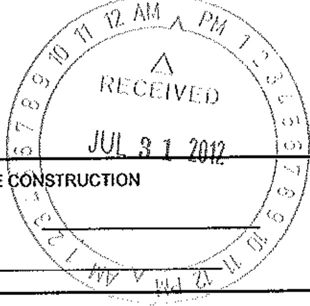

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ____ B. WING ____	07/12/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 by: Based on observation, staff interview, and record review the facility failed to provide adequate ADL (activities of daily living) care for 2 of 6 sampled residents who were dependent on staff for their ADL care. Resident #32 received improper perineal care during a bed bath, and Resident #67 had dirty fingernails. Findings include: 1. The purpose of the facility's procedure for providing perineal care, dated 02/07, was to cleanse the perineum and prevent infection and odors. Resident #32 was admitted to the facility on 07/26/05 and re-admitted on 03/16/12. Cumulative diagnoses included diabetes mellitus, dysphagia with gastrostomy tube, dementia and hypertension. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/03/12 indicated he had long and short term memory problems as well as severely impaired decision making skills. He required total assistance from	F 312	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles J. Hasle Jr.	ADMINISTRATOR	7-26-12

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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F 312	Continued From page 1 staff for all activities of daily living and was incontinent of both bowel and bladder. The care area assessment (CAA) trigger sheet indicated he triggered in 11 areas, 6 of which were carried to care plan. Activities of daily living did not trigger. Resident #32's care plan, last revised 06/30/12, identified a problem of requiring assistance for ADLs. Interventions included totally dependent for ADLs. Resident #32 was observed receiving a bed bath provided by Nurse Aide #1 (NA#1) on 07/11/12 at 9:50 AM. NA#1 prepared 2 basins of water and began his bath. After she had washed and rinsed his upper body, she changed the 2 basins of water and proceeded to remove his brief. After she cleansed the front part of his body, she rolled him onto his right side. She used disposable wipes to remove a moderate amount of soft brown stool wiping from the midline crease downward toward the scrotom and perineal area. She used several wipes and wiped in the same manner. After she had removed the majority of the stool, she used a washcloth with soap and water and washed the area wiping from the top of the midline crease downward towards the scrotal region. She did not roll him over onto his back to check to make sure she had removed all of the stool from the perineal/scrotal area. After she rinsed wiping in the same manner, she rolled him onto his back and proceeded to finish his bath. NA#1 was interviewed on 07/11/12 at 2:36 PM.	F 312	F 312 1. Resident #32 was provided with proper perineal care following his bed bath on 7-11-12. All CNA staff on duty were inserviced on the proper procedure for giving a bath and perineal care by the Staff Facilitator on 7-11-12. All other CNA staff will be inserviced on the proper procedure for giving a bath and providing perineal care by the Staff Facilitator on 7-11-12 and completed by 7-27-12. All new CNA staff will be inserviced in the proper procedure for giving a bath and providing perineal care during orientation by the Staff Facilitator. All other residents in the facility have been bathed using the proper procedure for giving a bath and providing proper perineal care with no concerns identified through observations made by the DON or Administrative Nurses starting 7-11-12 with completion by 7-31-12. To ensure that all residents are bathed using the proper procedures for giving a bath and providing perineal care, the DON or the Administrative Nurses will observe bathing daily to include resident #32 for five days and then weekly for four weeks and then monthly for four months using a QI tool. Staff willl be provided with re-training by the DON or administrative nurse upon the identification of any potential bathing and/or perineal concern.	8-1-12

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F 312	Continued From page 2 She stated she had been trained to use incontinent wipes to wipe back to front. She stated she wipes from the anal area downward towards the scrotal region. NA#1 stated after she removed the majority of the stool, she had been taught to follow with a washcloth and soap and water to remove any residue left on the resident's body. During an interview with the Director of Nurses (DON), on 07/12/12 at 11:14 AM, she stated her expectation was that staff push the foreskin back from the penis if the male resident was uncircumcised. She stated she expected staff to always wash in a front to back motion never wiping back to front especially if removing stool. 2. Resident #67 was admitted to the facility on 07/08/10. The resident's documented diagnoses included cerebrovascular accident with hemiplegia, epilepsy, osteoarthritis, and congestive heart failure. The resident's care plan identified "bathing/hygiene deficit" as a problem on 04/12/12. Interventions included, "Fingernails, toenails cleaned and checked routinely." The resident's 06/22/12 Quarterly Minimum Data Set (MDS) documented the resident's cognition was severely impaired, he did not exhibit rejection of care, and he was totally dependent on a staff member for personal hygiene.	F 312	F 312 Continued The results of the audits will be forwarded to the QI Executive Committee monthly x3 months, then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring. 2. Resident #67's fingernails were cleaned to ensure there is no foreign matter under his fingernails the CNA on 7-11-12. All staff on duty were inserviced in the proper procedure for nailcare by the Staff Facilitator on 7-11-12. All other CNA staff will be inserviced on the proper procedure for nailcare and by the Staff Facilitator on 7-11-12 with completion on 7-27-12. New CNA staff will be inserviced on the proper nailcare in orientation by the Staff Facilitator. All other residents in the facility were reviewed by the DON or Administrative Nurses on 7-11-12 and were provided with nailcare using the proper procedure as necessary.	

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F 312	Continued From page 3 At 5:18 PM on 07/09/12 Resident #67 had dark brown matter under his fingernails. At 8:47 AM on 07/10/12 Resident #67 had dark brown matter under his fingernails. At 5:24 PM on 07/10/12 Resident #67 had dark brown matter under his fingernails. At 8:22 AM on 07/11/12 Resident #67 had dark brown matter under his fingernails. At 1:05 PM on 07/11/12 Resident #67 received his tray in the dining room where the nursing assistant (NA) set the tray up, and asked the resident if he wanted her to cut up his fried chicken. The resident declined the NA's offer, and between 1:07 PM and 1:20 PM on 07/11/12 the resident ate his fried chicken using his fingers. At 2:50 PM on 07/11/12 NA #5 and the director of nursing (DON) observed Resident #67's fingernails. The DON stated fingernail care was provided by the NAs as needed, but nail care was not provided at specific intervals. She reported the NAs were responsible for cutting, cleaning, and filing rough or jagged fingernails. The DON commented that Resident #67's fingernails needed to be cleaned, and the resident did use chewing tobacco and sometimes used his fingers to eat with. The NA stated the resident could be verbal but not physical when he did not want to do something. She explained Resident #67 liked to engage in verbal banter with some of the NAs, and she would not consider his behavior as verbal abuse. According to NA #5, there were	F 312	F 312 Continued To ensure that all residents receive proper nailcare, the DON or administrative nurses will observe nailcare to include resident #67 for five days, using the bath QI tool and daily rounds tool, then weekly for four weeks and then monthly for four months. Staff will re-trained by the DON and/or administrative nurses upon the identification of any potential nail care concern. The results of the nail care audits will be forwarded to the facility QI Executive Committee monthly x 3 months, then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.	

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F 312	Continued From page 4 days when Resident #67 had to be reapproached in order to complete his care. The NA attempted to soak the resident's hands before cleaning his fingernails. Resident #67 pulled his hand away when the NA first took it, but did not resist care anymore after the NA explained what she needed to do and why she needed to do it. The NA used orange sticks to remove dark brown matter from under the resident's fingernails. She placed this brown matter on a white towel as she completed the task. At 2:57 PM on 07/11/12 NA #1, assigned to care for Resident #67 on first shift, stated the resident's cognition varied, and he required extensive assistance from the staff for his hygiene needs. She reported the resident refused basic care such as incontinent care and baths on some days. She also commented sometimes the resident refused to have his nails cut. For example, she explained she approached the resident yesterday, but the resident stated his fingernails did not need to be cut. NA #1 stated she did not ask Resident #67 if she could clean his fingernails yesterday. She reported she did not remember the last time she cleaned Resident #67's fingernails, and commented that a lot of residents complained that it hurt when the orange sticks were used to"dig out" their fingernails. At 3:03 PM on 07/11/12 Nurse #1, assigned to care for Resident #67 on first shift, stated the resident had some confusion, some days more so than others. She reported the resident required staff assistance with hygiene. She explained the NAs cut and cleaned fingernails as needed. According to the nurse, Resident #67 refused care at times, but would usually	F 312		

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F 312	Continued From page 5 cooperate if left alone and reapproached at a later time. She commented the resident chewed tobacco, and frequently the staff could get him to do things by offering him tobacco in exchange for his cooperation. At 3:18 PM on 07/11/12 Nurse #6, assigned to care for Resident #67 on second shift, stated the resident could get kind of messy with his chewing tobacco and spit cup. She reported the resident's cognition varied, and he refused care at times. However, she explained most of the time the resident would end up doing what the staff wanted him to do if they left him alone and reapproached him later, although several reapproaches were required at times. According to Nurse #6, NAs might have to cut and clean the resident's fingernails frequently since he enjoyed chewing tobacco. At 4:08 PM on 07/11/12 NA #6, assigned to care for Resident #67 on second shift, stated the resident had not refused care for him. He reported on some days the resident "gave him some lip", but the resident cooperated. The NA commented the resident was confused, and required staff assistance with hygiene. According to NA #6, most of the time first shift NAs cut and cleaned fingernails, but second shift NAs would cut and clean them if they saw the nails needed attention. However, he reported he had never tried to cut or clean Resident #67's fingernails.	F 312	F 318 Resident # 32 was provided with a hand contracture evaluation on 7-17-12 by the Occupational Therapist. No splint or therapy was determined to be warranted at this time. All residents in the facility have been provided with a 100% therapy screen for contracture management by the Occupational Therapist on 7-17-12 to 7-31-12 with implementation of services as appropriate. . To ensure that all residents are screened for contracture management services, therapy will screen all new admissions and readmissions using a QI tool. All residents will be screened quarterly by therapy using a QI tool. Nursing will communicate with therapy as needed when change in resident range of motion occurs through utilization of the Screen/Referral to rehabilitation. The DON and Therapy Manager will review the results of the QI audits for new admissions/readmissions weekly x 4, every two weeks x2, then monthly x2 and then quarterly. If issues are identified, nursing will request MD orders for an evaluation by therapy.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 6 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide contracture management services for 1 of 1 sampled dependent residents (Resident #32) who had a left hand contracture and no device in place. Findings include: Resident #32 was admitted to the facility on 07/26/05 and re-admitted on 03/16/12. Cumulative diagnoses included diabetes mellitus, dysphagia with gastrostomy tube, dementia and hypertension. An Annual MDS of 09/02/11 indicated Resident #32 had no splint or brace assistance with impairment on both upper and lower extremities in range of motion. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/03/12 indicated he had long and short term memory problems as well as severely impaired decision making skills. He required total assistance from staff for all activities of daily living and was incontinent of both bowel and bladder. He had functional limitation in range of motion of both upper and lower extremities and no passive or	F 318	F 318 Continued The results of the therapy audits will be forwarded to the QI Executive Committee monthly x 3 months, then quarterly for review and follow up as deemed necessary to determine the frequency and /or need for continued monitoring.	

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F 318	Continued From page 7 active range of motion services nor splinting or braces was noted. The care area assessment (CAA) trigger sheet indicated he triggered in 11 areas, 6 of which were carried to care plan. Activities of daily living did not trigger. Resident #32's care plan, last revised 06/30/12, identified problems with ADLs but there was no mention of contracture management. During an observation of Resident #32, on 07/10/12 at 3:00 PM, he was noted to be clenching his left hand tightly. There was no device in place to prevent fingernails from pressing into his palm. During an observation of personal care, on 07/11/12 at 9:50 AM, Resident #32 was noted to be holding his left hand clenched tightly. Nurse Aide #1 (NA#1) was observed extending his fingers about 50% of the way outward. When questioned she stated she was not able to fully extend his fingers. During an interview with NA#1, on 07/11/12 at 2:36 PM, she stated she had worked with Resident #32 routinely for about 3 months. She stated she had not seen any splinting devices or palm protectors used. NA#1 stated she was not able to fully extend the fingers on his left hand and that there were no devices in his room. When questioned about splinting, she stated restorative usually managed the splints.	F 318		

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F 318	Continued From page 8 During an interview with the treatment nurse, on 07/12/12 at 8:55 AM, she stated she had worked with Resident #32 in the past when he had blisters. When questioned about splinting devices, she responded that she did not remember but would check. Resident #32 was observed in bed with his left hand clenched tightly with no devices in place on 07/12/12 at 9:00 AM. During an interview with Nurse #1, on 07/12/12 at 9:00 AM, she stated she had worked with Resident #32 for about a year. She stated she did not remember him ever having any splinting devices. Nurse #1 added that he was on hospice. During the interview, the treatment nurse walked up and stated she had spoken with the rehabilitation department and the restorative aides and both had stated he had not had any splinting devices. Nurse #1 went into Resident #32's room and attempted to open his left hand. She stated she could only extend his fingers about half way and felt he would benefit from either rolled up washcloths or palm protectors in his left hand. She stated he was able to open his right hand as he removed his oxygen cannual from his nose often. Nurse #1 reported that if the aides reported changes in range of motion or if she noticed changes, she would refer them to therapy for evaluation. When questioned about Resident #32, she stated hospice would probably pay for an evaluation. Nurse #2 commented that she did not believe his limitation in range of motion had changed since she had worked with	F 318		

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F 318	Continued From page 9 him. During an interview with the occupational therapist (OT), on 07/12/12 at 9:20AM, she stated she had been employed in the facility for about a year. When questioned about Resident #32, she stated he had not been on caseload since she worked in the building. During an interview with the Director of Nurses (DON), on 07/12/12 at 11:14 AM, she stated rolled up washcloths or palm protectors could be used to protect the palms from breakdown. She stated if a resident had experienced changes in range of motion they would be referred to therapy for evaluation. The DON added that Resident #32 was on hospice. She commented that if Resident #32 kept his left hand clenched he would benefit from some type of device to maintain his current range of motion.	F 318	F 327 Resident # 48's fluid intake was accurately measured to follow physician's order for fluid restriction by the administrative nurse on 7-11-12. Staff were inserviced on entering all fluids that the resident receives including medication pass by the Staff Facilitator on 7-11-12. All residents with fluid restrictions were reviewed by the administrative nurse on 7-11-12 with no issues identified. To ensure that all residents to include resident # 48 with physician orders for fluid restrictions have accurate fluid intake, the DON or administrative nurses will monitor the fluid intake of residents with fluid restrictions to ensure the intake follows physician orders on a daily basis for five days, then weekly for four weeks and then monthly for four months, using a QI tool. The DON and/or Administrative Nurses will follow up on any potential issue upon identification. The results of the fluid intake audits will be forwarded to the QI Executive Committee monthly x 3months, then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.	8-1-12
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have a system in place to monitor the actual fluid intake for 1 of 1 sampled residents (Resident #48) who had physician's orders for fluid restrictions. Findings include:	F 327		

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F 327	Continued From page 10	F 327		

Resident #48 was admitted to the facility on 02/13/12 and re-admitted on 03/19/12. Cumulative diagnoses included end stage renal disease (ESRD) with hemodialysis, congestive heart failure and hypertension.

A physician's telephone order of 03/20/12 indicated Resident #48 was to be on a 1200cc per day fluid restriction.

The handwritten March 2012 medication administration record (MAR) for the time period of 03/21/12 through 03/31/12 included the 1200cc per day fluid restriction. In the HOUR section of the MAR, it was handwritten as follows: 360cc fluid with breakfast, 240cc fluid with lunch. In the HOUR section of the MAR, it was noted for the 7:00 AM - 3:00 PM shift: 180cc fluid as well as 240cc with dinner. It was noted for the 3:00 PM - 11:00 PM shift for nursing was 130 cc and the 11:00 PM - 7:00 AM shift 50 cc fluid. The date blocks beginning with 03/21/12 and ending with 03/31/12 had been initialled and or by staff. There were no amounts written in as to the actual intake for Resident #48. nursing 11-7 50 cc. Date blocks were initialled but no amounts were written on the MAR. No fluid restrictions found on April MAR.

According to Resident #48's electronic medical record, her daily fluid intake range from 3/20/12 through 04/03/12 was 360cc to 1010cc. Her intake range for 04/04/12 through 04/19/12 was 240cc to 1080cc. Her daily fluid intake from 04/20/12 through 05/05/12 was 600cc to 1325cc. Her daily fluid intake from 05/05/12 through 06/02/12 was 480cc to 1680cc. Her daily fluid

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F 327	Continued From page 11 intake from 06/03/12 through 07/10/12 was 480cc to 1560cc of fluid. A dietary assessment of 04/10/12 indicated Resident #48 was on a renal no concentrated sweets niet with no fried foods. She was also on a 1200 cc fluid restriction. A physician's telephone order of 04/24/12 indicated to continue the 1200cc per day fluid restriction. A dietary supplement assessment of 05/16/12 indicated Resident #48 was on a no added salt regular diet with a magic cup three times daily. Her nutritional requirements included 1659 calories, 68 grams protein, 1693 cc fluid. Her intake was calculated to be 2109 calories, 75grams protein, and 1800 cc fluid. There was no mention of her fluid restriction on this assessment. Resident #48's care plan, last reviewed 05/24/12, identified problems with a potential for fluid volume excess related to ESRD and dialysis. Included in the intervention section was a 1200 cubic centimeter (cc) per 24 hours fluid restriction It was noted on the May, June and July 2012 MAR that Resident #48 was on a 1200 cc daily fluid restriction as "INFO" only. There were no amounts documented and the date blocks were blank. The July 2012 physician's order sheet included orders for a 1200cc fluid restriction for Resident #48. Also included on the order sheet was magic cup (this is a milk based supplement) three times	F 327		

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F 327	Continued From page 12	F 327		

daily between meals.

Upon review of the MAR book located on the medication cart, an undated note was placed behind the room tab for Resident #48. There was no resident's name noted on this note. According to this note, the 7:00 AM-3:00 PM shift was to provide the following fluids: dietary 360 cc with breakfast and 240 cc with lunch. Nursing was to provide 180 cc. The 3:00 PM-11:00 PM shift was to provide the following fluids: dietary 240cc with dinner and nursing 130 cc. The 11:00 PM-7:00 AM shift was to provide the following fluids: nursing to provide 50 cc.

During lunch meal observations on 07/10/12 at 12:53 PM, Resident #48 was observed in her room. There was an 8 oz. glass of water (240cc) and an 8 oz. glass of iced tea (240cc) on her tray.

On 07/10/12 at 5:20 PM, Resident #48 was observed during dinner. She had 8 ounces (oz) of water (240 cc), 8 oz of iced tea (240cc) and a carton of milk on her tray (240cc). Upon review of the meal tray slip found on her tray, there was no mention of fluid restrictions.

During an interview with Nurse Aide #2 (NA#2), on 07/10/12 at 4:50 PM, she stated she recorded the amounts that the residents consumed in the electronic chart. She stated Resident #48 also received a magic cup supplement on her shift at 8:00 PM. NA #2 stated if she was not the person who picked up Resident #48's tray, the aide who did would write the amount on the meal tray slip so it could be documented in the computer.

During an interview with NA#3 on 07/10/12 at

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F 327	Continued From page 13 5:15 PM, she stated the hydration cart was on the hall about every 2 hours. She stated all residents had water pitchers in their rooms except those with thickened liquids and those on fluid restrictions. She stated residents who were on fluid restrictions did not usually get offered liquids from the snack cart. She stated if the resident wanted fluids, she would always ask the nurse if the resident was allowed to have fluid and how much. Resident #48 was observed eating a magic cup sitting on the side of her bed on 07/11/12 at 11:00 AM. Resident #48's lunch meal tray was observed to have an 8 oz. glass of iced tea and an 8 oz. glass of water on 07/11/12 at 1:11 PM. During an interview with the facility's consultant, on 07/11/12 at 4:45 PM, she stated dialysis residents were provided a food bag which included fluid. She stated the fluid that was in the food bag was not included in the daily intake totals nor was the amount that the nursing staff provided during medication pass. The consultant also stated supplements were not included in the amounts recorded in the electronic charts. NA#2 was interviewed again on 07/11/12 at 4:50 PM. She stated Resident #48 did not have a water pitcher in her room because she was on dialysis. She stated at one time she had been on a fluid restriction but was not sure if she still was. NA#2 stated she would ask the nurse if Resident #48 could have any fluids other than her meal trays. She added that Resident #48 received a magic cup snack on her shift. When questioned	F 327		

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F 327	Continued From page 14 about the magic cup, she stated she recorded the percentage eaten in the supplement section of the electronic chart but not in the fluid intake section. She also stated she recorded the amount of fluid Resident #48 drank in the fluid intake section of the electronic chart. NA#2 stated Resident #48 was not capable of self-propelling her wheelchair to obtain fluids elsewhere. During an interview with the hall nurse (Nurse #4), on 07/11/12 at 5:00 PM, she stated residents who had physician's orders for fluid restrictions had separate sheets of paper placed in the front of their individual MAR's. She stated these sheets listed the amount of the restriction and the amounts the resident was allowed to have. Nurse #4 stated she did not record the actual amounts the residents consumed nor did she look in the computer to see how much they consumed on a daily basis. She stated the fluid restriction order was also written on the MAR . When questioned if she could provide the actual amount a resident consumed in a 24 hour time period, she responded she had no idea how much those residents drank. Nurse #4 commented that dietary probably kept track of the fluids but she was not sure if anyone reviewed to see how much the resident actually consumed. NA#4 was interviewed on 07/12/12 at 9:35 AM. She stated Resident #48 was on a fluid restriction and it was also noted in the electronic chart as well so staff would be aware. She stated she documented the total amounts Resident #48 consumed from her meal tray into the electronic chart. NA#4 stated she recorded the percentage of the supplements in the supplement section but	F 327		

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F 327	Continued From page 15 not in the fluid intake section. NA#4 stated Resident #48 received a snack from dietary at 10:00 AM and 2:00 PM. She added that there was no water pitcher in her room. During an interview with the dietary manager (DM), on 07/12/12 at 10:13 AM, he stated he had a standard generic list that he provided to nurses so they would know the amounts that dietary provided when a resident had orders for fluid restrictions. He stated depending upon the amount of the restriction, he calculated how much the dietary department would send out on the meal trays. The DM added that supplements were not included in his totals. When questioned about Resident #48, he stated she was on a fluid restriction but was not currently. The DM stated he had received a new diet order of 06/27/12 that indicated nothing about her fluid restriction. He commented as far as he was concerned that was her diet order and he would not question it's validity. When questioned as to who actually added up the fluids taken in over the 24 hour time frame, he responded that nursing should be doing that. He stated he knew how much dietary sent out on the meal trays. The DM stated he was sending out the same amount of fluids on Resident #48's tray as the other residents were receiving. He also commented that Nurse #3 had written the dietary clarification order of 06/27/12. Nurse #3 was interviewed on 07/12/12 at 10:30 AM. She stated Resident #48 was still on a fluid restriction as it had not been discontinued. When questioned about the 06/27/12 diet order, she responded that she was simply following the registered dietician's recommendations when she wrote the clarification order for the physician to	F 327		

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F 327	Continued From page 16 sign. Nurse # stated that the DM tracked the total amounts of fluid. She also stated the nursing staff should be recording the amounts that they provide as well. She commented that she could add the amounts to the MARs for the nurses and the third shift nurse could document the totals in the electronic chart. The Director of Nurses (DON) was interviewed on 07/12/12 at 11:14 AM. She stated when a resident was placed on a fluid restriction a dietary sheet was placed in the front of the MAR book so nursing staff knew how much fluid to provide. The DON stated that there was no current system in place that would provide the actual amount consumed in a 24 hour time period for Resident #48 as all of the amounts were not being recorded. She stated the nurse aides were recording the amounts from the meal trays as well as the total amounts they provide to the residents into the electronic record.	F 327	F 367 Resident #112 was provided with a theraputic diet as ordered by the resident's primary physician. All other residents in the facility were reviewed by the administrative nurse on 7-11-12 to ensure that they are provided with a diet as ordered by the resident's primary physician with no issues identified. To ensure that residents are receiving diet as ordered by the primary physician on an ongoing basis, diet orders are audited by the dietary manager or assistant dietary supervisor for four weeks and then monthly on an ongoing basis, using a QI tool. Nursing staff have been inserviced on approved diets by the Staff Facilitator on 7-11-12. The results of the diet audits will be forwarded to the QI Executive Committee monthly x3, then quarterly for review and follow up as deemed necessary for any potential needs and to determine the frequency and/or need or continued monitoring.	8-1-12
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide 1 of 1 sampled residents (Resident #112) with a therapeutic diet recommended in a hospital discharge summary and ordered by the resident's primary physician. Findings include: Resident #112 was admitted to the facility on	F 367		

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F 367	Continued From page 17 12/30/11. The resident's documented diagnoses included chronic kidney disease (stage IV), hypertension, anemia, atrial fibrillation, congestive heart failure, and chronic obstructive pulmonary disease. The resident's care plan identified "State of nourishment; less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to: being on a therapeutic diet" as a problem on 07/11/12. Interventions to this problem included "Diet as ordered." Record review revealed Resident #112 was hospitalized between 04/28/12 and 05/03/12 due to an exacerbation of congestive heart failure. A 05/03/12 hospital discharge summary documented, "The patient will need to be on special diet.... Diet: Low salt renal diet as tolerated." A 05/04/12 physician's order placed Resident #112 on a no-added salt, no fried foods, regular texture diet with a 1200 cubic centimeter (cc) fluid restriction. A 05/14/12 physician progress note documented the resident had end stage renal disease with a poor prognosis. The note also documented the resident was deciding whether he wanted to begin dialysis treatment, and had an upcoming appointment with the nephrologist. A 05/24/12 Report of Consultation from Resident #112's nephrologist documented that the resident was to be placed on a low potassium diet.	F 367		

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F 367	Continued From page 18 A 05/24/12 physician's order began the resident on a low potassium diet. At 1:02 PM on 07/09/12 the a review of Resident #112's tray slips documented the resident was on a regular texture no-added salt diet with a 1200 cc fluid restriction. They also documented the resident received orange juice and milk at breakfast and milk at lunch and supper. At 4:31 PM on 07/11/12 the facility's dietary manager (DM) stated that the facility did not offer a low potassium diet. However, he reported if physicians wanted residents on such a diet, he listed bananas and orange juice as dislikes on the tray slips since these two food/beverage items were a major source of potassium in the nursing home population. The DM commented the facility did offer a renal diet which corporate literature documented was "used in the management of renal and liver diseases. (It) regulates the amount of protein, potassium, phosphorous, and sodium in the diet....No additional salt will be served on the tray and no highly salted foods will be allowed. Only cranberry or apple juice will be allowed." The DM explained when a diet order was received which the facility did not offer, he went back to the nurse who took the order, and asked him/her to get clarification from the physician about the desired diet prescription. At 4:46 PM on 07/11/12 Nurse #1 ,who took the 05/24/12 physician order to place Resident #112 on a low potassium diet, stated she did not remember anyone asking her to seek a clarification order related to the request for Resident #112 to be placed on a low potassium	F 367		

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F 367	Continued From page 19 diet. She reported, however, that the DM usually approached the nursing staff for a clarification order when physicians' ordered a diet not in the facility's formulary. Nurse #1 reviewed physician orders and electronic progress notes, and reported that there was no documentation of seeking a diet clarification order for Resident #112. At 5:04 PM on 07/11/12, during a telephone interview with the facility's registered dietitian (RD), she stated when the facility received a low potassium diet order, which was not in the facility's formulary, she usually recommended the facility list bananas, orange juice, and possibly potatoes as dislikes on the tray slips. She reported she also expected the facility to contact the physician to let him/her know that an official low potassium diet was not offered by the facility, and review options such as listing high potassium foods in the dislikes section of tray slips or such as changing the resident to a renal diet which limited other nutrients that often posed problems for residents with renal disease. At 10:39 AM on 07/12/11 Nurse #5, who wrote Resident #112's 05/04/12 diet order for a regular texture no-added salt, no fried foods diet with a 1200 cc fluid restriction, stated the facility did offer a renal diet. She reported when a resident returned from the hospital the facility usually started the resident on the diet specified in the hospital discharge summary, and then sought a clarification order if they felt the diet needed to be changed later. If the hospital diet was one not offered by the facility, the nurse commented she would seek out the DM to determine a comparable diet or to find out what kind of diet	F 367		

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F 367	Continued From page 20 the resident was on before departing for the hospital. Nurse #5 could not explain why Resident #112 was not placed on a renal diet, specified in the hospital discharge summary, when he returned to the facility on 05/03/12. At 10:51 AM on 07/12/11 the DM stated he did not remember any staff member asking him about what type of diet to place Resident #112 on when he returned from the hospital on 05/03/12. He reported that as far as he could tell the resident should have been placed on a renal diet, which the facility offered, on 05/03/12 when he returned from the hospital since this was the diet specified in the hospital discharge summary.	F 367	F 371 1. The cold salad made with mayonnaise (slaw) at or below 41 degrees F. on *7-9-12 was removed from the serving*line by the dietary manager. All other foods on 7-9-12 were inspected by the dietary manager to ensure that that they were within the proper temperature range with no further issues identified. All dietary staff were inserviced on ensuring that food is served at the proper temperature on 7-9-12 by the dietary manager.	8-1-12
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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to hold a cold salad made with mayonnaise (slaw) at or below 41 degrees Fahrenheit during the operation of the trayline and failed to dry kitchenware before stacking it in storage. Findings include:	F 371	To ensure that food is served at the proper temperature, the dietary manager or lead cook will inspect food items for five days and then daily for 12 weeks, using a QI tool. Any potential food identified with temperatures above or below recommended levels will be removed from the serving line. All new dietary staff will be inserviced on the procedures for serving food at the proper temperature during orientation by the dietary manager. The results of the food temperature audits will be forwarded to the QI Executive Committee monthly x3 then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.	

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F 371	Continued From page 21 1. At 12:50 PM on 07/09/12 there were cups of slaw already sitting on trays in the meal carts which were still left in the kitchen. As staff was placing food on the meal trays, a calibrated thermometer was used to check the temperature of the slaw. The thermometer registered 52 degrees Fahrenheit. At his time the cook stated she assembled the slaw around 7:00 AM that morning (07/09/12) using a cabbage mix, mayonnaise, and a small amount of mustard. She reported she placed the slaw into shallow tray pans, and transported it to the walk-in refrigerator. The dietary manager (DM) stated at about 11:45 AM on 07/09/12 the slaw was placed in cups, but left in the walk-in. The DM commented when the trayline started at 12:25 PM on 07/09/12 the cups of slaw were placed on meal trays which were already set up in carts. The DM reported he thought placing the cold salad in warm cups may have contributed to the problem on not being able to maintain the slaw at or below 41 degrees Fahrenheit during operation of the trayline. At 4:31 PM on 07/11/12 the DM stated all the ingredients used to make chilled salads were taken from the cooler. He reported the preferable method was to prepare chilled salads such as slaw the day before being served, and to store them in the walk-in refrigerator. However, he commented, at the latest, chilled salads should be prepared at least by early morning of the same day they were being served. Typically the DM remarked that slaw was not stored in bowls. He explained usually chilled salads were stored in shallow tray pans over ice in the walk-in refrigerator, and removed from the walk-in as the trayline began operation. At the trayline the DM	F 371	F 371 Continued 2. The wet dishware was removed and dried before use for the lunch meal on 7-11-12 by the dietary manager. All dietary staff were inserviced on the proper procedure for drying dishes and kitcheware on 7-9-12 by the dietary manager. All other dishes and kitchenware on 7-11-12 were inspected before use to ensure they were dry by the dietary manager with no issues identified. All dishes and kitchenware will be inspected before use by the dietary manager or dietary staff to ensure they are dried for five days and then weekly for 12 weeks. A QI tool will be used to record the results of the audits. The dietary manager and/or dietary staff will take follow up action as appropriate for any potential dish storage issue upon identification. All new dietary staff will be inserviced on the proper procedure for drying dishes and kitcheware during orentation by the dietary manager. The results of the kitchenware audits will be forwarded to the QI Executive Committee monthly x3, then quarterly for review, follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.	8-1-12

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F 371	Continued From page 22 reported the tray pans of salad were kept over ice on an utility cart, away from the heat of the steam table. He commented the salad was scooped up and placed on plates or in bowls as individual meal trays were prepared. According to the DM, the need to keep chilled salads at or below 41 degrees during the entire operation of the trayline was discussed during recent scheduled in-services which were held on a monthly basis for the dietary staff. At 4:52 PM on 07/11/12 a dietary aide stated she did not prepare foods, but the usual procedure in order to keep salads below 41 degrees at the trayline was to keep the salads on ice in the walk-in refrigerator, remove them as the trayline began operation, keep them in tray pans over ice on a cart during the trayline operation, and dip the salads out as needed when serving resident plates. 2. During the initial tour of the kitchen on 07/09/12, beginning at 10:32 AM, 6 of 13 tray pans were stacked wet on top of one another. At this time the dietary manager (DM) stated these tray pans were used at the breakfast meal, and had just been washed and placed in final storage. During operation of the trayline at 12:20 PM on 07/11/12 5 of 5 sippy cups, which were placed on trays which had already been prepped with beverages and utensils, had moisture inside of them. At 4:31 PM on 07/11/12 the DM stated he held scheduled in-services monthly for the dietary	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ____ B. WING ____	07/12/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 department and impromptu meetings as problems arose. He reported his expectation was, and the staff was in-serviced that, kitchenware placed in final storage needed to be clean and dry. In addition, he commented staff was trained not to place food and beverages in wet kitchenware. He stated part of the problem was the lack of space in the small kitchen in which to air dry kitchenware before placing it into storage. At 4:52 PM on 07/11/12 a dietary aide stated scheduled dietary in-services were held monthly, and as needed (PRN) as problems arose in the kitchen. She stated recent in-services covered the need to make sure kitchenware was dry and clean before placing it in storage. She reported the DM wanted kitchenware air dried before stacking it in storage areas. She also commented staff were instructed not to place food and beverage into wet kitchenware.	F 371	F 441 The glucometer for use with resident # 54 was disinfected with an EPA registered detergent/germicidal agent in accordance with facility policy by the licenced nurse on 7-10-12. Nurse #2 was retrained in the procedure for disinfecting glucometers in accordance with facility policy by the DON on 7-10-12. All licensed nurses and medication aides will be retrained in the proper procedure for disinfecting glucometers in accordance with facility policy by the DON and Administrative Nurses beginning on 7-10-12 with completion on 7-31-12. New licensed nurses and medication aides will be trained in the proper procedure for disinfecting glucometers in accordance with facility policy during orientation by the Staff Facilitator.	8-1-12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	The DON or Administrative Nurses will audit licensed nurses and medication aides to ensure they are following the proper procedure for disinfecting glucometers in accordance with facility policy for five days, then weekly for four weeks and then monthly, using a QI tool. These audits will include resident #54.	

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
	345366	A. BUILDING ______ B. WING ______	07/12/2012

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

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F 441	Continued From page 24 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to disinfect a glucose meter with an EPA (Environmental Protection Agency) registered detergent/germicidal agent after use on 1 (Resident #54) of 2 sampled residents observed for glucose monitoring. Findings included: According to the manufacturer's care instructions for the Assure Platinum glucose meter which was not dated, cleaning and disinfecting could be completed by using a commercially available EPA registered disinfectant detergent of germicide	F 441	F 441 Continued The results of the glucometer audits will be forwarded to the QI Executive Committee monthly x3, then quarterly for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	07/12/2012

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

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F 441	Continued From page 25 wipe. To use a wipe, remove from the container and follow product label instructions to disinfect the meter. Review of the facility's procedure, which was not dated, stated: "Glucometers must be cleaned after each use. Thoroughly wipe the glucometer with the [name of germicidal disposable wipe]. Then unfold a clean wipe and thoroughly wet the surface. Wrap the wipe around the surface for a full 2 minutes to assure 2 minutes wet time. Use additional wipes if necessary. Let air dry." While conducting an observation of Resident #54 on 07/10/12 at 4:10 PM, Nurse #2 removed the glucose meter from the drawer of the medication cart. Nurse #2 took the glucose meter out of a basket which contained single use lancets (device used to obtain blood sample) and alcohol wipes. Nurse #2 opened a [name of germicidal disposable wipe] and wiped the meter and wrapped the wipe around the surface of the meter and set the meter on top of the medication cart for about 2 minutes. Then Nurse #2 picked up the meter, dried it off, placed a strip in the meter and entered the resident's room with the basket which she placed on the resident ' s over bed table. Nurse #2 took one of the alcohol wipes and lancets from the basket and obtained a blood drop from the resident in which she placed it on the strip in the glucose meter. Nurse #2 obtained the reading, removed the strip from the meter and placed the meter back in the basket on top of the lancets and alcohol wipes and left the resident ' s room and placed the basket back in the drawer of the medication cart. On interview at 4:20 PM, Nurse #2 said the policy was to clean the glucose meter before using it by placing the [name of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING ______ B. WING ______	07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 26 germicidal disposable wipe] around the meter and letting it soak for 2 minutes and then drying it off. On 07/10/12 at 4:40 PM, Nurse #2 said the policy was to clean the glucose meter before and after use by soaking it for 2 minutes using the [name of germicidal disposable wipe]. Nurse #2 said she did not clean the meter after use prior to placing it in the basket and putting it in the medication cart. In an interview with the Director of Nurses (DON) on 07/12/12 at 9:40 AM, she said it was her expectation that the glucose meter was cleaned and disinfected after each use.	F 441		

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
	345386	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/06/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 09/06/2012 there was a return grill in the laundry that was missing the radiation damper. 42 CFR 483.70 (a)	K 012	Greendale Forest Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Greendale Forest Nursing and Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greendale Forest Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	
K 051 SS=D	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	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 9-27-12

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.

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

PRINTED: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/06/2012

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

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 09/06/2012 the loss of the phone lines could not be tested. 42 CFR 483.70 (a)	K 051	K012 A radiation damper has been installed in the return grill in the laundry that was missing the radiation damper. There are no other laundry return grills in the facility that require a radiation damper. The return grill in the laundry will be inspected monthly by maintenance to ensure that it is functioning properly on an ongoing basis.	9-30-12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: A. Based on observation 09/06/2012 the corridors were used as a return air plenum. An annual waiver request is needed to continue. 42 CFR 483.70 (a)	K 067	K051 The phone line at the remote annuciator in building one has been located and marked for testing. All other annunciator panels in the facility have been inspected by maintenance to ensurethat the phone line is visible for testing. Maintenance will inspect the annuciators in the facility monthly to insure that they are visible for testing on an ongoing basis.	9-30-12

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St, Suite 4T20
Atlanta, Georgia 30303-8909

April 5, 2007

Britthaven of Snow Hill
1304 SE Second Street
Snow Hill, NC 28580

Re.: SNF CMS Certification Number (CCN): 34-5366

Dear Administrator:

This is to inform you that as a result of the Centers for Medicare and Medicaid Services Ruling (CMS-R-92-1) and Section 1819 and 1919 of the Social Security Act (the Act), agreements for Skilled Nursing Facilities and Nursing Facilities will no longer be time limited. Therefore, your facility's provider agreement will not automatically expire. The ruling affirms CMS's intention to assure consistency between the nursing home reform provisions of Section 1819 and 1919 of the Act and other program regulations.

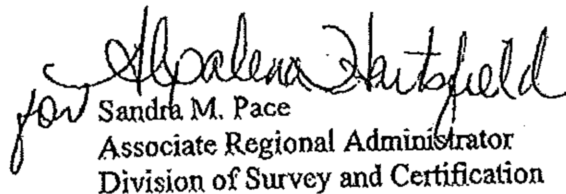
Your facility must comply with the Requirements for Participation as specified in Sections 1819(b),(c), and (d) and/or 1919(b),(c), and (d) of the Act. An onsite survey by the State Agency is still required and will be conducted periodically to verify compliance.

Waiver has been approved for K-067/Life Safety Code.

Waivers are not open-ended. The State Survey Agency will evaluate the justification for continuing these waivers or variances during each annual survey.

If you have any questions, please contact Hayri Ozdener at (404) 562-7541.

Sincerely,



for Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

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

PRINTED: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING 02 - BUILDING 02 B. WING ______	09/06/2012

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

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K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: A. Based on observation on 09/06/2012 the exits at the maintanance office and the front entrance only had one bulb to light the exit path. 42 CFR 483.70 (a)	K 047	K 067 A waiver request is attached to the Plan of Correction. The provider certifies that the following conditions are met: 1. Air handling units are equipped with smoke detectors. 2. There is a complete corridor smoke detection system. 3. Smoke detectors are wired to the fire alarm system. 4. The fire alarm system will shut down all air handling units when activated. K047 The exits at the maintenance office and the front entrance have been changed so that two light bulbs light the exit pathway. All other exits in the facility that require pathway lighting have been inspected by maintenance to ensure that they have proper pathway lighting. All lighting exits will be inspected monthly by maintenance to ensure that they are functioniing properly on an ongoing basis.	9-30-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles 2. Hall Jr.	ADMINISTRATOR	9-27-12

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.

CD

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
	345366	A. BUILDING 03 - BUILDING 03 B. WING	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Based on observation there were no LSC deficiencies noted. 42 CFR 483.70 (a)	K 000		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charles J. Dale Jr.	ADMINISTRATOR	9-27-12

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