STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

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

(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
E0000	Initial Comments An unannounced complaint investigation and recertification survey were conducted on 6/30/25 through 7/3/25. Additional information was obtained on 7/8/25. Therefore, the exit date was changed to 7/8/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # LMX011.	E0000		07/29/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 6/30/25 to conduct a recertification and complaint investigation survey and exited on 7/3/25. Additional information was obtained on 7/8/25. Therefore, the exit date was changed to 7/8/25. Event ID # LMX011. The following Intakes were investigated NC00218224, NC00218703, NC00221365, NC00222531, NC00228535, NC00228723, NC00228770, NC00229452, NC00229503, NC00229548, NC00232075, and NC00232078. 7 of 36 complaint allegations resulted in a deficiency.	F0000		07/29/2025
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.	F0565	Resident Council Grievances for March 2025, April 2025, May 2025, and June 2025 were reviewed by the Administrator and the Director of Nursing (DON) by 7/31/25. to include the facility efforts to address grievances voiced in resident council. An audit was completed of the Resident Council Grievances for July 22,2025 by the Administrator by 7/31/25 of all current residents' voiced grievances during Resident Council to ensure that the facility is addressing grievances voiced. Any identified unaddressed grievance will be followed up by the Administrator On 7/23/25, the Nurse Consultants educated the Director of Nursing (DON) and the Administrator related to ensuring that the facility is making effort to address and follow up with Resident Council Grievances voiced.	08/01/2025

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 reverse for further 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.

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

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F0565 SS = D	Continued from page 1 (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council, resolve repeat grievances, and communicate the facility's efforts to address grievances voiced during Resident Council meetings for 4 of 4 consecutive months: March 2025, April 2025, May 2025, and June 2025. The findings included: A review of the grievance policy that was revised on 10/12/2020 indicated that "Resident Council concerns that are voiced through Resident Council are recorded on the Facility Concern/ Grievance Form and are handled in a similar manner to individually voiced concerns., complaints and grievances. The Administrator is informed that the concern is referred to a department head, investigated and resolved, and the Resident Council is informed of the progress of the resolution. a. A review of the Resident Council minutes completed on 3/19/25 had no stated author and revealed the following grievances were expressed: Shower room floor needs to be cleaned more, want better access to the phone, call bells are not being answered for 45 minutes, and staffing at night and weekends were not available. A review of the grievances for the month of March 2025	F0565	Continued from page 1 On 7/23/25, the Administrator educated the Activity Director on how to properly completed the Resident Council minutes, where the council grievances are to be documented on the resident council minutes form, how to completed facility grievance forms of any identified grievance voiced in resident council, ensuring that the investigation is being completed to included stated resolution of the grievance and follow up provided back to the resident council. On 7/23/25, an in-service was initiated with the facility Department Heads to include Dietary Manager, Housekeeping/Laundry Manager, Social Services, Activities Director, and Maintenance Director related to the ensuring Resident Council Grievance have been addressed. Any facility Department Heads who have not completed the education by 7/31/25 will not be allowed to work until the education is completed. Newly Hired/Agency, DONs, Administrator and Department Heads will be required to receive this education in orientation. The Administrator will review the Resident Council Grievances monthly for 3 months to ensure continued compliance and follow up as needed. The Administrator will present the findings of the Resident Council Grievances Monthly to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further intervention and the need for additional monitoring. The Administrator will be responsible for compliance. Date of Compliance: 8/1/25	

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F0565 SS = D	Continued from page 2 revealed no Resident Council grievances were submitted. b. A review of the Resident Council minutes completed by the Activities Director dated 4/8/25 revealed the following grievances were expressed: resident food had been stolen from the nutritional room, cigarettes and lighters are getting missing, call bells not answered for 30 minutes, laundry is getting missing, nursing assistants have attitudes when residents ask for assistance after 6 pm, sandwiches are hard. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of April 2025 revealed no Resident Council grievances were submitted. c. A review of the Resident Council minutes completed by the Activities Director dated 5/6/25 revealed the following grievances were expressed: third shift staff are not assisting residents, call lights are not answered for 30 minutes, lack of sheets, staff are asleep at 4:00 AM, residents did not get baths and staff made racist comments during 2nd shift. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of May 2025 revealed a Resident Council grievance was submitted on 5/6/25. The grievance indicated resident concerns regarding 3rd shift call light response times, sheets, staff on phones/sleeping. The only noted action taken was that nursing will follow up with 3rd shift staff. d. A review of the Resident Council minutes completed by the Activities Director dated 6/4/25 revealed no new grievances for this month. There was no documented discussion or resolution of the previous month's grievances noted in the minutes. A Resident Council meeting was held on 7/2/25 at 3:3P PM with Residents #2, # 8, 28, #53 and #55. During the meeting, Resident #8, the resident council president, expressed that the Resident Council has made repeated grievances month after month which had not been fully addressed or resolved. Resident #53 stated the resident council's complaints were not resolved and the residents were never provided follow up to their stated grievances. An interview with the Activities Director on 7/3/25 at 10:12M revealed that she completes the resident council minutes and then provides a copy of the minutes to the Administrator. She further indicated that she did not fill out grievance forms for Resident Council	F0565		

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F0565 SS = D	Continued from page 3 grievances nor did she provide follow-up to the Resident Council members at the next meeting because she did not know that she needed to do it. An interview with the Administrator on 7/3/25 at 1:35 PM revealed that Resident Council grievances were reviewed in morning meetings by the Administrator but neither he nor the Activities Director documented any actions taken to address the grievances and did not communicate the facility's efforts to address the grievances. He further indicated that these actions should have been taken and felt this was an oversight.	F0565		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of a narcotic medication (oxycodone-acetaminophen) prescribed to treat pain for 1 of 1 resident reviewed for misappropriation of property (Resident #56). The findings included: Resident #56 was admitted to the facility on 04/14/22. A review of Resident #56's quarterly Minimum Data Set assessment, dated 04/26/25, indicated his cognition was intact. Resident #56 had an order dated 5/25/23 for oxycodone-acetaminophen 5-325 milligrams (mg) two times a day every Tuesday, Thursday, Saturday, Sunday, for pain. The second oxycodone-acetaminophen 5-325 mg order dated 6/25/25 for oxycodone-acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain on hemodialysis days on Monday, Wednesday, and Friday.	F0602	"Past Noncompliance - no plan of correction required"	07/29/2025

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F0602 SS = D	Continued from page 4 a. A review of Resident #56's June 2024 Medication Administration Record (MAR) revealed the resident received oxycodone -acetaminophen 5-325 mg administered as ordered. A review of the investigative report dated 6/25/24 read in part, a narcotic card of oxycodone-acetaminophen with 30 pills was missing from the medication cart. On 6/20/24 during shift change the narcotic card count sheet indicated 21 cards (a card is a bubble pack used for storage of medications) total during shift change at 07:00 PM. On 06/24/24 on the morning of shift change the unit coordinator (Director of Nursing) counted and took keys from the night shift nurse (Nurse #8) due to first shift nurse (Nurse #3) running late and the narcotic card count resulted in 23 total cards, which included 2 additional cards delivered on 06/21/24. At about 7:30 AM the first shift nurse (Nurse #3) came in and the unit coordinator (Director of Nursing) handed over the keys to the medication cart to the first shift nurse without counting the narcotics, including the number of cards, due to the unit coordinator (Director of Nursing) just holding the keys and not opening the cart after she counted with the night shift nurse (Nurse #8). The first shift nurse worked the cart until 3:00 PM when another nurse (Nurse #9) came in to relieve her. During the count the incoming nurse (Nurse #9) counted 22 narcotic cards, and the first shift nurse (Nurse #3) brought it to her attention there were supposed to be 23 cards based on what was written. The incoming nurse (Nurse #9) recounted again while the first shift nurse (Nurse #3) flipped the sheets to confirm, and there were 22 cards. The first shift nurse (Nurse #3) assumed it was probably a miscount. On 06/25/24 at approximately 7:00 AM the outgoing nurse counted off 22 cards and sheets with oncoming nurse. Resident #1 requested a pain pill, and the oncoming nurse administered the medication. The oncoming nurse mentioned to Resident #56 there was only 1 oxycodone-acetaminophen left, and she would have to notify the hospice physician to receive a script to order a refill. Resident #56 informed the oncoming nurse (Nurse #3) he was told on the day before that he had another full card of the medication. The oncoming nurse (Nurse #3) called hospice to get a script and was informed they had sent 44 tablets of the oxycodone-acetaminophen on 06/21/24. The oncoming nurse (Nurse #3) informed management of her findings, and an investigation was initiated into the missing medication. A review of the Pharmacy delivery manifest sheet dated 06/21/24 revealed 44 oxycodone-acetaminophen tablets	F0602		

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F0602 SS = D	Continued from page 5 delivered to the facility. A review of the controlled substance count sheet record dated 06/21/24 indicated 1 of 2 cards for 30 of 44 tablets revealed 14 oxycodone-acetaminophen tablets signed for on the record. There were 14 tablets signed out from 06/22/24 through 06/25/24. An interview was conducted on 07/02/25 at 11:30 am with the Director of Nursing (DON) (who was the Unit Manager during the timeframe of the missing medications that counted narcotics with Nurse #8 at 07:00 AM. The DON indicated she counted the narcotic sheets with Nurse #8 and the narcotic cards and sheets they counted matched. She stated she did not open the medication cart again until Nurse #3 came in at approximately 7:30 AM on 06/24/24 and she didn't recall if they counted the cards and the sheets, but she did know she did not go back in the cart after counting with Nurse #8. On 07/02/25 at 4:05 PM an interview was conducted with Nurse # 3, and she indicated she was called in to work on her day off due to a call out on 06/24/24. She stated when she arrived at work she counted the narcotic cards with the Unit Manager, however she did not count the narcotic cards. She indicated at 3:00 PM at the end of her shift Nurse #9 counted the cards and she was counting the pages, and they noticed the cards and the narcotic sheets were not matching. Nurse #3 indicated she thought it was a mistake and she and Nurse #9 corrected the narcotic count sheet with the narcotic cards. She stated she thought someone forgot to put the right number of cards on the sheet. Nurse #3 indicated she received a call at home the following day about the missing narcotics, and she was informed she had been suspended pending an investigation. She stated when the investigation was complete, she was able to return to work and receive education training on counting the narcotic sheets and cards. On 07/03/25 at 9:38 AM an interview was conducted with Nurse #8, and she indicated she counted the narcotic sheets and cards on 06/24/24 after working the night shift, and the count was correct. She indicated she did not recall the number of narcotic sheets and cards but there was no discrepancy that she was aware of. Nurse #8 indicated she was contacted by the facility, they informed her they were doing an investigation of the missing narcotics, and she informed them the count was correct when she left. She stated prior to working again she received education on counting the narcotic sheets and cards b. A review of Resident #56's August 2024 Medication	F0602		

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F0602 SS = D	Continued from page 6 Administration Record (MAR) revealed the Resident received oxycodone-acetaminophen 5-325 mg as ordered. A review of the Pharmacy delivery manifest sheet dated 08/12/24 revealed 28 oxycodone-acetaminophen tablets delivered to the facility. A review of the controlled substance count record dated 08/21/24 indicated 1 of 1 card for 28 tables revealed 28 oxycodone-acetaminophen tablets signed for on the record. There were 28 tablets signed out from 08/13/24 through 08/19/24. The record noted to have dates illegibly documented over with unrecognizable times and signatures on 08/17/24. An interview was conducted on 07/03/25 at 9:55 AM with the previous Assistant Director of Nursing (ADON) and she indicated the previous DON investigated the missing narcotics in June 2024 and she had investigated the discrepancies with the narcotic sheets in August 2024. The previous ADON indicated she was reviewing the narcotic sheets and recognized some discrepancies with the signatures. She indicated she started an investigation and identified Nurse #9 was signing medications out and changed some of the dates by writing over the numbers and it appeared medications could have been diverted but it was hard to tell due to the number changes. The previous ADON reported Nurse #9 was suspended pending the investigation and she did not cooperate with the investigation, so she was terminated. She indicated Resident # 56 did not complain of any increased pain and he was very vocal and if he thought he was not getting his medication he would have voiced it. She indicated Resident #56 acted unaware that anything was going on with his medication. On 07/03/25 at 10:26 AM an interview was conducted with the previous Director of Nursing (DON), and she indicated the previous ADON was doing an audit, and she found discrepancies with Resident #56's oxycodone-acetaminophen narcotic sheets. She indicated it was signed out on 8/17/24 by Nurse #9 and she did not work on that day. The previous DON stated, "I was out of the country and the ADON and Administrator did most of the investigation and by the time I returned the investigation was completed." She indicated she made multiple attempts to contact Nurse #9 to follow up with the investigation, however she was unable to contact her. The previous DON stated the contact attempts included phone texts, phone calls, and certified mail. The previous DON stated Nurse #9 was terminated due to not complying with the investigation. She reported they did not substantiate the investigation because the Resident stated he had no	F0602		

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F0602 SS = D	Continued from page 7 issue with getting his medications and the other alert and oriented residents interviewed also did not have any concerns with receiving their pain medications. On 07/03/25 at 11:08 AM an interview was conducted with the previous administrator, Administrator #3, and he indicated there were concerns with missing medications and documentation with the count sheets. He reported they put processes in place to ensure the Nurses understood the importance of counting the narcotic sheets and cards. Administrator #3 stated there was no evidence that a specific person had taken the medications and they were unable to determine where the narcotics went. He also indicated they interviewed all the nurses, did audits and put process in place through the quality assurance and performance improvement (QAPI) process. An interview was conducted with Resident #56 on 07/03/25 at 9:20 AM and he indicated he did not have any problems currently getting his pain medication and he did not remember having any problems getting pain medications in June or August of 2024. Attempts to interview Nurse #9 were unsuccessful. The facility provided the following corrective action plan with a completion date of 09/03/24: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 06/24/24, the facility identified Resident #56 was missing 1 card of 30 oxycodone-acetaminophen 5-325 milligrams (mg). A pain assessment of Resident #56 was completed by the licensed nurse on 06/24/24 with no pain identified by Nurse #12. The medication administration record was reviewed by the Director of Nursing (DON) on 06/25/24 with no missed doses identified and the pharmacy was notified to replace the identified missing medications at the expense of the facility on 06/25/24. On 6/25/25 the pharmacy delivered the missing card that was paid for by the facility. 8/23/24, the Assisted Director of Nursing (ADON) identified a discrepancy in the controlled substance declining count sheet of 2 Percocet 5-325mg related to Resident #56.	F0602		

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F0602 SS = D	Continued from page 8 On 08/27/24, the pain assessment was completed by the licensed nurse with no pain notes. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All the current residents are at risk for this deficient practice. On 06/26/24, the ADON/DON reviewed the electronic medical record (EMAR) of the current residents and compared it to the declining count sheets for all current narcotics and narcotics dispensed in the last 30 days to ensure the narcotic medications cards are accounted for and present on the medication carts. On 06/26/24, the ADON/DON reviewed the shift change controlled count check form of the current residents for the last 30 days to ensure medication cards that were delivered from the pharmacy were added to the count and their declining count sheet was present with no concerns identified. On 06/26/24, the ADON completed an audit of the current residents for the last 30 days of the ordered narcotic medications to ensure that medication cards in the medication cart matched the total number of counts sheets on the shift change controlled substance count check form with no concerns identified. On 06/26/24, Pain assessments were completed on the current residents with no concerns identified. On 08/26/24, the ADON/ Unit Managers completed a 100% audit of the current residents' medication administration record (MAR) starting from 8/1/24 to 8/26/24 to ensure that the medication cards and the declining counts sheets reflect that medications had been given as ordered. No concerns were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 06/25/24, the Staff Development Coordinator (SDC) initiated in-service training with all the licensed nurses and medication aides regarding the Controlled Substance Diversion to include: the definition, implications, and the process for counting medications cards and ensuring medication cards and declining count sheets match and are accounted for. If discrepancies are noted the Director of Nursing and the Administrator should be notified immediately. by 09/02/24.	F0602		

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F0602 SS = D	Continued from page 9 On 08/27/24, the SDC initiated training with 100% of the licensed nurses and the medication aides related to the 6 rights of Medication Administration to include reading the MAR, accurately administering medications per the physician order, and what to do with medications which cannot be administered. This training was to be completed by 09/02/24. Licensed nurses and medication aides will be required to complete the education prior to working. Newly hired staff will complete the education during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON/SDC will audit of a medication carts weekly x 4 weeks then monthly x 2 months to ensure medications cards and declining count sheets continue match and medication cards are accounted for. Any areas of concern medication cards will be immediately addressed during the observation including staff retraining. The Administrator or DON will review and initial the audits weekly x 4 weeks then monthly x 2 months to ensure all areas of concern are addressed appropriately. The Administrator or DON will present the findings of the Audit Tools to the QAPI committee monthly for 3 months. The QAPI committee will meet monthly for 3 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of Compliance 09/03/24 Validation of the corrective action plan was completed on 07/03/25: The corrective action plan was validated by reviewing the education provided to the staff, reviewing the interviews with staff and residents, and reviewing the daily Quality Monitoring documentation. Residents were interviewed during the survey, and none reported untreated pain. Nursing staff were interviewed and indicated they had all received education on narcotic diversion. No evidence of drug diversion was discovered during the validation. The facility completion date of 09/03/24 was validated on 07/03/25.	F0602		
F0641 SS = D	Accuracy of Assessments	F0641	What corrective action will be accomplished for each	07/29/2025

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

(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
F0641 SS = D	Continued from page 10 CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of vision for 1 of 1 resident reviewed for communication (Resident #57). The findings included: Resident #57 was admitted to the facility on 9/8/24 with a diagnosis of cardiac arrythmia, dementia, and essential hypertension.	F0641	Continued from page 10 resident found to be affected. Resident #57 Minimum Data Set (MDS) assessment in the area of vision was corrected by the MDS nurse 7/15/25. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice Current residents are at risk for this deficient practice. An audit was completed by the MDS Consultant on 7/24/25 of all current residents' assessment in the area of vision for accuracy. Any identified concerns will be corrected by the MDS nurse. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/22/25, the MDS Consultant educated the MDS Nurse related to ensuring MDS vision assessments are coded correctly. Any MDS nurse to include agency and contract MDS nurses who has not completed the education by 7/28/25 will not be allowed to work until the education is completed. Newly hired MDS nurses will be required to receive this education in orientation. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing will review all the completed MDS weekly by 4 weeks and monthly x 2 months to ensure MDS assessments in the area of vision continue to be coded correctly. The Director of Nursing will present the findings of the MDS audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator will be responsible for compliance.	

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F0641 SS = D	Continued from page 11 A review of Resident #57's electronic medical record (EMR) included an ophthalmology consultation note dated 11/19/24. The assessment revealed a medical condition of cataracts in both eyes and related blurred vision. The consultation note further indicated that cataract surgery was recommended and had been scheduled on 3/26/25 for the left eye and 4/30/35 for the right eye. A review of Resident # 57's Significant Change in Status MDS assessment dated 3/19/25 was completed by MDS Nurse #2 and revealed the resident had severely impaired cognition , adequate vision and had corrective lenses. Resident #57's most recent Minimum Data Set (MDS) assessment dated 5/1/25 was completed by MDS Nurse #1 and revealed the resident had severely impaired cognition ,adequate vision, and had corrective lenses. Resident #57's care plan revised on 5/15/25 by MDS Nurse #1 did not include any identified problems or interventions related to visual impairment. An interview and observation was conducted with Resident #57 on 6/30/25 at 10:21 AM. Resident #57 indicated that she was waiting for cataract surgery for her eyes and that she had difficulty seeing her food. An interview was conducted with the scheduler for appointments and transportation on 7/1/25 at 3:01 PM. She indicated that Resident #57's cataract surgeries were delayed due to a hospital stay in March of 2025 prior to her scheduled surgery. She further revealed that a follow-up appointment was scheduled for 7/24/25. An interview was conducted with MDS Nurse #1 on 7/1/25 at 3:05 PM. She revealed that she completed the quarterly assessment of 5/15/25, and she was not aware of any blurred vision or that Resident #57 had bilateral cataracts. MDS Nurse #1 then indicated that Resident #57 should have been coded for visual impairment. An interview was conducted with MDS #2 on 7/2/25 at 11:22 AM. She indicated she was the interim MDS nurse	F0641	Continued from page 11 Date of Compliance: 07/29/25	

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F0641 SS = D	Continued from page 12 and completed Resident #57's Significant Change in Status Assessment of 3/19/25. She further revealed that she was not aware of an ophthalmology consultation note that indicated bilateral cataracts and blurred vision and if she had seen the report, she would have coded Resident #57 to have visual impairment and cataracts. An interview on 7/3/25 at 1:38 PM with the Administrator revealed that Resident #57's MDS assessments should have been coded to accurately reflect the resident's medical condition.	F0641		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F0655	What corrective action will be accomplished for each resident found to be affected. On 3/27/25 Resident #57's care plan was reviewed by the interdisciplinary team with the responsible party. On 7/25/2025, Resident #57's responsible party was updated on the resident's current status and the resident's plan of care and copy offered. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice Current residents are at risk for this deficient practice. An audit was completed by the Director of Nursing (DON) and Nurse Managers on the baseline care plans for the new admissions for the last 60 days by 7/28/25 to ensure that baseline care plans for new admissions were reviewed and a copy provided to the resident and/or responsible parties. Any identified concerns will be addressed. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/23/25, the Director of Nursing and the Staff Development Coordinator (SDC) initiated educated to the licensed nurses to include agency, contract and prn licensed nurses related to ensuring that the licensed nurse is reviewing new admission baseline care plans within 48 hours of admission with the resident and/or the responsible party and a copy provided. Licensed	07/29/2025

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F0655 SS = D	Continued from page 13 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to provide a copy of the baseline care plan to the responsible party for 1 of 23 residents reviewed for baseline care plans (Resident #57). Findings included: Resident #57 was admitted to the facility on 7/1/18 and readmitted on 3/12/25 with diagnoses that included, in part, non-traumatic intracerebral hemorrhage in the hemisphere (bleeding within the brain tissue of one cerebral hemisphere, occurring without any known trauma or injury). A review of the comprehensive Minimum Data Set (MDS) assessment dated 3/19/25 revealed Resident #57 was severely cognitively impaired. A review of the medical record revealed a baseline care plan was completed by Unit Manager #1 3/13/25. A review of the medical record revealed Resident #57 listed a family member as her own responsible party.	F0655	Continued from page 13 nurses to include agency, contract and prn nurses will not be allow to work after 7/28/25 until the education is completed. Newly hired licensed nurses will be required to receive this education in orientation. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing will review the baseline care plans of new admissions weekly for 4 weeks and monthly x 2 months to ensure new admission baseline care plans continue to be reviewed by the licensed nurse within 48 hours of admission with the resident and/or the responsible party and a copy provided. The Director of Nursing will present the findings of the baseline care plan audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator will be responsible for compliance. Date of Compliance: 07/29/25	

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F0655 SS = D	Continued from page 14 A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident or the responsible party. Multiple attempts were made to interview the responsible party, but attempts were not successful. An interview was conducted with Resident #57's admitting Nurse, Nurse # 7. She indicated she did not complete the baseline care plan and did not provide a summary of the baseline care plan. Multiple attempts were made to interview Unit Manager #1, but attempts were not successful. On 7/2/25 at 11:03 AM an interview was completed with Unit Manager #2. He stated that typically the unit managers develop the baseline care plan for new or readmitted residents and reviewed it with the resident and/or responsible party within 48 hours of admission. On 7/2/25 at 11:03 AM an interview was completed with the Director of Nursing (DON). She stated the baseline care plan was initiated and completed 3/13/25 by Unit Manager #1. She said she expected the baseline care plan to be developed within 48 hours of admission, and a copy provided to the resident or resident representative. The DON further stated she could not confirm that Resident #57's t baseline care plan summary was ever provided to the resident or responsible party. An interview was conducted with the Administrator on 7/3/25 at 1:30 PM and he indicated that he expected the resident and/ or the responsible party to receive a written summary of the baseline care plan within 48 hours of their admission.	F0655		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F0658	On 7/7/25, Resident #66's the provider was notified by Assistant Director of Nursing and the dosage of aspirin was clarified. An audit will be completed by the Director of Nursing (DON) and Nurse Managers of the current residents' medication admission record (MAR) by 7/30/25 to ensure that medication orders include dosage. Any identified missing medication dosage was clarified by the	08/01/2025

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F0658 SS = E	Continued from page 15 This REQUIREMENT is NOT MET as evidenced by: Based on interviews with staff and record reviews, the facility failed to clarify the dosage of aspirin to administer to 1 of 5 residents reviewed for unnecessary medications (Resident #66). The findings included: Resident #66 admitted to the facility on 3/01/24 with diagnoses including dementia, cerebral stroke syndrome, and cerebrovascular disease. Resident #66's quarterly Minimum Data Set (MDS) dated 5/10/25 documented she had severe cognitive impairment. The MDS noted she had a history of a stroke and she received antiplatelet medications (prevents the accumulation of platelets to prevent blood clots). Resident #66's Medication Administration Records (MAR) from January 2025-July 2025 were reviewed and included an order for staff to administer aspirin once every other day. The MAR did not have a dosage listed on the entry. In an interview on 7/03/25 at 3:30 PM, Nurse #12 stated she was the regular nurse on Resident #66's hallway and routinely gave her the aspirin. She stated she gave Resident #66 an 81 milligram (mg) every other day out of the facility stock of over-the-counter medications because she thought that was what was ordered. She stated she was not aware there was no dosage in the original order but stated she believed there was a standing order for aspirin for all residents of aspirin 81 mg if needed. Resident #66's standing physician's orders did not include an order for aspirin. In an interview on 7/03/25 at 9:27 AM, the Director of Nurses (DON) stated she had been at the facility since the end of 2024 and stated she was not aware there was no dosage listed for the aspirin until surveyor intervention. She stated all medications orders should have the strength of the medication to be given. She stated there were two dosages of aspirin in the over-the-counter facility stock, 81 mg and 325 mg. She	F0658	Continued from page 15 provider. On 7/23/25, the Director of Nursing and the Staff Development Coordinator (SDC) initiated educated to the licensed nurses, certified medication aide to include agency and prn staff related to ensuring medication orders include medication dosage. Certified medication aides will notify the licensed nurse of any medication discrepancies. The licensed nurses will notify the provider of any identified medication discrepancies. Licensed nurses and medication aide to include agency, contract and prn staff will not be allowed to work after 7/28/25 until the education is completed. Newly hired/agency, licensed nurses and medication aides will be required to receive this education in orientation. The Director of Nursing or Nurse Manager will review 10 residents weekly for 4 weeks and monthly x 2 months to ensure medication orders are free from discrepancies and if discrepancies are noted the licensed nurse has followed up with the provider. The Director of Nursing will present the findings of the audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. Date of Compliance: 8/1/2025	

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F0658 SS = E	Continued from page 16 stated Resident #66 should have received 81 mg of aspirin which was the usual dosage for residents with a history of stroke and the order should have been clarified. Resident #66's physician was unable to be interviewed during the survey.	F0658		
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to arrange or coordinate podiatry care for 1 of 5 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #31). The findings included: Resident #31 was admitted to the facility on 2/17/25 with diagnoses which included cellulitis of left lower limb, chronic kidney disease and congestive heart failure. Resident #31's quarterly Minimum Data Set (MDS) assessment dated 5/30/25 revealed the resident was cognitively intact and was dependent on staff for personal hygiene. The MDS further revealed the resident was coded for not being ambulatory. Resident #31 s care plan, revised 6/6/25, revealed the resident had a focus area of activities of daily	F0687	What corrective action will be accomplished for each resident found to be affected. On 7/2/2025 social services followed up with resident #31who declined to go to an outside of facility provider for podiatry services. Resident #31 requested to be added to the facility podiatry provider schedule on the next scheduled visit. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice Current residents are at risk for this deficient practice. An audit was completed by the Director of Nursing (DON) and Nurse Managers of the current residents' toenails by 7/28/2025 to ensure that residents' toenails being trimmed and podiatry service is being provided if needed. Any identified concerns will be followed up by the Director of Nursing and/or Unit Manager. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/24/25, the Director of Nursing and the Staff Development Coordinator (SDC) initiated education to the licensed nurses and certified nursing assistances (CNAs) to include agency and prn nursing staff related to ensuring resident toenails are being trimmed and follow up with podiatry if needed. The CNAs will notify the licensed nurse if any podiatry concerns are identified. The licensed nurses will follow up with social socials, Nurse Manager and/or DON if any podiatry concerns are identified. On 7/24/25, the Director of Nursing educated the social workers on ensuring residents receive podiatry services as needed.	07/29/2025

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F0687 SS = D	Continued from page 17 living/personal care. The goal was for Resident #31 to have staff complete activities of daily living as appropriate to maintain the highest practical level of functioning through the next review. There was no documentation in the medical record the resident had been seen by podiatry. An interview and observation with Resident #31 on 6/30/25 at 10:30 AM revealed the resident's great toenails on both feet to be extending beyond the end of her toes, and were thick, and yellow in color. Resident #31 indicated that she felt the nursing staff would not be able to cut her toenails and has not been offered a podiatry consult and would like to have a podiatry visit from the facility onsite provider. Resident #31 stated she was not in pain from the length of her toenails as she did not walk or wear shoes. An interview was conducted with Nursing Assistant (NA) #7 on 7/1/25 at 2:15 PM. She indicated that she was assigned to Resident #31 on 7/1/25 and that she completed personal hygiene care which included nail care. NA #7 indicated that she observed Resident # 31's toenails to be long, hard and overgrown and did not feel she was able to trim the toenails therefore she notified Nurse #7 of the status of her toenails and that she was in need of a podiatry consult. An interview conducted with Nurse #7 on 7/1/25 at 2:31 PM revealed she was not aware Resident #31 needed a podiatry consult and that NA #7 did not report this issue to her. An interview was conducted with the Director of Nursing (DON) on 7/1/25 at 3:05 PM. She indicated toenail care was to be provided by the nursing staff and if the nurses were not successful with trimming a resident's toenails, then the resident was offered a podiatry consult to the resident's toenails needs. The DON indicated the in-house podiatrist visited the facility quarterly. The DON reported the facility attempted to trim Resident #31's toenails in May of 2025, but she declined. The DON further revealed Resident #31 was not offered a podiatry consult at that time and should have been referred to the podiatrist for services in May when she declined to let staff trim her toenails.	F0687	Continued from page 17 Licensed nurses and certified nursing assistants to include agency and prn nursing staff will not be able to work after 7/28/25 until the education is completed. Newly hired licensed nurses, certified nursing assistants, and social services will be required to receive this education in orientation. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing complete foot care audits weekly by 4 weeks and monthly x 2 months to ensure residents' toenails are being trimmed and podiatry services continue to be provided if needed. The Director of Nursing will present the findings of the audit to the Quality Assurance and Process Improvement (QAPI) committee monthly to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator will be responsible for compliance. Date of Compliance: 07/29/25	
F0689 SS = G	Free of Accident Hazards/Supervision/Devices	F0689	What corrective action will be accomplished for each	07/29/2025

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F0689 SS = G	Continued from page 18 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to lock the brakes on a resident's wheelchair before leaving her unattended on the facility's front patio. Nurse Aide (NA) #5 positioned Resident #102 on the front patio and then walked away from the resident without securing the wheelchair brakes. Due to the brakes not being locked, and the resident's inability to stop the wheelchair when it began to roll due to weakness in all of her extremities, Resident #102 rolled approximately 10 feet across a circle drive and then struck her head on a brick wall which resulted in two lacerations to Resident #102's forehead that required sutures to repair. In addition, the facility also failed to provide care in a safe manner when Resident #310 rolled off the bed while NA #6 was providing a bed bath. This deficient practice occurred for 2 of 10 residents reviewed for accidents (Resident #102 and Resident #310). The findings included: 1. Resident #102 was admitted to the facility on 12/8/23 with diagnoses including quadriparesis (weakness in all four limbs) and chronic dislocation of right shoulder. Resident #102 was discharged from the facility on 4/24/25. Resident #102's most recent quarterly Minimum Data Set (MDS) dated 3/11/25 showed Resident #102 was cognitively intact, used a manual wheelchair, and was dependent on staff for all activities of daily living. The care plan last reviewed on 3/18/25 showed Resident #102 was care planned for falls and required assistance with activities of daily living due to chronic health conditions and weakness in extremities. The	F0689	Continued from page 18 resident found to be affected. Resident #102 is no longer in the facility. Discharged on 04/24/25. Resident #310 is no longer in the facility. Discharged on 06/17/25. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice Current residents are at risk for this deficient practice. An audit was completed by the Maintenance Director of the current residents' that require wheelchairs on 7/24/25 to ensure that residents' wheelchair brakes are functioning properly. Any identified concerns was followed up by the Maintenance Director. An audit will be completed by the Director of Nursing (DON) and the Nursing Managers of the current residents by 7/28/25 to ensure residents are being turned and positioned properly and safely positioned in the center of the bed with proper body alignment for comfort and safety. Any identified concerns will be addressed when observed. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/23/25, the Director of Nursing and Staff Development Coordinator (SDC) initiated education to the nursing staff to include licensed nurses, certified medication aides, certified nursing assistants, and agency and prn nursing staff related to ensuring residents are being turned and positioned properly and positioned in the center of the bed with proper body alignment for comfort and safety. On 7/23/25, the Director of Nursing and Staff Development Coordinator (SDC) initiated education to the nursing staff to include licensed nurses, certified medication aides, certified nursing assistants and agency and prn nursing staff related to ensuring	

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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
F0689 SS = G	Continued from page 19 interventions included the use of a manual wheelchair for mobility. Review of physician orders showed Resident #102 was not on any blood thinners. An incident report dated 3/28/25 at 3:30 PM completed by the Director of Nursing (DON) revealed NA #5 transported Resident #102 out to the front patio of the facility. The report read that Resident #102 had lost control of her wheelchair and had rolled into the wall. The report further read that staff assisted immediately to complete a head-to-toe assessment, including vital signs, and applied pressure to stop bleeding. The emergency contact and the Nurse Practitioner were notified. Resident #102 was sent to the hospital for evaluation and treatment. During an interview with NA #5 on 7/1/25 at 2:17 PM, she stated she had pushed Resident #102 outside to the front patio in the afternoon of 3/28/25. NA #5 stated Resident #102 liked to sit in the sun, so she had pushed to her usual spot which was all the way across the patio and beside the circular drive. NA #5 also reported Resident #102 naturally leaned slightly forward in her wheelchair and did not have the strength to propel or stop herself in a wheelchair. NA #5 indicated she always locked the brakes on the wheelchair and couldn't explain why she didn't that day other than she just forgot. NA #5 stated she had just walked back into the building when she turned and saw Resident #102 slowly rolling across the circular drive. NA #5 reported she didn't reach her fast enough and Resident #102 struck her forehead on the brick retaining wall. NA#5 stated Resident #102 did not fall out of her chair and she didn't lose consciousness. NA #5 further stated that Resident #102 told her she was trying to get into the sun more and couldn't stop the wheelchair from rolling. NA #5 stated she didn't remember calling for any assistance, but other staff members then appeared to assist with getting Resident #102 back into the building to assess her and address her wound on her head that was bleeding. During an interview with the DON on 7/1/25 at 3:34 PM, she stated that she was up front on 3/28/25 when the incident with Resident #102 occurred. The DON stated she heard a staff member (unable to recall whom) say a resident just had an accident outside. The DON stated she responded immediately and performed an assessment on Resident #102. The DON reported Resident #102 did not fall out of her wheelchair, did not lose consciousness, and was complaining of minimal to moderate pain around the wound on her forehead. The DON	F0689	Continued from page 19 residents' wheelchair brakes are locking properly and if a concern is identified maintenance is notified. Nursing staff to include licensed nurses, certified nursing assistants, and certified medication aides, agency, contract and prn staff will not be able to work after 7/28/25 until the education is completed. Newly hired nursing staff will be required to receive this education in orientation. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing will review 10 residents that require wheelchairs weekly for 4 weeks and monthly x 2 months to ensure residents' wheelchair brakes continue to lock properly. The Director of Nursing will observe 10 residents weekly for 4 weeks and monthly x 2 months to ensure residents continue to turned and repositioned properly and positioned in the center of the bed with proper body alignment for comfort and safety. The Director of Nursing will present the findings of the audit to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator is responsible for compliance. Date of Compliance: 07/29/25	

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F0689 SS = G	Continued from page 20 stated Resident #102 told her she was trying to move further into the sun and couldn't stop the chair from rolling. The DON stated she contacted the emergency contact and NP #1 who provided the order to send Resident #102 to the hospital to assess her wound. The DON stated her vital signs were normal and Resident #102 was verbally responding in her normal manner. Review of the Emergency Medical Service note showed they arrived on 3/28/25 at 3:31 PM to the facility and found Resident #102 sitting upright in her wheelchair in the lobby. The note further read "Resident had free rolled several feet across the drive into a brick wall. The resident had two small lacerations on her forehead. Bleeding was controlled, the area was cleaned and bandaged by staff ...Resident is not on blood thinners and did not lose consciousness. Resident requested transport to a specific hospital for treatment. Alert and oriented, vital signs normal. No complaints of dizziness, only some pain around laceration. Resident is a non-emergency transport today." Review of the emergency department note dated 3/28/25 at 4:09 PM showed Resident #102 sustained two lacerations- a 4.2-centimeter laceration over the middle of the forehead and a 1.0 centimeter laceration to the right of the other. There was a small amount of bleeding with no visible bone. Both wounds were closed with a total of 6 non-absorbable simple sutures. All lab work and diagnostic scans, including computed tomography of Resident #102's cervical spine and head were negative, and Resident #102 was transported back to the facility on 3/28/25. An observation of the facility main entrance front patio on 7/1/25 at 3:15 PM showed an approximate 10 foot by 20-foot concrete slab directly adjacent to a circular drive that was approximately 10 feet wide. The drive adjacent to the patio appeared slightly sloped away from the front patio and sloped down toward the wall on the opposite side of the drive. There was an approximately 4-foot-high brick retaining wall on the other side of the circular drive. During a follow-up interview with the DON on 7/2/25 at 9:24 AM, she stated after investigating the incident, they found that NA #5 inadvertently forgot to lock the wheelchair brakes on Resident #102's chair and they had addressed that with NA #5. Resident #102 stated she attempted to move herself further into the sun, began slowly rolling and was unable to stop due to the limited amount of strength in her extremities. The DON also stated the resident should not have been left alone with the brakes unlocked, was not safe to be left	F0689		

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F0689 SS = G	Continued from page 21 unsupervised with the wheelchair brakes unlocked, and that the facility continued doing neurological checks after Resident #102 returned for an additional 3 days. During an interview with the NP #1 on 7/3/25 at 2:08 PM, she stated she saw Resident #102 after she returned from the hospital and removed her stitches from her forehead. NP #1 stated the two wounds healed well, Resident #102 voiced no complaints of pain to her, and she had no other injuries related to the incident. 2. Resident #310 was admitted to the facility on 4/21/25 with diagnoses including unspecified dementia, and weakness. Review of physician orders showed Resident #310 was not on any blood thinners. Resident #310's admission MDS dated 4/28/25 showed Resident #310 was cognitively intact and was dependent on staff for all activities of daily living including bed mobility. The MDS showed Resident #310 weighed 275 pounds. The care plan last reviewed on 5/2/25 showed Resident #310 was care planned as totally dependent on staff for activities of daily living due to chronic health conditions and weakness. The care guide dated 5/2/25 being used by nurse aides to determine how much care Resident #310 needed with her activities of daily living showed the resident was totally dependent on staff for bed mobility and bathing. Review of the incident report by Nurse #6 dated 6/17/25 stated during morning care with NA #6, Resident #310 became weak and had a witnessed fall. Resident verbalized no pain. While still lying on the floor, during the nursing assessment, Resident #310 had a syncopal (fainting) episode and became unresponsive. Oxygen was immediately applied by Nurse #6, and 911 was called. Resident #310 never stopped breathing, regained consciousness in less than a minute, and left the facility with oxygen level of 93%. During an interview with NA #6 on 7/1/25 at 10:36 AM, she stated she was giving Resident #310 a bed bath sometime after breakfast on 6/17/25 and had raised the bed up to her waist height. NA#6 stated she was aware Resident #310's care guide showed she required two staff members, but she stated everyone was usually busy helping other residents so sometimes she just did it herself. NA#6 reported Resident #310 was on her left	F0689		

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F0689 SS = G	Continued from page 22 side facing away from NA #6, NA #6 was on the right side of the bed, and the NA was talking with the resident while she was washing the resident's back when Resident #310 stopped responding to her and slowly rolled away from her off the left side of the bed onto the floor, landing on her right side facing the bed. NA #6 stated she called for help and Nurse #6 responded quickly. NA#6 reported Resident #310 was alert at that time, rolled over to her back and asked how she got on the floor. During an interview with Nurse #6 on 7/1/25 at 2:20 PM, she stated she responded to Resident #310's room when NA#6 called for her (unsure of time) on 6/17/25 and found Resident #310 lying on her back beside her bed. Nurse #6 reported NA #6 told her she was giving Resident #310 a bath and NA#6 had the resident on her side washing her back when Resident #310 talking to her and then rolled forward off the bed onto the floor. Nurse #6 stated Resident #310 was alert but confused about how she ended up on the floor and was not complaining of any pain. Nurse #6 stated Resident #310's blood pressure was slightly low for her at 114/52 but was still within normal range. Nurse #6 reported Resident #310 was responding appropriately to questions and then became unresponsive. Nurse #6 stated another staff member (unable to recall whom) called 911, brought in oxygen, and it was applied. Nurse #6 reported Resident #310 regained consciousness quickly and was able to say her name and responded appropriately to questions. EMS arrived and transported the resident to the emergency room for evaluation. Nurse #6 reported that cardiopulmonary resuscitation was not needed nor provided, and Resident #310 never stopped breathing. Review of the Emergency Medical Service note showed they arrived on 6/17/25 at 10:55 AM to the facility and found Resident #310 lying on the floor. The report further stated "Resident fell presumably due to weakness and possibly hit her head. No blood thinners taken. Resident is hypotensive (low blood pressure) but responsive to stimulation. Intravenous fluids started... Resident became more responsive to verbal stimuli and spoke her name clearly upon leaving the facility ... Resident transported to the hospital for evaluation." Review of the emergency department note dated 6/17/25 at 11:25 AM showed Resident #310 was alert and oriented upon arrival and had no complaints of pain. Lab work and diagnostic tests showed possible pneumonia and a high creatinine indicating the need for possible dialysis. Resident #310 was admitted for further	F0689		

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F0689 SS = G	Continued from page 23 testing and did not return to the facility. During an interview with the DON on 7/2/25 at 10:49 AM, she stated she was made aware of the incident on 6/17/25 when Resident #310 rolled off the bed during a bed bath. The DON stated the facility did in-service training regarding bed mobility and the importance of following the care guide for each resident which is what NA#6 should have done which would have prevented Resident #310 from rolling off the bed. The DON also stated Resident #310 was diagnosed with pneumonia at the hospital and was found to be in need of dialysis based on her labs compared to her previous labs done prior to admission to the facility which likely contributed to her fainting episode.	F0689		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756	1. What corrective action will be accomplished for each resident found to be affected. On 07/07/25, the Assistant Director of Nursing notified the provided related to the pharmacists recommendation for Resident #66 and the order was clarified. 2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice An audit was completed by the Director of Nursing (DON) and the Nursing Manager of the current residents' pharmacist recommendations for the last 60 days by 7/28/25 to ensure pharmacy recommendations are completed. The current resident recommendations that had not been addressed were addressed with the provider and new orders obtained. 3. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/23/25, the Director of Nursing was educated by the Nurse Consultant related to ensuring pharmacist recommendations are reviewed, followed up with the provider, and completed timely. On 7/23/25, the Director of Nursing (DON) initiated education with the Nurse Managers related to ensuring pharmacist recommendations are reviewed, followed up with the provider, and completed timely. The DON/ADON will perform a secondary audit to ensure the MD/NP	08/01/2025

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F0756 SS = D	Continued from page 24 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interviews with staff and record reviews, the facility failed to address discrepancies identified by the facility consultant pharmacist when a recommendation was made to clarify the dosage of aspirin ordered for 1 of 5 residents (Resident #66) reviewed for unnecessary medications. The findings included: Resident #66 admitted to the facility on 3/01/24 with diagnoses including dementia, cerebral stroke syndrome, and cerebrovascular disease. Resident #66's quarterly Minimum Data Set (MDS) dated 5/10/25 documented she had severe cognitive impairment and had no behaviors or refusals of care. The MDS noted she had a history of a stroke and she received antiplatelet medications (prevents the accumulation of platelets to prevent blood clots). Resident #66's Medication Administration Records (MAR)s from January 2025-July 2025 were reviewed and included an order for aspirin once every other day. The MAR did not have a strength listed on the entries. Resident #66's monthly consultant pharmacist reviews dated 2/27/25, 4/30/25, and 6/27/25 noted she had an order for aspirin but there was no strength in the order, either 81 milligrams (mg) or 325 mg. There was no documentation of the facility addressing the recommendations. In an interview on 7/03/25 at 3:30 PM, Nurse #12 stated she was the regular nurse on Resident #66's hallway. She stated she gave Resident #66 aspirin 81 mg every other day out of the facility stock of over-the-counter medications because she thought that's what was	F0756	Continued from page 24 recommendations are signed and completed by the provider. Any identified concerns will be addressed by the DON/ADON immediately. Any DONs and Nurse Managers to include agency and contract Nurse Managers will not be able to work after 7/28/25 until the education is completed Newly hired Director of Nursing and Nurse Managers will be required to receive this education in orientation. 4. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing will review the pharmacist recommendations monthly x 3 months to ensure residents' pharmacist recommendations continue to be completed as required. The Director of Nursing will present the findings of the audits to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator will be responsible for compliance. Date of Compliance: 08/01/25	

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F0756 SS = D	Continued from page 25 ordered. She stated she believed there was a standing order for aspirin for all residents. Resident #66's standing physician's orders did not include an order for aspirin. In an interview on 7/03/25 at 9:27 AM, the Director of Nurses (DON) stated she had been at the facility since the end of 2024 and stated when she looked for the recommendations at the surveyor's request, she found there were several pharmacy recommendations that were not completed by the former DON and former Assistant Director of Nursing (ADON). She stated she was not aware of the missing dosage until surveyor intervention. She stated the recommendations should have been reviewed and the order clarified within a few days of receiving the recommendation.	F0756		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F0883	What corrective action will be accomplished for each resident found to be affected. Resident #52's resident representative was called related to the Pneumococcal Vaccine by the Assistant Director of Nursing on 7/28/25 and accepted the vaccine. New orders were obtained from the provider on 7/28/25. Resident #74's resident representative was called related to the Pneumococcal Vaccine by the Assistant Director of Nursing on 7/28/25 and accepted the vaccine. New orders were obtained from the provider on 7/28/25. Resident #66's resident representative (RR) was called related to the Pneumococcal Vaccine by the Assistant Director of Nursing on 7/25/25. The (RR) reports will talk to the resident and call facility with decision. On 7/28/25, the RR declined the vaccine. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice Current residents are at risk for this deficient practice.	07/29/2025

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F0883 SS = E	Continued from page 26 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record reviews, the facility failed to offer the opportunity to be vaccinated with the Pneumococcal 20-valent Conjugate Vaccine (PCV20) for 3 of 5 residents reviewed for pneumococcal immunizations (Resident #52, #74, and #66). Findings include: The Center for Disease Control and the Advisory Committee on Immunization Practices (ACIP), last reviewed on 10/26/24, recommends "routine vaccination against pneumococcal infection for all adults aged 65 years or older and 19-64 with certain underlying medical conditions. Beginning June 8, 2021, for persons aged 65 years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, they should receive 1 dose of PCV15 [Pneumococcal 15-valent Conjugate Vaccine] or 1 dose of PCV20."	F0883	Continued from page 26 An audit will be completed by the Director of Nursing (DON) and the Nursing Manager of the current residents' by 7/28/25 to ensure residents that are eligible for Pneumococcal Vaccine are offered and/or receive the vaccine as required. Any identified concerns will be addressed by the facility. What measures are put in place or systemic changes are made to ensure practice will not re-occur. On 7/23/25, the Director of Nursing (DON) initiated education of the licensed nurses to include agency, contract and prn licensed nurses related to ensuring Pneumococcal vaccines are being offered and/or provided as required. Any licensed nurses to include agency, prn and contact licensed nurses towho have not received this education by 7/28/25 will not be allowed to work until the education is completed. Newly hired licensed nurses will be required to receive this education in orientation. How will the facility monitor corrective actions to ensure the deficient practice does not re-occur The Director of Nursing will complete audits of 10 residents to include new admissions weekly x 4 weeks and monthly x 2 months of the current residents to ensure residents that are eligible for the Pneumococcal vaccine are offered and receive the vaccine as required The Director of Nursing will present the findings of the audits to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that needed further interventions and the need for additional monitoring. The Administrator is responsible for compliance. Date of Compliance: 07/29/25	

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F0883 SS = E	Continued from page 27 Review of the facility's immunization policy last reviewed 3/4/2024 stated that all residents would be offered a pneumococcal vaccine PCV13 (Pneumococcal 13-valent Conjugate Vaccine) or PPSV23 (pneumococcal polysaccharide vaccine) upon admission. A. Record review revealed Resident #52 was admitted to the facility on 5/7/20. Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #52 declined a pneumococcal vaccine on 8/11/21. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine. There was no documentation the resident was offered or received a pneumococcal 20-valent conjugate vaccine since the last recertification on 3/14/24. There was no documentation the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility. B. Record review revealed Resident #74 was admitted to the facility on 12/15/23. Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #74 declined to receive a pneumococcal polysaccharide 23 vaccine and a pneumococcal conjugate 13 vaccine on 7/14/23. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine since 7/14/23. There was no documentation that the resident received a pneumococcal 20-valent conjugate vaccine prior to admission or since the last recertification on 3/14/24. There was no documentation that the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility. C. Record review revealed Resident #56 was admitted to the facility on 3/1/24. Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #56 declined to receive a pneumococcal polysaccharide 23 vaccine and a pneumococcal conjugate 13 vaccine on 3/18/24. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine since the last recertification on 3/14/24. There was no documentation that the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility.	F0883		

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE , GREENSBORO, North Carolina, 27406

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F0883 SS = E	Continued from page 28 During an interview with the Director of Nursing (DON)/Infection Preventionist (IP) on 7/2/25 at 8:52 AM, she stated this was her first DON position and she had been with the facility since April 2025. The DON reported she was aware the facility offered pneumococcal polysaccharide 23 vaccine and to all pneumococcal conjugate 13 residents and was unaware they needed to also offer pneumococcal 20-valent conjugate vaccine. The DON indicated she would be setting up a vaccine clinic as soon as possible with an outside vendor who would be offering and providing the necessary vaccines, including pneumococcal 20-valent conjugate vaccine.	F0883		