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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - GREENSBORO	1201 CAROLINA ST GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation of 10/11/11-10/14/11. Event ID # K1YI11.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	345014	A. BUILDING _____ B. WING _____ NOV 08 2011	C 10/14/2011

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation of 10/11/11-10/14/11. Event ID # K1YI11.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to implement the Registered Dietician ' s recommendations for 1 (Resident #32) of 2 sampled residents with a potential for weight loss. Findings include: Resident #32 was admitted to the facility on 8-12-11, with cumulative diagnosis to include: cardiovascular accident (stroke), acute on chronic anemia, a right ankle fracture (casted), severe protein calorie malnutrition, chronic kidney disease state IV-V, and a history of gastro-esophageal reflux.	F 325	**F325** The facility will continue to ensure that a resident (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. ***Criteria I*** Resident #32 RD recommendation implemented as physician orders on 10/15/11.	10/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol McClure	Administrator	11/4/11

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F 325	Continued From page 1 Review of the resident ' s most recent Minimum Data Set, an Other Medicare Required Assessment, dated 10-9-11, revealed the resident ' s cognition was assessed as severely impaired. The resident feeding skills were assessed as extensive assistance of one staff member. The resident ' s care plan, dated 8/23/11, revealed a problem identified in part as: "Inadequate Oral Food/Beverage intake due to: Food and beverage intake less than required. Potential for weight changes " . The goal for the identified problem was documented as " Maintain nutritional status and body weight " and the target date was documented as 11/19/11. The medical record revealed the resident was 62 " tall and the resident ' s weight on 8-17-11 was recorded at 138 pounds. On 10-3-11, the resident ' s weight was recorded as 123 pounds. Resident #32 was documented as having had a cast on her right ankle when weighed on 8-17-11 and the cast had been removed prior to the weight of 10-3-11. Review of Nursing Assistant documentation on a facility form entitled " Co.-Meal Intake Detail - Active Residents " from 9-30-11 through 10-3-11, revealed the resident's breakfast intake ranged from " none to very little twice, 25% for one meal, and 75% for 2 meals. Lunch intake for the same period were documented as " none to very little " was eaten for 3 lunch meals, and 50% was eaten once. Dinner appetites for the same time period	F 325	***Criteria 2*** Audit will be completed for all current residents with RD recommendations from October to ensure recommendations were implemented timely. . Nursing Unit Supervisors will be in-serviced on the facility protocol related to timely implementation of nutrition recommendations upon approval from MD to physician orders. ***Criteria 3*** For those residents with identified RD recommendations, the Dining Service Manager and/or Diet Tech in absence of DSM will bring a copy of the Nutrition Recommendations to morning department meeting to ensure timely follow up and completion of the nutrition recommendations to physician orders based upon approval from MD. DNS/ RD/Diet	11/4/11 11/7/11

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F 325	Continued From page 2 revealed the resident ' s appetite was documented as " none to very little " for one dinner meal. There was 1 dinner the resident at 25%, one meal the resident at 50%, and one meal the resident ate 100% during that time frame. During an interview, on 10/13/11 at 8:45am, with Nurse #1, (who worked regularly with the resident), the nurse reported the resident required fed by staff and held foods in her mouth until it turned to liquid. The nurse described the resident as a very slow eater but drank well. During an observation of the resident on 10-11-11 at 8:53am, the resident was being fed by a Nursing Assistant. The resident accepted small bites of foods, but held the foods in her mouth for long periods of time, 30 seconds or more, before swallowing. The resident was last reviewed by the Registered Dietician (RD) on 10-4-11 for weight changes. Review of a form entitled " Nutritional Services Medical Nutrition Therapy Recommendations ", dated 10-4-11, revealed RD recommendations for Resident #32 as: 1.) Change diet to mechanical soft, 2.) Add 120 (cubic centimeters) of house 2.0 Med Pass (nutritional supplement) twice daily. Review of the current physician ' s orders revealed Resident #32 was ordered a concentrated carbohydrate, low-fat, mechanical soft diet and no orders for the supplement. During an interview with the RD on 10-14-11 at 2:40 pm, the RD reported she came in to the facility on a regular basis and when she came in, she was given a list of the residents that needed to be reviewed. The RD stated she turned over	F 325	Tech and/or Dining Services Manager will monitor the nutrition recommendations on a weekly basis to identify all patients with nutrition recommendations have been implemented timely as approved by MD ***Criteria 4*** The DNS will report monitoring results of the review in the monthly Quality Assurance (QA) Committee meeting for 3 months or until deemed necessary. Recommendations will be made as necessary. The Executive Director is responsible for overall compliance.	11/11/11

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F 325	Continued From page 3	F 325		

written recommendations over to the Director of Nursing (DON), and the DON gave them to the physicians to review for orders. The RD stated her recommendations were usually written as physicians ' orders within a week, but generally sooner.

Review of the resident ' s medical record revealed no changes were made in the resident ' s diet between 10-4-11 and 10-14-11. The RD stated she turned in the recommendations on 10-4-11 in the late afternoon or evening to the DON. The RD stated she followed up on the previous week ' s recommendations during the weekly weight meeting The RD stated her last notes were pulled during the meeting and she searched orders in the computer to assure they were carried and if not why. The RD reported she reviewed the records to see if the physician did not want to change the order or did the recommendation " get missed " . The RD stated she expected the new recommendations would be carried out by her next visit.

During an interview with the DON on 10-14-11 at 3:39pm, the DON reported she received the dietary recommendations of 10-4-11 on Friday, October 7, and typically, the Nurse Practioner (NP) reviewed dietary recommendations for the physicians ' on Thursdays. The DON reported when she got the 10-4-11 list on Friday, the NP had already been in the facility the day before and called out sick on 10/13/11, so none of the recommendations were completed. The DON stated her expectations when receiving dietary recommendations were to have them approved the same week.

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	345014	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/02/2011

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. based on observation on 11/09/2011 the mech. room outside had an nonrated access door into the attic and there were unsealed penetrations in the ceiling. 42 CFR 483.70 (a)	K 029	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. K029 *Criteria 1* A fire rated door was ordered and will be installed upon arrival. The unsealed penetrations were sealed *Criteria 2* Though all patients have the potential to be affected by the alleged deficient practice, none were adversely affected. The Maintenance Director assessed the mechanical room, there were no other access doors located in the mechanical room. There were no other unsealed penetrations in the ceiling. *Criteria 3* Maintenance Director/designee will monitor mechanical room ceiling and access door weekly for next 3 months to ensure one hour fire rating is maintained. *Criteria 4* Maintenance Director will provide results from the weekly monitoring to QA committee for 3 months at which time the committee will determine if the continued frequency of monitoring.	11/30/11
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the staff interviewed did not know about the master door release switch located at the nurses station. 42 CFR 483.70 (a)	K 038	K038 *Criteria 1* The staff member was immediately inserviced about the master door release switch.	11/30/11
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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Carol McClure	Executive Director	11/17/11

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K 072 SS=D	Continued From page 1 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 there were unused items left unattended in the egress corridors; 42 CFR 483.70 (a)	K 072	***Criteria 2*** Though all patients have the potential to be affected by the alleged deficient practice, none were. Maintenance Director assessed facility to determine location of all master release switches. ***Criteria 3*** Maintenance Director/designee will inservice all staff about the location and need of master door release switch. Maintenance Director will interview 3 staff members each week to ensure staff understanding and location of master door release switches. ***Criteria 4*** Maintenance Director/designee will report findings of staff interviews to QA committee for 3 months at which time the QA committee will determine the continued frequency of staff interviews. **K072** ***Criteria 1*** The unattended items were immediately removed from egress corridors. ***Criteria 2*** Though all patients have the potential to be affected by the alleged deficient practice, none were adversely affected. MD assessed the facility to ensure there was no other unattended items in egress corridors. ***Criteria 3*** Maintenance Director/designee will inservice all staff about leaving unattended items in egress corridors. ***Criteria 4*** Maintenance Director/designee will make rounds daily to ensure there are no unattended items in egress corridors. Round information will be provided to QA committee for the next 3 months, at which time the QA team will determine the continued frequency of the rounds.	11/30/11

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K 000	INITIAL COMMENTS A. Based on observation on 11/09/2011 there were no LSC deficiencies noted.	K 000		

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Carol McClure | Executive Director | 11/17/11

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