**Greenhaven Health & Rehab**

A **deficiency statement** ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting if it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, deficiencies cited above are discernable 90 days following the date of survey unless otherwise noted.

**#28**

- Resident #28 obtained consent form and was seen by Paradigm Health Services. The results had no negative outcome.
- Physician order reconsideration of identified resident(s).
- 100% of all current physician orders to ensure that physician psychiatric services referrals have been carried through to completion.
- In-service social worker and admission director conducted training for physician psychiatric service referrals.
- 5 times a week review of new orders (pink slips) and verification that new orders were completed. The plan of correction is ongoing.

**имер идентификатора: 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

- Based on observation of staff interviews and record reviews, facility failed to obtain/provide psychiatric services as ordered by the physician for 1 of 3 sampled residents with behaviors. (Resident #28).

Findings included:

- Resident #28 was admitted to the facility on 01/20/12 with diagnoses which included: psychosis, bipolar disorder with references to schizophrenia, vascular dementia with delirium, incontinence of cerebrovascular accident, anxiety state, insomnia, muscle weakness, diabetes mellitus, dysthria, dysphagia: abnormal posture; and, multiple contracts. The Admission Assessment (1/27/12) indicated the resident was cognitively intact but had verbal and wandering behaviors. The most recent Assessment (4/22/12) indicated the resident's cognition was severely impaired, but had no behaviors.

Review of the Care Plan initiated 1/20/12 and updated 4/12/12, revealed the resident received...
**NAME OF PROVIDER OR SUPPLIER**
GREENHAVEN HEALTH AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
801 GREENHAVEN DR
GREENSBORO, NC 27406

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<tr>
<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 309</td>
<td>Continued From page 1 psychoactive drugs with the potential for side effects; was resistant to treatment/care; and had problems of verbal/physical aggression or combativeness; and had a problem of wandering in and out of residents rooms. Interventions by the facility for these problem areas included: monitor resident's mood/behaviors (bipolar disorder/anxiety) with documentation per facility policy. Notify physician of any significant changes; DISCUS evaluation; administer medications per physician's orders; document care being resisted and notify physician of patterns in behavior; if resident refuses care, leave resident and return in 5-10 minutes; redirect undesirable behavior; and approach resident slowly and from the front before speaking or touching. Review of the Physician's Orders (1/20/12) and Medication Administration Records revealed Resident #28 received the following psychoactive medications: haloperidol (10mg) for his bipolar disorder; and klonopin for his diagnosis of anxiety. The resident also received congercin for extrapyramidal side effects. The review of the DISCUS Evaluation dated 2012 documented Resident #28 had a score of 1.0 (minimal-abnormal movements difficult to detect or movements are easy to detect but occur only once or twice in short non-repetitive manner). The conclusion of the evaluation indicated the resident had probable tardive dyskinesia. The review of the Behavior Records and Progress Notes from 3/1/12-5/21/12 documented Resident #28's abnormal behaviors, including: agitation, kicking, yelling, screaming, cursing,</td>
<td>F 309</td>
<td>4. The DON/charge nurse will audit all physician orders for physician psychiatric service referrals orders using a Quality Improvement audit tools. This will be done 5 days a week for 4 weeks then twice a week for 6 weeks and then 1 time a week for three months. The administrator will review the completed QI audit tool weekly for 4 months to assure current monitoring is effective. The results of the QI audit tools will be submitted to Executive Quality Improvement Committee for review, recommendations of monitoring and continue compliance in this area.</td>
<td>STARTED 6-2-12, ONGOING</td>
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Continued From page 2

hitting, and swinging at staff and other residents. As a result, on 4/20/12, the Physician ordered a Psychiatric Consultation/Evaluation due to the resident's verbal/physical abusive behaviors.

There was no documentation indicating the facility followed through with the physician's order for Resident #28 to be evaluated by Psychiatric Services.

On 5/22/12 at 2:30pm, Resident #28 was observed propelling himself in his wheelchair near the nursing station. There was a wanderguard on the resident's ankle and, the resident had repetitive tongue movements.

During an interview on 5/23/12 at 4:34pm, the facility's SW (Social Worker) stated that the Psychiatric Consulting Services would not accept a patient without a signed Consent form from a resident's Guardian or Responsible Party. The SW revealed she spoke with Resident #28's Guardian on 4/27/12 via telephone concerning the need for a signed psychiatric consent and faxed the Consent form to the Guardian. At the time of this interview, the resident's Guardian had not faxed a completed Consent form. The SW revealed she failed to follow up with the resident's Guardian concerning the Psychiatric Consent form due to an emergency in her (SW) family.

During an interview on 5/23/12 at 4:30pm, the DON (Director of Nursing) revealed she was informed by the facility's SW that the consent form for psychiatric services was faxed to Resident #28's Guardian on 4/27/12, but had not received a response. The DON revealed her
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expectation was that the SW would have followed up with a certified letter to the resident’s Guardian within two business days. Also, to ensure continuity of care, the SW should have informed her (DON) of any works in progress when she had the family emergency.

On 5/24/12 at 10:00am, Resident #28 was observed in his wheelchair in the dining room calmly drinking a cup coffee at table, alone.

During an interview on 5/24/12 at 10:14am, NA#1 (Nursing Assistant) revealed Resident #28 would often become resistive and combative when staff attempted to shave, or check him for incontinence (the resident hated to lie down during first shift, even when his adult diaper needed changing). NA#1 stated she observed the resident kick another staff, slap a staff nurse in the face when she was giving him his medication; calling out profanities and slanderous names to staff; and, using profanities to other residents when he would accidentally run into them with his wheelchair. These episodes usually only lasted approximately five minutes, then the resident would forget and requests a cup of coffee which he really enjoyed. NA#1 revealed that whenever a resident was verbally or physically abusive, the nursing assistants report the behavior to a nurse and record it on the POC (Point of Care) Behavior Record.

During an interview on 5/24/12 at 10:41am, the DON stated that when residents had behaviors that were deemed socially inappropriate, the resident would be referred to the physician, who would conduct an assessment then refer, accordingly. A copy of the physician’s order would
**F 309 Continued From page 4**

be given to the SW and if the resident had a completed Consent form in his/her clinical record, then the SW would complete a “Referral Fax” form to the Intake department of the Psychiatric Services. If there was no completed consent form in the resident’s record, then SW was to contact and obtain written consent from the resident’s Responsible Party or Guardian.
Greenhaven Health & Rehabilitation 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. This plan of correction is submitted as a written allegation of compliance.


1) Facility purchased and will install latching type hardware. Employee break room door has been ordered. The break room door and latching hardware to be installed ASAP when door arrives
2) The maintenance supervisor will do a walk through of the building to identify any others and remove upon finding and correct.
3) The maintenance supervisor will monitor via facility weekly inspections of doors during regular rounds for three months.
4) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections


Smoke barriers are constructed to provide at least one half hour fire resistance rating in
K 025 Continued From page 1

accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observation on Wednesday 6/8/12 at approximately 10:00 AM onward the following was noted:
1) On the 200 hall the smoke wall above the corridor door has holes and penetrations that were not properly sealed. There are also pipe penetrations in the smoke wall equipped with foam insulation that was cut back and sealed around pipe penetration on all halls.


1) Corrective action has been accomplished for the alleged deficient practice by removal of the foam sealant and application of an approved fire rated sealant in the holes in the ceiling located on the 200 hall.
2) The maintenance supervisor will visually check all of the attic area to identify any other areas of concern and repair these areas as identified with fire barrier sealant.
3) The maintenance supervisor will inspect monthly for the next three months for proper sealing of any holes with fire barrier sealant.
4) The maintenance supervisor will provide the results of the inspection to the Executive Committee for review on a monthly basis for three months to identify any trends and or patterns corrective to determine the duration of the inspections


1) a. The maintenance supervisor installed a self-closer on the kitchen corridor door.
2) The maintenance supervisor inspected all doors that required a closer to ensure they are fully operational and in place.
Continued From page 2

This STANDARD is not met as evidenced by:
Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted:
1) The corridor door to the kitchen was not self-closing.

42 CFR 483.70(a)

This STANDARD is not met as evidenced by:
Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted:
1) Based upon observation at the time of the survey the kitchen was experiencing a severe negative pressure.
One of two exhaust fans for the hood were not operational and the make-up air hood for the kitchen was not operational at the time of the survey.
Section 5-3* Replacement Air. - "Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa)."
42 CFR 483.70(a)

K 069


1. The facility maintenance supervisor restored power to the exhaust fan for the hood in the kitchen. The facility ordered and will replace the make-up-air hood for the kitchen ASAP upon arrival.

2. The maintenance supervisor will inspect the exhaust fans for the hood in the kitchen to ensure proper function. The maintenance supervisor will inspect the new make-up-air hood for proper function.

3) The maintenance supervisor will inspect the exhaust fans for the hood, and the make-up-air hood in the kitchen 5 days a week for one month for proper function.
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<td>K144</td>
<td>SS=6F</td>
<td>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</td>
<td>4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections.</td>
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<td>K140</td>
<td>SS=D</td>
<td>This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/8/12 at approximately 10:00 AM onward the following was noted: 1.) The generator annunciator panel was missing in the facility. The generator annunciator panel was removed when the area was remodeled and not replaced. 2.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections.</td>
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<tr>
<td>K140</td>
<td>SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.8.3.1.1</td>
<td>4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections.</td>
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4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections.