STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Significant Change MDS (Minimum Data Set) assessment on one out of one resident (Resident #15) who was admitted to hospice. Findings include: Resident #15 was admitted to the facility on 7/15/17 with diagnoses that include major depressive disorder, anxiety disorder, anemia, type 2 diabetes mellitus with diabetic neuropathy, unspecified dementia with behavioral disturbance, and cognitive communication deficit. A review of Resident#15's most recent quarterly MDS dated 12/1/17 revealed the active diagnoses were anemia, hypertension, diabetes mellitus, anxiety disorder, depression, unspecified osteoarthritis, iron deficiency anemia, and vascular dementia with behavioral disturbance. The MDS coded Resident #15 as cognitively impaired. A review of Resident #15's medical record revealed a physician's order was obtained on	F 637	Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greenhaven Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal	3/14/18

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

Electronically Signed | 03/10/2018

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F 637	Continued From page 1 1/29/18 for a Hospice consult. A hospice consult was faxed to hospice on 1/29/18. Resident #15's medical record revealed a hospice nurse admitted the resident to hospice care on 1/29/18. A review of Resident #15's care plan revealed the care plan was updated on 2/13/18 to include hospice care with goal of resident will not experience pain without appropriate nursing intervention through next review. The interventions included consulting hospice and the physician regarding pain management. An interview with the MDS coordinator was conducted on 2/14/18 at 5:05pm. The MDS coordinator reported a significant change MDS is completed within 14 days when there is a significant change in a resident's care. She reported a Significant Change MDS should have been completed within 14 days when Resident #15 was admitted to hospice. She stated it was an oversight on her part as to why it was not completed. An interview was conducted with the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) on 2/14/18 at 5:30pm. During the interview, the DON and ADON reported it is their expectation that the MDS coordinator complete all MDS assessments including significant change assessments timely.	F 637	proceeding. 1. Resident #15 no longer resides in the facility. In review of the resident # 15□s medical record the facility determined the MDS nurse did not timely review resident #15□s physician order for hospice. The facility will perform timely reviews of hospice orders in morning clinical meeting to ensure significant change assessments are initiated timely. 2. As of 02/15/2018 re-training of the Minimum Data Set Nurse, Quality Improvement/ Assistant Director of Nursing, and Staff Development Coordinator on the completion of significant change assessment when a resident begins hospice services was completed by the DON. As of 03/06/2018 training of the Minimum Data Set Nurse, Quality Improvement/ Assistant Director of Nursing and Staff Development Coordinator on the timely review of all physician orders to provide timely assessment of all resident□s physical or mental conditions that may result in a significant change completed by the Director of Nursing. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 02/15/2018 a 100% audit of all MDS assessments for significant change assessment completion for all current residents beginning hospice services in the last quarter was completed by the	

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F 637	Continued From page 2	F 637	SDC. As of 02/16/2018 Administrative Nurses (Director of Nursing, Quality Improvement/ Assistant Director of Nursing and/or Staff Development Coordinator) will review the MDS assessments of 100% of all hospice residents utilizing the MDS Tracking Form for 3 months. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The DON, QI/ADON, or SDC will share the results of the completed MDS Tracking Form review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON, or SDC will share the results of the audit with the Quality Improvement Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) on 2 out of 5 residents (Resident #36 and Resident #48) to include special treatments or pressure ulcers. Findings include: 1.a. Resident #36 was admitted to the facility on	F 641	1. As of 02/14/2018 Resident #48□s MDS Assessment dated 01/22/18 was modified to reflect one stage four pressure ulcer by MDS nurse. The facility determined the MDS nurse did not review resident #48's most current wound ulcer flow sheet during the assessment period.	3/14/18

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F 641	Continued From page 3 11/13/17 with diagnoses that include DM (Diabetes Mellitus), Malignant Neoplasm of the Colon, Chronic Kidney Disease stage 5, End Stage Renal Disease, and Gout. A review of Resident #36's medical record revealed a progress note dated 1/10/18 from the dialysis center revealed the resident receives hemodialysis every Monday, Wednesday, and Friday at the dialysis center. A review of the most recent MDS dated 1/12/18 was coded as a 14 day assessment. The active diagnoses were coded as Anemia, Hypertension, DM, Seizure Disorder, Malignant Neoplasm of the Colon, Gout, Chronic Kidney Disease, and End Stage Renal Disease. A review of the MDS Section O: Special Treatments, Procedures, and Programs revealed it was coded as resident does not receive dialysis. 1.b. Resident #48 was admitted to the facility on 12/31/2013 with diagnoses that include Cellulitis, Respiratory Disorder, Contractures of Right and Left hips, and pressure ulcer of sacral region, unspecified stage. A review of the MDS dated 11/22/17 and coded as an annual assessment, revealed the MDS was coded under skin conditions that Resident #48 had a stage I or greater pressure ulcer, a scar over bony prominence, or a non-removable dressing/device. The MDS was also coded as having one or more unhealed pressure ulcers at Stage 1 or higher but was marked at 0 for each stage pressure ulcer. A review of the MDS dated 1/22/18 and coded as a quarterly assessment, revealed the MDS was coded under skin conditions that Resident #48 had a stage I or greater pressure ulcer, a scar over bony prominence, or a non-removable dressing/device. The MDS was also coded as having one or more unhealed pressure ulcers at	F 641	The facility will review the most current wound ulcer flow sheet during MDS assessment to ensure accuracy of assessment for the number of pressure ulcer coding. As of 02/14/2018 Resident # 36□s MDS assessment dated 01/12/2018 was modified to reflect dialysis treatment received. The facility determined the MDS nurse did not perform timely review of resident #36□s physician order for dialysis treatment. The facility will review physician orders in clinical meeting and physician orders will be reflected on the current applicable MDS assessments. 2. As of 02/15/2018 re-training of the MDS nurse, SDC and QI/ADON on correct coding of resident assessments to include coding the number of pressure ulcers in section M Skin Conditions and dialysis treatment under special treatments, procedures and programs section of the MDS was completed by the DON. As of 03/08/2018 training of the MDS nurse on reviewing the most current wound ulcer flow sheet during MDS assessment to ensure accuracy of assessment for the number of pressure ulcer coding was completed by the Administrator. As of 03/06/2018 training of the Minimum Data Set Nurse, Quality Improvement/ Assistant Director of Nursing and Staff Development Coordinator on the timely review of all physician orders to provide timely assessment of all resident□s physical or mental conditions completed by the Director of Nursing. As of 03/09/2018 the	

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F 641	Continued From page 4 Stage 1 or higher but was marked at 0 for each stage pressure ulcer. An interview was conducted on 2/14/18 at 5:15pm with the MDS coordinator. During the interview, the MDS coordinator reported she missed coding the dialysis treatment on Resident #36's MDS dated 1/12/18. She stated it was an oversight. The MDS coordinator reported it was her oversight that she did not code the pressure ulcer stage on the MDS assessments dated 11/22/17 and 1/22/18 on Resident #48. An interview with the DON (Director of Nursing) and the ADON (Assistant Director of Nursing) was conducted on 2/14/18 at 5:45pm. The ADON reported the MDS coordinator is responsible for completing all MDS assessments. The DON and the ADON revealed that it is their expectation that all MDS assessments are coded correctly. An interview with the Administrator was conducted on 2/14/18 at 6:00pm. The administrator reported it is her expectation that all MDS assessments are coded correctly.	F 641	DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 02/16/2018 a 100% audit of pressure ulcer coding was completed on all MDS Assessments in the last 30 days by the SDC. Any inaccuracies were corrected by facility protocol. As of 02/15/2018 a 100% audit of dialysis treatment coding was completed on all MDS assessments in the last 30 days by the QI/ADON. Any inaccuracies were corrected per facility protocol. As of 02/15/2018 the Administrative Nurses (Director of Nursing, Quality Improvement/ Assistant Director of Nursing and/or Staff Development Coordinator will review the MDS Assessment coding for 100% of all residents with pressure ulcers utilizing the MDS Tracking Form for 3 months and 100% of all residents receiving dialysis treatment utilizing the MDS Tracking Form for 3 months. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The DON, ADON/QI and/ or SDC will share the results of the completed MDS Tracking Tool weekly with the Administrator. To maintain continued compliance the DON, ADON/QI and/ or SDC will share the results of the review with the QI committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of	

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F 641	Continued From page 5	F 641	Nursing is responsible for the completion of the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		3/14/18

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F 656	Continued From page 6 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop and implement a comprehensive care plan on 1 out of 1 resident (Resident #36) who was on dialysis to monitor the graft access site and remove the dressing to site nightly. Findings include: Resident #36 was admitted to the facility on 11/13/17 with diagnoses that include DM (Diabetes Mellitus), Malignant Neoplasm of the Colon, Chronic Kidney Disease stage 5, End Stage Renal Disease, and Gout. Resident #36's medical record was reviewed and revealed a progress note dated 1/10/18 from the dialysis center revealed the resident receives hemodialysis every Monday, Wednesday, and Friday at the dialysis center. A review of Resident #36's medical record revealed an order was obtained on 1/15/18 from the dialysis center for the nursing home staff to remove bandage off of the graft dialysis access site nightly and clean with soap and water and leave open to air to dry. A review of Resident #36's care plan dated 11/13/17 did not address dialysis care.	F 656	1. As of 02/14/2018 Resident # 36□s care plan was updated by the MDS Nurse. In review of the resident # 36□s medical record the facility determined the MDS nurse did not timely review resident #36□s dialysis order. The facility will perform timely reviews of dialysis orders in clinical meeting to ensure timely care planning is initiated. 2. As of 02/15/2018 Re-training of the MDS Nurse, SDC and QI/ADON on developing care plans for dialysis care was completed by the DON. As of 03/06/2018 training of the Minimum Data Set Nurse, Quality Improvement/ Assistant Director of Nursing and Staff Development Coordinator on the timely review of all physician orders to provide timely assessment of all resident□s physical or mental conditions completed by the Director of Nursing. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 02/15/2018 100% audit of care plans for dialysis care was completed by	

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F 656	Continued From page 7 A review of Resident #36's updated care plan dated 1/29/18 did not address dialysis care. An interview with the MDS (Minimum Data Set) coordinator was conducted on 2/14/18 at 5:10pm. The MDS coordinator reported that ii is her responsibility to develop and revise care plans. She reported that she should have included dialysis in Resident #36's care plan. An interview with the ADON (Assistant Director of Nursing) was conducted on 2/14/18 at 5:30pm. The ADON reported that the MDS coordinator is responsible for implementing care plans for the residents. She reported it is her expectation that the care plan should be individualized and address all care areas.	F 656	QI/ADON Nurse for all current residents receiving dialysis care. As of 02/15/2018 the Administrative Nurses (Director of Nursing, Quality Improvement/ Assistant Director of Nursing and/or Staff Development Coordinator will review care plans for 100% of all residents with dialysis orders utilizing the MDS Tracking Form for 3 months. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The DON, QI/ADON, and/or SDC will share the results of the completed MDS Tracking Form review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON, and/or SDC will share the results of the review with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		3/14/18

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F 657	Continued From page 8 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to update the resident's care plan to reflect how the resident transferred for 1 of 5 residents reviewed for Activities of Daily Living (Resident #20). Findings included: Resident #20 was admitted on 12/6/17 with diagnoses of Quadriplegia, Neuralgic dysfunction, and anemia. The resident had a care plan dated 12/7/17 in place for Activities of Daily Living. The care plan stated that for transfers that the resident used to "aid of 2 people and/or mechanical lift/total dependence" and for "Bed mobility: provide constant supervision with 2 staff for physical assistance." The resident's Admission Minimum Data Set	F 657	1. As of 02/14/2018 resident # 20□s care plan was updated to reflect how the resident is to be transferred by the MDS Nurse. During review the MDS Nurse and Therapy did not have effective communication of resident #20□s transfer status at discharge from therapy. The facility will review transfer status and reflect change in transfer status on the resident□s care plans. 2. As of 02/15/2018 re-training of the MDS Nurse, SDC and QI/ADON on developing and revising care plans to include revising care plans for transfer status was completed by the DON. As of 03/09/2018 training of the MDS Nurse on reviewing resident changes in condition with therapy at discharge from therapy for accurate care planning of resident condition was completed by the	

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F 657	Continued From page 9 (MDS) dated 12/18/17 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. The resident had a catheter and was always incontinent of bowel. A physical therapy discharge note dated 1/10/18 revealed for transfers the resident met her goal of performing bed to wheelchair transfers with minimal assistance (25%) using a sliding board. Incontinence care was observed on 2/12/18 at 9:04 AM by Nurse Aide (NA) #1 and NA #2. The resident was transferred to the bed with the assistance of 2 NAs with a sliding board. Incontinence care was performed on the resident and NA #1 assisted the resident back to the wheelchair via the sliding board with the assistance of 1 staff member. NA #1 was interviewed 2/12/18 at 12:30 PM. She stated the resident only needed help with being changed, emptying her catheter bag and set up for meals. The resident could slide from the wheelchair to the bed with assistance from 1 person. NA #2 (restorative aide) was interviewed on 2/12/18 at 1:55 PM. She stated the resident required 1 person assistance with care and transferred with the sliding board. Nurse #6 was interviewed on 2/12/18 at 1:49 PM. She said the resident required 1 person assistance with transfers with the use of the sliding board. The resident was alert and oriented and required 1 person assistance with activities of daily living (ADL) care. Physical Therapist #1 was interviewed on 2/13/18	F 657	Administrator. As of 02/16/2018 a 100% audit of all care plans for correct transfer status was completed by the SDC. Any care plans identified as not having the most current transfer status were revised to reflect the current status of transfer of the residents by the MDS Nurse. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 02/15/2018 the Administrative Nurses (Director of Nursing, Quality Improvement/ Assistant Director of Nursing and/or Staff Development Coordinator will review care plans for 100% of all residents with change in transfer status utilizing the MDS Tracking Form for 3 months. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The DON, QI/ADON, and/or SDC will share the results of the completed audit tool and review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON, and/or SDC will share the results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	

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F 657	Continued From page 10 at 4:00 PM. She stated that the resident transferred with 1 person assistance with use of the sliding bed. The MDS nurse #1 was interviewed on 2/14/18 at 3:18 PM. She stated that the nurses would initiated the baseline care plans and then she would add/update the care plans. She stated she talked to staff and that's how she got information to add to the care plan. She stated that therapy gave her updates on residents' ADLs. Resident #20's care plan for transfers was created 12/7/17. She stated that therapy would usually let her know when to update the care plan but she would correct it. She looked and couldn't find anything on the care plan that mentioned the use of the sliding board. The MDS nurse #1 stated on 2/14/18 at 3:48 PM that she just updated the resident care guide and would make a copy of the updated version. The DON stated on 2/14/18 at 6:20 PM that if the care plan is written then it needed to be followed and revised as needed. The resident used to use the lift but now uses the sliding board.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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 record review, observations and staff and resident interviews. The facility failed to provide incontinence care to 1 of 5 resident's	F 677	1. As of 02/14/2018 Resident #20 received incontinence care by NA. As of 02/16/2018 training of NA #1 on providing	3/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 11	F 677		

reviewed for activities of daily living (Resident #20).

Findings included:

Resident #20 was admitted on 12/6/17 with the diagnosis of Quadriplegia, Neuralgic dysfunction, and anemia.

The resident's admission Minimum Data Set (MDS) dated 12/18/17 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. The resident had a catheter and was always incontinent of bowel.

The resident had a care plan dated 12/7/17 in place for Activities of Daily Living. The resident's care plan stated "preferred routine" for personal hygiene: "5:00 AM to 5:15 AM- suppository and catheter care, 5:30 AM to 6:00 AM- ADL care, and 8:30 AM - breakfast." The care plans also stated to "please have resident ready before breakfast."

There were no nursing notes or assessment for 2/12/18.

Breakfast trays were observed being passed on Hall 100 on 2/12/18 at 8:41 AM.

The resident was interviewed on 2/12/18 at 8:50 AM. The resident stated that she had been waiting 45 minutes since she asked the Nursing Assistant to change her. She stated she asked Nursing Assistant #1 in the hall to clean her up at 8:10 AM and told NA #1 that she "needed to be changed". She stated that Nursing Assistant #1

timely incontinence care to include communicating assistance needs with other clinical staff was completed by the DON. During review the facility determined the Certified Nursing Assistant did not have effective communication with other clinical staff to ensure timeliness of care for resident #20. The facility will communicate resident care needs to provide timely care.

2. As of 03/03/2018 training of 100% of certified nursing assistants on providing timely incontinence care to include during meal times was completed by the SDC any new hires will be trained regarding timely incontinence care during orientation by the Staff facilitator or DON. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator.

3. As of 03/08/2018 a 100% audit of all incontinence care was completed by the DON and QI/ADON. Any inaccuracies were corrected per facility protocol. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency. As of 02/21/2018 an Incontinence monitoring tool was initiated by the QI/ADON, SDC, DON or Social Worker. Monitoring will be conducted for interviewable residents at a frequency of 100% weekly x4 weeks, 50% weekly x 4 weeks, 25% weekly x 4 weeks.

4. The DON, QI/ADON, Social Worker and/or SDC will share the results of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 12 didn't say anything to her and just "blew her off." She stated that she was still waiting on NA #1 and she was the only NA that made her wait this long. She stated she had received her breakfast tray but really didn't want to eat until she was changed. She stated she had not been changed yet this morning. On 2/12/18 at 9:01 AM, The resident wheeled her wheelchair out in the hall and saw Nursing Assistant #1 and asked NA #1 for help. NA #1 entered the resident's room at 9:02 AM, spoke to the resident and then left. The resident stated on 2/12/18 at 9:03 that NA #1 had disappeared again and left. The resident put on her call light again and NA #2 (another NA) entered the resident's room on 2/12/18 at 9:03 AM and stated that she would assist her. The resident thanked NA #2 for offering to assist her and told her that she had been waiting a long time. NA #1 then entered the room at 9:04 AM. Incontinence care was observed on 2/12/18 at 9:04 AM by NA #1 and NA #2. The resident was transferred to the bed with the assistance of 2 NA's with a sliding board. NA #2 removed the resident's brief and the resident had a large bowel movement. The resident was cleaned and then NA #1 put the resident's underwear on the resident and the resident was placed back in her wheelchair. The resident was observed to have a small deep tissue injury to her buttock. Resident #20 was interviewed again on 2/12/18 at 9:31 AM. She stated that it is her routine that the nurse would give her a suppository early in the	F 677	completed audit tool and review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON, SDC and/ or Social Worker will share the results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 13	F 677		

morning around 5:00 AM and she would put a brief on. Then she would have a bowel movement and let the staff after she has went. She stated that this was the second time she has had to wait almost an hour for NA #1 to come change her. She stated it made her feel like dirt. She added that she has been a Quadaplegic for 11 years but had some movement in her hands and sensation in her legs. She stated the staff knew about her bowel regimen because it was her typical routine every morning. She stated that waiting 40 minutes was a long time but it only occurred with NA #1 worked and all the other NAs were good.

NA #1 was interviewed 2/12/18 at 12:30 PM. She stated she usually worked first shift. She stated that the resident usually got up on 3rd shift. She stated the resident only needed help with being changed, emptying her catheter bag and set up for meals. The resident could slide from the wheelchair to the bed with assistance from 1 person. From what she had heard from therapy, the resident would have a bowel movement and after she gets her suppository. She added she thinks a suppository was given around 5:00 AM. The resident only liked to wear the brief after she had the suppository. Then the resident would wear panties during the day. She stated the resident usually goes to the bathroom around 8:15 AM to 8:30 AM in the morning. NA #1 stated this morning that she was giving patient care and resident #20 had her call light on. Another NA told the resident that she (NA #1) was giving patient care and that she would be in after she was finished. She stated that the resident called her initially before breakfast tray carts came out. Then the resident rang her call light again and another staff member answered it (she didn't know who). The resident had also told her in the

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 677	Continued From page 14	F 677		

hall that she had to go to the bathroom. NA #1 stated she went to answer the light but breakfast trays had come out and she needed to pass out the trays and the other nursing assistant was providing patient care at that time. She stated after she answered the Resident's call light the last time, she went to ask the Director of Nursing if they are allowed to change residents while passing out breakfast trays. She stated then she came back in the resident's room and NA #2 (restorative aid) was in the resident's room helping her. Everyone (all staff) knew the resident needed help with being changed around that time and it's not that they are ignoring the resident. It was just they couldn't help her right then and there. She also added that she felt she was able to manage her assignment. The resident wanted the call light answered as soon as it came on. She stated she was not exactly sure how long the resident waited to be changed this morning. She stated that it typically takes 15- 20 minute to change this resident and breakfast trays would have been cold by that time so they had to be passed out.

NA #2 (restorative aid) was interviewed on 2/12/18 at 1:55 PM. She stated the resident required 1 person assistance with care and transferred with the sliding board. She stated that resident #20 was alert and oriented. This morning she stated that she went in the resident's room and the resident told her that NA #1 (that was assigned to her) was "brushing her off" and that she needed to be changed so she went in to help the resident and change her. She thinks NA #1 (that was assigned) to the resident was busy passing out breakfast trays or helping others residents. She stated that when she went in the resident's room, it was the first time she knew

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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F 677	Continued From page 15	F 677		

that the resident needed help.

Nurse #6 was interviewed on 2/12/18 at 1:49 PM. The resident required 1 person assistance with transfers with the use of the sliding board. The resident was alert and oriented and required 1 person assistance with ADL care. She stated that the resident got a suppository and her catheter irrigated in the same hour every morning around 5:00 AM. Then the NAs would get the resident up. Typically, the resident would call after having a bowel movement about an hour after being up. She stated it might take the NAs a little while to get to the resident. She was not told this morning that the resident had to go to the bathroom. If it takes the NA a little while to get to the resident, then the resident would typically come to the nursing station and tell them that she needed help. She stated the resident knew when she needs to be changed. The resident just does not have control of the bowels. Usually, the resident was changed after having a bowel movement around shift change but sometimes it occurs while they were passing out trays and there will only 1 NA on the hall. The NA will attempt to pass trays as fast as she could then would change the resident or would have someone else change the resident. It usually takes 15 minutes to pass out the trays to the hall. She stated she would also help with care if needed while trays were being passed out.

Administrator was interviewed on 2/14/18 at 6:18 PM. She stated that she would expect for care to be provide in a timely manner.

The Director of Nursing stated on 2/14/18 at 6:20 PM that NA #1 came to him and asked him if she could provide care while breakfast tray were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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F 677	Continued From page 16 being passed out. He stated he told her that she could provide care as long as she performed good hand hygiene after delivering care.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to timely administer pain medication when requested by 1 of 5 residents reviewed for unnecessary medication. (Resident #18). Findings included: Resident #18 was originally admitted to the facility on 12/1/17 with the diagnoses of diabetes, a recent amputation of his leg and depression. The resident's Mini Mental assessment dated 1/29/18 revealed that the resident had no cognitive impairment. The resident's Minimum Data Set (MDS) dated 2/4/18 revealed the resident was cognitively intact. The resident was on an anti-psychotic, anti- anxiety, anti-depressant, anti-coagulant medication. The resident was on scheduled pain medication, had received as needed pain medications and frequently had pain present. The MDS revealed the resident's pain was a 5 out 10.	F 697	1. As of 02/16/18 resident #18 received physician order for scheduled pain medication. As of 02/14/2018 training of NA#3 on timely notification to the nurse of residents request for pain medication was completed by SDC. During review the facility identified the C.N.A. did not have effective communication with the nurse to maintain pain management of resident #18. The facility will communicate resident care needs to maintain pain management. 2. As of 03/03/2018 training of 100% of certified nursing assistants on providing timely pain management notification to the nurse regarding pain requests was completed by SDC. As of 03/03/2018 training of 100% of nurses and medication aides on providing timely pain management was completed by the SDC. Any new C.N.A. hires will be trained regarding providing timely notification to the nurse during orientation by the SDC. Any new nurse or medication aide hired	3/14/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 17 The resident had a care plan in place for pain dated 2/13/18. Interventions included to administrator pain medication as per the physician's orders and note the effectiveness. Physician orders for 2/2018 revealed the resident was getting Percocet (a pain medication) 10/325 milligrams (ml) every 4 hours as needed for pain. The Medication Administration Record (MAR) dated 2/2018 revealed that on 2/14/18, the resident received Percocet pain medication as needed at 9:15 AM. There were no nursing notes for 2/14/18. The resident was interviewed on 2/14/18 at 4:31 PM. He stated he has pain in his stump and back. He stated his pain level was a 9/10 in his stump from the amputation and his pain was sharp and throbbing. He stated he has usually been asking for pain medication every 4 hours. He stated that he requested for pain medication at 3:30 PM and had told nursing assistant (NA) #3. He stated that NA #3 said she would tell the nurse but he stated he still has not received the pain medication yet. He stated this happens a lot of the time. He stated that as of 2:30 PM, he was technically able to ask for the medication and receive it. He stated he was at an appointment earlier today so he couldn't ask for the pain medication until he got back. The resident grimaced as he touched his stump to indicate where the pain was. Nursing Assistant #3 was interviewed on 2/14/18 at 4:55 PM. She stated she usually worked 2nd and 3rd shift. She stated the resident could use the call bell and around 3:20 PM, the resident called for something for pain and told her that he	F 697	will be trained regarding timely pain management during orientation by the Staff facilitator or DON. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 03/09/2018 a 100% audit of all residents receiving PRN pain medication was completed by the DON. No concerns were identified. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency. As of 02/15/2018 a PRN Pain Interview form was initiated by the DON. Monitoring will be conducted for interviewable residents currently receiving PRN pain management by the QI/ ADON, SDC or DON at a frequency of 100 % of residents weekly x4 weeks, 50% weekly x 4 weeks, 25% weekly x 4 weeks. 4. The DON, QI/ADON, and/ or SDC will share the results of the completed audit tool and review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON, and/ or SDC will share the results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	

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	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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F 697	Continued From page 18	F 697		

wanted something for pain. She stated then she had to go help another resident and the resident called again around 3:45 PM and wanted his banana peel to be thrown away and a menu. She stated that she told resident #18 that she didn't forget about him and his pain. She stated then she went and told nurse #5 (1st shift nurse) that the resident was having pain. She stated the resident asked for pain pills all the time and she was not sure if it was time for the resident to have pain medications or not.

Nurse #5 was interviewed on 2/14/18 at 5:23 PM. She stated she worked 100 hall today (not Resident #18's hall). She stated the resident did typically ask for pain medication regularly though. She stated that she was not told by the staff or the resident that he needed pain medication at any point today. She stated she worked the 100 hall today and nurse #6 was the nurse that worked 1st shift with resident #18 today.

Nurse #6 (worked with the resident on 1st shift) was interviewed on 2/14/18 at 5:32 PM. She stated she worked the 200 hall today. She stated she knew the resident got morning pain medication at 9:15 AM. She stated the resident had an appointment and got back around 3:00 PM. The resident had not called her for pain medication. No one had ever told her that the resident was having pain when he got back. The resident usually did get his pain medication every 4 hours. She stated if the resident was having pain then she would have given the pain medication to the resident. She stated this resident usually had pain in the same area (stump). She stated it usually took about 10 minutes for her to administer pain medication to a resident once she is told that a resident is having

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	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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F 697	Continued From page 19	F 697		

pain. An hour was a long time for the resident to wait for pain medication.

Nurse #4 (nurse working 2nd shift) was interviewed on 2/14/18 at 4:35 PM. She stated resident #18 gets medication for pain and anxiety. The resident gets Percocet every 4 hours as needed for pain. The resident will sometimes say the medication helps and the resident makes sure he gets it every 4 hours. The resident will not really express pain, he will just say that he needs his pain medication. The nurse in report told her that the resident would probably be calling for his pain medication at any point because he was out for an appointment earlier today. She stated the resident was last given pain medication at 9:15 AM. She added that the resident got back from his appointment around 3:00 PM and the resident was back when she came in at 3:00 PM today. There were no new orders from the patient's appointment today. She stated that neither a staff member nor Resident #18 himself told her that the resident was having pain or that he requested pain medication.

Nursing Assistant #3 was observed asking nurse # 4 on 2/14/18 at 5:10 PM if the off going nurse had told her that the resident was having pain. Nurse #4 said no. NA #3 told nurse #4 that the resident had told her that he was having pain and that she had told nurse #5.

Nurse #4 (2nd shift nurse) was interviewed again on 2/14/18 at 6:04 PM. She stated she gave the resident his Percocet pain medication around 5:00 PM. She stated that the resident was alert and oriented times 3 (person, place, and time) to 4 (person, place, time, situation)

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	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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F 697	Continued From page 20 The resident was interviewed again on 2/14/18 at 6:07 PM. He stated that he received his pain medication at 5:15 PM tonight and that his pain level was at 9/10 at that time. NA #3 was interviewed again on 2/14/18 at 6:10 PM. She stated that she was sure that she told nurse #5 because the other nurse that was assigned to the resident was very busy. She stated that when she told nurse #5, she said "ok". The Administrator was interviewed on 2/14/18 at 6:34 PM. She stated that she would expect pain medications to be given in a timely manner.	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	F 757		3/14/18

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 757	Continued From page 21 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain lab work as ordered by the physician for 1 of 7 residents that were reviewed for unnecessary medications (Resident #2.) Findings Included: Resident #2 was admitted to the facility on 11/28/17 and diagnoses included vascular dementia with behavioral disturbance, schizoaffective disorder and cognitive communication deficit. A comprehensive minimum data set (MDS) dated 12/12/17 for Resident #2 revealed her cognition was severely impaired, she exhibited symptoms of being depressed 7 to 11 days during the look back period, exhibited trouble concentrating 12 to 14 days during the look back period and displayed physical behaviors directed towards others 4 to 6 days during the look back period. The MDS also identified she had received antipsychotic and antidepressant medications for 7 days during the look back period. Review of a psychiatric evaluation for resident #2 on 12/28/17 revealed she had been seen for a follow-up medication check and staff request. The evaluation stated staff reported the patient was exhibiting bizarre behavior, labile mood, inconsistent compliance with medications and difficulty communicating distress. Recommendations included to start Depakote sprinkles (a medication used to treat seizure disorder and mood/mental disorders) 125 milligrams (mg) every evening for 3 days, then	F 757	1. As of 02/14/2018 resident # 2 received valporic acid lab ordered by nurse practitioner by hall nurse. The lab results of resident #2's valporic acid lab were communicated to the Nurse Practitioner on 02/14/2018. During review the facility determined the nurse did not input resident #2□s valporic acid lab into the lab portal. The facility will input physician lab orders into the lab portal for residents. 2. As of 03/03/2018 Re-training of 100% of all hall nurses on timely collection of all ordered labs was completed by SDC. As of 02/15/2018 a 100% audit of all residents receiving Depakote were audited for valporic acid lab timely collection by the QI/ADON. Any discrepancies were addressed per facility protocol. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. Any new nurse hired will be trained on timely collection of all ordered labs in orientation by the SDC or DON 3. As of 02/15/2018 a Valporic Acid Lab Monitoring tool was initiated by the QI/ADON. Monitoring will be conducted at a frequency of 100% of residents weekly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

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F 757	Continued From page 22 125 mg twice daily for 3 days, then 250 mg twice daily for 3 days, then 250 mg three times daily with meals to stabilize mood. Check VPA (valproic acid level) on 1/28/18 to monitor medication. A review of the electronic and hard copy medical record for Resident #2 revealed no lab result for a VPA level as of 2/14/18. A telephone order dated 2/14/18 at 12:25 pm for Resident #2 was provided by the Director of Nursing (DON.) The order stated to discontinue the VPA lab scheduled for 1/28/18 and draw a VPA level stat. An interview on 2/14/18 at 2:15 pm with Nurse #6 revealed when lab work was ordered it was supposed to be transferred from the telephone order to the computer so it would be added to the list for lab draws. She stated the lab company comes to the facility on Mondays, Wednesdays and Fridays to draw routine labs. Nurse #6 added she was not sure why the VPA level for Resident #2 was not drawn on 1/28/18 as ordered. She stated since Resident #2 had started the Depakote she hadn ' t seen any significant improvements in her behaviors; she still had episodes of crying and yelling. An interview on 2/14/18 at 2:30 pm with the DON revealed the telephone order to draw the VPA level on 1/28/18 had not been transferred into the computer system and had not been obtained. He stated he contacted the psychiatric Nurse Practioner (NP) that had ordered the lab work today and she re-ordered the lab to be drawn stat. The DON added it was his expectation that lab work was completed timely and as ordered.	F 757	4. The DON, QI/ADON, and/or SDC will share the results of the completed audit tool and review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON and/or SDC will share the results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	

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F 757	Continued From page 23 A phone interview on 2/14/18 at 3:04 pm with the psychiatric NP revealed she had seen Resident #2 twice since she was admitted to the facility. She stated she had started the resident on the Depakote towards the end of December to help stabilize her mood. The NP explained she ordered the VPA level to be drawn 1/28/18 as a pharmacy protocol. The NP stated she did expect lab work would be obtained as ordered and she re-ordered the VPA level today when she was notified it had not been done.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		3/14/18

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F 761	Continued From page 24 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to lock the medication cart when not in use for 1 out of 2 carts and left medications unattended on top of the cart for 1 out of 2 residents receiving medications. Findings include: On 2/12/18 at 4:22pm observed Nurse #4 passing medications on the 200 hall. She positioned the medication cart against the wall to the right of the door for room 201. Nurse #4 prepared Dicyclomine 5ml in medication cup and set out Novolog insulin bottle and syringe on top of medication cart. She then went into room 201 to check the resident's blood sugar. An observation was made that revealed the metal bars that lock the medication cart were left in the open position while Nurse #4 was in the room out of eyesight from the cart. During this time, another resident rolled within 2 feet of the cart until redirected by other staff. Two visitors also passed by the cart on the way to other rooms while Nurse #4 was in room 201. On 2/12/18 at 4:30pm an interview was conducted with Nurse #4. She reported that she should always lock the cart when she leaves it unattended and that all medications need to be locked in the cart or taken in the room with her. An interview was conducted on 2/14/18 at 5:30pm with the ADON (Assistant Director of Nursing). The ADON reported it is her expectation that all medications are kept in a locked medication cart when the cart is left unattended. She reported it is the responsibility of the nurse to make sure the cart is locked and medications are secure in the cart when she leaves the cart.	F 761	1. As of 02/14/2018 training of nurse #4 on locking medication carts and storage of medication when the medication cart is unattended completed by the SDC. As 02/14/2018 the medication cart was locked and all medications were properly stored by nurse #4 when unattended. During the review the facility determined nurse #4 became unfocused and did not secure the medications and lock the cart on 02/14/18. The facility licensed nurses and medication aides will maintain focus and secure medication carts and medication at all times on all shifts. 2. As of 03/03/2018, 100% training of all hall nurses and medication aides on locking carts and storage of medication when the medication cart is unattended was completed by the SDC. Any new hired nurse or medication aide will be trained on locking carts and storage of medication when the medication cart is unattended by the SDC or DON. As of 03/09/2018 the DON, QI/ADON, SDC and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 02/15/2018 a 100% audit of medication carts was completed by the DON. No concerns identified. As of 02/15/2018 a Medication Cart Monitoring tool was initiated by the DON. Monitoring	

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F 761	Continued From page 25 An interview with the administrator was conducted on 2/14/18 at 6:00pm. The administrator reported it is her expectation that the medication carts are kept locked with all medications in the cart when the cart is unattended.	F 761	will be conducted at a frequency of 15 times weekly x 3 months. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The DON, QI/ADON, and/or SDC will share the results of the completed audit tool and review weekly with the Administrator. To maintain continued compliance the DON, QI/ADON and/or SDC will share the results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Director of Nursing is responsible for the completion of the plan of correction.	
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to serve food that was palatable and at temperatures acceptable to the residents that resided in the facility. This was evident in 1 of 1 meal observed. Findings Included:	F 804	1. As of 02/14/18 insulated bases and heated plates were added to all resident trays by dietary aide. As of 03/07/2018 all 22 insulated bases were replaced with new insulated bases by the Dietary Manager. Resident #33 and # 205 no longer reside in the facility. As of	3/14/18

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F 804	Continued From page 26 An interview with Resident #33 on 2/12/18 at 8:55 am revealed he ate his meals in his room and that his breakfast meal was always served cold. An interview with Resident #24 on 2/12/18 at 11:00 am revealed her meals were served cold and most of the staff would not reheat her tray. She added this was always a problem and if the facility had more staff it would be better. An interview with Resident #205 on 2/13/18 at 9:27 am revealed she hadn ' t been able to eat much of the food at the facility because it was cold when she received it. Resident #205 added the breakfast meal was especially served cold. A review of the facility grievance forms for the past 6 months, provided by the facility Administrator, identified there had been 11 resident grievances submitted about the food being cold when served. An observation of the kitchen steam table was conducted on 2/14/18 at 8:00 am. The Dietary Manager (DM) checked the temperature of a digital thermometer which read 42.2 degrees F. The DM obtained a stem thermometer and calibrated this thermometer to 32 degrees F. The temperatures of the food on the steam table were taken using the calibrated thermometer and were: oatmeal 180 degrees F, scrambled eggs 158 degrees F, grits 151 degrees F, pureed sausage 159 degrees F, pureed eggs 161 degrees F, ground sausage 156 degrees F and gravy 152 degrees F. A test tray was prepared for the 200 hall. The resident meals trays for the 200 hall were initially assembled without an insulated base underneath the plates of food. The insulated	F 804	02/28/2018 resident #24 was interviewed regarding food palatability and temperature by the Social Worker. No concerns were identified. During review the facility identified bases were not providing heat keeping. The facility will provide insulated bases that provide heat keeping to meal plates. 2. As of 02/14/2018 training of 100% of dietary staff on the use of insulated bases, heated plate lowerator and heated plate warmers at all meals was completed by the dietary manager. Any new dietary aide or cook hired will be inserviced on the use of insulated bases, heated plate lowerator and heated plate warmers in orientation by the Dietary Manager. As of 03/09/2018 the Dietary Manager and Social Worker were re-trained on monitoring form and frequency by the Administrator. 3. As of 03/10/2018 a 100% audit of test tray temperature for all halls to include the dining room was completed by the Dietary Manager. Any discrepancies were addressed per facility protocol. As of 02/28/2018 a 100% audit of all interviewable residents was completed on palatability of food by the social worker. No concerns were identified. As of 02/16/2018 a Meal Tray Monitoring Tool was initiated by the Dietary Manager. Monitoring will be conducted by the Dietary Manager at a frequency of 5 test trays weekly x4 weeks, 3 test trays weekly x 4 weeks, 1 test tray weekly x 4 weeks. As of 02/28/2018 a Dietary Monitoring	

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F 804	Continued From page 27 bases that were available were noted to be damaged with cracks and plastic peeling off of them. The test tray was delivered to the 200 hall with 10 resident meal trays at 8:50 am. The test tray was checked at 9:00 am when all of the resident meal trays had been served. The DM checked the temperatures of the test tray using a calibrated thermometer. The scrambled eggs were 100 degrees F and tasted cool. The oatmeal was 130 degrees F and tasted warm. The bacon and toast tasted cool. The coffee was 135 degrees F and tasted warm. An observation and interview with Resident #33 on 2/14/18 at 9:05 revealed he was eating his breakfast. He had been served scrambled eggs, bacon, toast and cold cereal. Resident #33 stated his breakfast tasted cold. He added he didn ' t ask the staff to reheat his food because it already took too long to get his food. . An interview with the DM on 2/14/18 at 4:49 pm revealed she had received resident complaints about cold food in the past. The DM added she had conducted some test tray checks and thought the reason the food was cold was because the trays set on the halls for a while before they were delivered to the residents. The DM explained the dietary staff were supposed to put the insulated base and top on the resident meal trays that were served on the halls. She added the insulated bases were in poor repair and that could be contributing to why the food wasn ' t staying warm. The DM stated it was her expectation that food was served timely, at the appropriate temperature and tasted good. An interview with the Administrator on 2/14/18 at 6:39 pm revealed she expected the residents	F 804	Tool- Resident Interview was initiated by the Social Worker. Monitoring of interviewable residents will be conducted by the social worker at a frequency of 100% weekly x 4 weeks, 50% weekly x 4 weeks and 25% weekly x 4 weeks. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The Dietary Manager and/ or Social Worker will share the results of the completed audit tools and review weekly with the Administrator. To maintain continued compliance the Dietary Manager and/ or Social Worker will share the results of the audits with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Dietary Manager is responsible for the completion of the plan of correction.	

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F 804	Continued From page 28 meals were palatable and served warm.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store opened food products in sealed, labeled and dated containers, failed to label and date nutritional supplements to identify their use by date, failed to maintain clean floors, walls and kitchen equipment, failed to maintain insulated plate bases in good repair and failed to wear hair restraints that fully covered their hair while working in the kitchen. This was evident during 2 of 2 kitchen observations. Findings Included:	F 812	1. As of 02/12/2018 the partial cases of hamburger patties, pork riblets, sliced carrots, green peas, Vegetable blend mix, biscuit dough, parker house rolls, chocolate chip cookie dough and sugar cookie dough that were opened were discarded by the dietary manager . As of 02/12/2018 the 2 partial boxes of lasagna noodles, partial box of egg noodles, partial box of elbow macaroni and a partial case of rice were discarded of by the dietary manager. As of 02/12/2018 the exterior of the gas	3/14/18

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F 812	Continued From page 29 1. An observation of the kitchen on 2/12/18 at 6:25 am revealed: a. The walk-in freezer contained partial cases of hamburger patties, pork ribettes, sliced carrots, green peas, vegetable blend mix, biscuit dough, parker house rolls, chocolate chip cookie dough and sugar cookie dough that were opened and exposed to air. The case of opened sugar cookie dough had ice covering the exterior of the box. b. The dry storage room contained 2 partial boxes of lasagna noodles, a partial box of egg noodles, a partial box of elbow macaroni, and a partial case of rice that were open and exposed to the air. c. The exterior surface of the gas range was grease covered. The exterior surface of the steamer was grease covered and the top had an accumulation of dust. d. The floor underneath and behind the cooking equipment located under the ceiling hood system had sections that were darkened, greasy and contained food particles. An interview with Cook #1 on 2/12/18 at 6:40 am revealed that all open food products should be sealed, labeled and dated. 2. An observation of the nourishment room located at the nursing station for the 400 hall was conducted on 2/12/18 at 6:50 am. The refrigerator contained 5 - 4 ounce thawed health shakes that were not labeled or dated. An interview with the Dietary Manager (DM) on 2/12/18 at 7:40 am revealed that opened food items should be sealed, labeled and dated. She stated there was a seal in the walk-in freezer that had been a problem and caused some ice build-up in the freezer. The DM explained the	F 812	range was cleaned by the Dietary Manager. As of 02/12/2018 the exterior surface of the steamer was cleaned and the top dusted by the Dietary Manager. As of 02/12/2018 the floor underneath and behind cooking equipment located under the ceiling hood system were cleaned by the dietary manager. As of 02/12/2018 the 5 □ 4oz health shakes were discarded of by the Dietary Manager. Upon review the dietary cook did not complete end of shift rounding/ cleaning on 02/11/2018 to ensure all stored food and nutritional supplements were sealed, dated and labeled; equipment and floor were clean. As of 03/07/2018 all 22 insulated bases were removed from service and replaced with new bases by the Dietary Manager. As of 02/14/2018 the wall around the entry doorway extending to the dish room was cleaned by the Dietary Manager. As of 02/14/2018 the base of the plastic storage caddy was cleaned and empty condiment packages removed by the Dietary Manager. As of 02/14/2018 Cook #1 and DM□s hair was fully covered with a hair restraint and not exposed. Upon review the dietary aid did not perform proper end of shift cleaning of the equipment and walls on 02/13/2018. Upon review the dietary aides did not have the right size hair restraint available for staff use on 02/14/2018. Upon review the	

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F 812	Continued From page 30 cooking equipment and floor should be clean and free from grease. She added the cooking equipment was scheduled to be cleaned on Mondays but should be cleaned daily as needed. The DM stated the health shakes should be labeled and dated when they are thawed and she believed they were good for 30 days in the refrigerator after being thawed. An interview with the DM on 2/13/18 at 9:30 am revealed she had checked on how long health shakes could be kept after thawing and they could be held refrigerated for 13 days. 3. An observation of the kitchen on 2/14/18 at 8:00 am revealed: a. 22 insulated plate bases were noted with pieces of plastic peeling off, had cracks and deep scratches. b. The wall around the entryway into the kitchen extending to the dish room had sections with food spills. c. The base of a plastic storage caddy that held dish machine racks had a layer of food debris and empty condiment packets. d. Cook #1 and the DM were working in the kitchen with the lower portions of their hair exposed, not in a hair restraint. An interview with the Regional Dietary Representative on 2/14/18 at 8:30 am revealed the facility needed new insulated plate bases and the damaged ones should be discarded. An interview with the DM on 2/14/18 at 4:52 pm revealed she expected the walls to be wiped down daily and not have food spills. She stated the insulated plate bases should be in good condition and free from any damage. The DM	F 812	facility identified bases were not removed by dietary staff as they identified as not being in good repair. The facility will store open food products in sealed, labeled and dated containers or bags. The facility will label and date nutritional supplements. The facility will maintain clean dietary equipment, walls and floors. The facility staff will wear hair restraints that fully cover their hair while working in the kitchen. The facility will maintain insulated bases in good repair. 2. As of 02/14/2018 in-servicing of the dietary manager on wearing a hair net to include covering all hair exposed was provided by the HCSG District Manager. As of 02/16/2018 100% in-servicing of dietary staff on storing open food products in sealed, labeled and dated containers; labeling and dating nutritional supplements; maintaining clean dietary equipment, walls and floors and maintaining insulated bases in good repair to include notification of dietary manager of equipment needs. Any newly hired dietary aid or cook will be trained on sealing, labeling and dating food products; labeling and dating nutritional supplements; maintaining clean equipment, walls and floors; wearing hair restraints that fully cover their hair while working in the kitchen by the Dietary Manager. As of 03/09/2018 the Dietary Manager was re-trained on monitoring form and frequency by the Administrator. 3. As of 02/12/2018 an audit of 100% food products was completed by the	

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F 812	Continued From page 31 added the plastic storage caddy should be clean and that all staff working in the kitchen should have their hair fully covered with a hair net. An interview with the Administrator on 2/14/18 at 6:43 pm revealed she expected all kitchen equipment and floors to be clean. She added all equipment should be in good repair. The Administrator stated she expected food would be stored correctly and hairnets would be worn by all dietary staff.	F 812	dietary manager. As of 02/12/2018 an audit of 100% dietary supplements was completed by the dietary manager. As of 02/14/2018 an audit of 100% dietary floors, walls, and equipment was completed by the Dietary Manager. As of 2/14/2018 an audit of 100% hair restraints was completed by the Dietary Manager. As of 02/14/2018 an audit of the dietary manager□s hair restraints was completed by the HCSG District Manager. As of 02/14/2018 an audit of 100% insulated bases was completed by the Dietary Manager. Any discrepancies were addressed per facility protocol. As of 02/14/2018 a dietary monitoring tool was initiated by the dietary manager. Monitoring will be conducted at a frequency of 5 reviews weekly x4 weeks, 3 reviews weekly x 4 weeks, 1 review weekly x 4 weeks. As of 03/09/2018 a hair restraint monitoring tool was initiated by the Administrator. Monitoring will be conducted at a frequency of 5 reviews weekly x 4weeks, 3 reviews weekly x 4 weeks and 1 review weekly x 4 weeks. As of 03/09/2018 the tracking tool was adjusted by the Administrator. 4. The Dietary Manager, Social Worker, DON, QI/ADON and/or SDC will share the results of the completed audit tool and review weekly with the Administrator. To maintain continued compliance the Dietary Manager, Social Worker, DON, QI/ADON and/or SDC will share the	

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	345132	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 32	F 812	results of the audit with the QI Committee on a quarterly basis. If additional issues are noted those issues will be addressed immediately and correction action taken. The Dietary Manager and the Administrator are responsible for the completion of the plan of correction.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility ' s Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on March, 2017. This was for three recited deficiency, which was originally cited in March, 2017 on a recertification and complaint survey and again on a follow up complaint survey in May 2017. The deficiency were cited again as in the area of Minimum Data Survey (MDS) accuracy and Activities of daily living (ADL's) on Recertification survey and complaint on 2/14/2018. The continued failure of the facility during three surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Finding Included: The tag is cross referred to:	F 867	1) On 02/28/18 the facility Executive QI Committee held a meeting. The Medical Director, Administrator, DON, QI nurse, MDS nurse, treatment nurse, staff facilitator, maintenance director, and housekeeping supervisor will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. All survey issues were reviewed on 02/28/2018 during QI meeting to include repeat issues for continued compliance. 2) As of 02/23/2018 training of the administrator on the QI process was completed by nursing consultant. As of 02/28/2018 training of the QI Team was completed by the Administrator As of 02/28/2018 after the administrator in-service with the QI team, the facility QI	3/14/18

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F 867	Continued From page 33 F 279 Based on record review and staff interviews the facility failed to develop a care plan for 1 of 1 resident who was reviewed for dialysis (Resident #79). During the recertification survey of March 17, 2017, the facility was cited for F279 for falling to develop a care plan for 1 of 1 resident reviewed for dialysis (Resident #79). On the current Recertification and complaint survey on February 14, 2018 the facility failed to develop and implement a comprehensive care plan (new F656) on 1 out of 1 resident (Resident #36) who was on dialysis to monitor the graft access site and remove the dressing to site nightly. F 312 Based on observations, record review, staff and resident interviews the facility failed to provide appropriate cleansing of the genitals, wash the skin on the left leg and thoroughly rinse the body soap off the skin of Resident #8. The facility failed to clean the finger nails of dependent Residents #36, #22 and #51. The facility failed to remove the hair from Resident #52's chin. The facility failed to comb the hair of Resident #51 who was dependent on staff for care. The facility failed to transfer Resident #5 out of bed per the physician order and resident choice. This was evident in 6 of 10 dependent residents in the sample reviewed for activities for daily living. This was during the recertification of March 2017. F312 Based on record reviews, resident and staff interviews, and the facility failed to turn and reposition and to assist with hydration for 1 of 5 sampled residents reviewed for activities of daily living (ADL) care, Resident #16. This was during the complaint survey of May 2017.	F 867	Committee began identifying other areas of quality concern through the QI review process, for example: review physician orders, review of Point Click Care (Electronic Medical Record), resident council minutes, resident concern logs, pharmacy reports, and regional facility consultant recommendations. 3) On 02/23/2018 the facility consultant in-serviced the facility administrator. As of 02/28/2018 the facility administrator in-serviced the director of nursing, MDS nurse, treatment nurse, maintenance director, dietary manager, social worker, activities director, QI/ ADON nurse, rehab director, accounts payable, admissions coordinator, and housekeeping supervisor related to the appropriate functioning of the QI Committee and the purpose of the committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns, to include F 656 Develop and Implement a comprehensive care plan and F 677 Activities of Daily Living. 4) The Facility QI Committee will meet at a minimum of Quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F 656 Develop and Implement a Comprehensive Care Plan and F 677	

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F 867	Continued From page 34 During the recertification and complaint survey on February 14, 2018, the facility was cited the new F 677 (old F312). The facility failed to provide incontinence care to 1 of 5 resident's reviewed for activities of daily living (Resident #20). During an interview with the Director of Nursing (DON) and the QA Nurse on February 14, 2017 at 5:45pm both revealed their expectation that the team meet monthly now to work on the issues and concerns. DON revealed he had just got to the facility the first of February he expected the team would meet as soon as possible to discuss improvements for this facility.	F 867	Activities of Daily Living as reflected in the plan of correction. The Committee will continue to meet at a minimum of monthly. The QI Committee, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The Administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The Administrator will report back to the Executive QI Committee at the next scheduled meeting. The Director of Nursing and the Administrator are responsible for the completion of the plan of correction.	