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 _____	C 10/10/2018

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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey on 10/10/18 Event ID #ZY4D11 for NC00143755, NC00139818, and NC00143726	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow physician orders by not obtaining labs that were due within one week of admission for 1 of 5 residents (Resident #83) observed for unnecessary medications. Findings included: Resident #83 was admitted to the facility on 09/18/18. Diagnoses included, in part, fracture of left humerus, hyponatremia (low sodium in the blood), high blood pressure, anxiety, and osteomyelitis. The Minimum Data Set (MDS) dated 09/25/18 revealed the resident was cognitively aware. A review of the physician orders revealed an order on 09/18/18 to obtain bloodwork (labs) for a	F 684	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.	10/25/18

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

Electronically Signed | 10/25/2018

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F 684	Continued From page 1 Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), B12 Folate, Thyroid Stimulating Hormone (TSH), and Lipid Panel one week after admission (09/25/18). A review of the admitting physician orders written on the Medication Administration Record (MAR) revealed the resident required labs to be drawn one week after admission (9/25/18) for CBC, CMP, B12 Folate, TSH and Lipid Panel. A review of the lab results for Resident #83 revealed the physician ordered labs were not done until 10/02/18. The results were within normal limits. An interview was conducted with the Patient Care Coordinator Nurse (PCC) on 10/09/18 at 2:45 PM. The PCC stated she ordered labs upon admission (routine) per the facilities ' standing orders as well as any specific physician ordered labs. The PCC stated the process for ordering labs was to complete a lab slip provided by their lab of what was needed and she would place it on the phlebotomist ' s door mail holder for her to draw. The PCC stated the facility obtained their own labs and sent the samples to the lab company. The PCC reported she could not find any lab results for Resident #83 that were supposed to be collected on 09/25/18 per the order and could only could find resulting labs that were done on 10/02/18. The PCC reported the reason the lab did not get drawn was because she did not put a collect date on the lab slip. The PCC provided the lab slip and revealed there was no collection date written on the slip. The PCC confirmed labs should have been obtained on 09/25/18 and there should have been a collection date written on the lab slip to obtain the selected	F 684	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 process that lead to the deficiency was the Patient Care Coordinator (PCC) failed to place a collection date on lab slip for Resident #83 who had an order for CBC, CMP, B12 folate, and TSH and lipid panel to be drawn on 9-25-18. 100% audit was conducted on 10-9-2018 by the Quality Assurance (QA) Nurse, Patient Care Coordinator (PCC), Minimum Data Set (MDS) Coordinator, and MDS nurse of all physician orders for labs in the past 30 days. No areas of concerns identified. 100% audit was conducted on 10-9-2018 by the Patient Care Coordinator (PCC) of all discharge summaries for the past 30 days to ensure all labs were drawn per the discharge summary and Physician orders. No areas of concerns identified. 100% audit of all admissions for the past 30 days was completed on 10-9-2018 by the Patient Care Coordinator (PCC) to ensure all labs were completed per facility protocol and Physician orders. No areas of concerns identified.	

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F 684	Continued From page 2 labs on 09/25/18. The PCC reported if there were specific physician orders to obtain labs, they should have a collect date of when the physician wanted the labs drawn written on the lab slip. The phlebotomist was unavailable for an interview. The PCC stated the phlebotomist recently retired and was only available once per week. An interview was conducted with the facility physician on 10/09/18 at 2:10 PM. The physician stated he was aware of Resident #83 ' s hyponatremia. The physician stated his expectation of the nursing staff was to obtain the labs as ordered so the hyponatremia could be monitored. The physician stated if labs were ordered on a specific date, the order should have been carried out. An interview was conducted with the Director of Nursing (DON) on 10/10/18 at 6:00 PM. The DON revealed her expectations of the nursing staff was to complete the lab slip correctly to ensure the ordered labs were drawn on the date they were ordered.	F 684	100% in-service of all licensed nurses was initiated by the Staff Facilitator on following Physician orders to include labs, documentation of lab draw attempts/failures, Physician notification if unable to obtain lab as ordered, and Physician/Resident Representative (RR) notification of lab results with documentation in electronic record. In-service to be completed by 10-15-2018. All newly hired licensed nurses will be in-serviced by the Staff Facilitator in orientation on the following Physician orders to include labs, documentation of lab draw attempts/failures, MD notification if unable to obtain lab as ordered, and Physician /RR notification of lab results with documentation in electronic record by the Staff Facilitator. 25% of all lab orders from physician orders, admission orders and discharge summaries will be monitored to include resident # 83 by the Patient Care Coordinator (PCC) , MDS Coordinator, MDS Nurse, Quality Improvement Nurse (QI nurse) and Staff Facilitator utilizing a Lab Audit Tool, 3 times a week x 2 weeks then weekly x 1 month then monthly x 1 month to ensure all labs are drawn as per Physician order. All identified areas of concerns will be addressed immediately by the Director of Nursing (DON) to include staff re-training completed as indicated. DON/Administrator will review and initial lab audit weekly x 4 weeks then monthly x 2 months to ensure all labs completed per Physician order.	

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F 684	Continued From page 3	F 684	The Administrator will forward the results of the Lab Audit Tools to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Lab Audit Tools 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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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	F 761		10/25/18

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F 761	Continued From page 4 by: Based on observations and staff interviews the facility failed to: 1) dispose of 5 out of 12 expired insulin vials from 1 of 4 medication carts observed for medication storage for Resident # ' s 27, 35, 52, and 62; and 2) failed to date an insulin syringe when opened for 1 of 12 insulin medications observed on 1 of 4 carts for Resident #54; and 3) failed to dispose 1 out of 3 expired ointments on 1 out of 4 carts observed for medication storage for Resident #80. Findings included: 1) A medication storage observation was conducted on 10/09/18 at 8:15 AM with Nurse #5 on cart #1 for the 100 hall. The observation revealed 5 out 12 insulin vials were expired. Resident #27s insulin vial was opened on 08/08/18 and was good for 28 days once opened. Resident #35 ' s insulin vial was opened on 08/25/18 and was good for 28 days once opened. Resident #54 had two open vials of insulin, one was opened on 08/11/18 and one was opened on 08/23/18 of which both were good for 28 days once opened. Resident #62 ' s insulin vial was opened on 08/09/18 and was good for 42 days once opened. 2) During the medication storage observation of cart #1 for the 100 hall on 10/09/18 at 8:15, the observation revealed an insulin syringe for Resident #54 was not labeled with the date it was opened. An interview was conducted with Nurse #5 on 10/09/18 at 8:30 AM. Nurse #5 reported the nurses were responsible for checking and cleaning their medication carts daily. Nurse #5	F 761	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. The process that lead to the deficiency was the staff nurse failed to remove expired medications from the 100 hall and 700 hall medication carts. The expired insulin for resident #27, # 35, # 52, # 62 and # 2 were immediately removed from medication cart by the staff nurse and returned to pharmacy per policy on 10-9-2018. The insulin syringe for resident # 54 was immediately removed	

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F 761	Continued From page 5 confirmed the insulin vials were expired and should have been disposed of. Nurse #5 also confirmed when an insulin syringe or vial was opened, it was the nurse ' s responsibility to label the vial or syringe with the date that it was opened. Nurse #5 confirmed the syringe for Resident #54 was not dated upon opening. Nurse #5 stated she had not checked her cart for expired and dated medications. 3) During a medication storage observation on 10/09/18 at 7:30 AM on cart #7 for the 700 hall with Medication Aide (MA) #5, it was noted that an ointment for Resident #80 had expired on 09/15/18. An interview with MA #5 at 7:30 AM was conducted. The MA confirmed that the ointment for Resident #80 had expired. The MA revealed that all the nurses and medication aides were responsible for checking their medication cart daily for any expired medications and disposing them. An interview was conducted with the Director of Nursing (DON) on 10/10/18 at 6:00 PM. The DON reported her expectation of the nurses was for each nurse to check the medication carts daily and dispose of any expired medications as well as ensuring all insulin syringes and vials were dated upon opening.	F 761	from the medication cart by the staff nurse and returned to pharmacy per policy on 10-9-2018. The expired ointment for resident # 80 was immediately removed from the medication cart by the staff nurse and returned to pharmacy per policy on 10-9-2018. 100% audit was conducted on 10/9/2018 by the Director of Nursing (DON), Patient Care Coordinator (PCC) , Quality Improvement Nurse (QI Nurse), Staff Facilitator, Minimum Data Set (MDS) Coordinator, and MDS nurse of all medication carts to ensure no expired medications were stored in the medication carts. No expired medications were found on the medication carts. An in-service was initiated by the Staff Facilitator on 10-9-2018 with 100% of licensed nurses and medication aides to include nurse # 5 and medication aide # 5 on checking medications before administration for expired dates and appropriately discarding expired medications per pharmacy policy to be completed by 10-15-2018. All newly hired licensed nurses and medication aides will be in-serviced by the Staff Facilitator in orientation 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. 100 % of Medication Carts will be monitored using a Medication cart/Expired medications QI Audit Tool to ensure all	

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F 761	Continued From page 6	F 761	medication carts do not have expired medications stored on the carts by the DON, Patient Care Coordinator, Quality Improvement Nurse (QI nurse), Staff Facilitator, MDS Coordinator, MDS nurse 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurse and/or 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. The Administrator will forward the results of the Medication cart/ Expired Medication QI Audit tool to the Executive Committee monthly X 3 months. The Executive committee will meet monthly and review the Medication cart/ Expired Medication QI Audit tool and address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		10/25/18

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F 812	Continued From page 7 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry kitchenware prior to stacking it in storage. Findings included: During initial tour of the kitchen, beginning at 10:35 AM, 4 of 14 tray pans stacked on top of one another on a storage rack had moisture trapped inside of them. At this time the cook stated these tray pans were placed in storage the night before. At 9:26 AM on 10/10/18, during a follow-up tour of the kitchen, 4 of 4 eight-ounce cups stacked on top of one another had moisture trapped inside of them. At this time the Dietary Manager (DM) stated he thought these cups were stacked on the shelf earlier the same morning. At 12:12 PM on 10/10/18 the DM stated he educated some staff during one-on-one and small group discussions about the need to make sure kitchenware was dry and clean before placing it in storage. However, he reported he had not had the chance to cover the policy/procedure about	F 812	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	

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F 812	Continued From page 8 air drying kitchenware prior to placing it in storage with the dietary department as a whole. He commented he had a couple of new employees working the PM shift who may have stacked wet tray pans on top of one another, but he was unable to explain how the cups got stacked while they still had moisture inside of them. According to the DM, stacking kitchenware while it was wet increased the chance that bacteria could grow on it, thus posing a health risk for residents. At 12:38 PM on 10/10/18 a dietary aide stated she had worked in the facility for a good while, and she was previously educated that any and all kitchenware should be air dried before it was stacked in storage. She reported trapped moisture could cause mold to grow which could make residents very sick.	F 812	Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or other administrative or legal proceedings. The process that led to this deficiency was the facility failed to allow pans and cups to air dry and increased the opportunity for cross-contamination in 4/14 tray pans and 4/4 cups. On 10/8/18 a 100% audit of all tray pans was completed by the Dietary Manager with no negative findings. On 10/10/18 a 100% audit of all cups and tray pans was completed by the dietary manager with no negative findings. On 10/8/18 100% in-service with all dietary staff was initiated by the Dietary Manager in regards to Wet Nesting, Proper storage of dishes, pots, pans, and cups to include: 1. After washing pots, pan, and items must air dry, and be completely dry before storing items. 2. When items are stored wet it can create a breeding zone for bacteria to grow. 3. Make sure all dishes & pans are 100% clean and dry. No dietary staff will be allowed to work until in-service is completed. In-service will be completed by 10/9/2018. All newly hired dietary staff will be trained during orientation by the Dietary Manager	

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F 812	Continued From page 9	F 812	on Wet Nesting, Proper storage of dishes, pots, pans, and cups to include: 1. After washing pots, pan, and items must air dry, and be completely dry before storing items. 2. When items are stored wet it can create a breeding zone for bacteria to grow. 3. Make sure all dishes & pans are 100% clean and dry. Dietary Manager or designee will audit all glasses and tray pans 5 x week, 2 x day x 30 days, then 2 x week, 2 x days x 1 month then 1 x week, 2 x day x 1 month. The Administrator will review and sign the Dietary Audit Tool weekly for 8 weeks, then monthly for one month to ensure all areas of concern were addressed. The Quality Assurance Nurse will forward the results of the Dietary Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Dietary Audit Tool 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 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		10/25/18

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F 867	Continued From page 10 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility quality assurance (QA) committee failed to prevent the occurrence of deficient practice related to removing expired medication from the medication storage carts which resulted in a repeat deficiency at F761. The re-citing of the F761 during the last year of federal survey history showed a pattern of the facility ' s inability to sustain an effective QA program. Findings included: F761: Medication Storage - Based on observations and staff interviews the facility failed to remove 6 out of 12 expired medications from 2 of 4 medications carts reviewed for medication storage. A review of the facility ' s survey history revealed F761 was cited during the facility ' s 08/24/17 annual recertification survey and was recited during the current 10/10/18 annual recertification survey. An interview was conducted with the Director of Nursing (DON) on 10/10/18 at 6:00 PM. The DON stated the deficiency reappeared due to the nurses ' and the nurse managers ' lack of attention in monitoring their medication carts.	F 867	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. On 10-10-2018 The Administrator, Director of Nursing (DON) and Quality Improvement (QI) Nurse were educated by the Facility Nurse Consultant on the QI process, to include implementation of	

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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 867	Continued From page 11	F 867	Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. On 10-10-2018 100% audit was completed by Administrator of previous citations and action plans within the past year to include medication storage/expired medication to ensure that the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. All data collected for identified areas of concerns to include medication cart audit tool will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Quality	

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F 867	Continued From page 12	F 867	Improvement (QI) nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include medication storage/expired medication and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	