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	345377	A. BUILDING ______ B. WING ______	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide adaptive eating utensils recommended by the occupational therapist for 1 of 1 sampled residents (Resident #55) requiring facility-implemented interventions to promote better food intake at meals. Findings included: Resident #55 was admitted to the facility on 02/19/08. The resident's documented diagnoses included cerebrovascular accident with left hemiplegia, dysphagia, multiple contractures, and cervical spondylosis. Resident #55's most recent diet order, ordered by the physician on 11/23/13, documented he was to receive finger foods with nectar thick liquids and orange juice at all meals. On 12/18/13 the resident's care plan identified "Resident at risk for complications due to hx (history) of chewing & (and) swallowing problems" as a problem. Interventions to this problem included diet modification as ordered, monitoring of diet tolerance, and speech therapy screens and treatment as ordered.	F 246	1. An adaptive spoon was obtained and given to resident #55 for all meals. The speech therapist looked at the resident and recommended a Finger Food diet for all meals and the adaptive spoon was discontinued. 2. All other residents with ordered adaptive equipment were observed to ensure that the adaptive equipment was in place. All dietary staff were inserviced on 4-7-15 regarding the use of adaptive equipment. 3. Random audits of a minimum of 10 residents a week x 4 weeks then monthly x 2 months will be performed by the Registered Dietitian or another designated staff member to ensure that adaptive equipment is being used as ordered. 4. The results of these audits will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of these audits.	4/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2015

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

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The Monthly Record of Vital Signs and Weights documented Resident #55 weighed 150.9 pounds on 06/07/14.

A 02/09/15 registered dietitian (RD) assessment documented speech therapy continued to work with Resident #55, but the resident was turning down foods that he used to like. The RD reported the resident would pick up and eat banana/mayonnaise sandwiches for the therapist.

The Monthly Record of Vital Signs and Weights documented Resident #55 weighed 134.3 pounds on 02/21/15.

A 02/22/15 occupational therapy (OT) Treatment Note documented, "Pt (patient) initially began self feeding with standard spoon. Noted pt to twist spoon cylindrically with attempt to obtain better grasp. Asked pt if he would attempt utilization of built-up utensil with pt shaking head 'yes' in agreement. Pt utilized built-up handle utensil with minimal assistance and consumed 50% of meal."

A 02/23/15 OT Treatment Note documented, "Two built-up adaptive spoons utilized for trials with pt who demonstrated ability to grasp spoon and scoop food completing hand to mouth 3/5 trials. Pt able to grasp liquids and complete hand to mouth with stand by assist. Pt with moderate spillage using built-up handled spoon slightly angled to left for right hand."

A 02/24/15 OT Treatment Note documented, "Pt reported he liked the built-up handle curved to left spoon he used yesterday. OTA (occupational therapy aide) requested dietary to send spoon on tray for all meals...."

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A 03/09/15 speech therapy (ST) discharge summary documented, "Patient exhibits increases in his prescribed compensatory and safety strategies with mechanically soft solids (particularly finger foods) and requires reduced intensity of supervision and oversight to insure his safety... Aspiration precautions. Pt's current recommended diet is mechanical soft solids with nectar thickened liquids."

At 1:02 PM on 03/18/15 Resident #55 was eating in his room. The resident was sticking his fork in mechanical soft beef tips and spinach and licking the tines. The resident had no built-up handle spoon on his meal tray. The resident received pudding and yogurt which he was not eating. His tray slip documented he was on a mechanical soft diet, and should have a sectional plate (which he did have) and a "left angled built-up handle spoon" (which he did not have).

At 12:33 PM on 03/19/15 Resident #55 was eating in his room. The resident had mechanical soft chicken, mashed potatoes, and green bean casserole on his tray. He was not eating any of these foods, but was sticking his fork in chocolate pudding and licking the tines. His tray slip documented he was on a mechanical soft diet, and should have a sectional plate (which he did have) and a "left angled built-up handle spoon" (which he did not have). The resident was asked if he would like feeding assistance, and he declined it.

At 12:48 PM on 03/19/15 nursing assistant (NA) #1 stated Resident #55 was eating much less now. She reported the resident preferred to feed himself, and did better with foods that he could

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pick up with his hands. She commented she thought the resident was supposed to have a special spoon, but she was not sure where it was.

At 1:10 PM on 03/19/15 the dietary manager (DM) stated dietary had to get adaptive utensils back from the hall on a timely basis so they could be sanitized and placed on the next meal tray. Resident #55's adaptive spoon was found sitting in a container on the dish machine line. The DM reported she was not aware the resident liked banana and mayonnaise sandwiches.

At 3:10 PM on 03/19/15 occupational therapist (OT) #1 stated Resident #55 was supposed to be getting a built-up handle spoon on his meal trays. He reported he worked with the resident on positioning during meals and adaptive utensils since the resident's meal intake was decreasing. The OT commented Resident #55 did well with the built-up handle spoon, and in conjunction with the sectional plate, it made it easier for the resident to get food up on his utensils and into his mouth.

At 3:20 PM on 03/19/15 speech therapist (ST) #1 stated the food which Resident #55 ate the best was finger food sandwiches made with banana and mayonnaise.

At 4:12 PM on 03/19/15 the facility's RD stated there was a definite change in Resident #55's appetite, and since he liked to be independent, supplying the resident with adaptive eating equipment would be important. She reported about the only person who could get the resident to eat was ST #1 who made banana and mayonnaise sandwiches for him.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 246	Continued From page 4 At 6:50 PM on 03/19/15 NA #2 stated Resident #55 liked to still feed himself, but he needed his sectional plate and special spoon to really be able to get much food to his mouth. She reported the resident was not eating as well in the past three or four months.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain a clean and sanitary environment for 1 of 30 rooms. (Room number 303) Findings include: During an observation of room 303 on 3/16/15 at 5:50pm, the room was noted to be cluttered and not clean. The bed (A) side of the room had an electric bed that was raised. There was a resident lying in the bed. The bedframe had dust visible on all metal pieces. Behind the head of the (A) bed, the floor was dirty with trash and other debris. The corner of the wall behind the head of the bed had cob webs, dust, and other unidentifiable light brown objects in the floor. The wall on left side of the bed had dust on the baseboard and dirt where the baseboard and wall meet as well as where the baseboard and floor meet. In the floor along the same wall, a dime and one light brown cheerio was noted. The	F 253	1. Room 303 and the adjoining bathroom were deep cleaned and repairs were made. 2. All other resident rooms and bathrooms were checked by the Environmental Services Director to see if they needed to be deep cleaned and/or repairs made. 3. A minimum of 15 rooms/week will be deep cleaned until all rooms in the facility are completed - all resident rooms and bathrooms will be deep cleaned within 6 weeks. The Environmental Services Director or designated staff member will check all deep cleaned rooms to ensure cleanliness and that repairs were made as they were done weekly x 4 weeks then monthly x 2 months. 4. The results of these	4/16/15

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F 253	Continued From page 5 floor beside the bed was square tiles. One of the tiles between the nightstand and head of bed had several gouges in the tile. The wall behind the headboard of the A bed was marred and had peeling paint and wasn ' t completely intact. On top of a small refrigerator kept in the room, there was a bottom piece of a right leg foot petal of a wheelchair lying on the top. The top of the refrigerator was covered in visible dust. The cubicle curtain for the A bed had a brown stain on the inside (area closest to the door) and a yellow stain on the inside of the curtain on the opposite side. The curtain was wrinkled. There was a motorized wheelchair sitting along the left side wall of the room. The motorized wheelchair was red and had rubber tires. Both the wheelchair and the tires had visible dust. There were a pack of briefs in the chair that appeared half full and some papers in the seat of the chair as well. The bedside table for the A bed had dust and some kind of dried liquid on the top of the bedside table. The base of the bedside table (Bottom wheels underneath) had visible dust and debris. The side arm and the base both showed signs of rust. The bedside table had a piece of veneer that wrapped around the table along the edges of the table. The veneer was missing from part of one edge of the table, broken on one edge of the table, and peeling on one edge of the table. The B side of the room also had a resident in it. The floor between the two beds had approximately 20-30 pieces of what appeared to be green beans. The bed was in low position. It was noted behind the headboard along the wall of bed B that there were cob webs, dust and other debris in the corner along the baseboard. There was a straw wrapper lying in the floor between the head of the B Bed and the nightstand. The nightstand had a pack of wipes, a towel, and other items stacked	F 253	audits/observations will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of these audits.	

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on top of each other stored on the top. At the foot of the B bed, a white pillow case was on the floor half under the bed and half under the p-tac (Packaged Terminal Air Conditioner) unit. The pillow case had visible dust. The window was open and the window seal had dirt and debris on the inside. Cob webs were noted in both top corners of the window seal as well as dust on the blinds. Sitting on the floor in the corner at the end of the p-tac unit there was a stand up white electrical fan. The fan was unplugged and was not operating. The cord was stored over the top of the fan. The entire outside of the fan including the legs and base were covered in a thick layer of gray dust. Each individual paddle on the inside was covered with a thick layer of gray dust on both sides. Inside the screen cover over the grill of the p-tac unit there were visible pieces of dirt, dust, and other debris. The front to the p-tac unit had dust as well as the inside filter. There were two closet doors, a bathroom door, and the door to enter the room observed to be scratched and marred. There was a shared bathroom between rooms 300 and 301. During the observation of room 300 the bathroom was observed to be clean except for there was a bariatric commode seat riser sitting over the commode. The rim of the seat was gray in color. There was a small dark brownish red mark on the back part of the seat. The area was not able to be identified what it was and if it were a stain or something washable. It was also noted there were cob webs in two of the four corners in the bathroom at the ceiling.

Another observation was made of room 303 at 12:30pm on 3/17/15. The room was unchanged from the previous observation made on 3/16/15 with the exception of the green beans were no longer on the floor. The pillow case also had

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F 253	Continued From page 7 been moved. However; a white pillow case with visible gray dust was at the foot of the bed (B) between the mattress and the footboard. The straw wrapper had been removed from between the head of the bed (B) and the nightstand. Under the head of bed (A), a plastic soufflé cup was noted to be on the floor under the bed. The bathroom between rooms 303 and 301 remained the same with cob webs in the corners at the ceiling and the bariatric commode seat riser still with the brownish red mark. There were two urinals sitting on top of the back of the commode. The urinals were empty. An observation was made of room 303 at 5:05pm on 3/18/19. The room was noted to be cluttered and not clean. The bed (A) side of the room had an electric bed that was raised. There was a resident lying in the bed. The bedframe had dust visible on all metal pieces. Behind the head of the (A) bed, the floor was dirty with dust and debris. The corner of the wall behind the head of the bed had cob webs, dust, and other unidentifiable light brown objects in the floor. The wall on left side of the bed had dust on the baseboard and dirt where the baseboard and wall meet as well as where the baseboard and floor meet. The floor beside the bed was linoleum square tiles. One of the tiles between the nightstand and head of bed had several gouges in the tile. The wall behind the headboard of the A bed was marred and had peeling paint and wasn ' t completely intact. The cubicle curtain for the A bed had a brown stain on the inside (area closest to the door) and a yellow stain on the inside of the curtain on the opposite side. The curtain was wrinkled. There was a motorized wheelchair sitting along the left side wall of the room. The chair was red and had rubber tires.	F 253		

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F 253	Continued From page 8 Both the wheelchair and the tires had visible dust. There were a pack of briefs in the chair that appeared half full and some papers in the seat of the chair as well. The bedside table for the A bed had dust and some kind of dried liquid on the top of the bedside table. The base of the bedside table (Bottom wheels underneath) had visible dust and debris. The side arm and the base both showed signs of rust. The bedside table had a piece of veneer that wrapped around the table along the edges of the table. The veneer was missing from part of one edge of the table, broken on one edge of the table, and peeling on one edge of the table. The B side of the room also had a resident in it. The bed was in low position. It was noted behind the headboard along the wall of bed B that there were cob webs, dust and other debris in the corner along the baseboard. The window was open and the window seal had dirt and debris on the inside. Cob webs were noted in both top corners of the window seal as well as dust on the blinds. Sitting on the floor in the corner at the end of the p-tac unit there was a stand up white electrical fan. The fan was unplugged and was not operating. The cord was stored over the top of the fan. The entire outside of the fan including the legs and base were covered in a thick layer of gray dust. Each individual paddle on the inside was covered with a thick layer of gray dust on both sides. Inside the screen cover over the grill of the p-tac unit there were visible pieces of dirt, dust, and other debris. The front to the p-tac unit had dust as well as the inside filter. There were two closet doors, a bathroom door, and the door to enter the room observed to be scratched and marred. There was a shared bathroom between rooms 300 and 301. During the observation of room 300, the bathroom was observed to be clean except	F 253		

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F 253	Continued From page 9 for there was a bariatric commode seat riser sitting over the commode. The rim of the seat was gray in color. There was a small dark brown dark red mark. The area was not able to be identified what it was and if it were a stain or something washable. It was also noted there were cob webs in two of the four corners in the bathroom at the ceiling. During an interview with maintenance director on 3/19/15 at 2:15 pm, the maintenance director stated that he usually staffs one housekeeper per hall and he has two floor technicians. He explained that the housekeepers clean every room every day. Furthermore, cleaning the room every day included, wiping all surfaces off, mopping the floor, emptying the trash, and cleaning and sanitizing the bathroom. He clarified that mopping the floor included cleaning the corners and edges of the room as well as the baseboard. He stated he was completely staffed the week of the survey and a housekeeper had been assigned to each hallway every day. He indicated that every room was deep cleaned once a month in addition to the daily cleaning. The maintenance director stated he does not have a formal written deep clean schedule for each room. He stated that he rounds behind the housekeepers to make sure the work has been done at least weekly but tries daily. He further indicated that he doesn ' t have a checklist or a sheet that details in writing what is expected from the housekeeping staff when performing daily cleaning of the rooms. He stated he has two maintenance assistants that will help when needed. The maintenance director explained the facility process of how needed repairs are communicated. He stated a work order is completed, and once it is fixed, the person that	F 253		

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F 253	Continued From page 10 makes the repair signs the work order and indicated he checks to make sure the repair has been completed or will complete himself. He indicated that he was over both maintenance and housekeeping for the facility. He further indicated that the maintenance staff made rounds to check to see for any needed repairs to maintain the facility environment. He indicated that if something identified could be repaired by the maintenance staff, it is repaired at the time noted. During an observation of room 303 on 3/19/14 at 2:30 pm, the room remained the same as the previous observations. The maintenance director was in the room during the observation. While in the room, the maintenance director apologized to the resident for his room not being clean, and that it would be cleaned soon. The maintenance director acknowledged the observations and stated that he had dropped the ball with his staff while in room 303. An interview with the maintenance director during the observation revealed that maintenance staff were responsible for cleaning and maintaining the p-tac units. He stated the filters and inside the grill of each p-tac unit are cleaned once a month. He indicated he did not have a formal schedule for the p-tac units cleaning. The fan remained the same as well with thick gray dust. The maintenance director indicated he would take care of the fan. The maintenance director indicated he was responsible for the laundry in addition to housekeeping and maintenance. He indicated the cubical curtains should be taken down and washed weekly and as needed. The maintenance director acknowledged the cob webs in the room and the bathroom, as well as the dust dirt and debris along the walls, corners and edges. The maintenance director indicated	F 253		

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F 253	Continued From page 11 that typically multi resident use equipment that is assigned to a resident is clean when delivered to the resident. He added once the equipment is no longer needed or in use, the equipment is cleaned and sanitized and stored for future use. The maintenance director indicated neither of the rooms used the restroom nor were any bariatric residents in either room. He also acknowledged the brown spot on raised commode seat in the bathroom.	F 253		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that staff were using the correct type of sling lift pad while transferring 1 of 1 residents (Resident #84) with a mechanical lift device when observed. Findings included: Resident #84 was admitted to the facility on 09/20/11. Cumulative diagnoses included severe dementia, hypertension, history of a cerebrovascular accident (CVA) and diabetes mellitus. The most recent quarterly Minimum Data Set	F 323	1. Nurse aide #1 was individually inserviced on 4-9-15 and nurse aide #2 was individually inserviced on 4-13-15 regarding the use of the proper mechanical lift pad on Resident #84. The dark green lift pad was thrown away and Resident #84 was given a full body lift pad. 2. All residents requiring the use of a mechanical lift were assessed by the DON and the Nursing Support employee responsible for ordering lift pads to assure all residents were utilizing the correct lift	4/16/15

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GREENFIELD PLACE	**2575 W 5TH STREET GREENVILLE, NC 27834**

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F 323	Continued From page 12 (MDS) assessment of 12/17/14 noted she had long and short term memory problems and was severely impaired in decision making. She required extensive assistance with transfers. On 03/18/15 at 1:20 PM, Resident #84 was observed sitting in her chair with a dark green sling lift pad noted underneath her. Nurse Aide #1 (NA #1) and NA #2 came into her room to place her in bed to provide personal care. They brought a mechanical lift device into her room and rolled it over to her chair. Both aides attached the four straps of the lift pad to the lift bar of the device. NA #1 began to operate the lift device and as she began to lift Resident #84 she began to slip and NA #1 commented that the pad wasn ' t positioned correctly. She lowered Resident #84 back onto the chair and NA #2 assisted her to reposition both Resident #84 and the green pad. They pulled the lower straps up between her legs and crossed them to attach them to the lift bar. They attached the upper straps of the pad to the lift bar and began to lift her. As NA #1 began to lift Resident #84 from her chair it was noted that the pad was positioned just above her waistline and extended up past her head. Her bottom torso with the entire incontinent brief was exposed. NA #1 continued to lift her and as she lifted Resident #84 she began to slip out of the pad exposing her back. Both aides quickly reached to catch her before she fell out of the sling pad. Both aides had both hands on her body as they quickly guided her to the bed. NA #1 then lowered her onto the bed. NA #1 reported that she had used the same green pad earlier in the day to get her out of bed. She also reported that she had slipped some when she moved her but not like she did this time. She stated she would tell the nurse about	F 323	pad. Some new pads were ordered and corrections were made as needed. Any new orders received for use of the mechanical lift will be assessed by the nursing department and the appropriate lift pad assigned. It was identified that there are 3 different style pads used in the facility. A picture/color code has been established for each type of lift pad. A picture/color sign will be placed on each residents closet door to alert staff of the type of lift pad to be used. 3. A minimum of 6 residents/staff will be assessed, using direct observation, while getting up using the mechanical lift weekly x 4 weeks then monthly x 2 months to assure the proper lift pad is being used. 4. The results of these direct observations will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of the direct observations.	

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F 323	Continued From page 13 the incident and see about using a different sling lift pad. When questioned who was responsible for deciding the size of the lift pads neither aide was sure who assessed or made the decision as to the appropriate pad but both felt the nurse would know. On 03/18/15 at 5:15 PM, the Director of Nurses (DON) reported that the facility used only two sizes of sling lift pads for the mechanical lifts. She stated one size was for residents up to a certain weight and the bariatric sling was used for the very obese residents. Resident #84 was observed eating breakfast in bed on 03/19/15 at 9:00 AM. The same green sling lift pad was observed on the chair. During another interview with the DON, on 03/19/15 at 10:30 AM, she stated one of the nurse aides had come to her and reported that Resident #84 ' s legs had slipped a little when she was moved with the lift yesterday but didn ' t tell her that she was actually falling out of the sling. She also stated the aide didn ' t tell her that she had to grab her to prevent her from falling out of the sling. She stated all staff had been shown the safe way to lift residents but she would arrange another in-service on the proper use of slings for the residents to prevent any further incidents. The restorative aide (RA #1) was observed preparing to roll a mechanical lift device down the hall on 03/19/15 at 10:40 AM. When questioned about the use of the mechanical lift devices and the sling pads that were used, she stated the beige full body sling lift pad was used with the lift device that was in restorative. She reported that there was no specific person responsible for	F 323		

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determining what size pad a resident needed for transfers with the mechanical lifts. She stated it depended on the staff members experience and knowledge of the residents. RA #1 also stated most of the residents had their own sling lift pads in their rooms. She went into Resident #84 ' s room and looked at the dark green lift pad. RA #1 stated that the dark green pad was not the appropriate pad that should be used on Resident #84 as she needed a full body sling lift pad. She took the dark green pad and went into the laundry room. She stated the dark green pad had belonged to a former resident. She placed in the dirty linen hamper. RA #1 found a dark blue full body sling lift pad and took it to Resident #84 ' s room. She reported that staff would use that pad for her in the future as long as it had her name on it and it was in the room.

During an interview with Nurse #1, on 03/19/15 at 10:45 AM, she stated she was responsible for ordering the sling lift pads. She stated the sling lift pads that they currently used had weight limits of 400 pounds and there was very little difference in sizes unless it was a bariatric sling lift pad.

On 03/19/15 at 3:00 PM, the DON reported there wasn't any specific person who determined how a resident was transferred. She also reported there was no formal assessment done as to how residents were transferred. She stated it depended upon the individual resident and their condition. She stated sometimes staff might report a change or decline in someone ' s mobility and the mode of transfer would be re-evaluated. The DON also stated sometimes family members would request a change in the mode of transfer. She stated she would retrieve the dark green sling pad.

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F 323	Continued From page 15 During another interview with Nurse #1, on 03/19/15 at 3:10 PM, she stated that Resident #84 needed a full body sling lift pad due to her lower extremity contractures. Nurse #1 stated that the dark green pad was not the appropriate sling lift pad for her. She also stated that the dark green lift pad was different from the other sling lift pads they used and wasn ' t sure where it came from. Nurse #1 went into Resident #84 ' s room to make sure the dark blue full body sling lift pad was the appropriate pad for her. She remarked that this pad was the appropriate pad and she would label it with Resident #84 ' s name and would instruct staff not to remove it. She also remarked that she would make sure all staff knew to use that pad from now on when lifting her. Nurse #1 commented that she was ordering 2 more sling lift pads for use in the facility and the dark green pad would be discarded. On 03/19/15 at 3:45 PM, the DON commented the dark green pad was different from the other sling lift pads currently used in the building and may have been used on a previous unit that they no longer used or had. The DON reported that she would assess all of the residents who currently were being transferred via the mechanical lift devices to ensure the correct pad was being utilized. She added that the dark green pad would be discarded.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper	F 364		4/16/15

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F 364	Continued From page 16 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to provide palatable food during 1 of 3 meals observations. Findings included: Review of the facility menus revealed the supper meal on 03/16/15 featured French dip sandwiches and steak fries. At 5:02 PM on 03/16/15 a resident, who requested to remain anonymous, stated the facility did not serve food that was good. The resident reported the appearance, taste, and temperature of the food was frequently not acceptable so snacks were kept in-room to keep from being hungry. When told what was on the supper menu, the resident stated, "It sounds good, but just and wait and take a look at it." According to this resident's most recent minimum data set, their cognition was intact, and they exhibited no behaviors. At 6:30 PM on 03/16/15 this resident was eating snacks in the room. The resident stated the supper meal was not acceptable, but was not going to ask for an alternate because "it would be just as bad." The resident lifted the lid on the supper plate to reveal two slices of white bread with two paper thin pieces of very dark brown meat covering about half of one of the slices. The resident commented the bread and meat were at room temperature, and were extremely dry. The resident also received a scoop of plain white rice. There was no gravy or au jus served	F 364	1. The anonymous resident did not want to ask for the alternate meal due to they felt that "it would be just as bad" per the state surveyor. 2. Due to the issues with this meal - it has been taken out of the meal rotation and will not be served again. All dietary staff were inserviced on 4-7-15 regarding the importance of following the menu and the likes/dislikes on the resident tray cards. 3. The Registered Dietitian or another designated staff member will interview a minimum of 10 residents/week x 4 weeks then monthly x 2 months to ensure that the meals are appetizing and palatable. 4. The results of these interviews will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of these audits.	

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with the meal. The resident reported the rice was very starchy, and presented with a gelatinous sheen.

At 11:18 AM on 03/19/15 the recipe for the French dip sandwich was reviewed. The recipe specified the use of three ounces of "wafer thin" roast beef per sandwich with the meat being served in rolls/buns/baguettes and accompanied by hot au jus.

At 11:25 AM on 03/19/15 the dietary manager (DM) stated she was not sure how to make au jus, and the facility did not have a recipe instructing them on how to make it. She reported she ordered buns which arrived on Friday, 03/13/15, but staff found mold on them on Monday, 03/16/15. She commented they could not be used. According to the DM, in the past when the residents received the French dip sandwiches they complained the roast beef was tough so she decided to order "sandwich style" roast beef this time. She stated she thought the roast beef was in a brown gravy at the trayline, and was not sure why some of the gravy did not appear on the sandwiches.

At 3:52 PM on 03/19/15 the PM cook stated there were no rolls for the French dip. She reported she used sandwich bread instead. The cook commented the roast beef was in a brown gravy at the trayline, but she did not want to put any gravy on the loaf bread because it would get too soggy and fall apart. She stated if a resident did not get steak fries with the French dip they had fries listed as a dislike on their tray slip, and if they did not get gravy on their rice they had gravy listed as a dislike on their tray slip.

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F 364	Continued From page 18 At 4:20 PM on 03/19/15 the tray slips for the anonymous resident who complained about the food were reviewed. Neither fries nor gravy were documented as dislikes on them. The resident stated the steak fries would have been better than plain white rice, and at least if they had to eat rice, the gravy would make it more palatable.	F 364		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to serve an alternate vegetable of the same nutritive value as the green vegetable on the main menu. Findings included: During food preparation observation on 03/18/15, beginning at 9:00 AM, the menu documented beef tips, spinach, noodles, and fruit crisp were being served for the lunch meal. At 9:28 AM on 03/18/15 the AM cook stated she was preparing corn as the alternate for the spinach. At 11:20 AM on 03/18/15 food temperatures were taken at the trayline. The AM cook identified spinach as the vegetable designated on the facility menus and corn as the alternate vegetable she selected. During the operation of the trayline between 11:40	F 365	1. The Dietary Manager's last day of work at the facility was 3-19-15. She was unable to be talked to regarding this issue. 2. All dietary staff were inserviced on 4-7-15 regarding appropriate alternative vegetable choices and that the alternate vegetable needs to be approved by the Registered Dietitian. 3. The alternate vegetable will be monitored weekly x 4 weeks and then monthly x 2 months to ensure that the alternate vegetable is of the same nutritional value as the original vegetable. 4. The results of these audits will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of these audits.	4/16/15

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F 365	Continued From page 19 AM and 11:48 AM on 03/18/15 trays for residents on regular texture diabetic diets contained beef tips, noodles (starch), corn (starch), and fruit crisp (carbohydrate/starch). At 11:50 AM on 03/18/15 the dietary manager (DM) stated she did not realize that it made a difference if a starchy vegetable was selected as a alternate for a non-starchy vegetable. However, she commented it made sense that diabetic residents probably did not need a starchy vegetable in addition to the other starch such as potatoes and rice served at every meal. At 4:20 PM on 03/19/15 the PM cook stated if residents did not like a green vegetable such as green beans she would select something like corn or squash as an alternate. She explained the way she chose an alternate vegetable was to look at tray slips to determine which residents would not eat the vegetable on the main menu, and then select an alternate vegetable she knew most of those residents would eat. She reported she did not realize it made a difference about using starchy vegetables as alternates for non-starchy vegetables.	F 365		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		4/16/15

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F 431	Continued From page 20 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date opened multi dose bottles of medication, keep medication bottles in the medication cart clean, remove expired medications from use and store medication as recommended by the manufacture, in 1 of 2 medication rooms (medication room 500 hall) and on 2 of 4 medication carts (200 hall cart and 300 hall cart) Findings include: 1. During an observation on 3/19/2015 at 11:02 am of the medication cart for 200 hall, one	F 431	1. Nurse #2, who was assigned to the 200 hall medication cart on 3-19-15 on the 7-3 shift, was inserviced on 4-10-15 regarding the importance of storing medications properly and dating opened vials. Nurse #3, who was assigned to the 300 hall medication cart on 3-19-15 on the 7-3 shift, was inserviced on 4-10-15 regarding the importance of keeping the medication cart clean and wiping off bottles as	

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F 431	Continued From page 21 multi-dose vial of Tuberculin Purified Protein Derivative (PPD) was noted in the second drawer of the medication cart with, other multi use medications for residents. The multi-dose vial had approximately ¾ of the solution still in the vial, had an expiration date of 7/2016, and was not dated as to when the vial was originally opened. The directions on the label were to keep the PPD solution refrigerated and to discard 30 days after being opened. An interview was conducted on 3/19/14 at 11:08 pm with Nurse # 2. Nurse # 2 was assigned to the 200 hall medication cart. During the interview, the nurse indicated the multi dose vial of PPD should have been labeled and dated when opened as well as refrigerated. 2. During an observation on 3/19/2015 at 11:21 am, of the medication cart for 300 hall, (6) bottles of Polyethylene Glycol, (2) Bottles of Chlorhexidine, (2) Bottles of Ferrous Sulfate, and (1) Bottle of Diocto, were noted in the bottom two drawers of the medication cart. The multi-dose bottles were covered with a sticky residue. The bottom two drawers of the medication cart were covered with a thick sticky substance. An interview was conducted on 3/19/15 at 11:25 am with Nurse # 3. Nurse # 3 was assigned to the 300 hall medication cart. During the interview, the nurse indicated the medication carts should be kept clean. During an interview with the ADON (Assistant Director of Nursing) on 3/19/15 at 11:30 pm, the ADON indicated that she expected the nurses to clean the medication carts. 3. During an observation of the medication room on the 500 hall on 3/19/2015 at 12:02 pm, (1) bag	F 431	needed. The nurse assigned to the 500 hall on 3-19-15 on the 7-3 shift was inserviced on 4-13-15 regarding proper storage of medication and properly returning discontinued or expired medications to the pharmacy. 2. The nurses and med aides were inserviced on 3-31-15, 4-1-15 and 4-9-15 regarding: 1) proper storage of medications 2) dating opened vials, containers, etc. 3) expired medications 4) cleanliness of medication carts and medication rooms. All medication rooms and medication carts are in the process of being cleaned and will be completed by 4-16-15. All expired medications have been returned to the pharmacy. All undated vials were returned to the pharmacy or destroyed and replaced. 3. All medication rooms and medication carts will be checked/audited by the Nursing department weekly x 3 weeks then bi-monthly thereafter to assure cleanliness of the medication room and cart, that all opened vials and containers are dated and that all expired medications have been returned to the pharmacy or destroyed. 4. The results of these checks/audits will be taken to the facility QA&A Committee meetings. Recommendations will be made based on the findings of these	

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F 431	Continued From page 22 of intra-venous (IV) fluids was noted to be under the sink in the medication room. The label on the bag read: (resident name), 5 %dextrose and 0.45% Sodium chloride, from Therapeutic Solutions dated 6/27/2014, expiration date not clear nor visible. During an interview with the Director of Nursing DON on 3/19/15 at 12:06 pm the DON stated she expected that the nurse to label and date every vial and house stock bottle at the time of opening. She further indicated the medication carts should be cleaned when dirty. She also revealed that IV bag should have not been under sink and resident it was ordered for " had not been on that medication in a very long time. "	F 431	checks/audits.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the dish machine drainage system in a functional manner which would protect the safety of employees and prevent build-up of debris behind and under the dish machine unit. Findings included: During observation of the dish machine operation in the kitchen from 9:13 AM until 9:55 AM on 03/18/15 each time the dish machine emptied between the wash and final rinse cycles dirty water flowed over the filter pan and into the floor. About every other cycle water also backed up in	F 456	1. On 3-18-15 at 10:15am the Maintenance Department came into the kitchen to fix the dish machine. The Maintenance Department unclogged the 2 areas of the drainage system that were causing the issues. 2. All dietary staff were inserviced on 4-7-15 on what to do in the event of water not draining properly in the dish machine. 3. The Registered Dietitian or designated staff member will monitor the drainage of	4/16/15

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F 456	Continued From page 23 the drain below white piping connected to the filter pan. Dirty wash water with debris was running out into the kitchen floor anywhere from two to five feet from under the dish machine. Dietary employees were having to step in this water to operate the dish machine. At 9:57 AM on 03/18/15 the maintenance manager (MM) stated the dish machine drainage system should not be overflowing like it was. He reported there must a clog in the system somewhere. At 10:15 AM on 03/18/15 an employee working in the maintenance department reported there where clogs in two areas of the drainage system. He stated there was a clog in the white pipe leading from the filter pan to a floor drain, and in the floor drain itself. He commented there were straws, salt and pepper packets, etc in the floor drain. According to the employee, the maintenance department usually had to use a de-clogging product in the floor drain every couple of weeks to keep it opened and draining efficiently. He was unsure when a de-clogging product was last placed in the floor drain. He also remarked that no dietary staff informed him of a potential clog in the white piping system. At 11:25 AM on 03/18/15 the dietary manager (DM) stated the dish machine drainage system overflowed onto the kitchen floor ever since she began her job in May 2014. At 4:20 PM on 03/18/15 the PM cook stated there were problems with the dish machine drainage system periodically overflowing. She reported it took a lot of mopping to keep the kitchen floor around the dish machine dry and free of debris.	F 456	the dish machine during the wash cycle a minimum of 2 times per week x 4 weeks then monthly x 2 months to ensure that the machine is in proper working order. 4. The results of these audits will be taken to the facility QA&A Committee meeting. Recommendations will be made based on the findings of these audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING ______ B. WING ______	03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	2575 W 5TH STREET GREENVILLE, NC 27834

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F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility record review, the facility failed to train 1 of 5 employees (Laundry aide #1) in emergency procedures. Findings include: During an interview with Resident #50 on 3/16/15 at 4:25pm, the resident indicated the facility had a fire recently. The resident was not able to recall the exact date of the fire, but stated it started in the laundry and the fire department came to the facility. He further stated that the staff moved residents off the 300 hall to another hall away from the laundry. He stated he thought the fire started due to someone drying mop heads but wasn ' t a hundred percent sure that was the correct reason for the fire. He indicated that after the fire department came to the facility the residents were moved back to their rooms. During a tour of the laundry on 3/19/15 at 4:15pm, the laundry was noted to be clean. There were no machines running at the time of the tour. The dryers were empty and free from lint. The washing machine had a load of laundry inside the machine but it had completed the washing cycle. There was also a metal shelf in the laundry used	F 518	1. Laundry aide #1 was individually inserviced on 3-19-15 and 4-9-15 regarding what to do during a fire, pull stations and fire extinguishers. 2. All staff were inserviced on 4-8-15 and 4-14-15 regarding the Fire Training policy and procedure, evacuating residents, pull stations and fire extinguishers. 3. A minimum of 10 employees will be interviewed regarding emergency procedures / fire training and pull stations weekly x 3 weeks then monthly x 3 months to assure compliance with the facility fire training policy and procedure. 4. The results of these interviews will be taken to the facility QA&A Committee meetings. Recommendations will be made based on the findings of the interviews.	4/16/15

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F 518	Continued From page 25 for storage of linen. It was noted that several mop heads were on the bottom shelf. Above the metal shelf, it was apparent there had previously been a fire due to part of the ceiling missing and peeling, the sprinkler head appeared new and there were some remnants of black soot on the ceiling and on the wall around the shelf. The maintenance director was present during the tour of the laundry as well as one laundry aide. At 4:20 pm on 3/19/14 an interview was conducted with the maintenance director. The maintenance director stated he supervised housekeeping, laundry and maintenance. He further stated there had been a fire in the laundry previously. He stated that he was unable to determine the reason for the fire. During an interview with Laundry aide #1 on 3/19/14 at 4:22, the laundry aide stated she was working the night of the fire. When questioned about what started the fire, she responded that she did not know. Further questioning revealed the laundry aide washed and dried the mop heads the evening of the fire. She stated she did not know that the mop heads shouldn ' t be dried. She explained that after washing them, she put them in the dryer. After the cycle had stopped, the laundry aide stated it was about 20 minutes before she removed them from the dryer and put them on the shelf. She stated they were not hot or warm to the touch when she put them on the shelf. She further stated that she left the laundry and when she returned, she noticed smoke was in the laundry. The laundry aide said she closed the door and went to 100 hall to call her supervisor. During the interview, she stated she had never been trained in what to do in case of fire. She was not able to identify a red pull	F 518		

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

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F 518	Continued From page 26	F 518		

station. One pull station was on the right side of the laundry door in the hallway and one was across the hall in an alcove along with a fire extinguisher. She also stated she did not pull either box nor did she get the fire extinguisher because she didn ' t know to nor know how to use a fire extinguisher.

Another interview was conducted the maintenance director on 3/19/14 at 4:25pm. He indicated the laundry aide had been educated about what to do in case of fire when she was hired. The laundry aide interrupted him during the interview and stated: " No, I wasn ' t. "

The maintenance director was asked for the laundry aide ' s personnel file and any training she may have attended.

At 5:05pm, the administrator provided the laundry aide ' s personnel file. Review of the file revealed the laundry aide was hired in April of 2014. There was a check off list in the personnel file with the laundry aide ' s initials beside fire training and signed at the bottom of the page. No other documentation was produced to show this laundry aide had received any further training.

Another interview was conducted with the Laundry Aide at 5:15pm on 3/19/14. She stated if she put her initials on the sheet then she must have been told to during her first day. She stated again she had never been trained on what to do in case of fire or had ever participated in an actual fire drill.