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 06/22/2018

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/18/2018

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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exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff and resident interviews, the facility staff failed to treat the resident with dignity by yelling at the resident when she came in to assist him with ADL (Activities of Daily Living) care provide care in 2 of 5 dependent residents (Resident #1 and Resident #2). The facility further failed to serve residents meal trays at the same time all table mates were served for 1 out of 3 residents (Resident #11).
Findings include:
1. Resident #2 was admitted to the facility on 1/18/17 with diagnoses of sepsis, contractures of the right and left hands, unsteadiness on feet, and type 2 diabetes mellitus.
A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment.
Resident #2's functional status was coded as needing 2 plus person assistance with bed mobility, dressing, bathing, toileting, and personal hygiene.
A review of Resident #2's care plan dated 4/20/18 included that the resident is at risk for further decline in ADLs related to impaired mobility.

A review of the facility's grievance reports for May and June 2018 revealed Resident #2 had filed 14 grievances involving lack of ADL assistance.

An interview was conducted with Resident #2 on 6/17/18 at 5:30pm. Resident #2 reported on that on 5/28/18 NA#10 entered his room around 9:30am and he asked her to pull him up in bed. The resident reported that NA #10 stated she

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An acceptable plan of correction must contain the following elements:
- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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,

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F 550	Continued From page 2 would have to find someone to help her and left the room. Resident #2 reported after about an hour he rang his call bell but no one answered so he called the facility. He reported the DON (director of nursing), the treatment nurse and NA #10 arrived in his room. He reported the NA #10 started yelling at him and called him "a liar." He reported NA #10 "made me feel uncomfortable." Resident #2 reported doesn't know what happened with NA #10 but that she was no longer one of his caregivers. Resident #2 stated that on 6/11/18 he pushed the call bell at 8:30am because he had had a bowel movement. He reported a NA (nursing assistant) came in and told him that she would have to find someone to help her. Resident #2 reported no one came back in the room until 11:30am when the treatment nurse arrived to perform his wound care to his left leg. The resident reported the treatment nurse told him she would let the staff know to come and change him. Resident #2 reported at 12:00pm no one had shown up to change him so he rang his call bell again. He reported a NA arrived and told him it would have to be after lunch as she could not find anyone to help her change him. Resident #2 reported at 1:45pm he still had not been changed and he rang his call bell again. He reported the DON (director of nursing) and the treatment nurse arrived in his room and they cleaned him and changed him at that time. The resident reported that he felt like he was being ignored and that him lying in stool wasn't important to the staff. An interview was conducted on 6/20/18 at 11:31am with NA #10. She reported that on 5/28/18, Resident #2 had asked her to pull him up in bed when she was collecting the breakfast trays. She reported it takes 2 people to provide	F 550	Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failure promote dignity during activities of daily living (ADL) care, and during meal- was failure to follow established procedure. During the complaint survey resident #1 and resident #2 were provided ADL care to promote dignity, including without yelling, by the certified nursing assistants. On 6/19/18 at the lunch meal, resident # 11 was provided a dignified dining experience by all tablemates being served the meal at the same time by a certified nursing assistant The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/2018, the social worker (SW) began interviewing all residents determined to be interviewable. This interview consisted of questions including 1. Are you provided with adl assistance	

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care for Resident #2 and she told him she would find someone to assist her. She reported when she went back in the room with the DON, Resident #2 reported he needed changing. NA #10 reported that was the first time she had heard he needed changing and she reported she was upset with the resident. She reported he told her he didn't want her touching him so she left the room. She reported she knew she should not have gotten angry with the resident.

An interview was conducted on 6/20/18 at 11:40am with the treatment nurse. She reported that on 6/11/18 she went into Resident #2's room around 11:30am and he told her he needed changing. She reported she told the NA working with Resident #2 that he needed to be changed. The treatment nurse reported when she arrived back in his room close to 2:00pm he was still waiting to be changed from a morning bowel movement so she and the DON changed the resident.

An interview was conducted on 6/20/18 at 11:45am with the DON. She reported she was in Resident #2's room on 5/28/18 with NA #10 when an altercation occurred between the resident and NA #10. The DON reported she had NA #10 leave the room as soon as NA #10 began yelling at the resident. The DON reported it was her expectation that the residents are treated with dignity and respect from all the staff members. When the DON was questioned about Resident #2 having to wait so long on 6/11/18 to be changed, she stated she expected residents to be promptly taken care of when they had incontinence.

An interview was conducted with the acting

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timely, and with dignity? and 2. Have you been yelled at by the staff during adl care? Interviews will be complete by 7/20/18. Any negative findings will be addressed immediately by the sw.
Beginning on 7/12/18 the facility treatment nurse and/or director of nursing observed all non-interviewable residents to ensure dignity was provided during adl care, including no yelling. Observations were completed on 7/13/18 with no negative findings.
On 7/12/18 the facility treatment nurse observed meal delivery to ensure all residents had a dignified dining experience, including all tablemates served at one time.
All nursing staff, including agency, will be in-serviced by 7/20/18 by the director of nursing, or Administrator on promoting dignity during adl care, including not yelling at residents, timely incontinent care, and residents must be served one table at a time. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursing staff, including agency.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The director of nursing, administrator, facility consultant, and/or minimum data set nurse will audit 10 residents weekly for 12 weeks to ensure adl care is provided to promote dignity, and meal is served at the

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F 550 Continued From page 4

administrator on 6/21/18 at 11:55am. He reported it was his expectation that all staff treated all the residents with dignity and respect and are prompt in responding to call lights and requests.
2. Resident # 1 was admitted to the facility on August 2, 2018 with current diagnoses of anemia, absence of both left and right legs below the knee, hypertension and diabetes mellitus.

Resident # 1's Minimum Data Set (MDS) dated May 5, 2018 revealed Resident # 1 was cognitively intact. Resident # 1 required extensive assistance with bed mobility and transfer with two person physical assist. Locomotion on/off unit, dressing, toilet use and personal hygiene required extensive assistance with one person physical assist. Resident # 1 was incontinent of bladder and bowel.

During an interview with Resident # 1 on June 17, 2018 at 4:45 pm, she revealed that she has had several issues with staff not answering her call bell in a timely manner. Resident #1 reported issues on 4/2/2018 when she was left in bed for 2 hours waiting to be changed because staff told her, that she was not wet enough to be changed. She added this had been going for weeks. Resident #1 stated she had filed a grievance about this and nothing had been done. Resident #1 also indicated that a second shift staff person would come in the room and place the call bell out of reach. Resident #1 stated, "that made her feel really bad." Resident #1 also indicated this happened to her last in May, 2018 when she waited three hours for staff to change her. She stated she had urine on herself, "that's a bad feeling to be wet too." Resident # 1 indicated this would always be a problem until the facility get more staff. Resident #1 indicated this went on

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same time as their tablemates. This audit will be documented on the F550 Audit Tool.
The monthly QI committee will review the results of the F550 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

The title of the person responsible for implementing the acceptable plan of correction.
The Director of nursing is responsible for implementing the acceptable plan of correction.

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F 550	Continued From page 5	F 550		

weekly here and "She felt helpless". Resident #1 revealed she had not had a shower in two months.. Resident #1 indicated her shower days were Mondays and Thursdays. She explained she was a large person and needed her showers weekly so she would not have an odor. Resident #1 indicated if she could have a shower this would make her feel better. She stated "staff came in, shut off the bell, moved it out of reach and care was not provided., that was not right."

Observation of the clock beside Resident #1's TV with the correct time on it on June 17, 2018 at 5:10pm. Resident #1 indicated that she knew how long it took staff to answer because of her clock on the wall.

On June 19, 2018 at 2pm during a review of the grievance/concern forms dated April 2, 2018 and May 29, 2018 revealed that Resident #1 had submitted concerns about her call bell not being answered, being removed out of reach and not being changed in a timely manner.

During an interview on June 19, 2018 at 4pm with Nursing Aide (NA) # 1 who worked with Resident #1 she denied any wrong doing to Resident #1. NA #1 stated she always answered her call bells within 10 to 15 minutes and always treated her residents with respect and dignity. She added it was hard sometimes because she had 15 to 20 residents to care for at times.

No interview was done with the named NA on the compliant because the information was not made available from the facility due to the NA was no longer employed.

During an interview with the family member (FM)

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F 550	Continued From page 6 for Resdient #1 on June 20, 2018 at 3:30 pm revealed they had tried to talk with the Administrator about the concerns with the call bell being out of reach and Resident #1 sitting in her urine for hours. During an interview on June 20, 2018 at 4:40 pm, with the Director of Nursing, she indicated that her expectation was all residents would be treated with dignity and respect. This included timely answering of residents call lights and provision of personal care. During an interview with the Administrator on June 21, 2018 at 4:30pm, he indicated that his expectation was residents would be treated with dignity and respect at all times. 3. Resident #11 was admitted to the facility on 5/31/18 and diagnoses included adult failure to thrive and dysphagia. An admission minimum data set (MDS) for Resident #11 dated 6/7/18 identified her cognition as being intact. An observation of the dining room on 6/19/18 at 12:26 pm revealed Resident #11 was in the dining room and seated at a table with 2 other residents. Resident #11 had not been served her lunch meal and her 2 tablemates had been served and were almost finished eating their meals. An interview with Resident #11 on 6/19/18 at 12:26 pm revealed she had not been served her lunch meal. She stated she had been sitting there for 15 to 20 minutes just waiting and trying to be patient. Resident #11 added she came to the dining room for some of her meals and ate in her	F 550		

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F 550	Continued From page 7 room for some meals. She stated she didn ' t know if the staff were getting her meal. An interview with Nursing Assistant (NA) #5 on 6/19/18 at 12:30 pm revealed they were waiting for Resident #11 ' s lunch tray to come out from the kitchen. She stated the resident ' s meal tray usually came out on the cart that went to the hall and not the dining room cart. NA #5 added the resident did not consistently come to the dining room and when she did the NAs would ask the kitchen for her tray. She stated the kitchen staff would tell them to wait for it to come out on the cart that went to the hall. An interview with Dietary Manager (DM) #1 on 6/19/18 at 2:00 pm revealed she thought Resident #11 typically ate in her room and her meals were sent out on the cart that went to the hall. She stated if the resident came to the dining room to eat the NAs should request her tray form the kitchen and she shouldn ' t have to sit there and wait for her meal. An interview with the Administrator on 6/21/18 at 10:01 am revealed it was his expectation that residents sitting together at the same table in the dining room be served their meals at the same time.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		7/20/18

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F 558	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, family interview and resident interviews the facility failed to accommodate the need of 1 of 3 residents (resident #1) by not providing the resident a shower chair to fit the resident, resulting in the resident not receiving a shower in two months. Findings included: Resident # 1 was admitted to the facility on August 2, 2016 with current diagnoses of absence of both left and right legs below the knee, hypertension and diabetes mellitus. Resident # 1's Minimum Data Set (MDS) dated May 5, 2018 revealed Resident # 1 was cognitively intact. Resident #1 required extensive assistance with bed mobility and transfers with two person physical assist. Locomotion on/off unit, dressing, toilet use and personal hygiene required extensive assistance with one person physical assist. Resident # 1 was incontinent of bladder and bowel. During an interview with Resident # 1 on June 17, 2018 at 4:45 pm, she revealed that she had not had a shower in two months. Resident #1 indicated her shower days were Monday and Thursday's. "Resident #1 stated "I am a large person and need my showers weekly so I would not have an odor." Resident #1 indicated she just wanted a shower and she would feel better." Review of the daily shower sheet on June 19, 2018 at 10 am revealed that on Mondays and Thursdays Room 104 A and B were scheduled for	F 558	F558 The plan of correcting the specific deficiency The process that lead to the deficiency of failure to accommodate the need of Resident #1 was the nursing staff did not communicate to the maintenance staff Resident #1's shower chair needs to accommodate Resident #1 receiving assistance with showers. The nursing staff should have completed a work order for a proper size shower chair and submitted the work order to the maintenance director. On 7/11/18, the facility maintenance director inspected all shower chairs with no negative findings. There are no broken shower chairs in the facility. On 6/20/18, Resident #1 refused a shower. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 7/13/18, the director of nursing (DON) reviewed residents in the facility for showers given in the last 7 days to ensure no showers were omitted due to equipment needs and showers were given per resident preference (plan of care). No negative findings were noted.	

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their showers on 2rd shift.

During an observation on June 19, 2018 from 3pm until 7:15 pm, Resident #1 was not observed to receive a shower.

During an interview with Resident #1 on June 20, 2018 at 9:30 am, Resident #1 indicated she had not received her shower and no staff asked her about taking a shower.

During an interview with Nursing Aide (NA) # 1 on June 20, 2018 at 3:15 pm she revealed that resident #1 did not have a shower because the shower chair for Resident #1 was broken. NA #1 also indicated that this information had been report to the former Administrator.

During an interview with Resident's #1's family member revealed on June 20, 2018 at 3:30 pm she had talked with the former Administrator concerning Resident #1 needing a shower and was told on several occasions that Resident #1 would get a shower. The family member stated on two dates (4/20/18 and 5/29/18) she knew the resident had requested a shower and never received one.

The former Administrator was not available during this investigation to be interviewed.

During an interview with the Director of Nursing (DON) on 6-21-18 at 4:45 pm she stated it was her expectation that residents have what was needed to meet their needs daily.

The Administrator was interviewed on 6-21-18 at 5pm and stated he expected that staff would inform him when special equipment was needed

F 558

All nursing staff, including agency, will be in-serviced by 7/20/18 by the DON or administrator on communication of resident equipment needs to maintenance using a work order, including equipment to accommodate resident showers. No nursing staff will be allowed to work after 7/20/18 until completing the in-service. This in-service will be added to the orientation process for all new nursing staff, including agency.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

The DON, staff facilitator, facility consultant, and/or minimum data set (MDS) nurse will audit 10 random residents weekly on random halls for 12 weeks to ensure showers were given per preference and appropriate equipment such as shower chairs are available to accommodate resident needs. This audit will be documented on the F558 Audit Tool.

The monthly quality improvement (QI) committee will review the results of the F558 Audit Tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance.

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F 558	Continued From page 10 so the facility can meet the needs of all the residents.	F 558	The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction: The DON is responsible for implementing the acceptable plan of correction.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		7/20/18

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F 561	Continued From page 11 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews the facility failed to honor a resident's choice of having weekly showers for 1 of 3 residents reviewed for choices (Resident #1.) Finding included: Resident # 1 was admitted to the facility on August 2, 2016 with current diagnoses of absence of both left and right legs below the knee, hypertension and diabetes mellitus. Resident # 1's Minimum Data Set dated May 5, 2018 revealed Resident # 1 was cognitively intact. Resident #1 required extensive assistance with bed mobility and transfer with two person physical assist. Locomotion on/off unit, dressing, toilet use and personal hygiene required extensive assistance with one person physical assist. Resident # 1 was incontinent of bladder and bowel. During an interview with Resident # 1 on June 17, 2018 at 4:45 pm, she revealed that she had not had a shower in two months". Resident #1 indicated her shower days were Monday and Thursday's. Resident #1 indicated she was a large person and need her showers weekly so she would not have an odor." Resident #1	F 561	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. 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.	

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F 561 Continued From page 12

indicated she just wanted a shower this would make her feel better."

A review of her care plan dated May 5, 2018 revealed there were interventions about Activities of daily living for Resident #1 for staff to provide assistant with all ADLs care but just set up help for eating.

During a Review of the daily shower sheet was done on June 19, 2018 at 10am revealed that on Mondays and Thursdays Room 104 A and B receives shower during 2rd shift.

During an observation on June 19, 2018 from 3pm until 7:15pm, revealed that Resident ##1 did not received a shower.
During an interview with Resident # 1 on June 20, 2018 at 9:30am, Resident #1 indicated she did not received her shower nor did anyone asked her about taking a shower.

During an interview with Nursing Aide (NA) # 1 on June 20, 2018 at 4pm she revealed that resident #1 refused her shower.

During an interview with the Director of Nursing (DON) on June 20, 2018 at 4:15pm, she revealed each resident's choice of having shower should be honored.

F 561

Greenhaven Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F561

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failure to allow resident choice of having weekly showers- was knowledge deficit, staff not educated on the process to report broken or needed equipment to allow for resident choices.

On 6/20/18 resident #1 was offered a shower by the certified nursing assistant and refused the shower.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 7/13/18 the Director of Nursing reviewed residents in the facility for showers given in the last 7 days to ensure

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F 561	Continued From page 13	F 561	no showers were not given due to equipment needs, and showers were given per resident preference (plan of care). With no negative findings noted. All nursing staff, including agency will be in-serviced by 7/20/18 by the director of nursing, or Administrator on resident choice including resident right to choose shower preferences, and be provided showers based on their preference. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for all new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, staff facilitator, and/or minimum data set nurse will audit 10 random residents on resident halls to include those residents who cannot speak for themselves and has family involvement weekly for 12 weeks to ensure showers were given per resident choice. This audit will be documented on the F561 Audit Tool. The monthly QI committee will review the results of the F561 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI	

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F 561	Continued From page 14	F 561	committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		7/20/18

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F 585	Continued From page 15 provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585		

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F 585	Continued From page 16 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to ensure prompt resolution of grievances and provide a written summary statement of grievances for 2 of 2 sampled residents (Resident #1 and Resident #2) who submitted grievances to the facility over the past 3 months concerning ADLs (Activities of Daily Living) call bells not being answer and our of reach of the resident and wound care. Findings include:	F 585	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and	

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1. Resident #2 was admitted to the facility on 1/18/17 with diagnoses of sepsis, edema, contractures of the right and left hands, and unsteadiness on feet.

A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment. Resident #2's functional status was coded as needing 2 plus person assistance with bed mobility, dressing, bathing, toileting, and personal hygiene.

A review of Resident #2's care plan dated 4/20/18 included that the resident is at risk for further decline in ADLs related to impaired mobility.

A review of the facility's grievance reports for the past 3 months revealed that Resident #2 and or a family member filed 15 grievances since 5/4/18. A review of these grievances revealed 14 of them involved lack of ADL assistance and 1 involved an issue about wound care not performed as ordered. A further review of Resident #2's grievances revealed none of the grievances had a written resolution or summary documented.

An interview was conducted with Resident #2 on 6/17/18 at 5:30pm. Resident #2 reported he filed grievances or had one of his family members file grievances with the facility administrator "many times" over past couple months due to lack of assistance with ADLs. He reported he had not heard back from any of the grievances filed.

An interview was conducted with the acting administrator and corporate nurse consultant on

F 585

that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F 585 Grievances

The plan of correcting the specific deficiency

The position of Greenhaven Health and

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F 585	Continued From page 18 6/21/18 at 11:55pm. The administrator reported it he had only been in the position of acting administrator since 6/15/18. He reported it had just come to his attention that grievances filed by Resident #2 had not been addressed. He stated it was his expectation that every grievance filed was taken seriously and that the resident or resident representative was given a written response to the grievance as soon as it was investigated. 2. Resident # 1 was admitted to the facility on August 2, 2018 with current diagnoses of anemia, absence of both left and right legs below the knee, hypertension and diabetes mellitus. Resident # 1's Minimum Data Set (MDS) dated May 5, 2018 revealed Resident # 1 was cognitively intact. Resident # 1 required extensive assistance with bed mobility and transfer with two person physical assist. Locomotion on/off unit, dressing, toilet use and personal hygiene required extensive assistance with one person physical assist. Resident # 1 was incontinent of bladder and bowel. During an interview with Resident # 1 on June 17, 2018 at 4:45 pm, she revealed that she has had several issues with staff not answering her call bell in a timely manner. Resident #1 reported issues on 4/2/2018 when she was left in bed for 2 hours waiting to be changed because staff told her, that she was not wet enough to be changed. She added this had been going for weeks. Resident #1 stated she had filed a grievance about this and nothing had been done. Resident #1 also indicated that a second shift staff person would come in the room and place the call bell out of reach. Resident #1 stated, "that made her feel really bad." Resident #1 also indicated this	F 585	Rehabilitation Center regarding the process that lead to this deficiency failure to ensure prompt resolutions, and written summary of grievances was- failure to follow established facility policy related to grievances. The Grievance Officer is the Administrator which is actively involved in the Plan of Correction. Grievances for resident #1 and #2 were resolved by 7/20/18 by the administrator. Written summary of grievances for resident #1 and #2 were issued upon request by the administrator on 7/13/2018. The procedure for implementing the acceptable plan of correction for the specific deficiency cited Starting on 6/18/18, the administrator and Social Worker reviewed all grievances for the past 90 days to ensure resolution is complete, and a written summary of the grievance was provided upon request. This audit was completed on 6/18/18. All negative findings were addressed by administrator on 6/18/18. On 7/13/18, the administrator and director of nursing (DON) were in-serviced by the vice president of Operations on the grievance process which includes timely resolution, and issuing a written summary upon response. Any new administrator or DON will receive this in-service during orientation.	

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happened to her last in May, 2018 when she waited three hours for staff to change her. She stated she had urine on herself, "that's a bad feeling to be wet too." Resident # 1 indicated this would always be a problem until the facility get more staff. Resident #1 indicated this went on weekly here and "She felt helpless". Resident #1 revealed she had not had a shower in two months.. Resident #1 indicated her shower days were Mondays and Thursdays. She explained she was a large person and needed her showers weekly so she would not have an odor. Resident #1 indicated if she could have a shower this would make her feel better. She stated "staff came in, shut off the bell, moved it out of reach and care was not provided., that was not right."

During an interview with the family member (FM) for Resdient #1 on June 20, 2018 at 3:30 pm revealed they had tried to talk with the Administrator about the concerns with the call bell being out of reach and Resident #1 sitting in her urine for hours. FM indicated that she filed 2 grievances and "nothing happen".
FM had copies of both grievances

A review of the facility's grievance reports for the past 3 months revealed that Resident #1 and or a family member filed 2 grievances since 4/2/18. A review of these grievances revealed 2 of them involved lack of ADL assistance and 1 involved an issue call bell being out of reach for resident. A further review of Resident #1's grievances revealed none of the grievances had a written resolution or summary documented.

An interview was conducted with the acting administrator and corporate nurse consultant on 6/21/18 at 11:55pm. The administrator reported it

F 585

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The DON, social worker, and/or administrator will review all grievances weekly x 12 weeks to ensure the grievance was resolved timely and if requested a written summary of the grievance was provided. This audit will be documented on the F585 audit tool.

The monthly QI committee will review the results of the F585 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight

The title of the person responsible for implementing the acceptable plan of correction

The administrator is responsible for implementation of the acceptable plan of correction.

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F 585	Continued From page 20 he had only been in the position of acting administrator since 6/15/18. He reported it had just come to his attention that grievances filed by Resident #1 had not been addressed. He stated it was his expectation that every grievance filed was taken seriously and that the resident or resident representative was given a written response to the grievance as soon as it was investigated.	F 585		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility staff failed to provide incontinence care for one and two hours respectfully for a resident that advised two different staff that he/she was soiled and needed assistance in 1 of 3 dependent residents (Resident #2). Findings include:	F 600	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	7/20/18

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F 600	Continued From page 21 1. Resident #2 was admitted to the facility on 1/18/17 with diagnoses of sepsis, contractures of the right and left hands, unsteadiness on feet, and type 2 diabetes mellitus. A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment. Resident #2's functional status was coded as needing 2 plus person assistance with bed mobility, dressing, bathing, toileting, and personal hygiene. A review of Resident #2's care plan dated 4/20/18 included that the resident is at risk for further decline in ADLs related to impaired mobility. A review of the facility's grievance reports for May and June 2018 revealed Resident #2 had filed 14 grievances involving lack of ADL assistance. An interview was conducted with Resident #2 on 6/17/18 at 5:30pm. Resident #2 reported on that on 5/28/18 NA#10 entered his room around 9:30am and he asked her to pull him up in bed. The resident reported that NA #10 stated she would have to find someone to help her and left the room. Resident #2 reported after about an hour he rang his call bell but no one answered so he called the facility on the phone. He reported the DON (director of nursing), the treatment nurse and NA #10 arrived in his room. Resident #2 stated that on 6/11/18 he pushed the call bell at 8:30am because he had had a bowel movement. He reported a NA (nursing assistant) #9 came in and told him that she would have to find someone to help her. Resident #2 reported	F 600	• The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. F600 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failure to provide incontinence care was- failure to follow established facility policy of providing perineal care will be after each incontinent episode. On 6/11/18 resident #2 was provided with incontinent care at 145pm by the director of nursing (DON) and treatment nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/18, the social worker (SW) began interviewing all interviewable residents. This interview consisted of questions including 1. Are you provided with adl assistance timely, and with dignity? and 2. Have you been yelled at by the staff during adl care? Interviews will be complete by 7/20/18. Any negative findings will be addressed immediately by	

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F 600	Continued From page 22 no one came back in the room until 11:30am when the treatment nurse arrived to perform his wound care to his left leg. The resident reported the treatment nurse told him she would let the staff know to come and change him. Resident #2 reported at 12:00pm no one had shown up to change him so he rang his call bell again. He reported a NA arrived and told him it would have to be after lunch as she could not find anyone to help her change him. Resident #2 reported at 1:45pm he still had not been changed and he rang his call bell again. He reported the DON (director of nursing) and the treatment nurse arrived in his room and they cleaned him and changed him at that time. The resident reported that he felt like he was being ignored and that him lying in stool wasn't important to the staff. An interview was conducted on 6/20/18 at 11:31am with NA #10. She reported that on 5/28/18, Resident #2 had asked her to pull him up in bed when she was collecting the breakfast trays. She reported it takes 2 people to provide care for Resident #2 and she told him she would find someone to assist her. She reported when she went back in the room with the DON, Resident #2 reported he needed changing. NA #10 reported that was the first time she had heard he needed changing and she reported she was upset with the resident. She reported he told her he didn't want her touching him so she left the room. She reported she knew she should not have gotten angry with the resident. An interview was conducted on 6/20/18 at 11:40am with the treatment nurse. She reported that on 6/11/18 she went into Resident #2's room around 11:30am and he told her he needed changing. She reported she told the NA working	F 600	the sw. Beginning on 7/12/18, the facility treatment nurse and/or director of nursing observed non-interviewable residents to ensure dignity is provided during adl care, including no yelling. Observation was completed on 7/13/18 with no negative findings. All nursing staff, including agency, will be in-serviced by 7/20/18 by the director of nursing, or Administrator on promoting dignity during adl care, including not yelling at residents, timely incontinent care, and residents must be served one table at a time. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursing staff, including agency. All staff, including agency, will be in-serviced by 7/20/18 by the director of nursing, or Administrator on Abuse/neglect. No staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, and/or administrator will review all grievance received each week to ensure if abuse, neglect, or exploitation is indicated a 24 hour and 5 day report is submitted. This	

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F 600	Continued From page 23 with Resident #2 that he needed to be changed. The treatment nurse reported when she arrived back in his room close to 2:00pm he was still waiting to be changed from a morning bowel movement so she and the DON changed the resident. When the DON was questioned about Resident #2 having to wait so long on 6/11/18 to be changed, she stated she expected residents to be promptly taken care of when they had incontinence. An interview was conducted with the acting administrator on 6/21/18 at 11:55am. He reported it was his expectation that all staff treated all the residents with dignity and respect and are prompt in responding to call lights and requests.	F 600	audit will occur weekly x 12 weeks. This audit will be documented on the F600 Tool. The monthly QI committee will review the results of the F600 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable 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 1 out of 3 residents (Resident #7) who was reviewed for pressure ulcers and the facility failed to code dialysis on the minimum data set (MDS) for 1 of 1 resident reviewed for dialysis (Resident #6).	F 641	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the	7/20/18

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F 641 Continued From page 24

Findings include:

1. Resident #7 was admitted to the facility on 12/18/17 with diagnoses that included pressure ulcer heel stage 3, unspecified mood disorder, anxiety disorder, muscle weakness (generalize), peripheral vascular disease, major depressive disorder, and gangrene.

A review of Resident #7's most recent MDS (Minimum Data Set) dated 5/14/18 was coded as a quarterly assessment. The resident was coded with no cognitive impairment. Active diagnoses were heart failure, peripheral vascular disease, diabetes mellitus, hyperlipidemia, cerebral vascular accident, anxiety disorder, depression, pressure ulcer of heel stage 3, other symbolic dysfunctions, unspecified mood disorder, insomnia, and pressure ulcer of sacral region stage 3. The MDS coded the resident under skin conditions as having one stage 3 pressure ulcer with measurements documented as 7.4x10.0x0.3cm.

A review of Resident #7's care plan revealed the care plan was last updated on 2/22/18 and included interventions for stage 3 pressure ulcer to heel and stage 2 pressure ulcer to sacrum.

A review of Resident #7's medical record revealed a nursing note dated 3/8/18 that stated the pressure ulcer to the sacrum was healed.

An observation of Resident #7 on 6/20/18 at 8:30am with the treatment nurse revealed no skin breakdown to the sacral area.

An interview was conducted on 6/20/18 at

F 641

acceptable plan of correction for the specific deficiency cited;

- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F641 Accuracy of Assessments
The plan of correcting the specific

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F 641	Continued From page 25 9:26am with the wound care physician's assistant who sees Resident #7 weekly for the wound to her left heel. He reported he has been coming to the facility since March 2018 and the resident has not had a pressure ulcer on her sacrum since he has been seeing her. An interview was conducted on 6/20/18 at 2:35pm with the RAI (Resident Assessment Instrument) reimbursement coordinator. She reported she is assisting with MDS assessments as the facility does not have a MDS coordinator at this time. She reported the MDS assessment dated 5/14/18 was coded incorrectly under skin condition section. She reported she will correct and resubmit. An interview was conducted with the acting administrator and the corporate nurse consultant on 6/21/18 at 11:55am. They both reported it is their expectation that the MDS assessments are to be coded correctly. 2. Resident #6 was admitted to the facility on 3/24/18 and diagnoses included end stage renal disease on hemodialysis. A care plan dated 3/26/18 for Resident #6 stated resident was at risk for complications due to hemodialysis. Interventions included to receive dialysis on Mondays, Wednesdays and Fridays. An admission MDS dated 3/31/18 for Resident #6 did not identify that the resident was receiving dialysis. An interview on 6/20/18 at 2:27 pm with the	F 641	deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately coding pressure ulcers and dialysis. On 6/20/18 resident #7's minimum data set (MDS) assessment dated 5/14/18 was modified to accurately code skin status by the Corporate RAI Reimbursement Auditor. On 6/20/18 resident #6's MDS assessment dated 3/31/18 was modified to accurately code dialysis by the Corporate RAI Reimbursement Auditor. On 6/20/18, the modified assessments were transmitted to the National Repository by the Corporate Clinical/Reimbursement Director. On 6/21/18, the modified assessment was accepted by the National Repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited From 7/2/18 through 7/4/18, the Corporate minimum data set(MDS) consultant audited all assessments completed in the past 30 days to ensure residents skin status and dialysis were coded correctly. Any negative findings were corrected immediately by the auditor. Newly hired MDS nurses will be properly trained by Corporate MDS Consultants to accurately code the MDS assessments to include coding skin and residents	

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F 641	Continued From page 26 interim MDS Nurse revealed the MDS dated 3/31/18 for Resident #6 should have been coded for dialysis. She stated the MDS would need to be corrected. An interview on 6/21/18 at 10:01 am with the Administrator revealed it was his expectation that the MDS be coded to reflect the resident ' s health condition.	F 641	receiving dialysis services. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, or treatment nurse will audit MDS assessments for correct skin status and residents receiving dialysis services coding using the F641 Audit Tool. 25% of completed assessments will be audited weekly x 4 weeks, then 25% of completed assessments biweekly x 8 weeks. The monthly QI committee will review the results of the F641 Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or director of nursing (DON) will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable 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	F 656		7/20/18

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F 656	Continued From page 27 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 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:	F 656		

F 656 Continued From page 28

Based on record review and staff interviews the facility failed to develop a care plan to address behaviors that included refusal of medications and dialysis treatment for Resident #6. This was evident for 1 of 1 resident that was reviewed for dialysis.

Findings Included:

Resident #6 was admitted to the facility on 3/24/18 and diagnoses included end stage renal disease with hemodialysis, congestive heart failure, acute respiratory failure, arteriosclerotic heart disease, cerebral vascular accident, depression and anxiety.

An admission minimum data set (MDS) dated 3/31/18 for Resident #6 did not identify any behaviors of rejection of care and did not identify the resident received dialysis. The MDS identified the resident ' s cognition was intact.

Review of the March 2018 medication administration record (MAR) for Resident #6 revealed the following medications were circled as not administered: Amlodipine (a medication to treat high blood pressure and angina) 10 milligrams (mg) once a day on 3/26/18, 3/27/18, 3/28/18 and 3/30/18, Carvedilol (a medication to treat high blood pressure) 25 mg twice daily on 3/26/18, 3/27/18, 3/28/18 and 3/30/18 at 9:00 am, Plavix (an anticoagulant) 75 mg every day on 3/26/18, 3/27/18, 3/28/18 and 3/30/18, Depakote (a medication to treat seizures and / or bipolar disorder) 500 mg twice daily on 3/26/18, 3/27/18, 3/28/18 and 3/30/18 at 9:00 am, Apresoline (a medication to treat high blood pressure) 50 mg every 8 hours on 3/26/18, 3/28/18 and 3/29/18 at 6:00 am and 2:00 pm and Isordil (a medication to

F 656

F656 Development/Implement Comprehensive Care Plan

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in failed to develop a care plan to address behaviors that included refusal of medications and dialysis treatment

What measures did the facility put in place for the resident affected:

Resident #6 was discharged from the facility on 5/16/18.

What measures were put in place for residents having the potential to be affected:

From 7/2/18 until 7/4/18 the Corporate minimum data set (MDS) consultant compelted an audit of resident's who refuse care including refusal of dialysis, and medications care plans to ensure accuracy of refusal. All negative findings were addressed by the auditor from 7/2/18 through 7/4/18 during the audit.

What systems were put in place to prevent the deficient practice from reoccurring:

On 7/18/18, the Corporate MDS consultant in-serviced the director of

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F 656 Continued From page 29

treat chest pain) 10 mg three times a day on 3/26/18, 3/27/18, 3/28/18 and 3/30/18 at 9:00 am and 1:00 pm.

Review of a nursing note dated 3/31/18 for Resident #6 stated the resident had an appointment for dialysis today and the resident refused to go.

An interview on 6/18/18 at 5:35 pm with the Director of Nursing (DON) revealed she had contacted the dialysis center that Resident #6 attended and determined that he had missed his scheduled dialysis on 3/30/18 and 4/6/18.

An interview on 6/19/18 at 10:12 am with Nurse #5 revealed she was the nurse for Resident #6 on first shift (7:00 am to 3:00 pm). She stated the resident consistently refused his medications on her shift. Nurse #5 added the resident would tell her he couldn't take his medications on the days that he went to dialysis, but he would also refuse them on non-dialysis days.

An interview on 6/20/18 at 2:27 pm with the interim MDS Nurse revealed a care plan should have been developed to address Resident #6 ' s consistent refusal of medications and dialysis.

An interview on 6/21/18 at 10:01 am with the Administrator revealed it was his expectation that care plans were in place to reflect the resident ' s needs.

F 656

nursing (DON) related to accurately care planning resident refusals to include refusal of dialysis and medications.

Newly hired MDS nurses will be properly trained by title related to accurately care planning resident refusals of care to include refusal of dialysis and medications.

How the facility will monitor systems put in place:

The Treatment nurse, staff facilitator, and/or corporate consultant will audit resident care plans to ensure that all refusals of care including refusal of dialysis, and medications are accurately care planned using the F656 audit tool. Five random residents on random halls care plans will be audited weekly x 12 weeks.

The monthly QI committee will review the results of the F656 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight

The person responsible for implementation of plan:

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F 656	Continued From page 30	F 656	The DON is responsible for implementation of this 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 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 care plan on 1 out of 3 residents (Resident #7) reviewed for pressure ulcers.	F 657	Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that	7/20/18

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Findings include:

Resident #7 was admitted to the facility on 12/18/17 with diagnoses that included pressure ulcer heel stage 3, unspecified mood disorder, anxiety disorder, muscle weakness (generalize), peripheral vascular disease, major depressive disorder, and gangrene.

A review of Resident #7's most recent MDS (Minimum Data Set) dated 5/14/18 was coded as a quarterly assessment. The resident was coded with no cognitive impairment. Active diagnoses were heart failure, peripheral vascular disease, diabetes mellitus, hyperlipidemia, cerebral vascular accident, anxiety disorder, depression, pressure ulcer of heel stage 3, other symbolic dysfunctions, unspecified mood disorder, insomnia, and pressure ulcer of sacral region stage 3. The MDS coded the resident under skin conditions as having one stage 3 pressure ulcer with measurements documented as 7.4x10.0x0.3cm.

A review of Resident #7's care plan revealed the care plan was last updated on 2/22/18 and included interventions for stage 3 pressure ulcer to heel and stage 2 pressure ulcer to sacrum.

A review of Resident #7's medical record revealed a nursing note dated 3/8/18 that stated the pressure ulcer to the sacrum was healed.

An observation of Resident #7 on 6/20/18 at 8:30am with the treatment nurse revealed no skin breakdown to the sacral area.

An interview was conducted on 6/20/18 at

F 657

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F tag 657 Care Plan Timing and Revision

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established policy related to revision of the resident care plan/guide.

On 6/20/18, resident #7s care plan was reviewed and updated related to current skin status by the corporate minimum data set (MDS) consultant.

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F 657	Continued From page 32 9:26am with the wound care physician's assistant who sees Resident #7 weekly for the wound to her left heel. He reported he has been coming to the facility since March 2018 and the resident has not had a pressure ulcer on her sacrum since he has been seeing her. An interview was conducted on 6/20/18 at 2:35pm with the RAI (Resident Assessment Instrument) reimbursement coordinator. She reported she is assisting with care plans as the facility does not have a MDS coordinator at this time. She reported the care plans should be reviewed and updated with each MDS assessment. She reported Resident #7's care plan should have been updated when the pressure ulcer to the sacrum was healed. She stated she will update the resident's care plan to reflect the correct care to provide. An interview was conducted with the acting administrator and the corporate nurse consultant on 6/21/18 at 11:55am. They both reported it is their expectation that care plans are to be reviewed and updated when the MDS assessments are completed.	F 657	The procedure for implementing the acceptable plan of correction for the specific deficiency cited From 7/2/18 until 7/4/18, the Corporate MDS consultant completed an audit of 100% of resident care plans to ensure that resident care plans are accurate related to skin status. Care plans were updated as needed immediately by auditor. On 7/18/18, the corporate MDS consultant in-serviced the IDT related to the revision of care plans. The in-service includes that the care plan will be updated and/or reviewed routinely with completion of each comprehensive and quarterly MDS assessment as well as upon any change in resident's condition to include skin status when appropriate. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Director of Nursing will audit resident care plans to ensure that care plan reviews and revisions have been completed and the care plan is accurate related to skin status. Five resident care plans will be audited weekly x 12 weeks. This audit will be documented on the F657 audit tool.	

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F 657	Continued From page 33	F 657	The monthly QI committee will review the results of the F657 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	
F 677 SS=E	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 observations, record review, and staff and resident interviews, the facility failed to provide incontinence care for 2 out of 4 residents (Resident #1 and Resident #2) reviewed for ADLs (Activities of Daily Living). Findings include: 1. Resident #2 was admitted to the facility on	F 677	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	7/20/18

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F 677

Continued From page 34

1/18/17 with diagnoses of contractures of the right and left hands, unsteadiness on feet, unspecified open wound left lower leg initial encounter, and type 2 diabetes mellitus.

A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment. Resident #2's functional status was coded as needing 2 plus person assistance with bed mobility, dressing, bathing, toileting, and personal hygiene.

A review of Resident #2's care plan dated 4/20/18 included that the resident was at risk for further decline in ADLs related to impaired mobility.

An observation was made on 6/18/18 at 9:20am with NA (nursing assistant) #9 and GCA (Geriatric Care Assistant) #1. An observation was made of NA #9 and GCA #1 as they provided a bath and incontinence care to Resident #2.The resident had a bowel movement and NA #9 cleaned up the resident's bowel movement.

An interview with Resident #2 was conducted at 5:30pm on 6/17/18. Resident #2 stated that on 6/11/18 he pushed the call bell at 8:30am because he had had a bowel movement. He reported a NA (nursing assistant) came in and told him that she would have to find someone to help her. Resident #2 reported no one came back in the room until 11:30am when the treatment nurse arrived to perform his wound care to his left leg. The resident reported the treatment nurse told him she would let the staff know to come and change him. Resident #2 reported at 12:00pm no

F 677

- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F677

The plan of correcting the specific deficiency

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F 677	Continued From page 35 one had shown up to change him so he rang his call bell again. He reported a NA arrived and told him it would have to be after lunch as she could not find anyone to help her change him. Resident #2 reported at 1:45pm he still had not been changed and he rang his call bell again. He reported the DON (director of nursing) and the treatment nurse arrived in his room and they cleaned him and changed him at that time. Resident #2 reported that a lot of times the NA assigned to him would answer the call bell but then had to find someone to help with the care and that would take a long time. An interview was conducted with NA #9 at 9:20am on 6/20/18. She reported she responded to Resident #2's call bell as soon as she saw it go off or was notified but she had to have assistance to provide incontinence care. She reported if she was the only NA on the hall she would have to wait until she could find another NA to assist her with incontinence care. An interview was conducted on 6/20/18 at 11:40am with the treatment nurse. She reported that on 6/11/18 she went into Resident #2's room around 11:30am and he told her he needed changing due to having had a bowel movement. She stated she told the NA assigned to Resident #2 that he needed to be changed. The treatment nurse reported when she arrived back in the resident's room at 2:00pm he had not been changed from a morning bowel movement so she and the DON changed the resident. An interview was conducted with the acting administrator on 6/21/18 at 11:55am. He reported it was his expectation that all residents be provided incontinence care in a timely manner.	F 677	The position of Greenhaven Health and rehabilitation center regarding the process that lead to this deficiency-failure to provide incontinence care was staff failure to follow established procedure. Resident # 1 was provided with incontinent care during the complaint survey by the certified nursing assistant. Resident # 1 refused a shower on 6/20/18 that was offered by the certified nursing assistant. Resident #2 was provided incontinent care by facility certified nursing assistant on 6/18/18 at 920am. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/18, the social worker (SW) began interviewing all interviewable residents. This interview consisted of questions including 1. Are you provided with adl assistance timely, and with dignity? and 2. Have you been yelled at by the staff during adl care? Interviews will be complete by 7/20/18. Any negative findings will be addressed immediately by the sw. Beginning on 7/12/18, the facility treatment nurse and/or director of nursing observed non-interviewable residents to ensure dignity was provided during adl care, including no yelling. Observations were completed on 7/13/18 with no negative findings. On 7/13/18, the Director of Nursing	

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F 677	Continued From page 36 2. Resident # 1 was admitted to the facility on August 2, 2016 with current diagnoses of absence of both left and right legs below the knee, hypertension and diabetes mellitus. Resident # 1's Minimum Data Set dated May 5, 2018 revealed Resident # 1 was cognitively intact. Resident #1 required extensive assistance with bed mobility and transfer with two person physical assist. Locomotion on/off unit, dressing, toilet use and personal hygiene required extensive assistance with one person physical assist. Resident # 1 was incontinent of bladder and bowel. During an interview with Resident # 1 on June 17, 2018 at 4:45 pm, she revealed that she had not had a shower in two months". Resident #1 indicated her shower days were Monday and Thursday's. Resident #1 indicated she was a large person and need her showers weekly so she would not have an odor." Resident #1 indicated she just wanted a shower this would make her feel better." Resident #1 also indicated that she had been left for 2 hours lying in her urine because she did not think she was wet enough to be changed. A review of her care plan dated May 5, 2018 revealed there were interventions about Activities of daily living for Resident #1 for staff to provide assistant with all ADLs care but just set up help for eating. During a Review of the daily shower sheet was done on June 19, 2018 at 10am revealed that on Mondays and Thursdays Room 104 A and B receives shower during 2rd shift.	F 677	reviewed residents in facility for showers given in the last 7 days to ensure no showers were not given due to equipment needs, and showers were given per resident preference (plan of care). All nursing staff, including agency will be in-serviced by 7/20/18 by the director of nursing, or Administrator on resident choice including resident right to choose shower preferences, and be provided showers based on their preference. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for all new nursing staff, including agency. All nursing staff, including agency, will be in-serviced by 7/20/18 by the director of nursing, or Administrator on promoting dignity during adl care, including not yelling at residents, timely incontinent care, and residents must be served one table at a time. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursing staff, including agency The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, administrator, and/or minimum data set nurse will audit 10 residents weekly for 12 weeks to ensure showers were given per resident choice, and adl care, including incontinent care, has been provided. This audit will be	

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F 677	Continued From page 37 During an observation on June 19, 2018 from 3pm until 7:15pm, revealed that Resident ##1 did not received a shower. During an interview with Resident # 1 on June 20, 2018 at 9:30am, Resident #1 indicated she did not received her shower nor did anyone asked her about taking a shower. During an interview with Nursing Aide (NA) # 1 on June 20, 2018 at 4pm she revealed that resident #1 refused her shower. During an interview with Resident #1's Family Member (FM) on June 20,2018 at 3:30pm revealed that on several visits with Resident #1, Resident #1 indicated that she had not had shower. FM also indicated that Resident #1 had an odor and FM had discussed all the concerns with the previous administrator who according to FM "did not do a thing for my Aunt". During an interview with the Director of Nursing (DON) on June 20, 2018 at 4:15pm, she revealed each resident's needs and activities of daily living are expected to be done and given on a daily bases. An interview was conducted with the acting administrator on 6/21/18 at 11:55am. He reported it was his expectation that all residents be provided incontinence care in a timely manner.	F 677	documented on the F677 audit tool. The monthly QI committee will review the results of the F677 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		7/20/18

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F 725	Continued From page 38 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to provide sufficient nursing staffing to provide incontinence care in a timely manner for 2 of 4 dependent residents (Resident #1 and Resident #2) and failed to provide 1 of 4 residents a shower as scheduled (Resident #1) and failed to honor a resident's choice of having showers (Resident #1) and failed to provide incontinence care for one and two hours respectfully for a resident that advised two different staff that he/she was soiled and needed assistance in 1 of 3 dependent residents	F 725	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains	

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F 725

Continued From page 39
(Resident #2)

Findings Included:

This tag was cross-referred to

F-550 - Based on observations, record review, and staff and resident interviews, the facility staff failed to treat the resident with dignity by yelling at the resident when she came in to assist him with ADL (Activities of Daily Living) care, failed to provide care for 2 of 5 dependent residents (Resident #1 and Resident #2). The facility further failed to serve residents meal trays at the same time all table mates were served for 1 out of 3 residents (Resident #11).

F-561 Based on observation, staff and resident interviews the facility failed to honor a resident's choice of having weekly showers for 1 of 3 residents reviewed for choices (Resident #1.)

F-600-Based on observations, record review, and staff and resident interviews, the facility staff failed to provide incontinence care for one and two hours respectfully for a resident that advised two different staff that he/she was soiled and needed assistance in 1 of 3 dependent residents (Resident #2).

F -677 - Based on observations, record review, and staff and resident interviews, the facility failed to provide incontinence care for 2 out of 4 residents (Resident #1 and Resident #2) reviewed for ADLs (Activities of Daily Living).

An interview with Resident #1 on 6/17/18 at 4:45 pm revealed she has had several issues with staff not answering her call bell in a timely manner.

F 725

corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F725

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the

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F 725

Continued From page 40

Resident #1 reported issues on 4/2/2018 when she was left in bed for 2 hours waiting to be changed because staff told her she was not wet enough to be changed. She added this had been going for weeks. Resident #1 stated she had filed a grievance about this and nothing had been done. Resident #1 stated in May 2018 (exact day not known) she waited three hours for staff to change her. She added this would always be a problem until the facility got more staff. Resident #1 revealed she had not had a shower in two months. She added her shower days were Mondays and Thursdays. She explained she was a large person and needed her showers weekly so she would not have an odor.

An interview with Resident #2 was conducted at 5:30pm on 6/17/18. Resident #2 stated that on 6/11/18 he pushed the call bell at 8:30am because he had had a bowel movement. He reported a NA (nursing assistant) came in and told him that she would have to find someone to help her. Resident #2 reported no one came back in the room until 11:30am when the treatment nurse arrived to perform his wound care to his left leg. The resident reported the treatment nurse told him she would let the staff know to come and change him. Resident #2 reported at 12:00pm no one had shown up to change him so he rang his call bell again. He reported a NA arrived and told him it would have to be after lunch as she could not find anyone to help her change him. Resident #2 reported at 1:45pm he still had not been changed and he rang his call bell again. He reported the DON (director of nursing) and the treatment nurse arrived in his room and they cleaned him and changed him at that time. Resident #2 reported that a lot of times the NA assigned to him would answer the call bell but

F 725

process that lead to this deficiency-failed to provide nursing staff of sufficient quantity to provide timely incontinent care, and provide showers per resident preference and as scheduled- was a communication deficit.

During the complaint survey, resident #1 and resident #2 were provided ADL care to promote quality of life, including without yelling, by a certified nursing assistant. On 6/20/18, resident #1 refused a shower that was offered by the certified nursing assistant.
On 6/11/18 resident #2 was provided with incontinent care at 145pm by the director of nursing (DON) and treatment nurse.

Throughout the duration of the survey, resident # 2 received ADL Care per resident preference.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

By 4/13/18, the facility had signed a contract with a staffing agency to provide sufficient nursing staffing.

By 4/13/18, the facility began offering sign on a sign on bonus for certified nursing assistants, licensed practical nurses, and registered nurses.

On 7/13/18, the social worker (SW) began

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then had to find someone to help with the care and that would take a long time.

An interview on 6/19/18 at 4:00 pm with Nursing Assistant (NA) #1 revealed she had provided care for Resident #1. She stated she always answered her call bells within 10 to 15 minutes, but it was hard to do this when there were times she had 15 to 20 residents to care for on her assignment.

An interview was conducted with NA #9 at 9:20am on 6/20/18. She reported she responded to Resident #2's call bell as soon as she saw it go off or was notified but she had to have assistance to provide incontinence care. She reported if she was the only NA on the hall she would have to wait until she could find another NA to assist her with incontinence care.

An interview was conducted on 6/20/18 at 11:40am with the treatment nurse. She reported that on 6/11/18 she went into Resident #2's room around 11:30am and he told her he needed changing due to having had a bowel movement. She stated she told the NA assigned to Resident #2 that he needed to be changed. The treatment nurse reported when she arrived back in the resident's room at 2:00pm he had not been changed from a morning bowel movement so she and the DON changed the resident.

An interview on 6/21/18 at 10:01 am with the Administrator revealed it was his expectation that the nursing staff met the needs of the residents in a timely manner.

F 725

interviewing all interviewable residents. This interview consisted of questions including 1. Are you provided with adl assistance timely, and with dignity? and 2. Have you been yelled at by the staff during adl care? Interviews will be complete by 7/20/18. Any negative findings will be addressed immediately by the sw.

Beginning on 7/12/18 the facility treatment nurse and/or director of nursing observed non-interviewable residents to ensure dignity is provided during adl care, including no yelling. Observations were completed on 7/13/18 with no negative findings.

On 7/13/18, the Director of Nursing reviewed residents in facility for showers given in the last 7 days to ensure no showers were not given due to equipment needs, and showers were given per resident preference (plan of care). No negative findings noted.

On 7/2/18, the administrator in-serviced the director of nursing, and scheduler on staffing expectations including ensuring showers are completed per policy, and incontinent care is provided timely per procedure.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The DON, staff nurse on duty, scheduler and or administrator will audit daily staffing for 8 weeks. This monitoring tool will be documented on the F725

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(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 725	Continued From page 42	F 725	monitoring tool. The monthly QI committee will review the results of the F725 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		7/20/18

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	345132	A. BUILDING ______ B. WING ______	C 06/22/2018

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F 732	Continued From page 43 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post daily nurse staffing information during one (1) of four (5) days; and the facility failed to post the correct resident census on the daily nurse staffing information for one (1) of four (5) days during the complaint survey. Finding included: An observation on 6/17//2018 at 4:30 PM revealed the daily nurse staffing information for 6/15/2018 was posted in the facility's front lobby on the wall. The staffing information was not posted for 6/17/2018.	F 732	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for	

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F 732

Continued From page 44

An observation on 6/18/2018 at 10 AM revealed daily nurse staffing information was posted in facility's front lobby and was dated 6/18/2018. The facility's resident census sheet revealed there were 53 on 6/18/2018.

An interview with the Director of Nursing on 6/19/2018 at 3:10 PM revealed that the census was 52 on 6/18/2018. She stated that no one was here on the weekend to the post the daily nurse staffing sheets and she was not aware the posting was wrong on 6/18/2018.

An interview with the Administrator on 6/20/2018 at 4:20 PM he stated that it was his expectation that the posted nurse staffing be correct and posted on a daily bases.

F 732

implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F732

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failure promote to post daily nursing staffing, and post correct resident census on one daily

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F 732	Continued From page 45	F 732	nursing staffing posting- was knowledge deficit. On 6/19/18 and 7/9/18, the nursing staffing posting was present with correct census. This was verified by the Director of Nursing. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/2/18, the Director of Nursing was in-serviced by the Administrator on the daily nursing staffing posting, including correct census. By 7/16/18, all people involved with scheduling will be in-serviced by the Administrator or Director of Nursing on completion of staff posting information. This in-service will be part of the orientation process for all newly hired staff involved with scheduling. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The administrator, and/or director of nursing will review the daily nursing staffing posting 5 times weekly x 12 weeks to ensure it is posted with correct census. This audit will be documented on the F732 audit tool. The monthly QI committee will review the results of the F732 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for	

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F 732	Continued From page 46	F 732	continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		7/20/18

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F 755	Continued From page 47 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility allowed a nursing assistant instead of a licensed nurse to administer a prescription ointment to 1 out of 3 residents (Resident #2) reviewed for skin conditions. Findings included: Resident #2 was admitted to the facility on 1/18/17 with diagnoses of unsteadiness on feet, and unspecified open wound left lower leg initial encounter. A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment. Resident #2's MDS was coded as no pressure ulcers noted. The MDS coded the resident as having an open wound to left lower leg that was present on admission. A review of Resident #2's medical record revealed a physician's order written on 2/8/18 that read "Triamcilone ointment 1% to left flank area prn (as needed). A review of Resident #2's treatment record for	F 755	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. 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	

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F 755 Continued From page 48

June 2018 revealed Triamcilone ointment had not been documented as being applied any day in June.

An observation of Resident #2 receiving personal care from NA (Nursing Assistant) #9 and GCA (Geriatric Care Assistant) #1 was conducted on 6/18/18 at 9:20am. The DON (director of nursing) was present during the observation. The observation revealed NA #9 applying Triamcilone ointment to all of resident's back and sacral area during care. Resident #2 instructed NA #9 where to apply the Triamcilone ointment during ADL (Activities of Daily Living). NA # 9 obtained the Triamcilone ointment from the closet in the resident's room.

An interview with the treatment nurse was conducted on 6/18/18 at 5:00pm. She reported there is an order for Triamcilone ointment but Resident #2 refused to let the treatment nurse apply the ointment as he preferred it applied after his bath. The treatment nurse revealed the nurse who had Resident #2 was to apply the Triamcilone ointment and document on the treatment record when she applied it. She reported because Triamcilone ointment is a prescription medication, only a nurse not a NA should be applying the ointment.

An interview was conducted on 6/19/18 at 1:45pm with the DON. She reported any prescription medications including ointments are to be applied by a nurse not a NA. She reported she is not sure why NA# 9 applied Triamcilone ointment to Resident #2's back.

An interview was conducted on 6/20/18 at 9:58am with NA #9. She reported she "does what

F 755

written allegation of compliance.

Greenhaven Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F755

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-allowing s nursing assistant to administer a prescription ointment- was knowledge deficit.

On 7/13/18, resident #2's skin was checked by the facility treatment nurse, with no negative findings.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 7/13/18, the facility treatment nurse started an audit of all resident rooms to ensure no prescription creams or ointments are present. This audit will be

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F 755	Continued From page 49	F 755		

he (Resident #2) tells me to do" when she performed personal care on the resident. She reported she put the Triamcilone ointment on Resident #2's back "where it itches." NA # 9 reported she is not supposed to apply any prescription ointments to residents. She reported she did not know Triamcilone ointment was a prescription medication. NA #9 stated she had only cared for Resident #2 for the past 2 weeks and had applied the ointment to the resident's back with each bath because Resident #2 told her she was supposed to apply the ointment.

An interview was conducted with the acting administrator on 6/21/18 at 11:55am. He reported only nurses can administer prescription ointments. He reported it is his expectation that all prescription ointments were to be administered by the nurses not the nursing assistants.

An interview was conducted on 6/22/18 at 10:03am with the facility's consultant pharmacist. The pharmacist reported that Triamcilone ointment is a steroidal ointment with an increased strength than over the counter steroidal ointments and creams. She reported because it is an increased strength steroid, it can only be obtained with a prescription. She reported nonprofessionals are not allowed to apply a prescription ointment.

completed by 7/20/18. Any negative findings will be addressed immediately by the auditor.
On 7/13/18, the Administrator started an in-service for all nursing staff, including agency, on application of prescription creams and ointments. This in-service includes that nursing assistants cannot apply prescription creams or ointments. In-service will be completed by 7/20/18. No staff will be allowed to work after 7/20/18 until in-service is completed. This in-service will be part of the orientation for new nursing staff, including agency.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The administrator, director of nursing, social worker and/or staff development coordinator will audit 10 rooms weekly x 12 weeks to ensure no prescription creams or ointments are present in the resident room. This audit will be documented on the F755 audit tool.
The monthly QI committee will review the results of the F755 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

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F 755	Continued From page 50	F 755	The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to administer scheduled medications to 3 out of 4 residents (Resident #2, Resident #3, and Resident #9) that were to receive 5:00pm medications on 6/19/18. Findings include: a. A review of Resident #2's MAR (Medication Administration Record) revealed that on 6/19/18 at 5:00pm, the resident's Metformin HCL 1000mg tablet for diabetes, Gabapentin 300mg capsule for chronic pain, and Pradaxa 150mg capsule for preventing blood clots were documented as not given with no explanation on the MAR as to why the medications were not given. A review of Resident's medical record showed no documentation as to why the medications were not given on 6/19/18 at 5:00pm. b. A review of Resident #3's MAR revealed that on 6/19/18 at 5:00pm the resident's Clonazepam 0.5mg tablet for anxiety and Baclofen 20mg tablet for chronic pain were documented as not given with explanation on the MAR that read "Klonopin	F 760	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. 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	7/20/18

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F 760	Continued From page 51 and Baclofen not given as late on med pass." A review of Resident #3's medical record revealed no documentation as to why the resident did not receive her 5:00 pm Oxybutynin medication on 6/19/18. c. A review of Resident #9's MAR revealed that on 6/19/18 at 5:00pm the resident's Furosemide 60mg tablet for heart failure were documented as not given with the explanation on the MAR as "late start to med pass." An interview was conducted on 6/21/18 at 9:14am with the DON (director of nursing). She reported that she thought Nurse #7 assigned to Resident #2, Resident #3, and Resident #9's hall on 6/19/18 on second shift had an emergency on the evening of 6/19/18 and left suddenly. The DON reported she does not know how long the nurse was present or if the nurse gave any medications that evening. The DON reported she was not notified if any medication doses were missed. The DON stated she was not aware of who took over Nurse #7's cart and hall when she left. An interview was conducted with Resident #3 on 6/21/18 at 9:30am. Her quarterly MDS (Minimum Data Set) dated 5/18/18 coded the resident with no cognitive impairment. She reported she was told on the evening of 6/19/18 that the reason she was not given her 5:00pm medications was because the facility was "having trouble with the nurse." She stated she was not given any medications that evening until around 8:30pm. Resident #3 stated she was not to miss any doses of her medications as she could get anxious and nervous without her medications. An interview was conducted on 6/21/18 at 11:47am with Medication Aide #1. She reported that on 6/19/18 she was assigned as a CNA (certified nursing assistant) on the 100 hall for	F 760	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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F760 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to administer medications as ordered-was the staff failure to follow policies for administration of medications due to lack of knowledge. Resident #2, #3, and #9 were assessed by the Director of Nursing on 7/13/18 for any adverse effects from missed medication doses on 6/19/18. No negative findings noted.	

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F 760	Continued From page 52 4pm - 11pm. She reported she was pulled to the 400 hall at 7:20pm on 6/19/18 to serve as medication aide because she was told the nurse had to leave suddenly and was supposed to be back in an hour. The Medication Aide reported she was put on the medication cart at 7:30pm. She reported she did not give the residents their 5:00pm medications because she was not sure if any medications had been given as nothing had been documented on the MAR. She stated the nurse never came back during her shift. She reported she did not notify the physician about the missed medications as she is a medication aide and that is the nurse's responsibility. An interview was conducted on 6/21/18 at 11:50am with Nurse #7. She reported she was the nurse assigned to the 400 hall medication cart on 6/19/18 during the evening shift. She reported she came to work on 6/19/18 but had a family emergency and had to leave soon after she arrived for work. Nurse #7 reported she cannot remember if she gave any medications the evening of 6/19/18. She reported if she did, it was only for one resident. She stated when she had to leave, she gave her keys to another staff member to handle the medication pass but doesn't remember who she gave the medication cart keys to hold. Nurse #7 reported she did not come back to work that evening. An interview with the acting administrator was conducted on 6/21/18 at 12:15pm. The administrator reported it is his expectation that all medications are to be given as ordered and the physician be notified if a medication is not given.	F 760	The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/18, a Quality assurance nurse audited the last 14 days of medication administration records to ensure medications were administered as ordered. No negative trends noted. All licensed nurses, including agency, will be in-serviced by 7/20/18 by the director of nursing(DON), on administration on medication administration, including medications must be administered as ordered. No licensed nurse will be allowed to work after 7/20/18 until in-service is completed. This in-service will be part of the orientation of new licensed nurses including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, treatment nurse, and or minimum data set nurse will audit 10 residents' medication administration records weekly x 12 weeks to ensure medications are given as ordered. This audit will be documented on F760 audit tool. The pharmacy consultant will review 25% of residents medication administration records during monthly pharmacy consultant reviews. The monthly QI committee will review the results of the F760 tool monthly for 3 months for identification of trends, actions	

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F 760	Continued From page 53	F 760	taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree)	F 801		7/20/18

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F 801	Continued From page 54	F 801		

with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or

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F 801	Continued From page 55 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to employ a qualified director of food and nutrition services with the competencies and skills required to carry out food and nutrition services. This was evident for failure to follow the planned menu for 2 of 2 meal observations, failure to provide food that was palatable for 1 of 2 meal observations and failure to understand the components of a clear liquid diet. Findings Included: This tag was cross referenced to: F801 - Based on observations, record review and staff interviews the facility failed to follow the planned menu, failed to document menu substitutions and failed to provide menu substitutions that were of similar nutritive value of the planned menu items. This was evident in 2 of 2 meal observations. F804 - Based on observation, record review, resident and staff interviews the facility failed to provide food that was palatable for 1 of 2 meal	F 801	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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 801	Continued From page 56 observations. An interview with DM #1 on 6/19/18 at 2:08 pm revealed if she received a diet order for a clear liquid diet she would serve chicken broth and maybe some crackers. She added she would serve the crackers if that was the residents preference. DM #1 stated she was not sure what other foods would be served on a clear liquid diet. She explained the beverages that were identified on the resident ' s meal card would be served such as tea, water and milk. A phone interview with the Registered Dietitian (RD) on 6/19/18 at 3:16 pm revealed Dietary Manager (DM) #1 was not a certified dietary manager. She stated DM #1 was in the course to complete her certification. The RD added she believed she was the RD preceptor for DM #1 ' s course, but she didn ' t recall having reviewed any of DM #1s assignments for the course yet. She stated she had provided some additional education to DM #1 after the last annual certification survey which resulted in multiple dietary deficiencies. The RD stated she was at the facility once a week. An interview with DM #1 on 6/20/18 at 2:53 pm revealed she believed her start date at the facility was sometime in May of 2017. She stated she was enrolled in the Certified Dietary Managers course several months after she was hired. DM #1 added she had completed approximately half of the course and she thought she would be completed with the course by November 2018 and then she could take the certified dietary managers exam. She stated the RD consultant was her preceptor for the course.	F 801	F801 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitations center regarding the process that led to the deficiency of failing to employ a certified dietary manager with the competencies and skills to carry out food and nutrition services was a dietary manager who has not completed the certified dietary manager training. On 6/20/2018 the facility began employing a certified dietary manager. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 6/19/18 the meal was observed by Certified Dietary Manager and the meal was served according to the posted menu, with substitutes available with comparable nutritional value. The meal was palatable (served at the correct temperature). The current dietary manger was in-serviced on 6/20/18 by the District Food Service Director related to following the established menu, nutritional value of substitutes, and correct temperatures of food. This in-service will be provided to any new dietary manger. The certified dietary manager was	

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F 801	Continued From page 57 An interview with the Administrator on 6/20/18 at 3:30 pm revealed DM #1 worked for a contract company. He confirmed her actual start date at the facility was 6/28/18 and she had not meet the requirements as a Certified Dietary Manager. An interview with the Administrator on 6/21/18 at 10:01 am revealed he expected the DM to be competent and follow the guidelines when running the dietary department.	F 801	in-serviced on 7/18/18 by the District Food Service Director on clear liquid diets. This in-service will be provided to any new dietary manger. The current dietary manager is a Certified Dietary Manager. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The payroll clerk and/or administrator will validate every two weeks for 3 months the employment of a certified dietary manager (CDM) in the kitchen. The validation will be accomplished through review of payroll submission and supporting CDM credentials. The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature, meal served according to planned menu, and appropriate substitutes are available. This audit will occur on random days, at different meal times. This audit will be documented on the F803 audit tool. The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature and food is palatable. This audit will occur on random days, at different meal times. This audit will be documented on the F804 audit tool. Contracted Dietician will review audit tools monthly during monthly facility visit.	

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F 801	Continued From page 58	F 801	The monthly QI committee will review the status of the CDM position monthly for 3 months for the need of continued monitoring and make recommendations. The administrator will present the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		7/20/18

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F 803	Continued From page 59 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow the planned menu, failed to document menu substitutions and failed to provide menu substitutions that were of similar nutritive value of the planned menu items. This was evident in 2 of 2 meal observations. Findings included: An observation of the supper meal on 6/18/18 revealed the residents were served pork chops, white rice, lima beans a dinner roll and a chocolate chip cookie. The alternate meal available was a sandwich and potato chips. Review of the planned menu titled "hcsg1southernflare2018" week 2 provided by DM #1 revealed the planned supper meal for 6/18/18 was beef macaroni casserole, capri mixed vegetables, a dinner roll and chilled pears. The planned alternate meal was a grilled cheese sandwich, potato chips and green peas. An observation of the lunch meal on 6/19/18 revealed the residents were served diced chicken topped with sweet and sour sauce, white rice, broccoli, a dinner roll and a brownie. The alternate meal available was a sandwich and potato chips.	F 803	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. 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 Heath and Rehabilitation	

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F 803

Continued From page 60

Review of the planned menu titled "hcsg1southernflare2018" week 2 provided by DM #1 revealed the planned lunch meal for 6/19/18 was fried fish fillet, pinto beans, yellow squash with onions, cornbread and summer fresh fruit cup. The planned alternate meal was swedish meatballs, mashed potatoes and green peas.

An interview with Cook #1 on 6/19/18 at 1:00 pm revealed DM #1 told her yesterday afternoon to make the diced chicken with sweet and sour sauce for the 6/19/18 lunch meal because there was no ground beef available to make the beef macaroni casserole. She stated on average the menu on her shift was changed twice a week because the planned food items were not available. Cook #1 added this typically occurred the days before their food delivery came in, which was on Tuesdays.

An interview with DM #1 on 6/19/18 at 2:00 pm revealed the lunch menu served today was changed due to a resident choice meal. She stated when menu substitutions were made they were supposed to be recorded on a menu substitution record and approved by the Registered Dietitian (RD). DM #1 explained she was not able to find the substitution log. She stated the menu substitution for the 6/18/18 supper meal was because she didn't have any spinach available and she changed the vegetable to lima beans. She acknowledged that lima beans were not a correct substitute for spinach. DM#1 stated she didn ' t realize the residents were served white rice for 2 consecutive meals. She added she was not sure why the additional substitutions were made and she had not documented the menu substitutions routinely.

F 803

Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F803

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to follow the planned menu and the food substitutions provided were not of similar nutritional value as the planned meal.

On 6/21/18 the Certified Dietary Manager observed the lunch menu which was served according to menu, with substitutes of similar nutritive value available.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 6/19/18, the District Food Service Director in-serviced the dietary manager on 1. Following the approved menu, 2. If needed following the substitutions lists

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F 803

Continued From page 61

A phone interview with the RD on 6/18/18 at 3:16 pm revealed she had not been made aware of the menu substitutions except for the change of chicken for pork in the sweet and sour pork recipe. She stated the menu substitutions were not appropriate. The RD added she was supposed to approve all menu substitutions and they were supposed to be recorded on the menu substitution log.

An interview on 6/20/18 at 1:50 pm with Resident #4 revealed she didn't like the food served at the facility including the alternative meal choices. She added her family had purchased tv dinners that she kept in the nourishment room freezer and she would have the kitchen staff fix those for her to eat.

A phone interview on 6/21/18 at 8:30 am with the facility Ombudsman revealed she had received concerns from the residents regarding their menu choices. She stated residents had voiced the alternate meal was always a sandwich, potato chips or cheese puffs. The Ombudsman added this information had been shared with the Administrator.

An interview with the Administrator on 6/21/18 at 8:45 am revealed there were no dietary concerns or grievances for the past 3 months.

An interview with Cook #1 on 6/21/18 at 9:20 am revealed she was told by DM #1 what to prepare for the alternate meals and it was typically a sandwich with chips or cheese puffs.

An interview with the RD on 6/21/18 at 9:37 am revealed she expected the planned menus to be

F 803

(ensuring nutritive value).This in-service will be provided to any new certified dietary manager.
On 6/19/18, the District Food Service Director in-serviced the dietary staff on 1. Following the approved menu, 2. If substitutions are needed the correct process, to ensure similar nutritive value. This in-service will be complete by 7/20/18. The in-service will be part of the orientation process for all newly hired dietary staff.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided according to approved menu. This audit will occur on random days, at different meal times. This audit will be documented on the F803 audit tool.
The monthly QI committee will review the results of the F803 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.

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F 803	Continued From page 62 followed, including service of the planned alternate menus. She added menu substitutions should be of similar nutritive value as the originally planned menu item. An interview on 6/21/18 at 10:01 am with the Administrator revealed he expected residents were served their meals according to the planned menu and if a menu substitution was made it would be correct and approved by the RD.	F 803	The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 804 SS=E	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 observation, record review, resident and staff interviews the facility failed to provide food that was palatable for 1 of 2 meal observations. Findings Included An observation of the lunch meal on 6/19/18 was conducted related to a complaint (no named resident) regarding food palatability. Dietary Manager (DM) #1 took the temperatures, using a calibrated thermometer, of the food items on the steam table. The temperatures were: diced chicken 205 degrees F, beets 204 degrees F,	F 804	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	7/20/18

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F 804	Continued From page 63 mashed potatoes 199 degrees F, rice 205 degrees F, broccoli 200 degrees F, pureed broccoli 196 degrees F and pureed chicken 202 degrees F. A test tray was prepared and delivered to the main dining room with 10 resident meals trays at 12:00 pm. Six of the resident meal trays were delivered to residents eating in the dining room and the other 4 resident meal trays were distributed to residents on the 400 hall and then the 100 hall. The temperatures of the test tray were taken by the DM using a calibrated thermometer at 12:20 pm. The temperatures were diced chicken 141 degrees F, broccoli 145 degrees F and rice 149 degrees F. The food tasted warm. The broccoli was light green, gray in appearance and tasted very mushy. The sweet and sour chicken was the diced chicken with a small amount of sweet and sour sauce over it. The chicken tasted grainy and dry. An interview with DM #1 on 6/19/18 at 12:25 pm revealed she had changed the menu to sweet and sour chicken, rice and broccoli. She stated the regular diets and the mechanical soft diets were both getting the same diced chicken with sweet and sour sauce over it. DM #1 added she wasn't sure if there was a recipe for the sweet and sour chicken. An interview with Resident #1 on 6/19/18 at 12:43 pm revealed she had received a sandwich and broccoli for lunch. She stated she choose the alternate meal (a sandwich) because the food was always "nasty and had no flavor". Resident #1 added the broccoli was very mushy and she wasn't going to eat it.	F 804	• The title of the person responsible for implementing the acceptable plan of correction. F804 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to serve food that was palatable and at an acceptable temperature- was knowledge deficit: the dietary manager at the time of survey, and dietary staff were not able to consistently verbalize correct food serving temperatures, placing food on the steam table appropriately to maintain temperatures, how to correctly cook vegetables, and that recipes must always be followed. On 6/21/18, the Certified Dietary Manager observed the lunch meal which was served according to menu, and the last tray was served to hall at time and resident reported his food was warm and tasted good. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 6/19/18, the District Food Service Director in-serviced the dietary manager on 1. The process for placing food onto the steam table to maintain food temperatures, and 2. Trays will be served at the appropriate temperature. Any new	

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F 804

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An interview with Resident #7 on 6/19/18 at 12:50 pm revealed she had a sandwich and beets for lunch. She stated the food was usually "nasty" and that's why she choose a sandwich instead of the sweet and sour chicken.

An interview with DM #1 on 6/19/18 at 1:30 pm revealed she had found a recipe for sweet and sour pork. She stated the staff should have used this recipe for the sweet and sour chicken and substitute the chicken for the pork. Review of the recipe revealed it called for the addition of snow peas, carrots and green peppers with the chicken and sweet and sour sauce. DM #1 stated she didn't know why these items weren't added to the sweet and sour chicken that was prepared for the lunch meal.

An interview on 6/21/18 at 9:37 am with DM #2 revealed he expected meals to be well-seasoned, palatable, pleasing to the eye and prepared according to the recipe guidelines.

An interview on 6/21/18 at 10:01 am with the Administrator revealed it was his expectation that the residents were served food that was palatable.

F 804

dietary manger will receive in-service during orientation.
On 7/18/18, the District Food Service Director in-serviced the dietary manager on proper cooking of vegetables, and that recipes must be followed. Any new dietary manager will receive in-service during orientation.
On 6/19/18, the District Food Service Director in-serviced the dietary staff on 1. The process for placing food on the steam table to maintain temperature, 2. The need temperatures for each food type, and 3. Trays must be served timely and according to the established meal schedule. This in-service will be complete by 7/20/18. The in-service will be part of the orientation process for all newly hired dietary staff.
On 7/18/18, the dietary manager began an in-service with the dietary staff on proper cooking of vegetables, and that recipes must be followed. This in-service will be completed by 7/20/18. This in-service will be part of the orientation process for newly hired dietary staff member.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

The dietary manager, or administrator will observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature and food is palatable. This audit will occur on random days, at

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F 804	Continued From page 65	F 804	different meal times. This audit will be documented on the F804 audit tool. The monthly QI committee will review the results of the F804 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		7/20/18

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F 842	Continued From page 66 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842		

F 842 Continued From page 67 — F 842

(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to maintain a complete medical record that included assessment of a resident's health condition after receiving dialysis treatment. This was evident for 1 of 1 resident that was reviewed for dialysis (Resident #6).

Findings included:

Resident #6 was admitted to the facility on 3/24/18 and diagnoses included end stage renal disease with hemodialysis.

A care plan dated 3/26/18 for Resident #6 stated he had end stage renal disease and was at risk for complications due to hemodialysis. Interventions included dialysis on Mondays, Wednesdays and Fridays, to communicate with dialysis center as indicated for adjustments to resident's care or treatment plan, to assess the resident upon return from dialysis treatment and notify the physician of any significant changes.

An admission minimum data set (MDS) dated 3/31/18 for Resident #6 did not identify that he received dialysis. The MDS revealed the

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• The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
• The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
• The title of the person responsible for implementing the acceptable plan of correction.

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.

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F 842

Continued From page 68

resident's cognition was intact.

Review of nursing progress notes for Resident #6 from admission on 3/24/18 through discharge on 5/16/18 revealed one entry dated 4/21/18 that addressed the residents condition upon return from dialysis.

Review of the March 2018, April 2018 and May 2018 medication administration records (MARs) and treatment administration records (TARs) for Resident #6 revealed there was no assessment of the resident's condition upon return from dialysis.

An interview on 6/19/18 at 10:12 am with Nurse #5 revealed she was the first shift (7:00 am to 3:00 pm) nurse for Resident #6. She stated the resident attended dialysis on Mondays, Wednesdays and Fridays and left the facility around 12:00 pm. Nurse #5 added the nurse on the second shift would be responsible to assess him upon return from dialysis.

An interview on 6/19/18 at 3:29 pm with Nurse #6 revealed she was the second shift (3:00 pm to 11:00 pm) nurse for Resident #6. She stated the resident returned from dialysis around dinner time and she would check his vital signs and for bleeding or swelling around his dialysis site. Nurse #6 stated she was supposed to document this information in the electronic medical record but she would forget to do this at times.

An interview on 6/20/18 at 3:14 pm with the Director of Nursing (DON) revealed residents that received dialysis were supposed to have a communication form with their vital signs on it sent with them to dialysis. She stated when the

F 842

The Plan of Correction is submitted as a written allegation of compliance.

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F842

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain a complete medical record including assessment of resident post dialysis- was knowledge deficit.

Resident #6 was discharged on 5/16/18.
The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 7/13/18, the Director of Nursing (DON) completed auditing the last 14 days dialysis residents progress notes to ensure documentation of resident status

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F 842	Continued From page 69 resident returned from dialysis the nurses were supposed to check their vital signs, bruit and thrill. The DON added this information was supposed to be documented in the electronic medical record. An interview on 6/21/18 at 10:01 am with the Administrator revealed he expected residents that received dialysis were assessed and this was documented per their plan of care.	F 842	is present post-dialysis. Negative findings were be addressed immediately by the DON by completing an assessment of resident status. All licensed nurses, including agency, will be in-serviced by 7/20/18 by the Director of Nursing on documentation of resident status post dialysis in the medical record. No licensed nurse will be allowed to work after 7/20/18 until in-service is completed. This in-service will be part of the orientation of new licensed nurses including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, social worker, administrator, and/or facility consultant will audit 10% of dialysis residents' medical record weekly x 12 weeks to ensure post dialysis status is documented in the medical record. This audit will be documented on the F842 audit tool. The monthly QI committee will review the results of the F842 audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 842	Continued From page 70	F 842	The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 867 SS=E	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, record reviews, and resident and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the Annual Recertification and complaint survey of 2/18/18. This was for 5 recited deficiencies which was originally cited during the annual recertification and complaint 2/18/18, were subsequently cited again during the complaint survey of 6/22/18. The repeat deficiencies were in the areas of F641 accuracy coding, F 656 Care Plan development, F657 Update care plans, F677 Activities of daily living, and F804 Palatable foods. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included:	F 867	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; • The procedure for implementing the acceptable plan of correction for the specific deficiency cited; • The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; • The title of the person responsible for implementing the acceptable plan of correction. Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes	7/20/18

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F 867

Continued From page 71

This tag is cross referred to:

1.F641 Based on record review and staff interviews, the facility failed to accurately code, the MDS (Minimum Data Set) on 1 out 3 residents (resident #7) who was reviewed for pressure ulcers and the facility failed to code dialysis on the Minimum Date Set (MDS) for 1 0f 1 resident reviewed for dialysis (Resident #6).

During the recertification and complaint survey dated 2/18/2018 the facility was cited for F 641 for 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.

2. F656 Based on record review and staff interviews the facility failed to develop a care plan to address behaviors that included refusal of medications and dialysis treatment for Resident #6. This was evident for 1 of 1 resident that was reviewed for dialysis.

During the recertification and complaint survey dated 2/18/2018 the facility was cited for F 656 for 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.

3. F 657 Based on record review, observations and staff interviews the facility failed to update the care plan on 1 out of 3 residents (resident #7) reviewed for pressure ulcers.

During the recertification and complaint survey dated 2/18/2018 the facility was cited for F 657

F 867

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.

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F 867 QAPI Committee

The plan of correcting the specific deficiency

The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI by the Administrator. No policies were amended, re-training to current procedures were implemented.

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F 867	Continued From page 72 for 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). 4. F677 Based on observations, record review, and staff and resident interviews, the facility failed to provide incontinence care for 2 out of 4 residents (Resident #1 and Resident #2) reviewed for ADLs (Activities of Daily Living). During the recertification and complaint survey dated 2/18/2018 the facility was cited F 677 for failed to provide incontinence care to 1 of 5 resident's reviewed for activities of daily living (Resident #20). 2/14/2018 5. F 804 Based on observation, record review, resident and staff interviews the facility failed to provide food that was palatable for 1 of 2 meal observation. During the recertification and complaint survey dated 2/18/2018 the facility was cited for F804 for 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. During an interview with the Administrator on June 22, 2018 at 10:15am. The administrator reported it was his expectation that the facility continue to change the Quality Improvement system to prevent recurrent issues.	F 867	The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/2/18, the facility (Quality Assurance) QA Committee held a meeting to review the purpose and function of the QA committee and review on-going compliance issues. This meeting was conducted by the Administrator. Committee Members trained include: The director of nursing (DON), maintenance director, Social Worker, Activity Director, Therapy manager, Accounts Receivable Director, Payroll Manager, Admissions Director, Medical Director, Certified Dietary Manager, Treatment Nurse, and housekeeping supervisor. These committee members will attend QA Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 7/13/18, the vice president (VP) of Operations in-serviced the administrator related to the appropriate functioning of the QA Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641, F656, F657, F677, and F804. On 7/13/18, the administrator in-serviced the department heads related to the appropriate functioning of the QA Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641, F656, F657, F677, and F804.	

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F 867	Continued From page 73	F 867	As of 7/13/18, after the in-service, the facility QA Committee will begin identifying other areas of quality concern through the QA review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The Facility QA Committee will meet at a minimum of monthly and Executive Quality Assurance Performance Improvement (QAPI) committee meeting 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 F641, F656, F657, F677, and F804. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAPI committee will continue to meet at a minimum of Quarterly, and QA committee monthly with oversight by a corporate staff member.	

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F 867	Continued From page 74	F 867	The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QA report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI 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 title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that paid feeding assistants completed the state approved training program prior to assisting residents with feeding at meals for 1 of 1 paid feeding assistants.	F 948	An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	7/20/18

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F 948 Continued From page 75

The findings included:

Review the personnel file of GCA (Geriatric Care Assistant) #1, revealed that the GCA was hired on 2/27/18 and she had not completed the state approved training program for paid feeding assistants when she was hired

An interview was conducted on 6/19/18 at 12:00pm with GCA #1. She reported her duties included making beds, filling up ice pitchers, taking residents to the dining room, and assisting in feeding the residents. She reported she was hired in February 2018 and at the time of her hire she had not completed the state approved training for assisting residents with feeding at meals. She stated she when she was hired she was in school to become a nursing assistant and the facility told her since she would be taking the feeding training in school she did not need to take this training at the facility. She reported she started feeding residents within the first 2 weeks of beginning to work at the facility. She stated she did not complete the feeding of resident training in school until May 2018 and has not provided the facility a copy of the completed training.

An interview was conducted with the DON (Director of Nursing) on 6/19/18 at 1:30 pm. She reported she was not aware if GCA #1 had completed the state approved training for paid feeding assistants.

An interview was conducted on 6/21/18 at 11:55 am with the acting administrator and the corporate nurse consultant. They both reported that it was their expectation that all staff who were

F 948

cited;

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

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 Heath and Rehabilitation Center 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 on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

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F 948	Continued From page 76 hired to assist with feeding residents completed the state approved training for paid feeding assistants prior to feeding any residents. The corporate nurse consultant stated it is the responsibility of the administrator and the DON to assure newly hired GCAs completed the state training.	F 948	F948 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to ensure that paid feeding assistants completed the state approved training program- was knowledge deficit. Administrative nurses not educated on the GCA staff having to pass the state approved training program prior to feeding residents On 6/19/18 the Administrator suspended the GCA #1 until verification completion of the state approved training program was completed. GCA#1 completed the state approved training program on 6/21/18 and returned to work on 6/22/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 6/19/18, the Administrator started an audit of all GCAs on staff to ensure the state approved training program for paid feeding assistants has been completed. Those who have not completed course will be contacted and will not be allowed to assist in the meal process. On 7/2/18, the Administrator started an in-service for all nursing staff, including agency, on the role of GCAs in meal assistance and that the state approved training program must be completed prior to assistance being provided. This	

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 06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 948	Continued From page 77	F 948	in-service will be part of the orientation for new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The director of nursing, treatment nurse, social worker, and/or administrator will observe 5 meals weekly x 12 weeks to ensure any GCAs providing assistance have completed the state approved training course. This audit will occur on random days, at different meal times. This audit will be documented on the F948 audit tool The monthly QI committee will review the results of the F948 audit tool for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	