9/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 756	Continued From page	25	F 75	56		
		regimen reviews. Resident		regimen reviews for the n	nonths of April,	
		injectable and daily oral		May, June, and July of 20	-	
	-	without blood sugar testing		residents have been revie		
		ienced critically high blood		that were not transcribed	from the	
	-	e hospital. This deficient		discharge summary to the	e resident's	
	•	1 of 6 sampled residents		medical record, to ensure		
	reviewed for medicati	on regimen review		are receiving diabetic me		
	(Resident #72).			blood sugar checks and a	2	
	luovo diete le en endu	$b = r = r = \frac{4}{27} \frac{1}{20} $ where the		concerns and nurse man		
		began on 4/27/22 when the		reviewed 30 days of adm		
	facility failed to compl Resident #72 ' s med			accuracy of transcribing r the discharge summary to		
		monitor injectable and oral		medical records on 8/18/2		
		and failed to identify the		3. The Regional Directo		
		g of injectable and oral		Services educated the fac		
	-	as ordered to test blood		on reviewing the resident		
		y. The Immediate Jeopardy		orders to ensure orders fr		
	was removed on 8/19			discharge summaries are	implemented as	
	provided an acceptab	le credible allegation of		ordered, as well as diabe	tics that are	
	immediate jeopardy r	emoval. The facility will		reviewed monthly to iden	tify any	
	-	nce at a scope and severity		monitoring of blood gluco		
		th potential for more than		resident insulin and/or an		
		not immediate jeopardy) to		medications. This educa		
	ensure monitoring an	α all staπ have been		completed on 8/18/2022.		
	in-serviced.			be provided to the new pl		
	The findings included			facility has a change by th Director of Clinical Servic		
	The manys mouded			4. Effective 8/18/2022 t	` '	
	A review of Resident	#72 ' s hospital discharge		Director of Clinical Servic		
		4/17/2022 revealed orders		pharmacy monthly medic		
	to test blood sugar tw			new admissions for 2 mo	-	
	č	-		accuracy from the discha	rge summary to	
	Resident #72 was ad	mitted to the facility on		include medications and i	-	
		noses including diabetes		Results of these audits w		
	mellitus type 2, Parki	nson ' s disease, and		Quarterly Quality Assurar		
	dementia.			for further problem resolu		
				Director of Nursing will re		
	The Quarterly Minimu 7/21/22 revealed resi	ım Data Set (MDS) dated		of weekly audits to ensure identified are corrected.	e any issues	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345116	B. WING				C / 19/2022
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	 4/21/22 included Truli injectable medication sugar) 1.5 milligrams subcutaneously in the Metformin HCI (an ora 1000 mg give 1 tablet Nurse # 1 documented order documented for Manufacturer precaut Metformin indicate "C regularly." A review of pharmacy for the month of April Pharmacist #1 reveale 's medical record whi summary, vital signs, notes, Physician/Nurse done, and no recommendations sugar month of May Pharmacist #1 reveale 's blood sugar dated no recommendations sugar monitoring. A review of pharmacy for the month of June Pharmacist #2 reveale of Resident #72 's month 	nsulin during the orders revealed orders dated icity (an antihyperglycemic used to control high blood (mg)/0.5 milliliters (ml) e morning every Monday and al diabetes medication) t by mouth one time a day. d the admission orders. No blood sugar monitoring. ions for Trulicity and heck blood glucose levels r medication regimen review dated 4/27/2022 by ed a review of Resident #72 ich included discharge weight, labs, progress se Practitioner notes were nendations were made r monitoring. r medication regimen review dated 5/27/22 by ed a review of Resident #72 4/29/22 was 88 mg/dl and were made related to blood r medication regimen review dated 6/28/22 by ed a review was completed edical record including:	F	756			
	orders, available labs	edical record including: , progress notes and no re made related to blood					

Facility ID: 953473

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345116	B. WING				C 19/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	27	F	756			
	for the month of July of #2 revealed a review # 72 's medical recorn available labs, progree recommendation were sugar monitoring. A review of Progress part, Resident #72 wa lethargic, skin cool to to obtain vital signs. E (The glucometer manindicates "HI" displays mg/dl.) Spouse was p nurse to transfer Resid department (ED) for e placed to 911 and Re emergency medical s According to the revier documentation dated a blood sugar of 764 ((mg/dl) in the ED and Diabetic Ketoacidosis blood that can lead to death) /Hyperosmolar extremely high blood in the hospital at the t	ss notes and no e made related to blood note dated 8/13/22 read, in as found to be severely touch and staff were unable Blood sugar registered "HI". ufacturer ' s information s if the result is over 600 present and agreed with dent to hospital emergency evaluation & treatment Call sident transferred to ED by ervices. ew of hospital ED 8/13/22, Resident #72 had milligrams per deciliter was diagnosed with (a buildup of acids in your o diabetic coma or even thyperglycemia (an sugar level) and remained ime of the survey. The					
	status and was admit He was started on an hyperglycemia. On 8/18/2022 at 9:35 conducted with Pharm she was no longer the	o the ED with altered mental ted for further management. insulin drip for severe am an interview was nacist #1, and she indicated e Pharmacy consultant for was for the months of April					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2022 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345116	B. WING		_		C 19/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			1	09 S HOLDEN RD			
CARULIN	A PINES AT GREENSBOI		0	GREENSBORO, NC 274	07		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	see any documentation olonger having accert however she stated in the d/c summary and that the Nurse entered indicated it was usual verify orders with the the orders in the compunderstanding that the accurate. She indicated diagnosis of diabetes blood sugars monitore rather review their A1 accurate marker of hoc controlled verses a ble fluctuate. She indicate have had an incident recommend blood sugar blood sugars diabetes thave had an incident recommend blood sugar blood sugars diabetes are fingerstick blood sugars diabetes are fingerstick blood sugar	stated she was not able to on for Resident #72 due to ess to the facility records, a general she would look at the orders in the computer d in the computer. She ly the facility 's protocol to Physician and then enter outer. She stated it was her e orders in the system were ed residents that have the would not necessarily have ed daily, but she would c because it was a more ow residents ' diabetes are ood sugar check that can ed if the resident would that would warrant her to gar checks, then she would to be done. n 8/18/2022 at 11:50 am was indicated she noted une progress note that ecent A1c of 6.6%, and June ir was 155, which indicated sugar. She indicated issues whatsoever and was what she reviewed starting so indicated Resident had by the other Pharmacist. sn 't concerned and had in	F 756				
		I she reviewed Resident #72					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					LETED
			-				C
		345116	B. WING			08/	19/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN RD		
CAROLIN	A PINES AT GREENSBO	RO, LLC			GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	's medications on 8/1 had started Megace (stimulant) on 8/8/22 a been the cause of his increased. She stated not medications that r monitoring, and she w Resident had orders of sugar monitoring as s for the facility at the ti During an interview w (MD) on 8/18/22 at 4: facility had issues with transcribed as ordere #72 the blood sugar of facility should have be they were ordered. H been doing the blood could 've seen his blo of time and modified H The Administrator was jeopardy on 8/18/202. The facility provided t allegation of Immedia Identify those recipier are likely to suffer, a s because of the nonco The facility failed to co residents #72 medicat the need to monitor ir anti-diabetic medicatii medication regimen re- inadequate monitoring and anti-diabetic medication	 18/2022 and noted Resident ordered for an appetite and it could have possibly a blood sugar to have d Trulicity and Metformin are need blood sugar vould not have known the on admission for blood she was not the Pharmacist me of his admission. with the Medical Director 49 pm it was indicated the h orders that were not being d. He indicated for Resident checks were missed and the een doing the checks as the indicated if the facility had sugar checks, then staff bood sugar was rising ahead his medications. s notified of immediate 2 at 1:22 pm. the following credible the Jeopardy removal: ints who have suffered, or serious adverse outcome ompliance. omplete an evaluation of tion regimen that identified is used in administration and 	F	756			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345116	B. WING				19/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 756	and experienced critic identified at the hospi pharmacy medication months of April, May, revealed no identifica monitoring of insulin a anti-diabetic medication On 8/18/2022 the Reg Services (RDCS), rev diabetic medication p regimen reviews for th June, and July of 2022 been reviewed for orc transcribed from the or resident ' s medical re that are receiving dial sugar checks and ado Pharmacy medication include the discharge On 8/18/2022, nurse if days of admissions to transcribing medication summary to the reside Actions taken by the f process or system fai adverse outcome fror action will be complet The Regional Director educated the facility p resident ' s admission from the discharge su as ordered, as well as monthly to identify an glucose checks for re	bod sugar testing as ordered cally high blood sugars tal. A review of the regimen reviews for the June, and July of 2022 tion of inadequate administration and on. gional Director of Clinical iewed residents with harmacy medication ne months of April, May, 2 to ensure residents have lers that were not discharge summary to the coord, to ensure residents betic medication has blood dress any concerns. regimen reviews did not summaries. management reviewed 30 o ensure accuracy of ons from the discharge ents ' medical records. facility to alter to alter the lure to prevent a serious in reoccurring and when the ed. r of Clinical Services oharmacist on reviewing the orders to ensure orders immaries are implemented is diabetics that are reviewed y monitoring of blood	F	750	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		345116	B. WING				C 19/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLIN	A PINES AT GREENSBO	RO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 756	provided to the new p a change by the Regi Services (RDCS). Effective 8/18/2022 th Clinical Services will n monthly medication re for 3 months to ensur discharge summary to interventions. Effective 8/18/2022 th ultimately responsible of this immediate jeop alleged non-complian Alleged Date of Imme 8/19/2022 On 8/19/22 the credit jeopardy was validate which included record which verified the aud completed. An intervit Nurse Consultant rev pharmacy monthly me admissions for 3 mon orders from the disch medications and inter	22. Education will be harmacist if the facility has onal Director of Clinical he Regional Director of review the pharmacy egimen on new admissions e accuracy from the b include medications and he Administrator will be to ensure implementation bardy removal for this ce. ediate Jeopardy Removal: he allegation of immediate ed by onsite verification d reviews and interviews dits and education were ew with the Regional Clinical ealed they will review the edication regimens on new ths to ensure accuracy of arge summary to include ventions. te jeopardy removal date of	F	756			
F 812 SS=E	8/19/2022 was valida Food Procurement,St CFR(s): 483.60(i)(1)(2	ted on 8/19/2022. ore/Prepare/Serve-Sanitary 2)	F	812	2		9/14/22
	§483.60(i) Food safet The facility must -	y requirements.					

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPRENENCE TO THE APPROPRIATE DATE F 812 Continued From page 32 F 812		-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/09/2022 MAPPROVED D. 0938-0391		
346116 BINING 08/19/2022 STREET ADDRESS, CITY, STATE, ZIP CODE tops 16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE Colspan="2">STREET ADDRESS, CITY, STATE, ZIP CODE Colspan="2">STREET ADDRESS, CITY, STATE, ZIP CODE Colspan="2">STREET ADDRESS, CITY, STATE, ZIP CODE Colspan="2">Colspan="2" Colspan="2" Colspan="2" Colspan="2" Colspan="2" Colspan="2" <th <="" colspan="2" th="" th<=""><th></th><th></th><th></th><th>. ,</th><th></th><th>СОМ</th><th>PLETED</th></th>	<th></th> <th></th> <th></th> <th>. ,</th> <th></th> <th>СОМ</th> <th>PLETED</th>					. ,		СОМ	PLETED
199 SHOLDEN RD CREEMSBORO, NC 27407 OWING PREFIX TAG SUMMARY STATEMENT OF DEPRIENCIES INCOMMENT STATEMENT OF DEPRIENCIES REGULATION OR LSCIDENTIFYING INFORMATION) IDEPRIENCE PREFIX TAG OWING CROSS-REFERENCE TO THE APPORTATE DEFROENCY F 812 Continued From page 32 F 812 \$483.60(1)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authonities. F 812 \$483.60(1)(2) - Procure food from sources approved or considered satisfactory by federal, state or local authonities. F 812 \$483.60(1)(2) - Procure food from sources approved or regulations. (I) This may include food items obtained directly from local produce growing and food-handing practices. (II) This provision does not proclude residents from consuming foods not procured by the facility. 5483.60(1)(2) - Store, prepare, distribute and serve food in accordance with applicable safe growing and food-handing practices. 1. 1. F col items were discarded immediately upon notification on 8/15/202. 1. 1. F col items were discarded immediately upon notification on 8/15/202. 2. Effective 8/25/2022 the Dietary Manager inspected the walk-in and Reach-in refigerators to ensure appropriate labeling and dates were indicated on opened items. 3. Dietary Manager educated staff on appropriate labeling dat dates were indicated on opened items. 3.			345116	B. WING			-		
CARDUNA PINES AT GREENSBORO, LLC GREENSBORO, NC 27407 (W)(0) PRETIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOLL DS (EACH CORRECTIVE)) F 812 Continued From page 32 F 812 I. 1. Food Items were discarded timmediately upon portication on SI/15/22, at 10:40 AH with the Cook. The following observations were made in the walk-in corrective and tables and dates were indicated upon consultation of the skine action to the skine to do to back substance on the inside of	NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
CAREENSBORD, MC 27407 CARL DECOMPENTS PLANOF CONNECTION (EACH CORRECTIVE ACTION SHOLD BE CARDENTIFY AND F CONNECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REPERSENCE TO THE APPROPRIATE DEFICIENCY) Converter (EACH CORRECTIVE ACTION SHOLD BE CROSS-REPERSENCE TO THE APPROPRIATE DEFICIENCY) Converter (EACH CORRECTIVE ACTION SHOLD BE CROSS-REPERSENCE TO THE APPROPRIATE DEFICIENCY) F 812 Continued From page 32 F 812 \$483.60(1)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authonties. F 812 (i) This may include food items obtained directly from local producers, subject to applicable safe growing and food-handling practices. F (ii) This provision does not problem of the compliance with applicable safe growing and food-handling practices. I. 1. F 600 items were discarded immediately upon notification on 8/15/2022. Based on observations, record review and staff interviews, the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refigerated units. 1. 1. F Folditive B/2/2022 the Dietary Manager ducated staff on appropriate labels and dates were indicated on opened items. 3. 1. X container of 1 gallon of honey mustard dressing with no date with two dots of black substance on the inside of the container. 3. Dietary Manager ducated staff on appropriate labeling, dating, and discarding food items that are out o	CAROLIN	A PINES AT GREENSBO	RO. LLC						
Integrity Trag (EACH ORFICENCE MUST BE PRECIDED BY FULL REGULATORY OR USCIDENTEYING INFORMATION) PREFX Tag CEACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD BE CROSS-REFERENCE TO THE ATTOW SHOULD BE CROSS-REFERENCE TO TOW SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD SHOUL					GREENSBORO, NC 27407				
 \$433.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units. The findings included: An initial tour of the kitchen was made on 8/15/22 at 10:40 AM with the Cook. The following observations were made in the walk-in cooler: . 'y container of 1 gallon of honey mustard dressing with no date with two dots of black substance on the inside of the container. 2. 1 gallon of opened sweet pickle relish dated 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION		
approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 1. 1. Food items were discarded immediately upon notification on 8/15/2022. Based on observations, record review and staff interviews, the facility failed to label and date or food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units. 1. 1. Food items were discarded immediately upon notification on 8/15/2022. The findings included: 3. Dietary Manager educated staff on appropriate labels and dates were indicated on opened items. 1. 1% container of 1 galion of honey mustard dressing with no date with two dots of black substance on the inside of the container. 2. a galion of opened sweet pickle relish dated 2. 1 galion of opened sweet pickle relish dated 2. audity will inspect walk-in and reach-in refrigerators for proper storage and labeling weekly. X sweeks. Results of these audits will be reviewed at Quarter	F 812	Continued From page	e 32	F 8	12				
The following observations were made in the Administrator will review the results of Weekly audits to ensure any issues		approved or consider state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to con- safe growing and foo (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation interviews, the facility food, so it was used to discarded. Salad dreat thickened liquids were refrigerated units. The findings included An initial tour of the k at 10:40 AM with the observations were mat 1. ½ container of 1 dressing with no date substance on the insi 2. 1 gallon of opene 1/31/22.	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional rvice safety. T is not met as evidenced ons, record review and staff failed to label and date by its use-by-date or ressing, pickle relish and e not monitored in 2 of 2 t: itchen was made on 8/15/22 Cook. The following ade in the walk-in cooler: gallon of honey mustard e with two dots of black de of the container. ed sweet pickle relish dated		 immediately upon notification of 8/15/2022. 2. Effective 8/25/2022 the Di Manager inspected the walk-in Reach-in refrigerators to ensure appropriate labels and dates windicated on opened items. 3. Dietary Manager educated appropriate labeling, dating, and discarding food items that are on 8/17/2022. 4. Dietary manager will inspected and reach-in refrigerators for p storage and labeling weekly x Results of these audits will be Quarterly Quality Assurance M for further problem resolution i Administrator will review the resolution in an end to a storage and labeling weekly a storage and storage a	on letary a and re vere d staff on nd out of date ect walk-in proper 8 weeks. reviewed at leeting X 3 f needed. esults of			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
	345116	B. WING _				C 19/2022
NAME OF PROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAROLINA PINES AT GREENSBO	RO. LLC			9 S HOLDEN RD		
	, ===		G	REENSBORO, NC 27407		
PREFIX (EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 812 Continued From page	33	F 8	312	identified are corrected		
 an open date of 4/28/2 2. 46 fluid ounces (f apple juice with a date date. Manufacturer's grefrigerator up to 7 da 3. 32 fl. oz. of opene a date of 6/27/22 with Manufacturer's guidel refrigerator up to 7 da During the observation the Cook stated that the liquids was the date the kitchen but should have on the open date, the after three days. An interview with Diet 11:07 AM stated that it labeled of when it can would not have been a the should be labeled was opened. During a follow-up vis at 11:30 AM the Dieta prune juice was labeled 4/28/22 was the date it was opened. 	 I. oz.) of opened thickened e of 7/28/22 with no open guidelines stated to keep in ys after opening. ed thickened dairy drink with no open date. ines stated to keep in ys after opening. Ins on 8/15/22 at 11:05 AM the date on the thickened the item came into the ve had an open date. Based items should be tossed ary Aide #1 on 8/15/22 at tems should have a date he into the kitchen, but it labeled with an open date. ary Aide #2 on 8/15/22 at tems should have a date he into the kitchen, and ed with the date the item it to the kitchen on 8/17/22 ry Manager stated that the ed incorrectly, the date of that it came into the kitchen, it it came into the kitchen, and the into the kitchen of the kitchen, and the into the kitchen of kit to the kitchen of kit to the kitchen of kitchen of kitchen of kitchen of kitchen of kitchen of kitchen, it came into the kitchen, and kitchen of kitchen of kitchen, and kitchen of kitchen, and kitchen of kitchen, and kitchen of kitchen of kitchen, and kitc			identified are corrected.		

Facility ID: 953473

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/09/2022 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		345116	B. WING			C / 19/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIN	A PINES AT GREENSBOI	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	once a food item was marker and put an op the item was. An interview was com Administrator on 8/19 that foods should be I dispose of items when Dispose Garbage and CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose properly.	ated that she expected that opened, staff would get a en date on it and label what pleted with the /22 at 10:20 AM who stated abeled when opened and to n they are expired. I Refuse Properly e of garbage and refuse	F 8			9/14/22
	by: Based on observation facility failed to ensure dumpster was free of The findings included During an observation 8/17/22 at 10:45 AM a Manager (DM). The o utility tilt cart in betwe gray utility tilt cart had cart and on the inside pieces of wet cardboat tilted part of the cart (The ground area behi and in between the tw with garbage lying in t included cardboard, b cigarette butts, cigare	debris for 2 of 2 dumpsters.		 Items around the dumpster w cleaned up on 8/17/2022. On 8/17/2022, Administrator inspected the area around the dur free if debris. On 8/31/2022 Maintenance, housekeeping and dining services educated by the Administrator or of on the importance of keeping the dumpster area free of debris and of closed. Maintenance will monitor and maintain cleanliness around the d Monday-Friday at the beginning a of workday. Dining services will m and maintain cleanliness around the dumpster on the weekends. Admin will inspect the area around the dumpsters, weekly x 8 weeks. Rea these audits will be reviewed at Q Quality Assurance Meeting X 3 for problem resolution if needed. 	mpster is s were designee covers umpster nd end nonitor he nistrator sults of uarterly	

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
			D. MINO			С
		345116	B. WING		08	/19/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN RD		
CAROLIN	A PINES AT GREENSBO	RO, LLC		GREENSBORO, NC 27407		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 814	Continued From page	e 35	F 814	1		
	During the observation 10:45 AM she stated belonged to the house the dumpster area was between the kitchen a maintaining the area. had spoken to the Ho on 8/16/22 and offere the HM however, the had been working on A follow up telephone PM with the DM who take out the garbage dumpsters doors, if th shut them and if any	on with the DM on 8/17/22 at that the gray utility cart had ekeeping department and as a shared responsibility and housekeeping with The DM stated that she pusekeeping Manager (HM) ed to clean the area up with HM was short staffed and		Administrator will review the res weekly audits to ensure any iss identified are corrected.		
	on 8/18/22 at 3:02 PI take out the garbage should pick up and g	/ was completed with the HM M who stated that when staff to the dumpster area they arbage on the ground.				
	that when the dumps could fall out from the Administrator stated had just cleaned the Administrator explain garbage lying around homes.	W22 at 10:20 AM who stated ters were emptied garbage e dumpsters. The the Maintenance Manager area last week. The ed we would not want l as this was people's				
F 867 SS=E			F 867	7		9/14/22
	SADD 75(m) Outplitte	ssessment and assurance.				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/09/20 FORM APPROVE OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116			. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		C 08/19/2022		
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
CAROLIN	A PINES AT GREENSBO	RO, LLC		09 S HOLDEN RD GREENSBORO, NC 27407		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
F 867	assurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by: Based on observation and staff interview, the Assessment and Assis failed to maintain imp monitor interventions place following recert survey conducted on deficiency that was cl Assessment/Accurace on again recertification 12/16/21 and on the of complaint survey 08/ additionally failed to r procedures and monit committee put in place and complaint survey This was evident for 2 in the areas of Qualit Services and recited and complaint survey additionally failed to r procedures and monit committee put in place in the areas of Qualit Services and recited and complaint survey additionally failed to r procedures and monit committee put in place investigation on 02/09 deficiency in the area Services: Food Proce Store/Prepare/Service the current recertification 08/19/22. The dup four federal surveys of	aality assessment and e must: ement appropriate plans of tified quality deficiencies; T is not met as evidenced on, record review, resident he facility's Quality urance (QAA) Committee olemented procedures and the committee put into tification and complaint 11/01/2019. This was for 1 ited in the areas of Resident by of Assessment. And cited on and complaint survey on current recertification and 19/22. The QAA committee maintain implemented itor intervention the ce following recertification of Care and Nursing on the current recertification of 08/19/22. The QAA maintain implemented itor intervention the ce following complaint 5/21. This was evident of 1 a of Food and Nutrition	F 867	 The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F641, F684, F727, and F812 on 9/1/20 2. Current residents are potentially affected by this deficiency. The Regional Director of Clinical Services educated the Administrator a Director of Nursing on the appropriate functioning on the QAPI Committee ar the purpose of the Committee to inclusi identify issues and correct repeat deficiencies related to F641, F684, F7 and F812 on 9/1/2022. On 9/1/2022, the Administrator educated the QAPI committee member consisting of, the Medical Director, Administrator, Director of Nursing, Uni Support Nurse, Medical Records, Business Office Manager, Minimum D Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of a findings for compliance and/or revisior needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will 	D22. nd nd de 27, ers t ata udit	

Facility ID: 953473

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		(X1) PROVIDER/SUPPLIER/CLIA	· ,	(X2) MULTIPLE CONSTRUCTION		
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345116	B. WING		08/19/2	022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CAROLIN	A PINES AT GREENSBO	RO, LLC		109 S HOLDEN RD GREENSBORO, NC 27407		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CO THE APPROPRIATE	(X5) MPLETION DATE
F 867	Continued From page	e 37	F 86	7		
	Findings included:			continue to meet monthly	to identify	
	, č			issues related to quality as	3	
	This tag is cross refe	rence to:		assurance activities as ne develop and implement ap		
		cord reviews and staff		of action for identified facil	-	
		failed to accurately code a		Corrective action has been		
		terly Minimum Data Set		identified concerns related	-	
		or 1 of 2 residents reviewed (Resident #98) and 1 of 1		deficiencies. The monitorin ensure the plan of correcti	•	
		behaviors (Resident #30).		and specific cited deficient		
				corrected and/or in compli		
	During the recertifica	tion and complaint survey		regulatory requirements is		
		ity failed to accurately code		corporate staff. Corporate		
		g/Nutritional Status of the		validate the facility's progr		
		ADS) assessments for 1 of 6		corrective actions and date		
	sampled residents re	viewed for Nutrition.		completion. The Administr responsible for ensuring C		
	During recertification	and complaint survey on		concerns are addressed th		
		failed to accurately code the		training or other intervention	0	
	Minimum Data Set (N	IDS) for opiate medication				
	for 1 of 24 residents I	reviewed for MDS.				
		record review and interviews Assistant and the Medical				
		ailed to implement an order				
		charge summary to test				
		ily for Resident #72. The				
	facility administered i	njectable and oral diabetes				
		nt #72 who was diagnosed				
		monitoring the resident's				
	-	nission to the facility until				
	#72's blood sugar reg	pital. On 8/13/22, Resident				
		nt #72 was sent to the				
	emergency departme					
	lethargic and staff we	ere unable to obtain vital				
	-	l, Resident #72 ' s blood				
		as 764 milligrams per				
	deciliter (mg/dl) and t	he Resident received insulin				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345116	B. WING		C 08/19/2022			
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CAROLINA PINES AT GREENSBORO, LLC				109 S HOLDEN RD GREENSBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	levels. Resident #72 Diabetic Ketoacidosis blood that can lead to death) /Hyperosmolar extremely high blood practice occurred for reviewed for diabetes During the recertificat 12/16/21, the facility f complete wound care sampled residents. 3.727: Based on reco interviews the facility Nurse scheduled for 8 for 1 (07/25/22) of 30 During the recertificat 12/16/21, the facility f a registered nurse (R hours a day, 7 days a 4. F 812: Based on of and staff interviews, t date food, so it was u discarded. Salad dre thickened liquids were refrigerated units. During a complaint in 02/05/21, the facility f temperatures of hot fo kitchen's steam table (F.) or higher for five of	od to lower blood sugar was diagnosed with (a buildup of acids in your diabetic coma or even hyperglycemia (an sugar level). This deficient 1 of 3 sampled residents care (Resident #72). ion and complaint survey on ailed to consistently as ordered for 2 of 2 rd reviews and the staff failed to have a Registered consecutive hours a day days reviewed. ion and complaint survey on ailed to use the services of N) for at least 8 consecutive week for 7 of 31 days. oservations, record review he facility failed to label and sed by its use-by-date or ssing, pickle relish and e not monitored in 2 of 2 vestigation survey on ailed to maintain the bods being served from the at 135 degrees Fahrenheit of five resident meals that prepared from the steam	F	867				

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		ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 11/09/2022 FORM APPROVED B NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345116	B. WING			C 08/19/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	, ZIP CODE		
CAROLINA PINES AT GREENSBORO, LLC			109 S HOLDEN RD GREENSBORO, NC 27407				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 867	that his expectation w together to sustain ar to ensure the facility of deficient practice. Add	22 at 2:35 pm, he revealed vas for the team to work n effective QAPI Committee does not recite a previous ministrator indicated that this facility does not received	F 867				

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Facility ID: 953473

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