

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

DEC 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and facility policy review the facility failed to treat an alert and oriented resident with dignity and confidentiality by asking her family if she could receive mail from her attorney. This was evident</p>	F 164	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F164</p> <p>Resident #102 received mail delivered to her on 11/23/12. Resident #102 met with the administrator on 11/26/12 regarding her concerns regarding mail delivery. The mail delivery preferences for resident #102 was updated on 11/30/12 by the Social Services Director.</p> <p>An audit of all resident mail delivery preferences was conducted by the Social Services Director and the Director of Nursing on 11/30/12 to ensure all residents in the facility had a listed preference. Any residents found not to have a listed preference had their information updated. The mail preference list was verified by the Social Services Director on 12/3/12 to ensure that all alert and oriented residents were listed.</p>	12/21/12

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

TITLE

(X6) DATE

*Barbara D. Workus*

*Executive Director*

*12/14/12*

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.

*MR  
12/5  
10  
M. Cooney*

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>	
(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 164	<p>Continued From page 1 for 1 of 1 resident. (Resident #102)</p> <p>Findings include:</p> <p>Resident # 102 was admitted to the facility on 11/1/12. A review of the Minimum Data Set (MDS) dated 11/6/12 revealed Resident #102 was alert and oriented and able to make her needs known.</p> <p>An interview with Resident # 102 on 11/27/12 at 2:42 PM revealed she was very upset that the facility had someone call her (family member) to make sure she was allowed to receive mail from her attorney. She stated "It burned me, what if I did not want my (family member) to know I got something from my attorney." She continued, " I was waiting for the written correspondence from my attorney. When I visited with my (family member) on Saturday she told me someone from the facility called her to ask if it was okay to let me (resident) have this mail from the attorney ". "Why would they call her, I am not incompetent. Why did not they just come to talk to me?" The resident indicated she spoke with a staff member and was told they (facility staff) sometimes have to check on these kind of things to make sure the residents involved were competent to receive mail from attorneys. She continued she still was furious and was very angry. She stated to the staff member "how dare you question me getting correspondence from anyone, I am alert and aware of all my senses. It really burned me."</p> <p>An interview with Resident # 102 ' s family member on 11/27/12 at 4:50 PM indicated she was surprised the facility called her about the resident getting mail. She indicated the resident was aware of her rights. The family member</p>	F 164	<p>Facility staff were inserviced by the Director of Nursing Services and Director of Clinical Education regarding privacy and confidentiality with specific emphasis on mail delivery. Staff were also inserviced on printing the mail preference list from the facility electronic medical record system. The Admissions staff were inserviced by the Director of Nursing Services on completing this information on admission.</p> <p>The Director of Nursing Services, Social Services Director, Director of Clinical Education and/or the Unit Managers will audit all newly all new admissions to ensure that there is a mail delivery preference in the electronic medical record system. This audit will be conducted daily, five days per week for four weeks, then three times per week for four weeks, then once weekly for four weeks.</p> <p>The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.</p>	

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 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 164 Continued From page 2  
stated "when I spoke with her that afternoon she was very upset they had called me."

F 164

An interview with the Administrator on 11/29/12 at 11:07 AM revealed she was called by the MOD (manager on duty) who was concerned the resident received such a large package from an attorney and wanted to make sure it was okay to give it to the resident. She indicated she told her (MOD), Resident # 102 was new to the facility and she was unsure of her cognition or situation. She instructed the MOD to call the family to check to see if it was okay with them that she received mail from an attorney. She further indicated she never thought the resident may not have wanted the family to know she contacted an attorney. She stated " I spoke with the resident to apologize for upsetting her. "

An interview with the secretary on 11/29/12 at 1:15 PM (who was MOD on the day the package was received); indicated she was concerned when this large package from an attorney was sent to a resident. She indicated she called the Administrator to make sure the resident was alert and able to receive a package. She was unsure how to check herself if this resident was alert and able to receive mail. She was following the directions from her Administrator.

F 241 483.15(a) DIGNITY AND RESPECT OF  
SS=D INDIVIDUALITY

F 241

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>		
(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 241	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff, family and resident interviews, and record review, the facility failed to provide privacy bag covers for two external drainage bags. This was evident for 1 of 2 residents with external drainage bags (Resident # 174). The facility failed to treat an alert and oriented resident with dignity by asking her family if she could receive mail from her attorney. This was evident for 1 of 1 resident. (Resident #102)</p> <p>Findings included:</p> <p>1. A review of the (minimum data set) MDS dated 11/02/12 Resident # 174 was admitted to the facility on 11/10/12 due to complication following abdominal surgery. Resident # 174 was alert and oriented and able to make needs known.</p> <p>A review of the Care Plan dated 11/02/12 revealed the resident had altered skin integrity non pressure related to: Abdominal fistulas/ Eakin (external drainage bag), pouch place, and gastric tube. There were no interventions documented for the covering of the external drainage bags.</p> <p>An observation on 11/27/12 at 2:00 PM revealed Nurse #1 entered the resident's room to empty liquid stool from two external drainage bags. Both bags were not covered and contained liquid stool. One of the bags was hanging on the left side of the resident on the bedside table. The other bag was hanging on the intravenous pole on the right side of the resident. Both bags were in full view of staff, residents, and visitors passing by or entering the resident's room. Nurse #1</p>	F 241	<p>F241</p> <p>A dignity bag was provided for resident #174 on 11/30/12. Resident #174 is no longer a resident in the facility.</p> <p>Resident #102 received mail delivered to her on 11/23/12. Resident #102 met with the administrator on 11/26/12 regarding her concerns regarding mail delivery. The mail delivery preferences for resident #102 was updated on 11/30/12 by the Social Services Director.</p> <p>An audit of all residents in the facility who had drainage bags was conducted by the Director of Nursing Services on 11/29/12 to ensure dignity covers were in place for drainage bags. No other residents were found to be affected.</p> <p>An audit of all resident mail delivery preferences was conducted by the Social Services Director and the Director of Nursing on 11/30/12 to ensure all residents in the facility had a listed preference. Any residents found not to have a listed preference had their information updated. The mail preference list was verified by the Social Services Director on 12/3/12 to ensure that all alert and oriented residents were listed.</p>	12/21/12	

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 4</p> <p>emptied the two bags and exited the room leaving the drainage bags uncovered.</p> <p>An observation on 11/28/12 at 12 noon revealed Nurse #1 entered the resident's room to empty liquid stool from two drainage bags. Both bags were not covered and contained liquid stool. One of the bags was hanging on the left side of the resident on the bedside table. The other bag was hanging on the intravenous pole on the right side of the resident. Both bags were in full view of staff, residents, and visitors passing by or entering the resident's room. Nurse #1 emptied the two bags and exited the room leaving the drainage bags uncovered.</p> <p>An observation on 11/28/12 at 3:20 PM revealed a drainage bag containing approximately 300 cc of light milky brown drainage. The bag was not covered and was hanging on the bedside table to the left of the resident. On the intravenous pole on the right side of the resident's bed another uncovered drainage bag was noted to contain approximately 300 cc of dark brown liquid. Both bags were in full view of staff, residents, and visitors passing by or entering the resident's room.</p> <p>An interview with the resident on 11/28/12 at 3:20 PM revealed he hid the drainage bags when he had company or went out of the room. He did not want anyone to see the drainage bags or what drained from them. He stated "the nurses empty them, and they do not cover them after they are drained, when I first came here there was a bag to put them in, but now the staff just hang them on the bedside table and the other pole. I prefer to have them hidden."</p>	F 241	<p>Facility nursing staff were inserviced by the Director of Clinical Education and the Director of Nursing on ensuring all drainage bags were covered to ensure resident dignity.</p> <p>Facility staff were inserviced by the Director of Nursing Services and Director of Clinical Education regarding privacy and confidentiality with specific emphasis on mail delivery. Staff were also inserviced on printing the mail preference list from the facility electronic medical record system. The Admissions staff were inserviced by the Director of Nursing Services on completing this information on admission.</p> <p>The Director of Clinical Education and Unit Managers will audit residents who have drainage bags to ensure that they are covered. This audit will be conducted daily, five days per week for four weeks, then three times per week for four weeks, then once weekly for four weeks.</p> <p>The Director of Nursing Services, Social Services Director, Director of Clinical Education and/or the Unit Managers will audit all newly all new admissions to ensure that there is a mail delivery preference in the electronic medical record system. This audit will be conducted daily, five days per week for four weeks, then three times per week for four weeks, then once weekly for four weeks.</p>	

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 5</p> <p>An observation on 11/29/12 at 7:10 AM with the MDS Nurse revealed 2 uncovered drainage bags. An uncovered bag with milky brown drainage was hanging on the bedside table to the left of the resident. The other uncovered bag with dark brown liquid was hanging on the intravenous pole on the right side of the resident.</p> <p>An interview with the MDS Nurse on 11/29/12 at 7:45 AM revealed the care for the external drainage bags should be listed under the GI (gastro intestinal alteration) care plan. She indicated most residents with external drainage bags have interventions on the care plan which included privacy covers for the drainage bags at all times.</p> <p>An interview with the (staff development coordinator) SDC and the Unit Charge Nurse on 11/29/12 at 7:35 AM revealed the SDC's expectation was that all external drainage collection bags were to be covered with a dignity bag whether the resident was in their room or in a public area. The Unit Charge Nurse agreed.</p> <p>An interview with (nursing assistant) NA #1 on 11/29/12 at 7:36 AM revealed all drainage bags should have privacy covers on them. She stated " Resident # 174 had drainage bags, but the nurses cared for them. She continued, she was unsure if they had privacy bags on them. "</p> <p>Interview with NA #2 on 11/29/12 at 7:40 AM revealed a resident with a drainage bag should have privacy bags on them and they should not be on the floor. She indicated she was unsure if Resident # 174 had privacy bags since the</p>	F 241	<p>The results of this audit will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.</p>	
-------	---	-------	---	--

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 241	<p>Continued From page 6</p> <p>nurses took care of them.</p> <p>Interview with the DON (director of nursing) on 11/29/12 at 8:09 AM revealed her expectation was that all drainage bags were kept in privacy bag and kept off the floor. The NAs were supposed to be putting the privacy bags on the drainage bags and the nurses follow behind to make sure they were covered. After the external drainage bags were emptied the nurses should place them back in the privacy bags. All staff should be making sure the privacy bags were in use. She stated Resident # 174 was in a private room and no one could see them (the bags), so it would not matter except if the door was open anyone walking by can see they are uncovered so they really should be in privacy bags at all times. "</p> <p>Interview with Administrator on 11/29/12 at 8:11 AM indicated her expectation was that all the drainage bags should be covered. The staff was responsible to make sure it was covered. The administrative staff made rounds and they should have seen the bags were uncovered.</p> <p>An interview with Nurse #1 on 11/29/12 at 8:48 AM indicated the resident got up by himself so he removed the drainage bags from the privacy bags. She stated the staff that went into his room should make sure the bags were covered at all times. She indicated she must have forgotten to place them back in the privacy bags after she drained them the other day.</p> <p>2. Resident # 102 was admitted to the facility on 11/1/12. A review of the Minimum Data Set (MDS) dated 11/6/12 revealed Resident #102 was alert</p>	F 241		

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
--	---	--	---

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

(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 241 Continued From page 7  
and oriented and able to make her needs known.

F 241

An interview with Resident # 102 on 11/27/12 at 2:42 PM revealed she was very upset that the facility had someone call her (family member) to make sure she was allowed to receive mail from her attorney. She stated "It burned me, what if I did not want my (family member) to know I got something from my attorney." She continued, " I was waiting for the written correspondence from my attorney. When I visited with my (family member) on Saturday she told me someone from the facility called her to ask if it was okay to let me (resident) have this mail from the attorney ". "Why would they call her, I am not incompetent. Why did not they just come to talk to me?" The resident indicated she spoke with a staff member and was told they (facility staff) sometimes have to check on these kind of things to make sure the residents involved were competent to receive mail from attorneys. She continued she still was furious and was very angry. She stated to the staff member "how dare you question me getting correspondence from anyone, I am alert and aware of all my senses. It really burned me."

An interview with Resident # 102 's family member on 11/27/12 at 4:50 PM indicated she was surprised the facility called her about the resident getting mail. She indicated the resident was aware of her rights. The family member stated "when I spoke with her that afternoon she was very upset they had called me."

An interview with the Administrator on 11/29/12 at 11:07 AM revealed she was called by the MOD (manager on duty) who was concerned the resident received such a large package from an



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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 8  attorney and wanted to make sure it was okay to give it to the resident. She indicated she told her (MOD), Resident # 102 was new to the facility and she was unsure of her cognition or situation. She instructed the MOD to call the family to check to see if it was okay with them that she received mail from an attorney. She further indicated she never thought the resident may not have wanted the family to know she contacted an attorney. She stated " I spoke with the resident to apologize for upsetting her. "  An interview with the secretary on 11/29/12 at 1:15 PM (who was MOD on the day the package was received), indicated she was concerned when this large package from an attorney was sent to a resident. She indicated she called the Administrator to make sure the resident was alert and able to receive a package. She was unsure how to check herself if this resident was alert and able to receive mail. She was following the directions from her Administrator.  An interview with the SW (social Worker) on 11/29/12 at 10:56 AM revealed resident ' s mail was given to the activities coordinator to distribute during the week and the manager on duty distributed the mail on the weekends. If a resident is alert and oriented they should automatically get the mail addressed to them.  An interview with the activity coordinator on 11/29/12 at 3:50 PM revealed an alert resident would be able to read their own mail, but if they asked for assistance in opening the mail, or reading it she would help them of course she concluded.	F 241			
F 314	483.25(c) TREATMENT/SVCS TO	F 314			

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>		
(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 314 SS=D	<p>Continued From page 9 <b>PREVENT/HEAL PRESSURE SORES</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to provide a medically prescribed liquid protein supplement and an oral medication supplement to assist in the healing of a pressure ulcer for 1 of 3 sampled residents. (Resident #124)</p> <p>Resident #124 was admitted to the facility on 10/26/2012 and was readmitted on 11/18/12 with cumulative diagnoses of acute renal failure, dehydration, vascular dementia, candidiasis of mouth, muscle weakness, gastro esophageal reflux, and urinary tract infection. The resident had a history of recurrent pressure ulcers on bilateral buttocks.</p> <p>The initial resident assessment for the Minimum Data Set (MDS) was dated 11/2/12. The resident was coded as needing extensive assistance in all areas of daily care. She was unable to stabilize without human assistance and had impairment on one side due to an old cerebral vascular accident.</p>	F 314	<p>F 314</p> <p>The responsible party and attending physician were notified of the liquid protein order and the date the liquid protein was started for resident #124. No new orders were received. A new medication administration record was re-printed and placed on the medication administration record of resident #124 by the Director of Nursing Services.</p> <p>An audit of all residents who have had dietary recommendations was conducted by the Director of Nursing Services, Director of Clinical Education, Unit Managers, and Nursing Supervisors for the previous sixty days to ensure that there were no outstanding recommendations with needed follow up. No other residents were found to be affected.</p> <p>The facility nurses were educated by the Director of Clinical Education and Director of Nursing Services on the dietary recommendation process and ensuring that dietary recommendations are processed entirely with needed follow up.</p>	12/21/12	

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 314	<p>Continued From page 10</p> <p>The resident's care plan was updated upon readmission to the facility. The resident was care planed for pressure ulcers and for increased nutrient needs related to wound healing. Interventions listed included: weekly skin inspections, treatments as ordered, diet as ordered, vitamin and supplements as ordered, monitor lab data, and notify MD of weight changes.</p> <p>A review of the nursing admission assessment on 10/26/12 revealed a pressure ulcer on the right buttock that measured 0.5 cm (centimeters) x 2.5cm. The wound was assessed to be a Stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis or both).</p> <p>The resident was readmitted to the facility on 11/8/12. A review of the nursing admission assessment revealed documentation of bilateral pressure ulcers. The right buttock area was documented to measure 2cm x 3 cm and was assessed as being unstageable due to coverage of wound bed by slough and/or eschar. The left buttock area measured 5cm x 3cm and was staged as a suspected deep tissue injury.</p> <p>A dressing change to the right buttock was observed on 11/29/12 at 2:05 PM. The wound measured 1.6cm x 2.cm. The wound area was observed to be clean, the wound was closed, the surrounding skin had pink granulation, and there was no drainage. The left buttock had healed.</p> <p>A review of the dietary notes for this resident revealed an update by the facility dietician on 11/16/12. The dietician made a recommendation for Pro Stat (a liquid protein supplement used to</p>	F 314	<p>An audit of dietary recommendations for changes in will be reviewed by the Director of Nursing Services, Director of Clinical Education, or Unit Managers in the morning meeting weekly for two months to ensure that recommendations with changes that are needed on the medication administration record.</p> <p>The results of these audits will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assessment and Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.</p>		

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
--	---	--	---

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

(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 314 Continued From page 11  
enhance healing of wounds), large protein portions for all 3 daily meals, a regular diet, and weekly weights. The resident was documented as consuming 67% of meals.

Resident #124 had baseline Albumin levels drawn upon entry to the facility. Albumin levels are monitored for wound healing. Normal Albumin levels are in the range of 3.8 -5.3g/dl. Resident #124 had an Albumin level of 3.8g/dl on 10/31/12. Her hospital discharge labs on 11/8/12 documented a level of 2.9g/dl. The physician had not ordered any further Albumin levels drawn.

A review of physician orders for Resident #124 revealed an order on 11/16/12 for Pro Stat (a protein supplement) 30 ml 2 times a day and Decubi-Vite (a multi vitamin with the additives Vitamin C and Zinc) 2 tablets twice a day.

A review of the Medication Administration Record (MAR) for Resident #124 revealed no documentation the resident had received the ordered supplements Pro stat or Decubi-Vite. The supplements were not listed on the MAR for administration. Resident #124 was receiving a regular Multi Vitamin once daily.

An interview was conducted with the facility dietician on 11/29/12 at 4:45 PM. He stated he had reviewed the labs and documents from the hospital discharge of Resident #124. He revealed he recommended the protein supplement and specific vitamin due to weight loss and the presence of an increasing decubitus on the right buttock.

An interview with the Director of Nursing (DON)

F 314

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>		
(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 314	<p>Continued From page 12</p> <p>on 11/29/12 at 5:00 pm revealed she had seen the Dietician's recommendations on 11/16/12 and had called the Nurse Practitioner (PA). The DON stated the NP gave her a verbal order for Pro Stat 30 ml and Decubi-Vite. The DON stated she put the new orders into the computer, made a MAR page for the medications, and filled out a dietary slip to reflect the dietary changes on 11/16/12. She stated she put the dietary slip in the dietary box during the shift and gave the MAR and the order sheet to the staff nurse on duty. The staff nurse was asked to put the physician order in his box to be signed and to add the MAR page to the current MAR for resident # 124.</p> <p>The staff nurse was out on sick leave and could not be reached by phone for an interview.</p> <p>An interview was conducted with the Facility Consulting Pharmacist on 11/29/12 at 5:45 PM. She stated the difference between a regular multi vitamin and the ordered Decubi-Vite was the addition of Zinc and Vitamin C which are believed to assist with healing. The Pharmacist revealed she could not state any research studies that proved Decubi-Vite promoted healing. She indicated many physicians order Pro Stat to increase the total protein levels for healing. The Pharmacist stated she always defered to dietary consults who know more about nutrition and went with their recommendations.</p> <p>An interview was conducted with the North Carolina Department of Health Regulation's Consulting Pharmacist on 11/29/12 at 6:00 pm. He stated Decubi-Vite was multi vitamin tablet with an additional 500mgs of Vitamin C and 220mgs of Zinc. He stated due to the additional</p>	F 314		

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GREENSBORO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 CAROLINA ST GREENSBORO, NC 27401</b>		
(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 314	Continued From page 13 supplemental values Decubi-Vite was not interchangeable with the standard multi vitamin Resident # 124 was receiving.  During her interview the DON stated it was her expectation staff would take off all medical orders, put all telephone or verbal orders in the MD box to be signed, and would insure all new orders were placed in the MAR for administration. She stated she expected residents to receive all medications, supplements, and treatments as the physician ordered.	F 314			
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: ased on record review and interview with staff the facility failed to provide liquid nutritional supplement and protien supplement as recommended by the dietitian and ordered by the physician. This was evident 1 of 3 (Resident#124) Admitted: 10/26/12	F 325	F 325  The responsible party and attending physician were notified of the liquid protein order and the date the liquid protein was started for resident #124. No new orders were received. A new medication administration record was re-printed and placed on the medication administration record of resident #124 by the Director of Nursing Services.  An audit of all residents who have had dietary recommendations was conducted by the Director of Nursing Services, Director of Clinical Education, Unit Managers, and Nursing Supervisors for the previous sixty days to ensure that there were no outstanding recommendations with needed follow up. No other residents were found to be affected.  The facility nurses were educated by the Director of Clinical Education and	12/21/12	

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 325	Continued From page 14  Based on record review and interview with staff the facility failed to provide liquid nutritional supplement and protien supplement as recommended by the dietitian and ordered by the physician. This was evident 1 of 3 (Resident#124) Admitted: 10/26/12 Dx: Acute kidney failure, dehydration, bladder neck obstruction, hematuria, vascular dementia, HTN, cerebral artery occulsuion, UTI, dandidiasis of mouth, muscle spasms, GERD, muscle weakness  MDS Admission 11/15/12 BIMS 09 Bed Mobility - 3/3 Transfer 3/3 Locomotion 3/2, w/c Dsg 4/2 Eating 1/2 Toileting 4/2 Personal Hygiene 3/2 Bathing 4/2 Blance - needs human assist ROM 1/1  Facility dietician 11/19/12 3:49 Last diet order 11/29/12 Prostat 30 ml BID Lrg protein portions x 3 meals Regular diet Last 14 days meal consupction is at 67% Added food preferences vanilla ensure pudding supplement BID Wt q wk	F 325	Director of Nursing Services on the dietary recommendation process and ensuring that dietary recommendations are processed entirely with needed follow up.  An audit of dietary recommendations for changes in will be reviewed by the Director of Nursing Services, Director of Clinical Education, or Unit Managers in the morning meeting weekly for two months to ensure that recommendations with changes that are needed on the medication administration record.  The results of these audits will be reviewed by and brought to the Quality Assessment Performance Improvement Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assessment and Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.		

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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/30/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO		STREET ADDRESS, CITY, STATE, ZIP CODE 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 325 Continued From page 15

F 325

- MD orders dated 11/16/12
- Pro stat 30 ml 2
- Decubi-Vite (MVI w/minerals)

Labs - Albumin 10/31/12 3.8 (3.5-5.2)  
Albumin 11/5-11/8 from hospital stay was 2.9

Admission  
10/26/12 wt 140 lbs  
11/8/12 wt 132 lbs  
11/26/12 wt 127 lbs

- Care plan updated 11/15/12
- Increased nutritional needs r/t wound healing (potential wt changes r/t IV fluids in hospital, renal insufficiency, kidney failure, poor intake due to candidias in mounth, dementia, depression
- Cardiovascular status - monitor wts, diet as ordered
- Gastrointestinal distress r/t GERD
- Alteration in elimination of bowel & bladder - catheter due to bladder obstruction
- Alteration in hydration r/t DM, kidney failure

Review of Nov. MAR revealed no documentation of ordered Pro stat and decubi vite supplements.

Interviews with Dietician 11/29/12 at 4:45 PM revealed he had reviewed labs and documents from hospital discharge. He recommended two supplements due to weight loss and presence of increasing decubius on R buttocks.

Interview with DON on 11/29/12 at 5:00 PM revealed she called the NP with the recommendations and received a verbal order to put the recommendations in place. The DON



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

PRINTED: 12/07/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2012</b>
--	---	--	---

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

(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 325	<p>Continued From page 16</p> <p>entered the order into the computer, made a copy for the MD to sign, printed the MAR for the order and handed the MAR and the MD copy to nurse Rita Auff, RN. The DON made out a dietary meal slip and sent it to dietary.</p> <p>Attempted to call Nurse Auff who was out with bronchitis. Unable to reach her at home phone #.</p> <p>11/29/12 5:45 PM Phone interview with Facility Consulting pharmacist Charlotte Matheny. She stated the decubi vite and pro stat were all over the counter drugs. She indicated the difference between a regular mVI and the Debuti vite was the addition of Zinc and Vit. C which are believed to assist with healing. The pharmacist stated she could not state it promoted healing but she always deferred to dietary consultants who know more about the area. She stated she always went with the dietary recommendations to give the residents the best chance of healing.</p> <p>11/29/12 1800 Russell Carroll, DHHS pharmacist -Revealed decubi vite supplies 500mg vit C and 220 mg zinc. It is not interchangeable with MVI.</p>	F 325		
-------	--	-------	--	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	JAN 25 2013 (X3) DATE SURVEY COMPLETED  12/18/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	INITIAL COMMENTS  Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.	K 000	<b>K 000</b> <u>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 continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	
K 012 SS=E	The deficiencies determined during the survey are as follows: <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: sprinkler pipe penetrating the fire wall on 100 hall in attic was not seal to maintain the building construction rating of building.	K 012	<b>K 012</b> <u>Criteria 1</u> All areas identified as not meeting this standard have been sealed by Maintenance Director.  <u>Criteria 2</u> The Maintenance Director assessed the facility -all areas not meeting this standard have been identified and corrected.	1/31/13
K 038 SS=E	42 CFR 483.70(a) <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	<u>Criteria 3</u> Maintenance Director/designee will monitor facility monthly and after vendors work in the facility to ensure areas meet the building construction rating are identified, sealed and maintained.  <u>Criteria 4</u> Maintenance Director will provide results from the monthly monitoring to the Quality Assurance Process Improvement committee for 3 months at which time the committee will determine the continued frequency of monitoring.	

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

TITLE

(X6) DATE

*Barbara L. Perkins* Executive Director 1/17/2013

All deficiency statements 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2012
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 038	Continued From page 1  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: listed below are areas that, at time of survey, required two motions of hand to open door: 1. activity office door. 2. business office door.  Also, the delayed egress locking system at the ends of each corridor did not function per NCSBC or LSC. The doors would relock with use of keypad after the irreversible process of delayed egress locking system had been initiated.	K 038	<u>Criteria 1</u> Maintenance Director installed single motion locksets on all doors as indicated so that exits are readily accessible at all times.  Vendor contracted, maglocks reconfigured to comply with special locking according to NC Building Code; Chapter 4.  <u>Criteria 2</u> Though all patients have the potential to be affected by the alleged deficient practice, none were. Maintenance Director/designee will monitor facility monthly and after vendors work in the facility to ensure areas meet the building construction rating are identified, sealed and maintained.	1/04/13
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey no heat was provide in riser room(room on back of building) for sprinkler	K 062	<u>Criteria 3</u> Maintenance Director/designee will inservice staff about the impact of the reconfiguration of the maglock. The Maintenance Director/designee will monitor facility weekly for the next 3 months to ensure areas not meeting the building construction rating are identified, sealed and maintained.  <u>Criteria 4</u> Maintenance Director will provide results from the weekly monitoring to the QAPI committee for 3 months at which time the committee will determine the continued frequency of monitoring.	1/31/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  346014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 062	Continued From page 2 system. Also, no spare heads for sprinkler system in sprinkler box in riser room.  42 CFR 483.70(a)	K 062	<p><b>K062</b></p> <p><u>Criteria 1</u> Heater replaced and functioning in Riser Room and additional Spare Sprinkler Heads replaced and provided by vendor.</p> <p><u>Criteria 2</u> Though all patients have the potential to be affected by the alleged deficient practice, none were. The Maintenance Director assessed the facility, no other areas found to be affected.</p> <p><u>Criteria 3</u> The Maintenance Director/designee will monitor the function of the heater in the Riser Room weekly for the next 3 months. Inventory and par level of spare Sprinkler Head replacements will be assessed and monitored by the Maintenance Director.</p> <p><u>Criteria 4</u> Maintenance Director will provide results from the weekly monitoring to the Quality Assurance Process Improvement committee for 3 months at which time the committee will determine the continued frequency of monitoring. /</p>	1/19/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345014	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GREENSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III - construction, one story, with a complete automatic sprinkler system.</p> <p>No LSC deficiencies noted at time of survey.</p> <p>42 CFR 483.70(a)</p>	K 000		

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

A 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.

CW