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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING B. WING JAN 04 2012	12/15/2011

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

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F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to develop a care plan for falls for 1 of 3 sampled residents (Resident # 61) that experienced a fall, failed to develop a discharge care plan for 1 of 1 sampled residents (Resident # 61) that expressed a desire to return to the community and failed to develop a nutritional care plan for 1 of 4 sampled residents (Resident # 35) that experienced weight loss. Findings include: 1. A. Resident # 61 was admitted on 08/02/11	F 279	1. A discharge care plan and a falls care plan were developed for resident #61 on 12-15-11. A nutritional care plan was developed for resident #35 on 12-15-11. 2. All residents care plans will be audited by a MDS staff member by 1-12-12 to identify residents who are at a high risk for falls based on the most recent Fall Risk Assessment score (10 or above equals high risk) and those residents who have fallen in the past 6 months. The Falls Risk Assessment is completed upon admission and quarterly on each resident. Identified residents will have a care plan for falls developed.	1-12-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE: Administrator
(X6) DATE: 12-30-2011

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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F 279	Continued From page 1 with cumulative diagnoses of pressure ulcer on her left heel, hypertension, diabetes, peripheral vascular disease, stroke with left hemiparesis, vascular dementia, anxiety, and generalized muscle weakness. A Fall Risk Assessment completed on 08/02/11, scored Resident # 61 as a 14 (10 or above equaled high risk). The assessment directed the staff if the person was identified as high risk, a prevention protocol should be initiated immediately and documented on the care plan. Review of the care plan indicated no plan for falls or interventions to prevent falls. A Quarterly Minimum Data Set (MDS), dated 10/27/11, indicated Resident # 61 was usually understood and usually able to understand others. She was identified as having moderately impaired vision without the use of corrective lenses. Resident # 61 was identified as moderately cognitively impaired (11/15). She was not identified as having behaviors or rejection of care. Resident # 61 was identified as requiring extensive assistance with bed mobility, transfer and locomotion. Ambulation was coded as did not occur. She was identified as requiring extensive assistance for toilet use and personal hygiene. The resident was coded as having impairment in functional range of motion of both lower extremities. No mobility device was identified as used by the resident. Resident # 61 was not identified as having falls since the previous assessment. There was no plan to prevent falls added. The resident's care plan, last reviewed on 10/28/11, did not address falls.	F 279	All residents care plans will be audited by the Social Worker by 1-12-12 to identify residents who do not have a discharge care plan developed. All residents identified will have a care plan for discharge developed. All residents care plans will be audited by the Registered Dietitian/Dietary Manager by 1-12-12 to identify residents who need nutritional care plan developed. Residents who have had a weight loss/gain of 5% x 1 month or 10% x 6 months will have a nutritional care plan developed. All residents identified will have a care plan for nutrition developed.	1-12-12

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F 279	Continued From page 2 Interdisciplinary Progress Notes, dated 12/01/11 at 8:25 AM indicated the resident was found on the floor. Staff documented Resident # 61 stated she had hit her head. Vital signs were taken and the resident was placed back to bed. Emergency services was called and transported the resident to the hospital for evaluation. At 10:30 AM, the note indicated Resident # 61 returned to the facility. The facility Incident/Accident Report, dated 12/01/11, indicated Resident # 61 was found on the floor. The nurse documented the resident stated she hit her head. Under additional comments and/or steps taken to prevent recurrence, the facility indicted therapy would be contacted to discuss the resident's fall and would offer services. Review of the care plan indicated the 12/01/11 fall or interventions to prevent future falls were not added to the care plan. An interview was held with the resident on 12/15/11 at 8:50 AM. The bed was observed in the high position. The side rail was raised on the left side of the bed. On the right side, the rail was down with the overbed table placed against the bed. There were no alarms or floor mats seen. On interview, the resident stated she remembered the fall, but was unable to recall what had made her fall. She stated she guessed she had been asleep and rolled out of bed. An interview was held with Nurse # 2 on 12/15/11. Nurse # 2 stated he responded to Resident # 61's fall on 12/01/11. When he entered the room, the resident was lying by the side of the bed with her head was near the foot of	F 279	3. All new admission charts will be audited weekly by the MDS Coordinator and/or MDS Nurse to ensure that those residents with a fall risk assessment score of 10 or greater have a falls risk care plan developed. All falls will be reviewed daily in the morning interdisciplinary care management meeting and residents reported as having a fall based on the 24 hour report sheets will have a falls risk care plan developed. All new admission charts will be audited weekly by the Social Worker to ensure that a discharge care plan has been developed.	1-12-12

pages replaced.

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F 279	Continued From page 3 the bed and her feet propped on the wall near the head of the bed. Both side rails were up. The bed was in the low position with the head of the bed raised 30 to 45 degrees. The resident did not have a history of falls and the nurse stated he was not aware of any previous falls. Measures placed to prevent from further falls included referring to therapy for review. The resident told the nurse she had flipped out the bed and hit her head. No immediate interventions were placed at the time of the fall to protect the resident from further falls. Nurse # 2 stated falls were discussed in morning meeting and a weekly fall meeting. Morning meeting was attended by Department Heads, including the MDS Coordinator. Nurse # 2 stated the policy of the facility as to involve MDS in discussions regarding interventions to prevent falls. An interview was held with the Director of Nursing (DON) on 12/15/11 at 2:13 PM. Falls were discussed in morning meeting that was attended by all department heads including the MDS nurse. The DON stated the expectation was for all falls to be care planned as they occurred. Even if it were an isolated incident, the DON stated the fall should be care planned since at the time it would be hard to determine if Resident # 61's fall had been isolated. An interview was held with the Administrator on 12/15/11 at 2:37 PM. Accidents and incidents were discussed in stand up meeting every morning. The meeting was attended by all department heads including the MDS Coordinator. The Administrator stated the expectation was for accidents and injuries to be care planned.	F 279	All new admission charts will be audited weekly by the Registered Dietitian/Dietary Manager to ensure that those residents who are at a nutritional risk based on past history of poor nutrition, diagnosis and resident/family interview have a nutritional care plan developed. Those residents identified as having a weight loss/gain of 5% in 1 month or 10% in 6 months will have a nutritional care plan developed. 4. The Quality Assurance & Assessment (QA&A) Committee will review audits and findings to determine trends and establish corrective action based on findings.	1-12-12

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F 279	Continued From page 4 An interview was held with the MDS Coordinator on 12/15/11 at 2:53 PM. The MDS Coordinator stated the purpose of a care plan was to identify problems or potential problems, formulate a goal and interventions to reach that goal. The care plan also helped give the staff information in order to take care of residents. The information about residents was shared in morning meetings. This would include information such as resident falls. The MDS Coordinator stated she also received a weekly fall sheet after the fall meeting which listed residents that had sustained falls. The MDS Coordinator stated If an existing care plan for falls was not in place and a resident fell, a fall care plan was initiated. The MDS nurse stated she was aware Resident # 61 had fallen and stated the resident had a fall care plan. After review of the resident's care plan, the MDS nurse stated she had not realized Resident # 61 did not have a care plan for falls or the potential for falls. B. Resident # 61 was admitted on 08/02/11 with cumulative diagnoses of pressure ulcer on her left heel, hypertension, diabetes, peripheral vascular disease, stroke with left hemiparesis, vascular dementia, anxiety, and generalized muscle weakness. Social Work (SW) Progress Notes, dated 08/09/11, indicated Resident # 61 had no pending discharge plans. There was no documentation that indicated the resident and/or family had been involved in the discussion regarding discharge. The Admission Minimum Data Set (MDS), dated 08/10/11, indicated both the resident and family	F 279		

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F 279	Continued From page 5 participated in the assessment. The overall resident expectation of Resident # 61 was to remain in the facility. A determination was made that discharge to the community was not feasible. The most current SW Progress note, dated 10/21/11, indicated the resident was appropriate for long term care. No mention of discharge plans was seen. There was no documentation that indicated the resident and/or family had been involved in the discussion regarding discharge. A Quarterly MDS, dated 10/27/11, indicated Resident # 61 was usually understood and usually was able to understand others. Resident # 61 was identified as moderately cognitively impaired (11/15). .The MDS indicated the resident participated in the assessment process. The MDS also indicated return to the community was not feasible. There was no documentation that indicated the resident and/or family had been involved in the discussion regarding discharge. The resident's care plan, last reviewed on 10/28/11, did not address community discharge. On 11/10/11, the Registered Dietician documented the Responsible Party stated Resident # 35 had told him she was not going to eat because she wanted to go home. An interview was held with Resident # 61 on 12/15/11 at 8:50 AM. The resident stated she would rather be home, but was unsure if there was anyone available to care for her. She stated if no one was available, then she was content to stay at the facility.	F 279		

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F 279	Continued From page 6 An interview was held with the SW on 12/15/11 at 9:54 AM. The SW stated discharge plans were started when a note was received from therapy regarding the process. On admission, during the resident/family interview, questions were asked about discharge plans. An assessment was also included on the resident. The resident was asked about their desire to go back to the community. If the resident expressed a desire to return home, then she, the SW contacted local agencies. The SW stated conversations with the resident and/or family was documented in the Social Work Progress Notes. The SW stated discharge plans were formulated on both long and short term stay residents. The SW stated residents that were moderately cognitively impaired were able to make decisions regarding discharge. The SW stated she had talked with both Resident # 61 and her Responsible Party about potential discharge and both agreed there was no one to take care of the resident. The SW stated Resident # 61 had not expressed any desire for home discharge, therefore, no discharge plans or referrals had been made. The SW stated she had no documentation of the conversations. She stated on facility admission, the hospital SW informed her, Resident # 61 would be a long term resident. The SW stated she was responsible for discharge planning. Nurse # 2, who acted as the Unit Manager for Resident # 61, stated on 12/15/11 at 1:19 PM , that he was unsure if Resident # 61 had anyone to care for her if she were discharged. The UM stated with the resident's wound and the need for extensive/total care for activities of daily living, it was not feasible for the resident to return to the home at this time.	F 279		

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F 279	Continued From page 7 An interview was held with RD on 12/15/11 at 1:29 PM. She identified herself as the author of the November 2011 note where the Responsible Party informed her Resident #61 would not eat because she wanted to go home. The RD stated she could not remember if she provided that information to another staff member. The RD stated a care plan should have been developed since the resident stated she was not eating because she wanted to go home. Review of the care plan indicated no care plan for the behaviors nor were discharge plans seen. The RD stated the resident seemed to be alert, oriented and able to relay wants and needs. An interview was held with the Director of Nursing (DON) on 12/15/11 at 2:16 PM. The DON stated discharge planning should start on admission. The expectation was for interviews with residents/Responsible Party's to be documented in the appropriate section of the chart. Information/communication about any resident issue should be shared during morning meetings. The Administrator was interviewed on 12/15/11 at 2:40 PM. He stated the expectation was for staff to communicate resident needs during morning meeting. He stated he would have expected to see a care plan for Resident # 61's behavior and for her desire to return to the community. An interview was held with the MDS Coordinator on 12/15/11 at 3:01 PM. The MDS Coordinator stated the SW was responsible for care planning discharges. The discharge plan was initiated when there was a potential discharge. The SW was also responsible for care planning behaviors.	F 279		

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F 279	Continued From page 8 The MDS nurse stated she was not aware the resident had verbalized a desire to go home. The MDS nurse stated she was not aware the resident had said she was not going to eat because she wanted to go home. The MDS Coordinator stated a behavior that impacted the physical, mental and emotional well being of a resident should be care planned. A care plan should be in place to deal with the resident's desire to go home and the fact that returning home was not feasible. The MDS nurse then stated she was not sure the desire to go home and the feasibility issue should be care planned. 2. Resident # 35 was admitted on 07/20/09 and most recently readmitted on 02/28/11 with cumulative diagnoses of spinal stenosis, hypertension, vascular dementia, atria fibrillation, debility, edema and leg varicosity, pleural effusion, pulmonary collapse, anemia, Stage III chronic renal failure, adult failure to thrive and cardiomegaly. Review of the Monthly Record of Vital Signs and Weights indicated no weight had been recorded for Resident # 35 from January 2011 through October 2011. In the blank reserved for weight was the word "hospice". The Nutritional Progress Note, dated 05/20/11, indicated an annual review had been completed for Resident # 35. The Registered Dietician (RD) documented the resident's diet was regular with ice cream at lunch and dinner. Current body weight was listed as 107.4 pounds. She added the resident was no longer being weighed by the facility since she was under hospice care. Estimated energy needs were calculated as 1220	F 279		

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F 279	Continued From page 9	F 279		

calories, 49 grams of protein and 1220 cubic centimeters (cc's) of water per day. The RD documented the resident was able to feed herself after set up and would at times consume 100% of meals. She documented labs from 04/01/11 indicated the resident's electrolytes were within a normal limit. There was no care plan indicating the resident was at nutritional risk.

The Nutritional Progress Note, dated 10/25/11, indicated the last weight was obtained in January 2010 at 107.4 pounds. The Registered Dietician (RD) added the weight for Resident # 35 was not being obtained due to hospice care and facility protocol. The RD documented she spoke with staff that reported the resident's intake varied from 25% to 75% with no reported trouble chewing or swallowing a regular diet. The note indicated Resident # 35 received ice cream at lunch and dinner. There was no care plan indicating nutritional risk or interventions to prevent nutritional decline.

A Quarterly MDS, dated 10/27/11, indicated Resident # 35 usually understood and was able to usually understand. Her vision was coded as moderately impaired with the use of corrective lenses. Resident # 35 was identified as having both short and long term memory impairment with severely impaired cognitive skills for daily decision making. No behaviors were coded for Resident # 35. She was coded as independent with eating.

Review of the care plan with a problem onset date of 10/27/11 did not care plan the resident's failure to thrive, weight loss or interventions to prevent weight loss for Resident # 35.

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F 279	Continued From page 10 A Care Conference Signature Sheet indicated the care plan was reviewed on 11/16/11. The determination was made to continue the care plan through the next review. There was no care plan added to address nutritional risk. On 11/19/11 at 10:00 PM, a nurse documented the resident ate in her room. Resident # 35's appetite was described as fair with a usual intake of 50%. There was no care plan that indicated decreased intake or nutritional risk. The December 2011 Physician's orders indicated Resident # 35 received a regular diet. Orders also included ice cream at lunch and dinner to halt weight loss. Review of the care plan did not indicate a nutritional care plan had been devised that included interventions to identify potential weight loss. The December 2011 weight for Resident # 35 was recorded as 103.7 pounds. This reflected a 6.8 pound weight loss in one month or greater than 5% (indicated significant weight loss). The significant weight loss had not been care planned. There was no care plan that identified Resident # 35 had potential for weight loss. An interview was held with Nurse # 2, who acted as Unit Manager, on 12/15/11 at 1:08 PM. The nurse stated if a resident was on Hospice, they were not weighed monthly since weight loss was expected. Measurements of weights were dictated by Hospice. Nurse # 2 stated Resident # 35's appetite varied from day to day. He stated he thought the resident received supervision during meals and had to be supervision because	F 279		

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F 279	Continued From page 11 she sometimes played in her food rather than eating. An interview was held with the RD on 12/15/11 at 1:38 PM. The RD stated she was in the building on a daily basis Monday through Friday. Nutritional issues were discussed during stand up meeting every morning and weekly at the Wound and Weight Meeting. Routine weights were stopped on those residents on Hospice. The RD stated the former administrator had instructed her to stop tracking weight for residents on Hospice because weight loss was expected. The RD added that she had seen residents discharged from hospice. The RD stated she was unsure where the weights listed for Nov & Dec came from. There had been no new nutritional interventions for Resident # 35 since January 2010. The RD stated residents on Hospice still needed to be weighed and weights tracked and appropriate interventions implemented. She added she had stopped tracking weights because she had been instructed to do so. The RD stated she did not care plan nutritional issues since weights were not tracked. An interview was held with the Director of Nursing (DON) on 12/15/11 at 2:18 PM. The DON stated Hospice residents were excluded from monthly weights. A former administrator decided a year or two ago that monthly weights were not to be completed on Hospice residents. Hospice continued to ask for weights, so the facility would get them anyway. Hospice residents that lose weight should still be provided interventions to maintain weight. The DON stated a resident's potential weight loss, decision not to monitor a	F 279		

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F 279	Continued From page 12 resident's weight or actual weight loss should be care planned. The DON stated the December weight reflected a significant weight loss. She added the November weight was probably obtained at the request of Hospice. On the DON's review of the resident's care plan, no care plan to address nutritional issues was found. An interview was held with the Administrator on 12/15/11 at 2:31 PM. The Administrator stated if a resident had significant weight loss the weight loss should be care planned. If the resident was not to be weighed then either a care plan or documentation in the dietary notes or nurse's notes should be found.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. A care plan to reflect the use of support hose to help control edema was developed for resident #48 on 12-15-11. The care plan for resident #80 was updated to reflect the discontinuation of splinting for contracture management on 12-15-11.	1-12-12

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 ______	12/15/2011

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

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F 280	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to update care plans for 2 of 21 sampled residents (Resident #48 and #80) whose care plans were reviewed. Resident #48's care plan was not updated to reflect the use of support hose to help control edema. Resident #80's care plan was not updated to reflect the discontinuation of splinting for contracture management. Findings include: 1. Resident #48 was admitted to the facility on 03/25/11 and readmitted on 10/28/11 and 11/26/11. The resident's documented diagnoses included history of femoral/popliteal bypass (in August 2011), peripheral vascular disease, right leg edema and cellulitis, right great toe amputation, left below the knee amputation, and diabetes. A 11/11/11 consult documented for Resident #48 to "elevate leg & (and) daily support stockings to control swelling (of right lower leg)." A 11/22/11 physician order for Resident #48 documented, "Thigh high Ted hose measurements = thigh 23 " (inches), length 26", calf 14". Apply while OOB (out of bed). Remove at hs (night)." Resident #48's Nurse Aide's Information Sheet documented, "Thigh high ted on OOB, off HS." Review of Resident #48's December 2011 Medication Administration Record (MAR)	F 280	2. All residents charts will be audited by the MDS Coordinator and/or MDS Nurse by 1-9-12 to identify residents who have physician orders for support hose to control edema. Identified residents will have their care plan update to include the use of support hose to control edema. The MDS Coordinator and/or MDS Nurse will obtain a list of residents from the Rehab Director and Restorative Nurse to identify all residents who are currently using splints to ensure that the identified residents care plans have been updated regarding the use of splints. Of the residents identified, the care plans will be audited by the MDS Coordinator/MDS Nurse by 1-9-12 to ensure that only those residents listed have a care plan implemented for the use of splints.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 14 revealed beginning on 12/01/11 the application or the lack of application of support hose for the resident was being documented. Resident #48's care plan, last updated on 12/05/11, identified "Resident is at risk for complications due to edema site cellulitis (right) leg/foot" as a problem. However, the use of support hose was not documented as an intervention to the problem. At 1:22 PM on 12/15/11 Nurse #4 stated support hose were ordered from the pharmacy for Resident #48 because of swelling in his right leg. She commented Resident #48's support hose were received in the facility, from the pharmacy, during the first week of December 2011. This nurse reported the nursing assistants (NAs) applied the support hose to residents. At 4:30 PM on 12/15/11 Nurse #5 (a MDS nurse) stated resident care plans were updated at least quarterly. However, she explained the MDS personnel received the pink copies of physician orders in morning meetings or in their mail boxes. Nurse #5 reported that care plans were updated following review of these copies. This nurse commented she would need to check with the MDS Coordinator to make sure the use of support hose would be captured as a new intervention in the care plan for a resident who experienced edema and had a history of leg and toe amputation. Nurse #5 returned to report that the MDS Coordinator stated that initiation of support hose under such conditions should have been added to the resident care plan as a new intervention for management of edema and cellulitis.	F 280	3. All physician orders from the previous day will be reviewed in the daily morning interdisciplinary care management meeting to identify residents with new orders for support hose. Identified residents will have their care plan updated and/or a new care plan implemented to reflect the use of support hose. The Rehab Director will give the MDS Coordinator/MDS Nurse will give a copy of the Rehab Instruction Record daily. The Rehab Instruction Record identifies those residents who utilize splints. This record will be used to identify residents who need to have a new care plan implemented or an existing care plan updated to reflect the use of splints.	1-12-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

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F 280	Continued From page 15 2. Resident #80 was admitted to the facility on 02/19/08 with diagnoses of hypertension, cerebral vascular accident with left hemiplegia, and joint contractures. An annual Minimum Data Set assessment completed on 11/24/11 documented Resident #111 as having moderate cognitive impairment and functional limitation range of motion present on one side of his upper and lower extremities. Review of Resident #111's December 2010 Rehabilitation/Restorative Service Delivery Record, under the summary note section; documented the left hand splint had been discontinued due to refusals, removals, and lack of participation. Review of Resident #111's Care Plan reflected reviews had been done on 06/21/11, 09/08/11 and 12/05/11. Under the problems section, it was documented; "resident is exhibiting non-compliance behavior :application of hand splint, removing hand splint." Approaches listed were to encourage resident to wear hand splint; praise resident when he wears hand splint; and counsel resident on medical complications of not wearing hand splint. Observations made of Resident #111 on 12/13/11 at 2:05 PM and at 3:40 PM revealed Resident #111 sitting in a geri chair in his room holding his left hand clenched and no splint present. When	F 280	Audits of the care plans of the identified residents with who utilize support hose and splints will be done weekly x 4 weeks then monthly x 4 months to assure compliance. 4. The Quality Assurance & Assessment (QA&A) Committee will review audits and to determine trends and establish corrective action based on findings.	1-12-12

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F 280	Continued From page 16 asked if he had a splint for his hand, Resident #111 responded he did not want it on and demonstrated that he was able to open up his left hand last three fingers and partially open his left thumb and forefinger. In an interview with Resident #111's family member on 12/13/11 at 2:05 PM, the family member said Resident #111 had a splint for his left hand but it had no longer been used as he kept taking it off. The family member said she had not been sure when she saw the splint last. Observations made on 12/14/11 at 9:05 AM revealed Resident #111 lying in bed with his left hand clenched and no splint present. Additional observations made on 12/14/11 at 11:30 AM and 4:25 PM revealed Resident #111 sitting in a geri chair in his room with his left hand clenched and no splint present. In an interview with Nurse #1 on 12/14/11 at 5:00 PM, she said Resident #111's splint had been discontinued as he kept taking it off. Nurse #1 said the MDS nurses were responsible for updating resident care plans and received copies of physician orders as well as updates in the morning clinical meetings. During an interview with Nurse Aide (NA) #1 on 12/15/11 at 8:46 AM, NA #1 said Resident #111 had a splint in the past for his left hand but he always removed it. NA #1 said she could not remember the last time she saw the splint in Resident #111's room. In an interview with the Administrator on 12/15/11 at 2:45 PM, the Administrator said if an	F 280		

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GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

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F 280	Continued From page 17 intervention had been discontinued, his expectation was the care plan was updated and the interventions removed. In an interview with the MDS Coordinator on 12/15/11 at 2:55 PM, she said care plans were reviewed quarterly and updated as necessary. The MDS Coordinator said information was shared at the daily clinical meetings as well as review of new physician orders. The MDS Coordinator said the Resident #111's care plan should have been updated when the arm splint had been discontinued. The MDS Coordinator said all interventions should be reviewed with each review and updated as appropriate.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow physician's orders for applying a barrier cream after incontinent care for 2 of 2 sampled residents (Resident #24 and Resident #86) whose care was observed. Findings include: 1. The facility's policy for Perineal Care/Incontinent Care for a female, last revised 11/10/09, noted that perineal care would be done after urination and bowel movements. Cream or ointment was to be applied according to physician's orders and a clean brief placed.	F 281	1. Employee counseling and individual inservices were conducted with Nursing Assistant #3 (who was assigned to Resident #86) on 12-27-11 and with Nursing Assistant #2 (who was assigned to Resident #24) on 12-28-11. The individual inservices consisted of the importance of following physician orders and applying barrier creams when ordered. Skills validations on applying barrier cream were completed on 12-29-11 and 12-30-11 for Nursing Assistants #2 and #3 by a licensed nurse.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 18 Resident #24 was admitted to the facility on 07/07/11. Cumulative diagnoses included hypertension, atrial fibrillation, anemia and gastroesophageal reflux disease. According to the nurse aide's information sheet for Resident #24, which was undated, the [brand name barrier cream] was to be applied after each incontinent episode. The Admission Minimum Data Set (MDS) of 07/14/11 1/0/2 indicated she required moderate assistance from staff for toilet use and total assistance for hygiene. The Care Area Assessment (CAA) detail included activities of daily living and urinary incontinence. The CAA for urinary incontinence indicated she was incontinent of bowel and bladder. The activities of daily living CAA indicated she was totally dependent on staff for all activities of daily living. The physician's December 2011 order sheet noted an order with an original date of 11/07/11 for application of [a brand name barrier cream] to the perineum and buttocks of Resident #24 after each incontinent episode. The order specified the cream could be kept at bedside for the nurse aides to apply. Resident #24's care plan, last reviewed 10/13/11, identified problems with being at risk for development of pressure ulcers related to bowel and bladder incontinence. Included in the approach section was to apply barrier cream to protect and prevent breakdown. Pericare was to be provided after each incontinent episode. On 12/14/2011 at 4:15PM, Nurse aide #2 (NA#2)	F 281	2. An audit was completed on all resident medical records to identify those residents with barrier cream orders. Barrier cream orders were rewritten on all residents to assure consistency with how the barrier cream physician orders were written. All barrier cream orders were written on the Nursing Assistant Care Cardexes. Nursing Staff were inserviced 12-27-11 thru 12-29-11 and on 1-3-12 regarding the importance of following physician orders and applying barrier cream as ordered and as specified in the resident's plan of care. Skills validations were conducted by Nursing Administration on all nursing assistants from 12-23-11 thru 1-12-12 to assure compliance with applying barrier cream.	1-12-12

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F 281	Continued From page 19 was observed using a mechanical lift to place Resident #24 into bed for incontinent care. Once she was in bed, NA#2 provided incontinent care. When NA#2 was finished, she placed a clean brief. She did not apply any type of barrier cream. NA #2 was interviewed after the observation at 4:59 PM on 12/14/2011. She stated she was trained to wash all areas front to back. When asked about use of [a brand name barrier cream] she reached into Resident #24's nightstand drawer for a container of barrier cream. NA#2 stated she should have applied the cream and she would clean Resident #24 again and apply the barrier cream. During an interview with Nurse #4, on 12/15/11 at 10:20 AM, she stated the nurse aides were expected to apply (brand name barrier cream] after each incontinent episode. She stated the cream was always available and kept at bedside. Nurse # 4 added that it was also written on the resident's nurse aide information sheet. During an interview with the Director of Nurses (DON), on 12/15/11 at 4:15 PM, she stated the nurse aide information sheet was their "bible". She stated aides were instructed in orientation to follow that sheet as it directed their care for the residents. She stated if a physician wrote an order for aides to apply cream then the aides were expected to apply it. The DON remarked that she expected nurse aides to apply [brand name cream] cream after each incontinent episode. She remarked the cream was used as prevention for skin breakdown.	F 281	3. Skillsl validations will be completed on a minimum of 6 Nursing Assistants on the application of barrier cream weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with application of barrier creams. New admission charts will be audited on admission to assure all barrier cream orders are written consistently and correctly. All new physician orders will be reviewed daily in the interdisciplinary team meeting to identify residents with new barrier cream orders and the Nursing Assistant Care Cardex will be updated appropriately.	1-12-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 20 2.. The facility's policy for Perineal Care/Incontinent Care for a female, last revised 11/10/09, noted that perineal care would be done after urination and bowel movements. In the procedure section, it was noted that cream or ointment was to be applied according to physician's orders and a clean brief placed. According to the nurse aide's information sheet for Resident #86 , which was undated, the [brand name barrier cream] was to be applied to the buttocks and perineum after each incontinent episode. Resident #86 was admitted the the facility on 09/14/08. Cumulative diagnoses included acute respiratory failure with a tracheostomy, bilateral above the knee amputations and hypertension. The Annual Minimum Data Set (MDS) of 07/25/11 indicated Resident #86 needed moderate to extensive assistance with toileting and hygiene. Included in the Care Area Assessment (CAA)detail was urinary incontinence. The most recent quarterly MDS of 10/10/11 indicated Resident # 86 was incontinent of both bowel and bladder and needed extensive assistance with hygiene and toilet use. Resident #86's care plan, last reviewed 10/14/11, identified a problem with being at risk for pressure ulcers related to bowel and bladder incontinence. Included in the approach section was to apply [brand name barrier cream] after each incontinent episode to protect the skin and	F 281	4. The skills validations on the application of barrier cream, any deficiencies found and the results of the new admission chart audits will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the findings of the skills validations and chart audits.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

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F 281	Continued From page 21 prevent breakdown. According to the December 2011 physician's order sheet found in Resident #86 's chart, [brand name barrier cream] was to be applied to the buttocks and perineum after each incontinent episode. It also indicated the cream could be left at bedside. During an observation of incontinent care on 12/14/11 at 3:456 PM, Nurse Aide #3 (NA#3) cleansed Resident #86 to remove stool. Once she had removed the stool, she placed a clean brief. She did not apply [brand name cream] to his perineum or buttocks area. It was noted Resident #86 had whitish healed areas to his skin on the sacral region from previous pressure ulcers. NA#3 was interviewed on 12/14/11 at 4:15 PM. She stated barrier creams were available for use and usually in the resident's rooms. She remarked the [brand name barrier cream] which she had taken from his night stand drawer could be used after incontinent episodes. She had no explanation as to why she did not apply the cream. During an interview with nurse #4, on 12/15/11 at 10:20 AM, she stated the nurse aides were expected to apply (brand name barrier cream] after each incontinent episode. She stated the cream was always available and kept at bedside. Nurse #4 added that it was also written on the resident's nurse aide information sheet. During an interview with the Director of Nurses (DON), on 12/15/11 at 4:15 PM, stated the nurse	F 281		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 22 aide information sheet was their "bible". She stated aides were instructed in orientation to follow that sheet as it directed their care for the residents. She stated if a physician wrote an order for aides to apply cream then the aides were expected to apply it. The DON remarked that she expected nurse aides to apply [brand name cream] cream after each incontinent episode. She added that Resident #86 had skin breakdown in the past and the cream was being used as prevention.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to apply support hose to 1 of 1 sampled residents (Resident #48) with physician orders for the application of support hose. Findings include: Resident #48 was admitted to the facility on 03/25/11 and readmitted on 10/28/11 and 11/26/11. The resident's documented diagnoses included history of femoral/popliteal bypass (in August 2011), peripheral vascular disease, right leg edema and cellulitis, right great toe amputation, left below the knee amputation, and	F 309	1. The staff caring for Resident #48 was inserviced 12-27-11 regarding the importance of following physician orders and following the resident's plan of care to apply Ted Hose as ordered.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 23 diabetes. A 11/11/11 consult documented for Resident #48 to "elevate leg & (and) daily support stockings to control swelling (of right lower leg)." A 11/22/11 physician order for Resident #48 documented, "Thigh high Ted hose measurements = thigh 23 " (inches), length 26", calf 14". Apply while OOB (out of bed). Remove at hs (night)." Resident #48's 11/26/11 quarterly minimum data set (MDS) documented his cognition was intact. Resident #48's Nurse Aide's Information Sheet documented, "Thigh high ted on OOB, off HS." Resident #48's December 2011 Medication Administration Record (MAR) documented the resident's support hose were applied on 12/02/11 through 12/05/11. Resident #48's care plan, last updated on 12/05/11, identified "Resident is at risk for complications due to edema site cellulitis (right) leg/foot" as a problem. Interventions to this problem included "Provide treatments/meds as ordered." The resident's December 2011 MAR documented the resident's support hose were applied 12/06/11 through 12/11/11. At 12:06 PM on 12/12/11 Resident #48 was eating lunch in the dining room. The resident was not wearing support hose on his right leg.	F 309	2. An audit of the medical records on the other residents in the facility was conducted on 12-26-11 to identify other residents utilizing Ted Hose to assure compliance with physician orders. All Ted Hose orders have been written on the Nursing Assistants Care Cardexs. The nursing staff was inserviced 12-27-11 thru 12-29-11 and 1-3-12 regarding the importance of following physician's orders to apply Ted Hose as ordered.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 24 At 4:26 PM on 12/12/11 Resident #48 was sitting in the hallway in his wheelchair. The resident did not have support hose on his right leg. At 11:47 AM on 12/13/11 Resident #48 was sitting outside the dining room in his wheelchair. The resident did not have support hose on his right leg. At 4:29 PM on 12/13/11 Resident #48 was in the television room in his wheelchair. The resident did not have support hose on his right leg. At 11:34 AM on 12/14/11 Resident #48 was sitting outside the dining room in his wheelchair. The resident did not have support hose on his right leg. At 4:11 PM on 12/14/11 Resident #48 was in the television room in his wheelchair. The resident did not have support hose on his right leg. At 9:39 AM on 12/15/11 Resident #48 was in his room. The resident did not have support hose on his right leg. At 11:19 AM on 12/15/11 Resident #48 stated he received his support hose from the pharmacy about a week ago. However, he stated no staff member had attempted to apply the support hose to his right leg yet. The resident stated the support hose were in a bag which was stored in a basket on top of his chest of drawers. The bag had not been opened. At 1:22 PM on 12/15/11 Nurse #4 stated support hose were ordered from the pharmacy for Resident #48 because of swelling in his right leg.	F 309	3. Audits will be conducted by Nursing Administration of the residents identified with Ted Hose orders will be done weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with application of the Ted Hose. New admission charts will be audited on admission to assure that all Ted Hose orders are written on the Nursing Assistant Care Cardex. All new physician orders will be reviewed daily in the interdisciplinary team meeting to identify residents with Ted Hose and the Nursing Assistant Care Cardex will be updated appropriately. 4. The results of these audits will be taken to the facility QA&A committee for review. The committee will make recommendations based on the findings of these audits	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 25 She commented Resident #48's support hose were received in the facility, from the pharmacy, during the first week of December 2011. This nurse reported the nursing assistants (NAs) applied the support hose to residents. According to Nurse #4, Resident #48 refused to wear the support hose sometimes. She explained the resident would occasionally remove the support hose and apply his regular socks. The nurse stated Resident #48 was alert, oriented, reliable, and interviewable. At 1:30 PM on 12/15/11 NA #2 initially stated she did not apply anything special to Resident #48's right leg/foot, and that he wore shorts and a regular sock on his right foot. Later, she reported the staff attempted to apply support hose to the resident's right leg because he could experience swelling in it. The NA commented the staff was getting support hose from the supply room, but the resident was fussing about having to wear them. However, she reported Resident #48 had never refused to wear the support hose; it just took a lot of encouragement to get him to put them on. NA #2 also stated the resident would sometimes remove the hose himself after staff applied them. According to the NA, Resident #48 was alert, oriented, reliable, and interviewable. At 1:40 PM on 12/15/11 NA #3 stated thigh high support hose had to be ordered through the pharmacy. She stated the facility did not keep extra support hose in the general supply room. At 2:04 PM on 12/15/11 the director of nursing (DON) stated a facility treatment nurse obtained measurements when a physician's order for support hose was ordered. She explained the	F 309		

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F 309	Continued From page 26 hose were ordered through the pharmacy/supply, and after they were received in the facility, NAs placed the hose on residents, and nurses observed to make sure they were applied correctly. According to the DON, she thought some support hose were also stocked in the supply room, although certain sizes might not be available at all times. At 2:38 PM on 12/15/11 treatment nurse (TN) #1 stated she measured Resident #48 for support hose,and ordered them through the pharmacy. She reported she did not think that thigh high support hose were kept in the supply room. At 3:15 PM on 12/15/11 the facility's supply clerk stated she was not aware that Resident #48 wore support hose. She reported that the facility did keep extra support hose only in the central supply room, including thigh high hose. However, she stated any supplies which were removed by staff to use in the care of residents had to be signed out so the resident accounts could be charged. The supply clerk pulled Resident #48's account up on the computer, and reported the resident had never been charged for any support hose which were removed from central supply.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	1. Nursing Assistant #2 (assigned to care for Resident #24) was counseled and an individual inservice was conducted on 12-29-11 regarding the importance of following the policy and procedure for proper incontinent care correctly. A skills validation was completed on 12-30-11 to assure compliance with proper incontinent care.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 27 by: Based on observation, record review and staff interviews, the facility failed to provide proper incontinent care for 1 of 2 sampled dependent residents (Resident #24) whose care was observed. Findings include: The facility's policy for Perineal Care/Incontinent Care for a female, last revised 11/10/09, noted that perineal care would be done after urination and bowel movements. In the procedure section, it was noted that the soiled brief should be removed and placed in a plastic bag. A wet washcloth with soap should be used. The labia should be separated with one hand and washed with the other. Gentle downward strokes to cleanse front to back to prevent intestinal organisms from contaminating the urethra or vagina. A clean section of the cloth should be used for each downward stroke. Gloves should be removed, hands washed and fresh gloves donned. The resident was to be turned onto their side. The anal area was to be cleansed in a front to back manner. Gloves should be removed after cleansing, hands washed and clean gloves donned. Cream or ointment was to be applied according to physician's orders and a clean brief placed. Resident #24 was admitted to the facility on 07/07/11. Cumulative diagnoses included hypertension, atrial fibrillation, anemia and gastroesophageal reflux disease. According to the nurse aide's information sheet for Resident #24, which was undated, the [brand name barrier cream] was to be applied after each incontinent episode.	F 312	2. Skills validations were conducted by Nursing Administration on all nursing assistants from 12-23-11 thru 1-12-12 to assure compliance with the Care/Incontinent Care Policy and to assure compliance with proper incontinent care. The nursing staff was inserviced on 12-27-11 thru 12-29-11 and on 1-3-12 regarding the importance of proper incontinent care. 3. Skills validations will be completed on a minimum of 6 Nursing Assistants on completing proper incontinent care weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with proper incontinent care.	1-12-12

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F 312	Continued From page 28 The Admission Minimum Data Set (MDS) of 07/14/11 1/0/2 indicated she required moderate assistance from staff for toilet use and total assistance for hygiene. The Care Area Assessment (CAA) detail included activities of daily living and urinary incontinence. The CAA for urinary incontinence indicated she was incontinent of bowel and bladder. The activities of daily living CAA indciated she was totally dependent on staff for all activities of daily living. The physician's December 2011 order sheet noted an order with an original date of 11/07/11 for application of [a brand name barrier cream] to the perineum and buttocks of Resident #24 after each incontinent episode. The order specified the cream could be kept at bedside for the nurse aides to apply. Resident #24's care plan, last reviewed 10/13/11, identified problems with being at risk for development of pressure ulcers related to bowel and bladder incontinence. Included in the approach section was to apply barrier cream to protect and prevent breakdown. Pericare was to be provided after each incontinent episode. On 12/14/2011 at 4:15PM, Nurse Aide #2 (NA#2) was observed using a mechanical lift to place Resident #24 into bed for incontinent care. Once she was in bed, NA#2 untaped her soiled brief and pushed it down between her legs, rolled her onto her left side, and placed a clean brief underneath the dirty one. While doing so, she stated she was placing the clean brief to prevent Resident #24 from wetting the bed during care. She added Resident #24 usually voided during	F 312	4. The skills validations on proper incontinent care and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the findings of the skills validations.	1-12-12

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F 312	Continued From page 29 care. NA#2 used disposable wipes to remove stool from the anal area wiping front to back. As she wiped, it was noted that Resident #24 voided a large amount of urine which seeped down between her legs onto her buttocks and the soiled brief. NA #2 did not use any wipes to remove the urine from the perineum or the left buttock. She rolled her onto her back. Resident #24 held her legs together. NA#2 used disposable wipes to push down into her groin areas to cleanse and down the middle of the vaginal area. She did not ask Resident #24 to open her legs nor did she try to open them to remove the urine that had visibly pooled between her legs. The urine also had flowed over and ran down the upper left and right thighs. NA #2 did not wash to remove the urine from her upper thighs nor did she cleanse the perineal area to remove the urine. NA #2 did not roll Resident #24 back onto her side to clean the buttocks and perineal area after she voided. She pulled the clean brief that she had placed underneath her at the beginning of care up between her legs and taped it in place. She did not apply any type of barrier cream. NA #2 was interviewed after the observation at 4:59PM on 12/14/2011. She stated she was trained to wash all areas front to back. When questioned about her procedure, she stated she always placed a diaper on the bed because Resident #24 always voided when she was being washed. She stated she always washed her behind first due to the fact that she would void. when questioned as to reason she did not cleanse the buttocks and inner thighs NA#2 commented she was nervous with being observed and did not cleanse Resident #24's buttocks and inner thighs. When asked about	F 312		

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F 312	Continued From page 30 use of [a brand name barrier cream] she reached into Resident #24's nightstand drawer for a container of barrier cream and stated she should have applied it after she cleansed Resident #24. NA#2 stated she would clean Resident #24 again. NA#2 commented that it was difficult to open Resident #24's legs to wash her inner thighs. She stated when an incontinent resident voided, the urine went everywhere and she should have cleaned her better. During an interview with nurse #4, on 12/15/11 at 10:20 AM, she stated the nurse aides were expected to apply (brand name barrier cream] after each incontinent episode. She stated the cream was always available and kept at bedside. Nurse #4 added that it was also written on the resident's nurse aide information sheet. During an interview with the Director of Nurses (DON), on 12/15/11 at 4:15 PM, stated the nurse aide information sheet was their "bible". She stated aides were instructed in orientation to follow that sheet as it directed their care for the residents. She stated if a physician wrote an order for aides to apply cream then the aides were expected to apply it. The DON remarked that she expected nurse aides to provide [brand name cream] cream after each incontinent episode. The DON stated she expected staff to thoroughly clenase residents after they were soiled. She stated if a resident voided during care she expected the staff member to go back and cleanse the resident again to remove the urine from her skin. The DON commented staff should cleanse the buttocks, the anal area, the entire perineum as well as any other areas which had come into contact with urine. The DON	F 312		

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

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F 312	Continued From page 31 remarked the cream was being used as a preventative measure to prevent skin breakdown.	F 312		
F 364 SS=D	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 temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to preserve the nutrient content of a green vegetable by exposing it to prolonged heat on the stove and steam table. Findings include: During food preparation observation on 12/14/11 at 9:28 AM green peas were at a full boil on the stove in the kitchen. At 9:48 AM on 12/14/11 the cook reduced the heat of the stove burner under the green peas, but they continued to cook at a light boil until 10:30 AM. At 10:30 AM on 12/14/11 the cook removed the green peas from the stove, and transferred them in a tray pan which was placed into a well of the steam table which was set on high. At 10:34 AM on 12/14/11 the cook stated the green peas were the alternate for the lunch meal. He reported tray line temperatures were taken on foods served for lunch around 11:45 AM, and the tray line began operation at approximately 11:50	F 364	1. The cook on duty on 12-14-11 was inserviced on 12-16-11 on the importance of not exposing green vegetables to prolonged heat due to the possible loss of nutrient content of the vegetable. 2. All dietary employee will be inserviced by 1-12-12 on the importance of cooking vegetable to ensure that they are not exposed to prolonged heat to ensure that they retain their nutritional value. The Registered Dietitian/Dietary Manager will audit the Vegetable Cooking Sheets to ensure that green vegetables are not being exposed to prolonged heat.	1-12-12

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

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F 364	Continued From page 32 AM. At 9:42 AM on 12/15/11 a dietary employee stated when she had cooking duties in the kitchen she placed her vegetables for the lunch meal on the steam table around 10:45 AM with tray line beginning operation between 11:45 AM and 11:50 AM. She commented she wanted the vegetables on the steam table long enough that they would register at least 165 degrees Fahrenheit when checked using a calibrated thermometer as the tray line started up. However, she reported it was important not to overcook vegetables because they became mushy. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated green, orange, red, and yellow vegetables should not be placed on the steam table more than fifteen minutes before the tray line began operation. The acting DM explained the longer these vegetables were exposed to heat, the greater the chance some of their vitamin and mineral content would be destroyed.	F 364	3. The cook on duty will be responsible for ensuring that vegetables are not exposed to prolonged heat and that they retain their nutritional value. The dietary department was provided with a Boiling Times For Vegetables sheet to assure compliance with cooking vegetables appropriately. The Registered Dietitian/Dietary Manager will audit the Vegetable Cooking Sheets weekly x 4 weeks then monthly x 4 months to ensure that the vegetables are not being exposed to prolonged heat.	1-12-12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	4. The results of these audits and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the findings of these audits.	

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

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F 371	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to sanitize kitchenware at the dish machine, failed to follow procedures to assure kitchenware run through the three-compartment sink system was sanitized, failed to sanitize meal carts which were taken out on resident halls, failed to keep hot foods to be served to residents at or greater than 135 degrees Fahrenheit during operation of the tray line, failed to adequately clean the faces of fans blowing into the dish machine area and mounted on the wall above food preparation surfaces, failed to separate dented cans from undamaged canned goods, and failed to label and date opened food items. Findings include: 1. At 9:10 AM on 12/14/11 a dietary employee was spraying off dirty kitchenware, placing dirty kitchenware into a presoak solution, and scrubbing dirty kitchenware. The employee was wearing gloves while performing these tasks. At 9:17 AM on 12/14/11 this same dietary employee moved to the other side of the dish machine, removed sanitized kitchenware from racks which had been run through the dish machine, and placed coffee mugs and plastic dessert bowls into storage. This employee did not remove her gloves or wash her hands before she handled the sanitized kitchenware. At 9:23 AM on 12/14/11 the dietary employee removed her gloves, and washed her hands. Two other employees joined in the dish machine process at this time. One employee emptied dirty meal trays, one loaded dirty kitchenware into	F 371	1. The dishmachine was repaired by Ecolab on 12-14-11 to ensure that the sanitizing solution is reaching the dishes in the dishmachine properly. The correct testing strips to properly test the quaternary sanitizing solution in the 3 compartment sink were immediately given to the dietary staff on 12-14-11 to make sure the solution was adequate. The dietary staff on duty were inserviced on 12-15-11 on the proper way to sanitize using the 3 compartment sink and the importance of letting the dishes air dry before using them again. The dietary staff on duty were inserviced on 12-16-11 on the proper way to clean/sanitize the feeding carts that are sent to the halls.	1-12-12

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

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F 371	Continued From page 34 racks, and one removed sanitized kitchenware from the racks and placed it into storage. As kitchenware was run through the low temperature dish machine from 9:48 AM though 9:58 AM on 12/14/11 the final rinse gauge registered from 113 to 115 degrees Fahrenheit. At 10:00 AM on 12/14/11 strips, used to check the strength of the bleach-based sanitizing solution feeding into the dish machine, did not change color. At 10:06 AM on 12/14/11 the maintenance manager (MM) stated if the strips did not change color at all, then the sanitizing solution must not be reaching the dispensing system of the dish machine. Observation revealed there was sanitizing solution present in the tubing leading to the dispensing system of the dish machine, but that solution never advanced into the dispenser. At 10:20 AM on 12/14/11 a dietary employee stated she used a strip to check the sanitizing system of the dish machine when she first came into work that morning at approximately 7:00 AM. She reported the strip she used registered 50 parts per million (PPM) hypochlorite. However, she commented no strips were used to check the sanitizing system after 7:00 AM on 12/14/11. At 4:05 PM on 12/14/11 the dish machine service representative reported air in the lines was preventing the sanitizing solution in tubing from reaching the sanitizer dispensing system. The representative reported he repaired the dish machine, and also adjusted the digital cycle timing on the dish machine. He commented that	F 371	The dietary staff on duty were inserviced on 12-16-11 regarding how to ensure that soups are kept at 135 degrees or greater during the operation of the tray line. The fans in the dietary department were deep cleaned on 12-14-11 to make sure that all dust and debris were off of the fan blades and grills of the fan. The dented cans were immediately removed from the undented cans on 12-14-11 and placed on the bottom shelf in dry storage area so that the cans could be returned to the vendor. The unlabeled food items were discarded to ensure that no out of date items would be served. The dietary staff on duty were inserviced on 12-16-11 on the importance of labeling and dating all opened food items before placing those items back into storage.	1-12-12

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F 371	Continued From page 35 the final rinse temperatures of the dish machine should register between 120 and 140 degrees Fahrenheit on the gauge. He explained temperatures above 140 degrees and below 120 degrees did not optimize the sanitizing capabilities of the sanitizing solution. At 9:42 AM on 12/15/11 a dietary employee stated the staff was trained to use a strip to check the sanitizing solution feeding into the dish machine just before beginning to run breakfast kitchenware through at approximately 9:00 AM. She reported the employees running the dish machine were also supposed to watch the gauge to make sure the temperatures were in the recommended temperature range. This employee commented strips should register at least 50 PPM hypochlorite. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated dietary staff was supposed to use strips to check the strength of the dish machine sanitizing solution as they started running dirty kitchenware through and periodically during the process until the process was completed. She reported the staff should make sure the final rinse temperature of the dish machine registered at least 150 degrees on the gauge during the entire process of sanitizing kitchenware used during a meal. 2. At 8:58 AM on 12/14/11 there was kitchenware stacked in the sanitizing sink of the three-compartment sink system. There was no sanitizing solution in the sink which contained tray pans stacked on top of one another, pots, pans, and utensils.	F 371	2. All dietary staff will be inserviced by 1-12-12 on how to ensure that the dishmachine is properly sanitizing dishes, how to properly test the quaternary sanitizing solution in the 3 compartment sink and the importance of letting the dishes air dry before their next use, the proper way to sanitize the feeding carts that are sent to the halls, how to ensure that soups are kept at 135 degrees or greater during the operation of the tray line, the cleaning schedule of the fans to ensure dust and debris are removed, the removal and placement of dented cans, and labeling and dating all opened food items in storage.	1-12-12

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 ____	12/15/2011

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

(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 371	Continued From page 36 At 9:00 AM on 12/14/11 the cook obtained the top tray pan stacked in the sink, rinsed it under hot water from the faucet, and used it to place food in. At 9:28 AM on 12/14/11 the cook obtained the top tray pan stacked in the sink, rinsed it under hot water from the faucet, and used it to place food in. The cook reported at this time that the PM staff was leaving kitchenware in the sink overnight. At 9:44 AM on 12/14/11 the cook was asked to check the strength of newly made up quaternary sanitizing solution in the three-compartment sink system. The cook retrieved strips which were compatible only with bleach-based sanitizing systems. According to the cook, these were the strips the staff were using to check the quaternary sanitizing solutions in the kitchen for the last three or four months. At 9:42 AM on 12/15/11 a dietary employee stated the dietary staff was trained to air dry kitchenware before stacking it into storage. She reported leaving wet kitchenware in a sink overnight was not acceptable. According to the employee, after kitchenware was run through the sanitizing system at the three-compartment sink, it was to be stacked using an alternating criss-crossing pattern on the sink draining board to air day. She commented that the staff had been using white strips that changed different shades of blue to check all sanitizing solutions in the kitchen sink since the full time dietary manager went out on leave. The employee explained that she now understand these white strips were not meant to be used to test the	F 371	3. Audits will be conducted by the Registered Dietitian/Dietary Manager weekly x 4 weeks then monthly x 4 months to assure proper sanitation of the dishmachine, correct use of the quaternary sanitizing solution for the 3 compartment sink, sanitizing and cleaning of dietary carts, proper soup temperatures, cleanliness of fans, removal of dented cans, and the labeling and dating of opened food items to assure compliance with policy and procedures. 4. The results of these audits and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the findings of these audits.	1-12-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 37 strength of quaternary-based solutions. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated the PM dietary staff was not supposed to be leaving kitchenware sitting in sinks overnight. The DM stated she was unaware that the dietary staff did not have the correct strips with which to check the strength of quaternary-based solutions. 3. At 10:20 AM on 12/14/11 a dietary employee who had been taking meal carts outside stated she did not use any sanitizing solution when spraying the carts down with hot water outside near the compactor area. She reported these meal carts were taken into the dining room and onto resident halls. At 10:37 AM on 12/14/11 the maintenance manager (MM) stated that the meal carts were hosed down by the dietary staff with hot water from an outside faucet. He reported this water usually registered 150 to 155 degrees Fahrenheit when checked with a digital or calibrated thermometer. At 2:10 PM on 12/15/11 the MM used a digital thermometer system to check the temperature of water coming from the outside faucet where meal carts were hosed down. The water temperature ranged from 96 to 125 degrees Fahrenheit. The MM stated he thought the temperature needed to be be at least 130 degrees to kill germs and bacteria. He explained the temperature of this outside water varied depending on how much water was being used inside the kitchen. At 9:42 AM on 12/15/11 a dietary employee	F 371		

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

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F 371	Continued From page 38 reported, because the meal carts might pick up germs when taken throughout the building, she used a sanitizing solution to wipe down the carts outside, and then sprayed them with a hose. The employee commented she was not sure how other employees cleaned the meal carts. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated all dietary employees should be hosing out carts and then using a sanitizing solution to wipe them down with. She reported it was important that the carts be cleaned and sanitized. 4. On 12/14/11 the lunch trayline began operation at 12:06 PM. At 12:15 PM on 12/14/11 a dietary employee used the microwave to heat soup in four plastic soup bowls. One bowl was placed on a resident tray, and the other three were placed on the ledge of the steam table. At 12:24 PM on 12/14/11 another dietary employee placed the three bowls of soup in a hot water bath on the burner of the stove. At 12:26 PM on 12/14/11 a bowl of soup was removed from the hot water bath and taken to a resident eating in the dining room. At 12:28 PM on 12/14/11 a calibrated thermometer was used to check the temperature of the soup remaining in the hot water bath on the stove. The thermometer only registered 116 degrees Fahrenheit. At 9:42 AM on 12/15/11 a dietary employee	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 39	F 371		

stated the staff was trained to keep soup hot in a water bath on the stove burners. She reported microwaving soup, and then keeping bowls of the soup on the ledge of the steam table would not keep it hot enough. According to the employee, the facility liked all hot foods to remain at 165 degrees during the operation of the trayline.

At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated hot foods, including soups, should be kept at at least 135 degrees Fahrenheit during the entire operation of the trayline.

5. During initial tour of the kitchen on 12/12/11, beginning at 10:43 AM, the floor fan and the wall fan had dirt and dust encrusted on the grids of the fan faces. There were strands of dust and dirt on the back sides of both fan faces. The floor fan was turned toward the dish machine area, but was not turned on during initial tour. The wall fan was turned toward food preparation tables, but was not running during initial tour.

At 9:25 AM on 12/14/11, during observation of food preparation and the dish machine process, the floor fan in the kitchen was turned on and blowing into the dish machine area where kitchenware was being cleaned. Dirt and dust were encrusted on the grids of the both the floor and wall fan faces. There were strands of dust and dirt on the back sides of both fan faces.

At 10:37 AM on 12/14/11 the maintenance manager (MM) stated that the maintenance department was not responsible for cleaning the fans kept in the kitchen.

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F 371	Continued From page 40 At 9:42 AM on 12/15/11 a dietary employee stated the kitchen fans were supposed to be cleaned once to twice a week. She explained dietary staff notified the maintenance department when the fans needed cleaning, and maintenance hosed the fans down outside, and used a sanitizing solution on them. The employee commented is was important to keep the fan faces clean so dirt and germs did not get blown onto food and kitchenware. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated dietary employees were supposed to clean the kitchen fans once to twice a week. However, after looking at the fan faces, she reported it appeared the fan faces were just wiped down with a cloth rather than being hosed down and scrubbed. The DM commented if dirt and dust we encrusted on the grids of the fans faces, there was the chance that the food and kitchenware could be contaminated. 6. During initial tour of the kitchen on 12/12/11, beginning at 10:43 AM, two dented 6-pound 10-ounce cans of mandarin oranges and one dented 6-pound 11-ounce can of cheese sauce were mixed in with the stock of undamaged canned goods. At 9:42 AM on 12/15/11 a dietary employee stated dented cans were supposed to be placed on the bottom shelf in the dry storage room, separated from undamaged stock. She explained the dietary manager (DM) then notified the food vendor with the number of damaged items so the facility could get credit for and the vendor would pick up the damaged goods.	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

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F 371	Continued From page 41 At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated there was a special section in the dry storage room where the employee putting away stock was supposed to place dented cans. She reported the facility did not use the food in dented cans because it posed the risk of making residents sick from bacterial contamination. According to the DM, it was a good precautionary measure to separate damaged food items from undamaged ones. 7. During initial tour of the kitchen on 12/12/11, beginning at 10:43 AM, a plastic bag of sliced turkey in the reach-in refrigerator did not have a label and date on it. In the reach-in freezer a brown bag of steak fries, a plastic bag of chocolate chip cookie dough, and a 6.5-pound container of sliced strawberries which had been opened did not have labels or dates on them. In the walk-in freezer a bag of diced green pepper and a bag of breaded chicken patties which had been opened, did not have labels or dates on them. In the dry storage room a bag of vanilla waters in a plastic storage container, a bag of pasta noodles, and a bottle of condiment sauce which had been opened did not have labels or dates on them. During a follow-up tour of the kitchen on 12/14/11, beginning at 10:21 AM, a bag of diced chicken in the walk-in freezer which had been opened did not have a label or date on it. In the walk-in refrigerator a 16-ounce jar of baby dill pickles which had been opened did not have a label or date on it. In the dry storage room a package of brown gravy mix in a plastic bag, a	F 371		

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F 371	Continued From page 42 container of brown sugar in a plastic bag, a 42-ounce container of quick oats, and a bag of vanilla wafers in a plastic storage container which were opened did not have labels or dates on them. At 9:42 AM on 12/15/11 a dietary employee stated all opened food items, leftovers, and food items removed from their original packaging were supposed to have labels and dates on them. She reported the dietary manager (DM) checked all storage areas daily to make sure the facility was following its labeling policy. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting DM stated whoever opened food items, placed leftovers in storage areas, or removed food items from their original packaging was responsible for placing labels and dates on the foods. The DM reported she tried to tour the storage areas every morning to make sure there were labels and dates in place. She explained the labeling/dating system was important to help prevent foods from spoiling and to make sure the facility was following the principle of first in-first out (FIFO).	F 371		
F 456 SS=E	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 and operate kitchen	F 456	1. The frying machine was cleaned and frying oil changed on 12-15-11.	1-12-12

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

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F 456	Continued From page 43 equipment in a manner which protected the staff from harm and injury. Findings include: 1. During initial tour of the kitchen on 12/12/11, beginning at 10:43 AM, the oil in the deep fryer was a very deep dark brown with food debris in the oil, along the sides of the fryer, and on the ledge/lip of the fryer. At 11:44 AM on 12/14/11 the cook was using the deep fryer to cook battered chicken. There was a haze in the kitchen, and smoke was coming from the fryer. There was a very strong burnt odor in the kitchen, and the side door to the kitchen was open. The fumes in the kitchen burned the eyes and throats of the surveyors during time spent in the kitchen and for up to an hour after leaving the kitchen. At 9:42 AM on 12/15/11 a dietary employee stated most of the time the maintenance department cleaned the deep fryer and changed the oil. However, she commented the cooks sometimes changed the 100% vegetable oil in the deep fryer if maintenance was not available or was too busy. The employee could not say for sure when the deep fryer was last cleaned and the oil changed. She reported she thought maybe the cook had the temperature of the deep fryer set too high when he was frying chicken on 12/14/11. At 10:12 AM on 12/15/11 the facility's registered dietitian (RD) and acting dietary manager (DM) stated the side door to the kitchen had to be opened when the cook was frying chicken in the deep fryer on 12/14/11 because several staff members complained that the smoke and odor	F 456	2. All dietary employees will be inserviced by 1-12-12 on the fryer cleaning schedule and frying oil changing schedule. The cooks cleaning schedule was retyped so that the fryer cleaning schedule was visible. The policy of changing out the fryer oil was reviewed with the staff to ensure that the frying oil would be changed out after each use to ensure that the frying oil is in usable condition. 3. The Registered Dietitian/Dietary Manager will monitor the cleanliness of the frying machine and frying oiled changed per facility policy on a weekly basis x 4 weeks then monthly x 4 months. 4. The results of these audits and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the findings of these audits.	1-12-12

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F 456	Continued From page 44 was bothering them. The DM reported her expectation was for the oil to be changed in the deep fryer after each use. She commented she was not sure how often the cleaning schedule specified the deep fryer was to be cleaned and its oil changed because the administrator was handling that responsibility while the full time DM was out on leave. According to the acting DM, she was also suspicious that the cook had the oil too hot when frying chicken on 12/14/11. Review of the kitchen cleaning schedule revealed the cleaning and changing of the oil in the deep fryer was not addressed. At 2:10 PM on 12/15/11 the maintenance manager (MM) stated the maintenance staff was not responsible for cleaning the deep fryer or changing the oil in it. At 3:47 PM on 12/15/11 the administrator stated guidance for maintaining the deep fryer was lost when copies of the cleaning schedule were made because original pages got folded under during the copying process. He reported the master copy of the cleaning schedule documented the deep fryer was to be cleaned and the oil changed "as used". The administrator stated he would interpret this to mean this piece of kitchen equipment was to be cleaned as needed when food debris built up in and along the sides of the fryer, and the oil was to be changed when it became cloudy or there was a chance odors trapped in the oil could contaminate the taste of other foods cooked in the fryer. 2. During observation of the dish machine operation on 12/14/11, between 9:12 AM and	F 456		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 456	Continued From page 45 9:31 AM, when water drained from the dish machine between the wash and final rinse cycles, the water leaving the dish machine backed up in the drain and flooded out about four feet onto the kitchen floor. Staff moved back and forth in this water between the dirty and sanitized sides of the dish machine depositing and retrieving racks used to hold the kitchenware. At 9:32 AM on 12/14/11, after surveyor intervention, dietary staff stated they would call the maintenance manager (MM) because the drain at the dish machine must be stopped up. The staff reported this was not the way the dish machine drainage system was supposed to operate. At 9:40 AM on 12/14/11 the MM stated he could place a drain declogging product down the kitchen/dish machine drain to keep the water from backing up onto the kitchen floor. At 9:42 AM on 12/15/11 a dietary employee stated there had been problems with the kitchen/dish machine drain getting stopped up on and off over the last year. However, she reported the staff was trained when they saw water backing up into the kitchen, to stop running the dish machine and immediately notify the MM. At 10:12 AM the facility's registered dietitian (RD) and acting dietary manager DM) stated no dietary staff made her aware of and she had not noticed any problems with the dish machine drain. However, she reported having water on the kitchen floor posed a safety issue because staff could slip on the floor and hurt themselves.	F 456		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING 01 - MAIN BUIL[illegible]NG 01 B. WING ____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	2575 W 6TH ST GREENVILLE, NC 27[illegible]34

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K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: A. Based on observation on01/05/2012 the fire door at room 315 could not be opened with the panic bar. 42 CFR 483.70 (a)	K 011	K011 A. Fire Doo[r] not opening properl[y] with panic bar. 1. The Ma[i]ntenance Departm[e]nt was informed of door [n]ot opening properl[y] with panic bar and they im[m]ediately repaired the doo[r] so that it would open wh[e]n panic bar was pressed 2. All door[s] with panic bars in facility [w]ere checked to make su[r]e that they all opened [p]roperly when the panic ba[r] was pressed in. 3. All door[s] with panic bars will be c[h]ecked weekly x 4 weeks t[o] ensure they open by pres[si]ng in on the panic bars. Fo[l]lowing 1st 4 weeks the doo[rs] will be checked monthl[y] ongoing. 4. The res[u]lts of these audits will be [b]rought to the facility Q[u]ality Assurance & Assessm[e]nt Committee (QA&A) [t]o ensure that doors w[it]h panic bars open properl[y] when panic bar is pressed in.	2-9-12
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 01/05.2012 the facility's exit doors have NC Special Locking installed on them and they all failed to release upon activation of the fire alarm and failed to release with the master switch located at the nurses station. This situation had been present for at least two (2) week according the staff. B. The staff interviewed did not know about the master door release switch located at the nurses station.	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1.19.12

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

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

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	345377	A. BUILDING 01 - MAIN BUILD NG 01 B. WING ______	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, ST TE, ZIP CODE
GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27 34

(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 P AN OF CORRECTION (EACH CORREC IVE ACTION SHOULD BE CROSS-REFEREN ED TO THE APPROPRIATE DE ICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 C. Based on observation on 01/05/2012 there were doors that required more than one (1) motion of the hand in order to exit the room; a. kitchen dry storage b. kitchen exit into corridor c. rest home dining supply room 400B 42 CFR 483.70 (a)	K 038	releasing properly. Finally, the fire a arm will be activatec on its regular schedule as set up by the Environm ental Services Director.	2-9-12
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 the	K 051	The mast er switches will be tested 1 ime per week x 1 month tc ensure that when pressed all doors release properly. Then the master switches will be activated 1 time per month x 3 months to ensure that all doors release p operly. 4. The resu ts of these audits will be brought to the facility Q ality Assurance & Assessm nt Committee (QA&A) to ensure that fire alarm an master switches release doors when activatec. B. The Sta Interviewed Did Not Kn w About The Master Door Release Switch Locatec At The Nurses Station	2-9-12

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FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 051	Continued From page 2 battery back-up for the FACP would not operate the alarm and had been so for two (2) weeks according to the staff interviewed. (a)There was no audible signal at the FACP when the AC Power was disconnected. 42 CFR 483.70 (a)	K 051		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 there were unsecured 02 cylinders in the 400 hall storage room. 42 CFR 483.70 (a)	K 076	**K076** A. Medical (as Storage 1. The oxyg n tanks in the storage r(om were immediat ly placed in their appropri :e storage racks. 2. All areas i the facility where ox gen is in use or being sto ed was audited by Maint nance and Nursing S aff to ensure correct st rage. 3. All staff v ere inserviced on the prop r storage of oxygen t nks by the Quality Assuranc Director. We will n onitor at least 1 times pe day for the first 4 weeks ar d after that we will mon or 1 times a week for the n xt 4 weeks to ensure t nks are being stored p operly.	**2-9-12**

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K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: A. Based on observation on01/05/2012 the fire door at room 315 could not be opened with the panic bar. 42 CFR 483.70 (a)	K 011		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 01/05.2012 the facility's exit doors have NC Special Locking installed on them and they all failed to release upon activation of the fire alarm and failed to release with the master switch located at the nurses station. This situation had been present for at least two (2) week according the staff. B. The staff interviewed did not know about the master door release switch located at the nurses station.	K 038	K038 A. Facility's (xit doors failed to release u| on activation of fire alarm and failed to release w th the master switch lo(ated at nurses station. 1. We imm :diately contacted Solar Cre itions, Inc and made arı ıngements for them to ı ome out to the facility oı 1-5-12 to fix the circuit bc ard that was causing t ıe doors to not release v hen fire alarm was activate(and causing the master s vitches to not	2-9-12

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused fr n correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the fi ıdings 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 finding ı 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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K 038	Continued From page 1 C. Based on observation on 01/05/2012 there were doors that required more than one (1) motion of the hand in order to exit the room; a. kitchen dry storage b. kitchen exit into corridor c. rest home dining supply room 400B 42 CFR 483.70 (a)	K 038	release th doors when pressed. The door locking system w is immediately turned of and staff members were placed at the doors to make sure that no reside its left the facility. The staff remained at the doors unt l Solar Creations arrived at the facility and they fixec the circuit board. After the circuit board was fixed the fire alarm was activated and all doors released properly. The master switches that are located a each nurses station w is checked individua y to make sure they rele ised all doors properly when pressed.	2-9-12
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 the	K 051	2. We have identified the entire iss ie and it was fixed once Sol r Creations replaced the faulty circuit board. 3. The fire alarm will be activatec 1 time per week x 1 month to ensure that all doors ar releasing properly Then the fire alarm w l be activated 1 time pe month x 3 months to ensur that all doors are	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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GREENFIELD PLACE	2576 W 5TH ST GREENVILLE, NC 27 34

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K 051	Continued From page 2 battery back-up for the FACP would not operate the alarm and had been so for two (2) weeks according to the staff interviewed. (a)There was no audible signal at the FACP when the AC Power was disconnected. 42 CFR 483.70 (a)	K 051	2. There are no other life safety issues affecting residents in this tag. 3. The FACP will be tested 1 time per week x 4 weeks then 1 time per month x 3 months to ensure that the battery backup for the FACP would operate the alarm and that the audible signal would alarm when the AC power was disconnected. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that doors with panic bars open properly when panic bar is pressed in.	2-9-12
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 there were unsecured 02 cylinders in the 400 hall storage room. 42 CFR 483.70 (a)	K 076		

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K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 01/05/2012 the	K 051		

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K 038	Continued From page 1 C. Based on observation on 01/06/2012 there were doors that required more than one (1) motion of the hand in order to exit the room; a. kitchen dry storage b. kitchen exit into corridor c. rest home dining supply room 400B 42 CFR 483.70 (a)	K 038	C. Double Ha nd Motion To Exit Room 1. All door l andle were changed t o ensure that only 1 hand m otion was needed to exit th room.	2-9-12
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