STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		9/11/17

(b) Comprehensive Assessments

(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the
care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct
observation and communication with the resident, as well as communication with licensed and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/07/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to accurately assess a restraint device for one of twelve residents assessed, and for one of three residents assessed for having corrective lenses (Resident #101, Resident #16). Findings included: 1.Medical record review revealed Resident #101 was admitted to the facility on 12/23/2016 with diagnoses which included Anemia, Heart Disease, and Hypertension. The most recent Minimum Data Set (MDS) dated 7/7/2017 indicated Resident #101 was rarely/never understood and required extensive to total assist with all Activities of Daily Living (ADLs). The MDS indicated the resident did not have any restraints. The Care Area Assessment (CAA) indicated the resident was at a falls risk and used a winged mattress. The CAA for falls went to care plan and the winged mattress was included as a fall intervention. An observation of Resident #101 was conducted on 8/21/2017 at 2:20 PM. The resident was observed lying in bed. She was awake and moving around in the bed. There was a winged mattress in place with sides which were 16 inches	F 272	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center□s response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or other administrative or legal proceedings. Resident #101 winged mattress was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 272	Continued From page 2 high. The resident was observed attempting to place her legs over the raised sides of the mattress on the left side. A Nursing Assistant (NA) entered the room and talked to the resident and repositioned her in the bed. Review of the nursing notes revealed numerous notes of the resident throwing her legs over the winged mattress and staff repositioned the resident back in the bed. An interview was conducted with Nurse #7 on 8/23/2017 at 11:45 AM. Nurse #7 stated Resident #101 often attempted to get out of bed. Nurse #7 further stated the winged sides on the mattress kept the resident from getting out of bed. An interview was conducted with MDS Nurse #1 on 8/24/2017 at 9:31 AM. MDS Nurse #1 indicated she assessed Resident #101 for the MDS assessments. MDS Nurse #1 reported the winged mattress was not coded as a restraint because the resident could move around in the bed. MDS Nurse #1 indicated the high sides on the mattress kept the resident from falling to the floor at times and it probably should have been coded as a restraint. An interview was conducted with the Administrator on 8/24/2017 at 10:35 AM. The Administrator stated the expectation was for all residents' assessments to be accurate. 2. A review of the medical record revealed Resident #16 was admitted 9/20/2016 with diagnoses of dementia with behaviors, schizophrenia, major depressive disorder and allergies.	F 272	assessed for appropriate use on 8-24-2017 by the Quality Improvement Nurse. The winged mattress was determined not to be appropriate for the prevention of falls by the Quality Improvement Nurse and removed on 8-24-17. The resident was placed on a regular mattress on 8-24-2017 by Quality Improvement Nurse. A progress note was entered into resident #101 medical record and the resident care plan and care guide was updated to address that the winged mattress was removed by the Quality Improvement Nurse on 8-24-17. On 8-25-17 resident #16 was assessed for use of corrective lenses by the MDS nurse. Resident #16 MDS assessment was modified on 8-25-17 by the MDS nurse to add use of corrective lenses. Resident #16 care plan and care guide was updated on 8-25-17 by the MDS nurse to reflect use of corrective lenses. A 100% audit was initiated on all residents with fall prevention devices to include resident #101 and residents that had a winged mattress on the bed, to ensure that the devices were accurately assessed to include use as a restraint by the Quality Improvement Nurse on 8-24-2017. There was one of four residents with a winged mattress that was determined to be a restraint per the RAI manual. On 8-29-2017, one of four residents care plan and care guide was updated to reflect the use of a physical restraint by the Quality Improvement Nurse. A 100% audit on all residents to assess restraint use per the RAI manual was completed on 9-6-2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 272

Continued From page 3

The Annual Minimum Data Set (MDS) dated 7/14/2017 noted Resident #16 to be cognitively intact and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person. The MDS indicated Resident #16 had impaired vision and did not have corrective lenses. The Care Area Assessment (CAA) did indicate the area of vision as a focus, but the area did not go to care plan. The CAA worksheet noted Resident #16 could read large print, had glaucoma and received medication for glaucoma. Both previous quarterly MDS assessments dated 3/17/2017 and 6/2/2017 noted Resident #16 had impaired vision and no corrective lenses.

On 8/23/2017 at 4:00 PM, Resident #16 was interviewed in her room and was noted to be in bed with glasses on. Resident #16 stated she had had glasses for a long time.

Both MDS nurses were interviewed on 8/23/2017 at 4:25 PM, and stated the assessment for vision consisted of holding up cards for residents to read. The MDS nurse who had done Resident #16's assessment stated she did not remember Resident #16 having glasses on and indicated, if the resident could not read the cards, there were cards with large print to be used. The MDS nurse stated she also interviewed staff members on all shifts regarding resident's vision.

On 8/24/2017 at 8:52 AM, Nursing Assistant (NA) #1 stated she had cared for Resident #16 regularly and Resident #16 always wore her glasses, especially if the Resident was watching television or reading her Bible.

F 272

by the MDS Coordinator and MDS nurse with oversight by the DON to ensure the MDS was coded accurately. No identified areas of concern were noted. A 100% audit on all residents to assess for corrective lenses use per the RAI manual was completed on 9-6-2017 by the MDS Coordinator and MDS Nurse with oversight by the DON with documentation of the assessment in the medical record.

The MDS Coordinator and MDS nurse were re-educated on the requirement of completing an accurate comprehensive assessment to include ensuring accurate assessment is completed on each resident for physical restraint and corrective lenses per the RAI manual guidelines on 8-28-2017 by the Administrator.

The DON will audit 10% of all comprehensive assessments completed during the previous week to include any assessments for resident #101 and #16 weekly x 8 weeks, then monthly x 1 month to ensure the assessment is accurate and complete to include assessing for restraints and corrective lenses and updating the resident care guide and care plan accordingly utilizing a Comprehensive Assessment QI Audit tool. The DON will reeducate the MDS Coordinator and MDS nurse and significant corrections to the MDS assessment will be completed as necessary for any identified areas of concerns during the audit. The Administrator will review and initial the a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 272	Continued From page 4 On 8/24/2017 at 11:21 AM, in an interview, the Administrator stated the expectation was the assessment would be correct.	F 272	Comprehensive Assessment QI Audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the Comprehensive Assessment QI Audit tool to the Executive Quality Improvement Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		9/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 431	Continued From page 5 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 observation, staff interview and record review, the facility failed to discard expired medications on two of five medication carts inspected. Findings included: On 8/24/2017 at 9:30 AM, during an inspection of the 400-hall medication cart, a container of liquid	F 431	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(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 431	Continued From page 6 cough medication had an expiration date of 7/17. A container of liquid antacid was found to have an expiration date of 2/17. The cart also contained liquid pain reliever / fever reducer with an expiration date of 5/17. There was a bottle of aspirin 325 milligrams (mg) with an expiration date of 5/17. On 8/24/2017 at 10:15 AM, the 700-hall medication cart was observed to have a container of liquid pain reliever / fever reducer with an expiration date of 12/16. In an interview on 8/24/2017 at 10:36 AM, the Director of Nursing stated her expectation was to have no expired medications.	F 431	residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center□s response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or other administrative or legal proceedings. The five expired medications from the 400 & 700 hall medication cart were immediately pulled from the medication carts by the staff nurse and returned to pharmacy per policy on 8/24/17. 100% audit was conducted on 8-24-17 by the DON, Patient Care Coordinator, Quality Improvement Nurse (QI Nurse), Staff Facilitator, MDS Coordinator, and MDS nurse of all medication carts and medication rooms to ensure no expired medications were stored in the medication carts and medication rooms. No expired medications were found on the medication carts or medication rooms. An in-service was initiated by the Staff Facilitator on 8-24-17 with 100% of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET** **SNOW HILL, NC 28580**

(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 431	Continued From page 7	F 431	licensed nurses and medication aides on checking medications before administration for expired dates and appropriately discarding expired medications per pharmacy policy. All newly hired licensed nurses and medication aides will be in-serviced on checking medications before administration for expired dates and appropriately discarding expired medications per pharmacy policy will be completed during orientation by the Staff Facilitator. Medication Carts and medication rooms will be monitored using a Medication cart/Expired medications QI Audit Tool to ensure all medication carts and medication rooms do not have expired medications stored by the DON, Patient Care Coordinator, Quality Improvement Nurse (QI nurse), Staff Facilitator, MDS Coordinator, MDS nurse to include nights and weekends, 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurse and medication aides will be immediately re-trained by the DON, Patient Care Coordinator, Quality Improvement Nurse (QI nurse), Staff Facilitator, MDS Coordinator, and MDS nurse for any identified areas of concern. The Administrator will review and initial the Medication cart/Expired medications QI Tool for completion and to ensure all areas of concerns were addressed weekly X 8 weeks and monthly X 1 month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	**1304 SE SECOND STREET SNOW HILL, NC 28580**

(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 431	Continued From page 8	F 431	The Administrator will forward the results of the Medication cart/Expired medications QI Tools to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly and review the Medication cart/Expired medications QI Audit tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	