PRINTED: 08/07/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345132	B. WING _			06/2	22/2018
NAME OF PROVIDER OR SUPPLIER GREENHAVEN HEALTH AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406			2 -
PREFIX (EACH DEFICIENCY)	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
self-determination, and access to persons and outside the facility, inclithis section. §483.10(a)(1) A facility with respect and dignity resident in a manner all promotes maintenance her quality of life, recogning individuality. The facility promote the rights of the severity of condition, or must establish and main practices regarding train provision of services under residents regardless of \$483.10(b) Exercise of The resident has the rights as a resident of the Unite \$483.10(b)(1) The facility resident can exercise hinterference, coercion, from the facility. §483.10(b)(2) The residence of interference, coercion, from the facility.	dights. Int to a dignified existence, of communication with and services inside and uding those specified in an environment that or enhancement of his or gnizing each resident's y must protect and he resident. It was provide equal regardless of diagnosis, or payment source. A facility intain identical policies and insfer, discharge, and the inder the State plan for all of payment source. If Rights. If Rights. If to exercise his or her the facility and as a citizen and States. If the facility intain the insertion of the right to be ercion, discrimination, or reprisal dent has the right to be ercion, discrimination, and y in exercising his or her ried by the facility in the	F 5	TITLE			7/20/18 (X6) DATE

07/18/2018 **Electronically Signed**

Facility ID: 923238

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_			
		345132	B. WING				22/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	S ^r	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDEENHA	VEN HEALTH AND REH	ARII ITATION CENTER		80	01 GREENHAVEN DRIVE		
GREENHA	WEN HEALTH AND KEN	ABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	subpart. This REQUIREMENT by: Based on observation and resident interview treat the resident with resident when she can (Activities of Daily Live 5 dependent resident #2). The facility further meal trays at the same served for 1 out of 3	rights as required under this ris not met as evidenced ans, record review, and staff ws, the facility staff failed to a dignity by yelling at the ame in to assist him with ADL ring) care provide care in 2 of as (Resident #1 and Resident er failed to serve residents are time all table mates were residents (Resident #11).	F	5550	An acceptable plan of correction must contain the following elements: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The monitoring procedure to ensure	e	
	Findings include: 1. Resident #2 was admitted to the facility on 1/18/17 with diagnoses of sepsis, contractures of the right and left hands, unsteadiness on feet, and type 2 diabetes mellitus. A review of Resident #2's most recent MDS (Minimum Data Set) was coded as a quarterly assessment and was dated 4/12/18. The resident was coded with no cognitive impairment. Resident #2's functional status was coded as needing 2 plus person assistance with bed mobility, dressing, bathing, toileting, and personal hygiene. A review of Resident #2's care plan dated 4/20/18 included that the resident is at risk for further decline in ADLs related to impaired mobility. A review of the facility's grievance reports for May and June 2018 revealed Resident #2 had filed 14 grievances involving lack of ADL assistance. An interview was conducted with Resident #2 on 6/17/18 at 5:30pm. Resident #2 reported on that on 5/28/18 NA#10 entered his room around 9:30am and he asked her to pull him up in bed. The resident reported that NA #10 stated she				that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible implementing the acceptable plan of correction. Greenhaven Health and Rehabilitation	nd :	
					Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further,	t s. a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
					01 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND RE	HABILITATION CENTER			REENSBORO, NC 27406			
					<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 550	Continued From pa	ge 2	F t	550				
	would have to find s	someone to help her and left			Greenhaven Health and Rehabilitation			
		#2 reported after about an			Center reserves the right to refute any	of		
		Il bell but no one answered so			the deficiencies on this Statement of			
		v. He reported the DON			Deficiencies through Informal Dispute			
	-	, the treatment nurse and NA			Resolution, formal appeal procedure			
		oom. He reported the NA #10			and/or any other administrative or lega	I		
		m and called him "a liar." He			proceeding.			
	reported NA #10 "m	nade me feel uncomfortable."						
	Resident #2 reporte	ed doesn't know what						
	happened with NA #10 but that she was no longer				F550			
	•	rs. Resident #2 stated that on						
	•	the call bell at 8:30am			The plan of correcting the specific			
		d a bowel movement. He			deficiency			
		sing assistant) came in and						
		ould have to find someone to			The position of Greenhaven Health and	d		
	•	#2 reported no one came back			Rehabilitation center regarding the			
		:30am when the treatment			process that lead to this deficiency-fail			
	· ·	form his wound care to his left			promote dignity during activities of dail			
	-	ported the treatment nurse let the staff know to come and			living (ADL) care, and during meal- wa			
					failure to follow established procedure.			
		ent #2 reported at 12:00pm no to change him so he rang his			During the complaint survey resident #	1		
		reported a NA arrived and told			and resident #2 were provided ADL ca			
	•	b be after lunch as she could			to promote dignity, including without			
		nelp her change him. Resident			yelling, by the certified nursing assistar	nts		
		pm he still had not been			On 6/19/18 at the lunch meal, resident			
	•	ng his call bell again. He			11 was provided a dignified dining			
	-	director of nursing) and the			experience by all tablemates being ser	ved		
		ived in his room and they			the meal at the same time by a certifie			
		anged him at that time. The			nursing assistant			
		at he felt like he was being			The procedure for implementing the			
	•	m lying in stool wasn't			acceptable plan of correction for the			
	important to the sta	· ·			specific deficiency cited			
		onducted on 6/20/18 at			On 7/13/2018, the social worker (SW)			
		10. She reported that on			began interviewing all residents			
		2 had asked her to pull him up			determined to be interviewable. This			
		as collecting the breakfast			interview consisted of questions includ	•		
	trays. She reported	d it takes 2 people to provide			Are you provided with adl assistance	9		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا	C	
		345132	B. WING			1	22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CDEENIU	VEN HEALTH AND DE	WARII ITATION CENTER		80	01 GREENHAVEN DRIVE			
GREENHA	WEN HEALTH AND RE	HABILITATION CENTER		G	REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 550	find someone to ass she went back in the Resident #2 reported #10 reported that whe needed changing upset with the residhe didn't want her to room. She reported have gotten angry vanith and the first that on 6/11/18 she around 11:30am and changing. She reported with Resident #2 that The treatment nursed back in his room clowaiting to be chang movement so she are resident. An interview was considered that the Don Resident #2's room an altercation occur NA #10. The DON releave the room as sat the resident. The expectation that the	and she told him she would sist her. She reported when a room with the DON, and he needed changing. NA as the first time she had heard g and she reported she was ent. She reported he told her buching him so she left the d she knew she should not with the resident. Inducted on 6/20/18 at reatment nurse. She reported went into Resident #2's room d he told her he needed orted she told the NA working at he needed to be changed. The reported when she arrived reported she was in on 5/28/18 with NA #10 when red between the resident and reported she had NA #10 reported she had NA #10 reported it was her residents are treated with	F	550	timely, and with dignity? and 2. Have y been yelled at by the staff during adl ca Interviews will be complete by 7/20/18. Any negative findings will be addresse immediately by the sw. Beginning on 7/12/18 the facility treatm nurse and/or director of nursing observall non-interviewable residents to ensu dignity was provided during adl care, including no yelling. Observations were completed on 7/13/18 with no negative findings. On 7/12/18 the facility treatment nurse observed meal delivery to ensure all residents had a dignified dining experience, including all tablemates served at one time. All nursing staff, including agency, will in-serviced by 7/20/18 by the director on nursing, or Administrator on promoting dignity during adl care, including not yelling at residents, timely incontinent care, and residents must be served on table at a time. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service we he added to the orientation process for new nursing staff, including agency. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains corrections.	d nent red re be fill at nat cted		
	When the DON was #2 having to wait so changed, she stated promptly taken care incontinence.	from all the staff members. s questioned about Resident o long on 6/11/18 to be d she expected residents to be e of when they had			and/or in compliance with the regulator requirements The director of nursing, administrator, facility consultant, and/or minimum dat set nurse will audit 10 residents weekly 12 weeks to ensure adl care is provide promote dignity, and meal is served at	a ⁄ for d to		

Facility ID: 923238

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0.0.02		STREET ADDRESS, CITY, STATE, ZIP (ODE	06/2	2/2018
NAME OF FI	NOVIDER OR SUFFLIER				ODE		
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		801 GREENHAVEN DRIVE			
				GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 550	Continued From page	e 4	F 5	550			
F 550	administrator on 6/21 it was his expectation residents with dignity in responding to call I 2. Resident # 1 was a August 2, 2018 with absence of both left at knee, hypertension at Resident # 1's Minimum May 5, 2018 revealed cognitively intact. Resassistance with bed in person physical assist dressing, toilet use ar extensive assistance assist. Resident # 1 wand bowel. During an interview wand bowel. Resident # 1 wand bowel. During an interview wand bowel. During an interview wand bowel. Resident # 1 stated state wand bowel wand wand this had be resident # 1 stated state would come in the roof out of reach. Resident feel really bad." Resident feel really bad." Resident waited three hours fo stated she had urine feeling to be wet too."	At 11:55am. He reported that all staff treated all the and respect and are prompt ights and requests. admitted to the facility on current diagnoses of anemia, and right legs below the and diabetes mellitus. The Data Set (MDS) dated the Resident # 1 was sident # 1 required extensive mobility and transfer with two at. Locomotion on/off unit, and personal hygiene required with one person physical was incontinent of bladder. The Resident # 1 on June 17, revealed that she has had aff not answering her call the she was left in bed for 2 manged because staff told wet enough to be changed, een going for weeks. The had filed a grievance of had been done. Resident the a second shift staff person form and place the call bell to the them that also indicated this in May, 2018 when she restaff to change her. She on herself, "that's a bad." Resident # 1 indicated this in May, 2018 when she restaff to change her. She on herself, "that's a bad." Resident # 1 indicated this in May indicated this indica	F 5	same time as their tablema will be documented on the Tool. The monthly QI committee results of the F550 audit to for identification of trends, and to determine the need frequency of continued momake recommendations for continued compliance. The and/or DON will present the recommendations of the momentations of the momentation of the person respinglementing the acceptate correction. The Director of nursing is momentating the acceptate correction.	F550 Audit will review tool for 3 monactions take for and/or unitoring, and or monitoring administrate findings are nonthly QI executive Quamendations consible for ole plan of responsible f	the this in, if for the torind in A.	
	stated she had urine feeling to be wet too.' would always be a pr	on herself, "that's a bad					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED		
		345132	B. WING _			C 06/22/2018		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 550	weekly here and "Shrevealed she had no months Resident # were Mondays and she was a large persweekly so she would #1 indicated if she cwould make her feel came in, shut off the and care was not proposed to be shown to be	the felt helpless". Resident #1 It had a shower in two 1 indicated her shower days I hursdays. She explained I not have an odor. Resident I not have an odor. Resident I not have a shower this I better. She stated "staff I bell, moved it out of reach I not on June 17, 2018 at I indicated that she knew how I nswer because of her clock I 2pm during a review of the I may a review of the I rems dated April 2, 2018 and I ded that Resident #1 had I about her call bell not being I noved out of reach and not I imely manner. I who worked with Resident I wrong doing to Resident #1. I ways answered her call bells I tes and always treated her I tes and dignity. She added it I because she had 15 to 20	F5	550				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345132	B. WING _		,	C 6/ 22/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406		0/22/2010	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	revealed they had to Administrator about to being out of reach an urine for hours. During an interview of with the Director of Nother expectation was treated with dignity at timely answering of reprovision of personal During an interview of June 21, 2018 at 4:30 expectation was residignity and respect at 3. Resident #11 was 5/31/18 and diagnost thrive and dysphagia. An admission minimum Resident #11 dated 6 as being intact. An observation of the 12:26 pm revealed Resident #11 had no and her 2 tablemates almost finished eating. An interview with Resident Resident #12:26 pm revealed sident #12:26 pm revealed sident #12:26 pm revealed sident #15:26 pm reveale	une 20, 2018 at 3:30 pm fied to talk with the he concerns with the call bell and Resident #1 sitting in her on June 20, 2018 at 4:40 pm, fursing, she indicated that all residents would be and respect. This included esidents call lights and care. With the Administrator on Dpm, he indicated that his dents would be treated with the all times. admitted to the facility on es included adult failure to the sincluded adult failure to th	F 5	50			
	for 15 to 20 minutes patient. Resident #11	ed she had been sitting there just waiting and trying to be added she came to the e of her meals and ate in her					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345132	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	'	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	An interview with Nu 6/19/18 at 12:30 pm for Resident #11 's the kitchen. She star usually came out on and not the dining roresident did not cons room and when she kitchen for her tray. would tell them to work cart that went to the An interview with Die 6/19/18 at 2:00 pm room Resident #11 typical meals were sent out hall. She stated if the room to eat the NAs the kitchen and she and wait for her mea. An interview with the 10:01 am revealed it residents sitting together.	e getting her meal. Irsing Assistant (NA) #5 on revealed they were waiting funch tray to come out from ted the resident 's meal tray the cart that went to the hall foom cart. NA #5 added the sistently come to the dining did the NAs would ask the She stated the kitchen staff fait for it to come out on the hall. Letary Manager (DM) #1 on evealed she thought ly ate in her room and her on the cart that went to the eresident came to the dining should request her tray form shouldn't have to sit there	F	550		
F 558 SS=D	Reasonable Accomm CFR(s): 483.10(e)(3) §483.10(e)(3) The ri services in the facilit accommodation of ro preferences except	ght to reside and receive y with reasonable esident needs and	F	558		7/20/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		COILLILOTO	
				801 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	IABILITATION CENTER		GREENSBORO, NC 27406			
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F 558	Continued From page	e 8	F 55	8			
		Γ is not met as evidenced					
	by:						
		on, record review, staff		F558			
	interviews, family interviews the facility	failed to accommodate the		The plan of correcting the spec	ific		
	-	nts (resident #1) by not		deficiency	0		
		t a shower chair to fit the					
	_	the resident not receiving a		The process that lead to the de	•		
	shower in two month	S.		failure to accommodate the nee			
	Findings included:			Resident #1 was the nursing st communicate to the maintenant			
	i indings included.			Resident #1's shower chair nee			
	Resident # 1 was adı	mitted to the facility on		accommodate Resident #1 rece			
	August 2, 2016 with	•		assistance with showers. The			
		and right legs below the		staff should have completed a			
	knee, hypertension a			for a proper size shower chair a submitted the work order to the			
	Resident # 1's Minim May 5, 2018 revealed	um Data Set (MDS) dated d Resident # 1 was		maintenance director.			
		sident #1 required extensive		On 7/11/18, the facility mainten			
		nobility and transfers with		director inspected all shower ch			
		assist. Locomotion on/off use and personal hygiene		no negative findings. There are			
		ssistance with one person		broken shower chairs in the fac	ality.		
	· •	dent # 1 was incontinent of		On 6/20/18, Resident #1 refuse	ed a		
	bladder and bowel.			shower.			
	During an interview v	vith Resident # 1 on June 17,					
	-	revealed that she had not		The procedure for implementing			
	had a shower in two			acceptable plan of correction for	or the		
		days were Monday and at #1 stated "I am a large		specific deficiency cited:			
	person and need my	showers weekly so I would		On 7/13/18, the director of nurs			
		esident #1 indicated she just		reviewed residents in the facility	-		
	wanted a shower and	d she would feel better."		showers given in the last 7 days			
	Dovious of the deiler	hower about an lives 10		no showers were omitted due to			
		hower sheet on June 19, led that on Mondays and		equipment needs and showers per resident preference (plan or	-		
		4 A and B were scheduled for		negative findings were noted.	i caiej. No		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0.0.02	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/22/2016	
NAME OF T	TO VIDER OR OUT LIER			801 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER					
				GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 558	Continued From page	e 9	F 55	58			
	their showers on 2rd	shift.					
	During an observation on June 19, 2018 from 3pm until 7:15 pm, Resident #1 was not observed to receive a shower.			All nursing staff, including agend in-serviced by 7/20/18 by the DC administrator on communication resident equipment needs to mausing a work order, including equipment needs to make the control of the	ON or of aintenance		
	During an interview w	vith Resident #1 on June 20,		to accommodate resident shows			
	_	sident #1 indicated she had		nursing staff will be allowed to w			
	not received her shower and no staff asked her about taking a shower. During an interview with Nursing Aide (NA) # 1 on June 20, 2018 at 3:15 pm she revealed that			7/20/18 until completing the in-s This in-service will be added to to orientation process for all new n	the		
				staff, including agency.	aromig		
		ave a shower because the					
	shower chair for Resi	dent #1 was broken. NA #1		The monitoring procedure to en	sure that		
	also indicated that thi	s information had been		the plan of correction is effective	and that		
	report to the former A	dministrator.		the specific deficiency cited rem corrected and/or in compliance			
		vith Resident's #1's family June 20, 2018 at 3:30 pm		regulatory requirements:			
		ne former Administrator		The DON, staff facilitator, facility			
	concerning Resident	#1 needing a shower and		consultant, and/or minimum data			
		ccasions that Resident #1		(MDS) nurse will audit 10 rando			
	_	The family member stated		residents weekly on random hal			
		3 and 5/29/18) she knew the		weeks to ensure showers were	-		
		ed a shower and never		preference and appropriate equi			
	received one.			such as shower chairs are available as a such as shower chairs are available as a such			
	The former Administr	atar waa nat ayailahla during		accommodate resident needs. T			
	this investigation to b	ator was not available during e interviewed.		will be documented on the F558 Tool.	Audit		
	(DON) on 6-21-18 at her expectation that r needed to meet their	•		The monthly quality improvement committee will review the results F558 Audit Tool for 3 months for identification of trends, actions to determine the need for and/or	s of the r aken, and r		
		s interviewed on 6-21-18 at		frequency of continued monitoring	-		
		spected that staff would cial equipment was needed		make recommendations for mor continued compliance.	nitoring for		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.45400	D WING			l	С
		345132	B. WING _			06/	22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 11 GREENHAVEN DRIVE REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 558	Continued From page so the facility can med residents.		F	558	The administrator and/or DON will press the findings and recommendations of the monthly QI committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction: The DON is responsible for implementing the acceptable plan of correction.	ne S	
F 561 SS=D	promote and facilitate through support of res not limited to the right (1) through (11) of this §483.10(f)(1) The res activities, schedules (waking times), health care services consiste assessments, and pla applicable provisions §483.10(f)(2) The res choices about aspect facility that are signific §483.10(f)(3) The res	nination. right to and the facility must resident self-determination sident choice, including but s specified in paragraphs (f) s section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, in of care and other of this part.	F:	561			7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			C 6/ 22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	012212010	
				801 GREENHAVEN DRIVE			
GREENHA	AVEN HEALTH AND REH	ABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 561	Continued From page	÷ 11	F 5	61			
	community activities facility.	ooth inside and outside the					
	community activities both inside and outside the			An acceptable plan of correctic contain the following elements: The plan of correcting the deficiency. The plan should ad processes that lead to the deficited; The procedure for implement acceptable plan of correction for specific deficiency cited; The monitoring procedure that the plan of correction is efficiency cited recorrected and/or in compliance regulatory requirements; The title of the person respimplementing the acceptable procedure that the plan of correction is efficiency cited recorrected and/or in compliance regulatory requirements; The title of the person respimplementing the acceptable procedure. Greenhaven Health and Rehat Center acknowledges receipt of Statement of Deficiencies and this Plan of Correction to the extension to the extension of the plan of correction is submitted allegation of compliance written allegation of compliance of the plan of correction is submitten allegation of compliance	specific dress the ciency enting the or the to ensure fective and emains e with the ponsible for clan of collitation of the proposes xtent that ually nes and residents. nitted as a		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			C 06/22/2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010
				801 GI	REENHAVEN DRIVE		
GREENHA	WEN HEALTH AND REH	ABILITATION CENTER		GREE	ENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	e 12	F 5	561			
	make her feel better.' A review of her care p	nted a shower this would blan dated May 5, 2018 nterventions about Activities		Co Do wi	reenhaven Heath and Rehabilitation enter response to this Statement of eficiencies does not denote agreeme ith the Statement of Deficiencies nor oes it constitute an admission that an		
	of daily living for Res assistant with all ADL for eating.	dent #1 for staff to provide s care but just set up help		de G Ce th	eficiency is accurate. Further, reenhaven Health and Rehabilitation enter reserves the right to refute any e deficiencies on this Statement of	•	
	done on June 19, 20	ne daily shower sheet was 18 at 10am revealed that on ays Room 104 A and B ng 2rd shift.		Rear	eficiencies through Informal Dispute esolution, formal appeal procedure nd/or any other administrative or lega occeeding.	I	
	_	n on June 19, 2018 from realed that Resident ##1 did rr.		F	561		
	2018 at 9:30am, Res	vith Resident # 1 on June 20, ident #1 indicated she did ver nor did anyone asked			ne plan of correcting the specific efficiency		
	her about taking a sh	ower.			ne position of Greenhaven Health and ehabilitation center regarding the	d	
	June 20, 2018 at 4pn #1 refused her showe			to sh ec	cocess that lead to this deficiency-fail allow resident choice of having weel nowers- was knowledge deficit, staff in ducated on the process to report brok	kly not ken	
	(DON) on June 20, 2	vith the Director of Nursing 018 at 4:15pm, she revealed e of having shower should			needed equipment to allow for resid noices.	ent	
	be honored.			sh ar Th ac sp O re	n 6/20/18 resident #1 was offered a nower by the certified nursing assistand refused the shower. The procedure for implementing the exceptable plan of correction for the precific deficiency cited In 7/13/18 the Director of Nursing exiewed residents in the facility for nowers given in the last 7 days to ensigneed to the control of the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED					
		345132	B. WING			C 06/22/2018		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 561	Continued From pag	e 13	F 56	no showers were not given de equipment needs, and shower given per resident preference care). With no negative findin All nursing staff, including again-serviced by 7/20/18 by the nursing, or Administrator on rechoice including resident right shower preferences, and be provided to the process for all new nursing stagency. The monitoring procedure to the plan of correction is effect specific deficiency cited remain and/or in compliance with the requirements The director of nursing, staff and/or minimum data set nursing the stagency of the monitoring procedure to the plan of correction is effect specific deficiency cited remains and/or in compliance with the requirements The director of nursing, staff and/or minimum data set nursing the stagency of continued will be document to the plan of the F561 audit tool for identification of trends, act and to determine the need for frequency of continued monitimake recommendations for me continued compliance. The act and/or DON will present the firecommendations of the monitorial commendations of the monitorial pool of the monitorial commendations of the monitorial commendati	ers were e (plan of egs noted. ency will be director of resident at to choose provided erence. No o work after leted. This e orientation taff, including ensure that tive and that ains corrected e regulatory facilitator, se will audit dent halls to cannot speak y eeks to per resident umented on ill review the for 3 months tions taken, r and/or coring, and monitoring for dministrator findings and			

PRINTED: 08/07/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345132	B. WING _			l '	22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GREENHAVEN DRIVE REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	e 14	f f	561	committee to the quarterly executive Quarterly executive Quarterly executive Quarterly executive Quarterly executive Quarterly executive Quarterly executives and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	5	
F 585 SS=E	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as the furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The rest facility must make progresolve grievances the accordance with this selection how to file a grievator to the resident. §483.10(j)(4) The facility grievance policy to error all grievances regarders.	ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or ear of discrimination or eat include those with reatment which has been that which has not been or of staff and of other concerns regarding their LTC dident has the right to and the empt efforts by the facility to be resident may have, in paragraph.	F s	585			7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345132	B. WING		00	C 6/ 22/2018	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	E, ZIP CODE	<i>312212</i> 010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 585	to the resident. The include: (i) Notifying reside postings in promining facility of the right (meaning spoken) grievances anonyr of the grievance of can be filed, that is address (mailing a number; a reasonal completing the revito obtain a written grievance; and the independent entities be filed, that is, the Quality Improvemed Agency and State program or protect (ii) Identifying a Griesponsible for overeceiving and track conclusions; leading by the facility; main information associexample, the identifying a Grievances submit written grievance coordinating with since sary in light (iii) As necessary, prevent further por right while the alleginvestigated; (iv) Consistent with reporting all allege	age 15 a copy of the grievance policy e grievance policy must Int individually or through ent locations throughout the to file grievances orally or in writing; the right to file mously; the contact information fficial with whom a grievance s, his or her name, business and email) and business phone able expected time frame for iew of the grievance; the right decision regarding his or her contact information of es with whom grievances may expertinent State agency, ent Organization, State Survey Long-Term Care Ombudsman cion and advocacy system; ievance Official who is erseeing the grievance process, king grievances through to their and any necessary investigations intaining the confidentiality of all atted with grievances, for ity of the resident for those ted anonymously, issuing decisions to the resident; and state and federal agencies as of specific allegations; taking immediate action to cential violations of any resident ged violation is being in §483.12(c)(1), immediately d violations involving neglect, ujuries of unknown source,	F	585			

OLIVIEI	C . C	MEDIO/ ND CEITVICES					7. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 ti Boilebi	_		,	С
		345132	B. WING			l	22/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			01 GREENHAVEN DRIVE		
				G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	anyone furnishing se provider, to the admir as required by State (v) Ensuring that all v include the date the gummary statement of the steps taken to inv summary of the pertir regarding the resident as to whether the gric confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat accordance with Stat of the residents' right or if an outside entity the State Survey Age Organization, or local	ion of resident property, by rvices on behalf of the nistrator of the provider; and law; vritten grievance decisions grievance was received, a of the resident's grievance, restigate the grievance, a nent findings or conclusions tt's concerns(s), a statement evance was confirmed or not ctive action taken or to be s a result of the grievance, ten decision was issued;	F	585			
	rights within its area of (vii) Maintaining evided result of all grievance 3 years from the issurdecision. This REQUIREMENT by: Based on record revinterviews, the facility resolution of grievance summary statement of sampled residents (R who submitted grieval past 3 months concerning.)	of responsibility; and ence demonstrating the es for a period of no less than ance of the grievance T is not met as evidenced iew and staff and resident of failed to ensure prompt these and provide a written of grievances for 2 of 2 thesident #1 and Resident #2) ances to the facility over the rning ADLs (Activities of so not being answer and our			An acceptable plan of correction must contain the following elements: The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited; The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The monitoring procedure to ensu that the plan of correction is effective a	e ne re	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345132	B. WING _			06/	22/2018	
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CDEENHA	VEN HEALTH AND REH	ARII ITATION CENTER		80	1 GREENHAVEN DRIVE			
GREENHA	IVEN HEALTH AND KEN	ABILITATION CENTER		G	REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 585	Continued From page	e 17	F 5	585				
	1/18/17 with diagnose contractures of the rigunsteadiness on feet.	ht and left hands, and			that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible implementing the acceptable plan of correction.			
	(Minimum Data Set) vassessment and was was coded with no concession with the concession of the concess	was coded as a quarterly dated 4/12/18. The resident gnitive impairment. nal status was coded as			Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose 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 resident	t		
	included that the resid	#2's care plan dated 4/20/18 dent is at risk for further ed to impaired mobility.			The Plan of Correction is submitted as written allegation of compliance.	a		
	past 3 months reveals family member filed 1 review of these grieva involved lack of ADL a issue about wound ca ordered. A further rev grievances revealed in	•			Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute	у		
	6/17/18 at 5:30pm. R grievances or had on grievances with the fa times" over past coup assistance with ADLs	ducted with Resident #2 on esident #2 reported he filed e of his family members file acility administrator "many ble months due to lack of . He reported he had not			Resolution, formal appeal procedure and/or any other administrative or lega proceeding. F 585 Grievances	I		
	An interview was con	of the grievances filed. ducted with the acting porate nurse consultant on			The plan of correcting the specific deficiency The position of Greenhaven Health and	d		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING			C 6/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/22/2010	
				801 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	IABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 585	Continued From pag 6/21/18 at 11:55pm. he had only been in t	The administrator reported it	F 58	Rehabilitation Center regarding process that lead to this deficie			
	administrator since 6 just come to his atter	1/15/18. He reported it had nation that grievances filed by been addressed. He stated it		to ensure prompt resolutions, a summary of grievances was- fa follow established facility policy	and written ailure to		
	was his expectation to was taken seriously a	that every grievance filed and that the resident or ve was given a written		grievances. The Grievance Off Administrator which is actively the Plan of Correction.	icer is the		
	response to the grievinvestigated. 2. Resident # 1 was August 2, 2018 with absence of both left a	vance as soon as it was admitted to the facility on current diagnoses of anemia, and right legs below the and diabetes mellitus.		Grievances for resident #1 and resolved by 7/20/18 by the adn Written summary of grievances resident #1 and #2 were issued request by the administrator or 7/13/2018.	ninistrator. s for d upon		
	May 5, 2018 revealer cognitively intact. Re assistance with bed a person physical assistance dressing, toilet use a extensive assistance	um Data Set (MDS) dated d Resident # 1 was sident # 1 required extensive mobility and transfer with two st. Locomotion on/off unit, nd personal hygiene required with one person physical was incontinent of bladder		The procedure for implementin acceptable plan of correction for specific deficiency cited Starting on 6/18/18, the adminit Social Worker reviewed all gries the past 90 days to ensure rescomplete, and a written summare	estrator and evances for colution is		
	2018 at 4:45 pm, she several issues with s bell in a timely mann issues on 4/2/2018 whours waiting to be cher, that she was not She added this had be Resident #1 stated s about this and nothin #1 also indicated tha would come in the ro	with Resident # 1 on June 17, a revealed that she has had taff not answering her call er. Resident #1 reported when she was left in bed for 2 hanged because staff told to wet enough to be changed. Deen going for weeks. The had filed a grievance and had been done. Resident to a second shift staff person som and place the call bell and #1 stated, "that made her		grievance was provided upon rathis audit was completed on 6/2 negative findings were address administrator on 6/18/18. On 7/13/18, the administrator a of nursing (DON) were in-service vice president of Operations or grievance process which include resolution, and issuing a writter upon response. Any new admin DON will receive this in-service orientation.	and director ced by the hother timely n summary nistrator or		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345132	B. WING			06/	/22/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				8	01 GREENHAVEN DRIVE		
GREENHA	WEN HEALTH AND REH	ABILITATION CENTER		G	GREENSBORO, NC 27406		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 585	Continued From page	e 19	F	585			
	· ·	in May, 2018 when she			The monitoring procedure to ensure the	at	
		r staff to change her. She			the plan of correction is effective and the		
		on herself, "that's a bad			specific deficiency cited remains correct		
		Resident # 1 indicated this			and/or in compliance with the regulator		
	_	oblem until the facility get			requirements	•	
	more staff. Resident	#1 indicated this went on			-		
	weekly here and "She	e felt helpless". Resident #1			The DON, social worker, and/or		
	revealed she had not	had a shower in two			administrator will review all grievances		
		indicated her shower days			weekly x 12 weeks to ensure the		
		hursdays. She explained			grievance was resolved timely and if		
		on and needed her showers			requested a written summary of the		
	•	not have an odor. Resident			grievance was provided. This audit will	be	
		uld have a shower this			documented on the F585 audit tool.		
		petter. She stated "staff			The monthly Ol committee will review t	ha	
		bell, moved it out of reach			The monthly QI committee will review t results of the F585 audit tool for 3 mon		
	and care was not pro-	vided., that was not right."			for identification of trends, actions take		
	During an interview w	rith the family member (FM)			and to determine the need for and/or	,	
	_	ne 20, 2018 at 3:30 pm			frequency of continued monitoring, and		
	revealed they had trid	ed to talk with the			make recommendations for monitoring	for	
	Administrator about the	ne concerns with the call bell			continued compliance. The administrat	or	
	being out of reach and	d Resident #1 sitting in her			and/or DON will present the findings ar	nd	
		dicated that she filed 2			recommendations of the monthly QI		
	grievances and "nothi	- · · ·			committee to the quarterly executive Q		
	FM had copies of both	h grievances			committee for further recommendations and oversight	3	
	A review of the facility	's grievance reports for the			and overeign.		
	-	ed that Resident #1 and or a			The title of the person responsible for		
		grievances since 4/2/18. A			implementing the acceptable plan of		
		ances revealed 2 of them			correction		
	involved lack of ADL a	assistance and 1 involved an					
	_	ut of reach for resident. A			The administrator is responsible for		
	further review of Resi				implementation of the acceptable plan	of	
		grievances had a written			correction.		
	resolution or summar	y documented.					
	An interview was con-	ducted with the acting					
		porate nurse consultant on					
		The administrator reported it					

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345132	B. WING _		C 06/22/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	33/22/23 13
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE COMPLETION
F 585 F 600 SS=E	administrator since just come to his atte Resident #1 had no was his expectation was taken seriously resident represental response to the grie investigated. Free from Abuse an CFR(s): 483.12(a)(1) §483.12 Freedom frexploitation The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishmen	the position of acting 6/15/18. He reported it had ention that grievances filed by the been addressed. He stated it that every grievance filed and that the resident or tive was given a written evance as soon as it was diversed in the property, and the resident property, defined in this subpart. This mited to freedom from the involuntary seclusion and mical restraint not required to	F 5	85	7/20/18
	physical abuse, corplinvoluntary seclusion. This REQUIREMEN by: Based on observation and resident intervied provide incontinence respectfully for a residifferent staff that he	se verbal, mental, sexual, or poral punishment, or		An acceptable plan of correction mucontain the following elements: The plan of correcting the specideficiency. The plan should address processes that lead to the deficiency cited; The procedure for implementing acceptable plan of correction for the specific deficiency cited;	ific the y

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			C 06/22/2018		
NAME OF PR	ROVIDER OR SUPPLIER		1	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
				80	01 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	e 21	F6	300				
	1/18/17 with diagnose the right and left hand and type 2 diabetes r A review of Resident	#2's most recent MDS			 The monitoring procedure to ensure that the plan of correction is effective a that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible 	nd e		
	assessment and was was coded with no co Resident #2's functio needing 2 plus perso	was coded as a quarterly dated 4/12/18. The resident ognitive impairment. nal status was coded as n assistance with bed thing, toileting, and personal			implementing the acceptable plan of correction. F600 The plan of correcting the specific deficiency			
	A review of Resident included that the residecline in ADLs related A review of the facility and June 2018 reveals	#2's care plan dated 4/20/18 dent is at risk for further ed to impaired mobility. y's grievance reports for May led Resident #2 had filed 14 lack of ADL assistance.			The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failuto provide incontinence care was-failuto follow established facility policy of providing perineal care will be after each incontinent episode.	ure re		
	6/17/18 at 5:30pm. Ron 5/28/18 NA#10 er 9:30am and he asked The resident reported would have to find so the room. Resident #hour he rang his call he called the facility of the DON (director of nurse and NA #10 and Resident #2 stated the call bell at 8:30am be movement. He report	nat on 6/11/18 he pushed the cause he had had a bowel ted a NA (nursing assistant)			On 6/11/18 resident #2 was provided wincontinent care at 145pm by the direct of nursing (DON) and treatment nurse. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/18, the social worker (SW) be interviewing all interviewable residents. This interview consisted of questions including 1. Are you provided with adl assistance timely, and with dignity? and Have you been yelled at by the staff during adl care? Interviews will be	gan		
		nim that she would have to her. Resident #2 reported			complete by 7/20/18. Any negative findings will be addressed immediately	by		

Facility ID: 923238

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(C
		345132	B. WING			l	22/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CDEENILA	VEN HEALTH AND REH	IARII ITATION CENTER	801 GREENHAVEN DRIVE		01 GREENHAVEN DRIVE		
GREENHA	WEN REALIT AND REF	ABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	when the treatment of wound care to his left the treatment nurse to staff know to come a reported at 12:00pm change him so he rail reported a NA arrived to be after lunch as shelp her change him. 1:45pm he still had no rang his call bell agai (director of nursing) a arrived in his room at changed him at that the felt like he was lying in stool wasn't in the staff of the waster of the staff of	the room until 11:30am hurse arrived to perform his t leg. The resident reported old him she would let the and change him. Resident #2 no one had shown up to and his call bell again. He d and told him it would have the could not find anyone to the Resident #2 reported at ot been changed and he in. He reported the DON and the treatment nurse and they cleaned him and time. The resident reported as being ignored and that him amportant to the staff. Inducted on 6/20/18 at the stakes 2 people to provide and she told him she would st her. She reported when room with the DON, I he needed changing. NA as the first time she had heard and she reported she was ant. She reported he told her uching him so she left the she knew she should not the tresident. Inducted on 6/20/18 at attent nurse. She reported	F	600	the sw. Beginning on 7/12/18, the facility treatment nurse and/or director of nursi observed non-interviewable residents to ensure dignity is provided during addicated including no yelling. Observation was completed on 7/13/18 with no negative findings. All nursing staff, including agency, will in-serviced by 7/20/18 by the director on nursing, or Administrator on promoting dignity during addicare, including not yelling at residents, timely incontinent care, and residents must be served one table at a time. No nursing staff will be allowed to work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursing staff, including agency. All staff, including agency, will be in-serviced by 7/20/18 by the director on nursing, or Administrator on Abuse/neglect. No staff will be allowed work after 7/20/18 until in-service completed. This in-service will be added to the orientation process for new nursis staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, and/or administrator will review all grievance	o o o o o o o o o o o o o o o o o o o	
	around 11:30am and	vent into Resident #2's room he told her he needed ted she told the NA working			received each week to ensure if abuse, neglect, or exploitation is indicated a 24 hour and 5 day report is submitted. This	1	

Facility ID: 923238

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING			C 06/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	00/22/2010	
ODEENIIA	VEN HEALTH AND DEH	ADULTATION CENTED	801 GREENHAVEN DRIVE				
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 600	Continued From page	e 23	F 6	00			
	The treatment nurse back in his room clos waiting to be changed movement so she and resident. When the DON was of #2 having to wait so be changed, she stated a promptly taken care of incontinence. An interview was con administrator on 6/21 it was his expectation	ducted with the acting /18 at 11:55am. He reported that all staff treated all the and respect and are prompt		audit will occur weekly audit will be document Tool. The monthly QI common results of the F600 aumonths for identification taken, and to determine and/or frequency of continuation of the findings and recomment monitoring for continuation and the executive QA committee execu	ted on the F600 littee will review the dit tool monthly for 3 on of trends, actions he the need for ontinued monitoring, dations for ed compliance. The DON will present the endations of the to the quarterly ee for further d oversight. Tesponsible for esponsible for esponsible for	3	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 6	correction.		7/20/18	
	resident's status. This REQUIREMENT by: Based on record revifacility failed to accura (Minimum Data Set) of (Resident #7) who waulcers and the facility	ew and staff interviews, the ately code the MDS on 1 out of 3 residents as reviewed for pressure failed to code dialysis on t (MDS) for 1 of 1 resident		An acceptable plan of contain the following e The plan of correct deficiency. The plan s processes that lead to cited; The procedure fo	elements: cting the specific hould address the		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		l ,	С	
		345132	B. WING			1	22/2018	
NAME OF P	ROVIDER OR SUPPLIER	l	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
				8	01 GREENHAVEN DRIVE			
GREENHA	AVEN HEALTH AND REF	ABILITATION CENTER		G	GREENSBORO, NC 27406			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 641	Continued From pag	F	641					
	Findings include:				acceptable plan of correction for the specific deficiency cited;The monitoring procedure to ensu	re		
	1 Resident #7 was a	admitted to the facility on			that the plan of correction is effective a			
		ses that included pressure			that specific deficiency cited remains			
		nspecified mood disorder,			corrected and/or in compliance with the	3		
		scle weakness (generalize),			regulatory requirements;			
	peripheral vascular d	lisease, major depressive			The title of the person responsible			
	disorder, and gangre	ne.			implementing the acceptable plan of correction.			
		#7's most recent MDS						
	, ,	dated 5/14/18 was coded as			Greenhaven Health and Rehabilitation			
		ent. The resident was coded			Center acknowledges receipt of the			
	-	pairment. Active diagnoses			Statement of Deficiencies and propose this Plan of Correction to the extent that			
	-	eripheral vascular disease, perlipidemia, cerebral			the summary of findings is factually	ıı		
		nxiety disorder, depression,			correct and in order to maintain			
		el stage 3, other symbolic			compliance with applicable rules and			
	dysfunctions, unspec				provisions of quality of care of resident	S.		
		ure ulcer of sacral region			The Plan of Correction is submitted as			
	-	oded the resident under skin			written allegation of compliance.			
		one stage 3 pressure ulcer						
	with measurements	documented as			Greenhaven Heath and Rehabilitation			
	7.4x10.0x0.3cm.				Center response to this Statement of			
					Deficiencies does not denote agreeme	nt		
		#7's care plan revealed the			with the Statement of Deficiencies nor			
		odated on 2/22/18 and			does it constitute an admission that an	y		
		s for stage 3 pressure ulcer			deficiency is accurate. Further,			
	to neel and stage 2 p	pressure ulcer to sacrum.			Greenhaven Health and Rehabilitation			
	A review of Resident	#7's medical record			Center reserves the right to refute any the deficiencies on this Statement of	UI		
		ote dated 3/8/18 that stated			Deficiencies through Informal Dispute			
	_	the sacrum was healed.			Resolution, formal appeal procedure			
	and proceeds aloof to	and deciding mad findings.			and/or any other administrative or lega	1		
	An observation of Re	esident #7 on 6/20/18 at			proceeding.			
		tment nurse revealed no skin						
	breakdown to the sad							
					F641 Accuracy of Assessments			
	An interview was con	nducted on 6/20/18 at			The plan of correcting the specific			

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	OF DEFICIENCIES F CORRECTION	I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				C / 22/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12212010	
					01 GREENHAVEN DRIVE			
GREENHA	AVEN HEALTH AND REF	IABILITATION CENTER			REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From pag	e 25	F 6	641				
		nd care physician's assistant 7 weekly for the wound to			deficiency			
	her left heel. He repo	orted he has been coming to ch 2018 and the resident has loer on her sacrum since he			The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in accurately coding pressure.	3		
	2:35pm with the RAI Instrument) reimburs reported she is assis as the facility does not this time. She reported dated 5/14/18 was condition section. She and resubmit. An interview was corradministrator and the on 6/21/18 at 11:55a	inducted on 6/20/18 at (Resident Assessment ement coordinator. She ting with MDS assessments of have a MDS coordinator at ead the MDS assessment oded incorrectly under skin e reported she will correct adducted with the acting a corporate nurse consultant in. They both reported it is a the MDS assessments are		procedure in accurately coding pressure ulcers and dialysis. On 6/20/18 resident #7's minimum data set (MDS) assessment dated 5/14/18 wa modified to accurately code skin status b the Corporate RAI Reimbursement Auditor. On 6/20/18 resident #6's MDS assessment dated 3/31/18 was modified to accurately code dialysis by the Corporate RAI Reimbursement Auditor. On 6/20/18, the modified assessments were transmitted to the National Repository by the Corporate		a was s by ed		
	3/24/18 and diagnosidisease on hemodial A care plan dated 3/2 resident was at risk finemodialysis. Intervedialysis on Mondays. An admission MDS odid not identify that the dialysis.	admitted to the facility on es included end stage renal ysis. 26/18 for Resident #6 stated or complications due to entions included to receive Wednesdays and Fridays. lated 3/31/18 for Resident #6 ne resident was receiving			On 6/21/18, the modified assessment of accepted by the National Repository. The procedure for implementing the acceptable plan of correction for the specific deficiency cited From 7/2/18 through 7/4/18, the Corporate minimum data set(MDS) consultant audited all assessments completed in the past 30 days to ensure residents skin status and dialysis were coded correctly. Any negative findings were corrected immediately by the auditor. Newly hired MDS nurses will be proper trained by Corporate MDS Consultants accurately code the MDS assessments include coding skin and residents	re rly s to		

Facility ID: 923238

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			C / 22/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE		72272010	
				GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 641	Continued From page	⊋ 26	F 6	41			
	3/31/18 for Resident a for dialysis. She state corrected. An interview on 6/21/ Administrator reveale the MDS be coded to	evealed the MDS dated #6 should have been coded ad the MDS would need to be 18 at 10:01 am with the ad it was his expectation that reflect the resident 's		receiving dialysis services. The monitoring procedure to ensure the plan of correction is effective an specific deficiency cited remains column and/or in compliance with the regular requirements The director of nursing, or treatment nurse will audit MDS assessments for the monitoring of the services.	d that rected itory		
	health condition.			correct skin status and residents red dialysis services coding using the Fi Audit Tool. 25% of completed assessments will be audited weekly weeks, then 25% of completed assessments biweekly x 8 weeks. The monthly QI committee will revier results of the F641 Audit Tool month 3 months for identification of trends, actions taken, and to determine the for and/or frequency of continued monitoring, and make recommendate for monitoring for continued compliated The administrator and/or director of nursing (DON) will present the finding and recommendations of the month committee to the quarterly executive committee for further recommendation and oversight. The title of the person responsible for implementing the acceptable plan of correction. The DON is responsible for implementing the acceptable plan of correction.	x 4 w the ally for the constance. In the constance of t		
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 6	56		7/20/18	
		ensive Care Plans cility must develop and nensive person-centered					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345132	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483.3 (iii) Any specialized significant are resided (ivi) Any specialized significant are resident in the resided (ivi) from the resident in the resident (ivi) from sultation with resident's representationale in the resident's representational in the resident (ivi) from sultation with resident in the resident (ivi) from sultation with resident in the re	sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial led in the comprehensive aprehensive care plan must prehensive practicable psychosocial well-being as prehensive previously and would otherwise be required previously as a second control of the region of the region of the nursing facility will previously disagrees with the previously disagrees	F 65	6	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(C
		345132	B. WING			06/	22/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ODEENIU	VEN HEALTH AND DEH	A DIL ITATION OF NITED		8	01 GREENHAVEN DRIVE		
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		G	GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,			(X5) COMPLETION DATE
F 656	Continued From page 28 Based on record review and staff interviews the facility failed to develop a care plan to address behaviors that included refusal of medications and dialysis treatment for Resident #6. This was evident for 1 of 1 resident that was reviewed for dialysis.		F 65		F656 Development/Implement Comprehensive Care Plan		
					The plan of correcting the specific deficiency		
	Findings Included:	The position of a Rehabilitation of a process that lea		The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency was			
	3/24/18 and diagnose	nitted to the facility on es included end stage renal alysis, congestive heart			the staff failure to follow established procedure in failed to develop a care pl to address behaviors that included refu	failed to develop a care plan	
		ory failure, arteriosclerotic			of medications and dialysis treatment		
	depression and anxie	ety.			What measures did the facility put in plate for the resident affected:	ace	
		um data set (MDS) dated #6 did not identify any			Posidont #6 was discharged from the		
	behaviors of rejection	n of care and did not identify dialysis. The MDS identified			Resident #6 was discharged from the facility on 5/16/18.		
	the resident 's cognit	-			What measures were put in place for residents having the potential to be		
		(MAR) for Resident #6			affected:		
	revealed the following	g medications were circled Amlodipine (a medication to			From 7/2/18 until 7/4/18 the Corporate minimum data set (MDS) consultant		
	treat high blood press milligrams (mg) once	sure and angina) 10 a day on 3/26/18, 3/27/18,			compelted an audit of resident's who refuse care including refusal of dialysis	,	
	treat high blood press	Carvedilol (a medication to sure) 25 mg twice daily on			and medications care plans to ensure accuracy of refusal. All negative finding	js	
	Plavix (an anticoagula	8/18 and 3/30/18 at 9:00 am, ant) 75 mg every day on 8/18 and 3/30/18, Depakote			were addressed by the auditor from 7/2/18 through 7/4/18 during the audit.		
	disorder) 500 mg twid 3/28/18 and 3/30/18	t seizures and / or bipolar ce daily on 3/26/18, 3/27/18, at 9:00 am, Apresoline (a	What systems were put in place to prevent the deficient practice from reoccurring:				
	every 8 hours on 3/26	gh blood pressure) 50 mg 6/18, 3/28/18 and 3/29/18 at and Isordil (a medication to			On 7/18/18, the Corporate MDS consultant in-serviced the director of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	<i>LL/L</i> 010	
				80	01 GREENHAVEN DRIVE			
GREENH	AVEN HEALTH AND REH	ABILITATION CENTER			GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	ntinued From page 29 F 656						
	treat chest pain) 10 mg three times a day on 3/26/18, 3/27/18, 3/28/18 and 3/30/18 at 9:00 am and 1:00 pm.				nursing (DON) related to accurately care planning resident refusals to include refusal of dialysis and medications.			
	Resident #6 stated the appointment for dialycrefused to go.	sis today and the resident			Newly hired MDS nurses will be proper trained by title related to accurately car planning resident refusals of care to include refusal of dialysis and medications.	•		
	Director of Nursing (E contacted the dialysis	18 at 5:35 pm with the DON) revealed she had s center that Resident #6 ined that he had missed his a 3/30/18 and 4/6/18.			How the facility will monitor systems puplace:	ut in		
	#5 revealed she was first shift (7:00 am to resident consistently her shift. Nurse #5 ac her he couldn't take h	18 at 10:12 am with Nurse the nurse for Resident #6 on 3:00 pm). She stated the refused his medications on ded the resident would tell his medications on the days is, but he would also refuse days.			The Treatment nurse, staff facilitator, and/or corporate consultant will audit resident care plans to ensure that all refusals of care including refusal of dialysis, and medications are accurate care planned using the F656 audit tool Five random residents on random halls care plans will be audited weekly x 12 weeks.			
	interim MDS Nurse re have been developed consistent refusal of i An interview on 6/21/ Administrator reveale	18 at 2:27 pm with the evealed a care plan should to address Resident #6 's medications and dialysis. 18 at 10:01 am with the ed it was his expectation that ace to reflect the resident 's			The monthly QI committee will review to results of the F656 audit tool monthly formonths for identification of trends, active taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. To administrator and/or DON will present findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	or 3 ons ng, The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345132	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE	
F 656	Continued From pag	e 30	F 65	The DON is responsible for implementation of this plan of corrections.	ction.
F 657 SS=D	Care Plan Timing an CFR(s): 483.21(b)(2)		F 65		7/20/18
	be- (i) Developed within the comprehensive at (ii) Prepared by an ir includes but is not lir (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent prather resident and the An explanation must medical record if the and their resident report practicable for the resident's care plan. (F) Other appropriated disciplines as determor as requested by the (iii)Reviewed and reviteam after each assessments. This REQUIREMENT by: Based on record revinterviews, the facility	prehensive care plan must 7 days after completion of assessment. Atterdisciplinary team, that mited to ysician. Be with responsibility for the d and nutrition services staff. Acticable, the participation of resident's representative(s). Be included in a resident's participation of the resident oresentative is determined to development of the e staff or professionals in a staff or profes		Greenhaven Health and Rehabilitat Center acknowledges receipt of the Statement of Deficiencies and propo this Plan of Correction to the extent	oses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING			1	C
NAME OF DE	ROVIDER OR SUPPLIER	040102		С.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	/22/2018
NAME OF PE	ROVIDER OR SUPPLIER						
GREENHA	VEN HEALTH AND RE	HABILITATION CENTER			01 GREENHAVEN DRIVE		
				G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		3E	(X5) COMPLETION DATE
F 657	Continued From page	ge 31	F	657			
	Findings include:				the summary of findings is factually correct and in order to maintain compliance with applicable rules and		
		mitted to the facility on			provisions of quality of care of residen		
		oses that included pressure			The Plan of Correction is submitted as	а	
		ınspecified mood disorder,			written allegation of compliance.		
		ıscle weakness (generalize),					
		disease, major depressive			Greenhaven Heath and Rehabilitation		
	disorder, and gangr	ene.			Center response to this Statement of		
					Deficiencies does not denote agreeme		
		sident #7's most recent MDS			with the Statement of Deficiencies nor		
		dated 5/14/18 was coded as			does it constitute an admission that ar	y	
	•	nent. The resident was coded			deficiency is accurate. Further,		
	_	pairment. Active diagnoses			Greenhaven Health and Rehabilitation		
		eripheral vascular disease, /perlipidemia, cerebral			Center reserves the right to refute any the deficiencies on this Statement of	OI	
		nxiety disorder, depression,			Deficiencies through Informal Dispute		
		el stage 3, other symbolic			Resolution, formal appeal procedure		
		cified mood disorder,			and/or any other administrative or lega	al	
		sure ulcer of sacral region			proceeding.		
		coded the resident under skin			p. cocounig.		
	•	g one stage 3 pressure ulcer					
	with measurements						
	7.4x10.0x0.3cm.				F tag 657 Care Plan Timing and Revis	ion	
		sident #7's care plan revealed ast updated on 2/22/18 and			The plan of correcting the specific deficiency		
	•	ns for stage 3 pressure ulcer					
		pressure ulcer to sacrum.			The position of Greenhaven Health an Rehabilitation center regarding the	d	
	A review of Res	sident #7's medical record			process that lead to this deficiency wa	s	
		note dated 3/8/18 that stated			the staff failure to follow established po		
	_	o the sacrum was healed.			related to revision of the resident care plan/guide.	•	
	An observation	of Resident #7 on 6/20/18 at					
	8:30am with the trea	atment nurse revealed no skin			On 6/20/18, resident #7s care plan wa	s	
	breakdown to the sa	acral area.			reviewed and updated related to curre		
	An interview wa	as conducted on 6/20/18 at			skin status by the corporate minimum data set (MDS) consultant.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			1	22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
				80	01 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page		F6	557				
	who sees Resident #' her left heel. He report the facility since Marc	nd care physician's assistant 7 weekly for the wound to rted he has been coming to th 2018 and the resident has cer on her sacrum since he			The procedure for implementing the acceptable plan of correction for the specific deficiency cited From 7/2/18 until 7/4/18, the Corporate	:		
	An interview was conducted on 6/20/18 at 2:35pm with the RAI (Resident Assessment Instrument) reimbursement coordinator. She reported she is assisting with care plans as the facility does not have a MDS coordinator at this time. She reported the care plans should be reviewed and updated with each MDS assessment. She reported Resident #7's care plan should have been updated when the pressure ulcer to the sacrum was healed. She stated she will update the resident's care plan to reflect the correct care to provide. An interview was conducted with the acting administrator and the corporate nurse consultant on 6/21/18 at 11:55am. They both reported it is their expectation that care plans are to be				MDS consultant completed an audit of 100% of resident care plans to ensure that resident care plans are accurate related to skin status. Care plans were updated as needed immediately by auditor.			
					On 7/18/18, the corporate MDS consulin-serviced the IDT related to the revisi of care plans. The in-service includes the care plan will be updated and/or reviewed routinely with completion of ecomprehensive and quarterly MDS assessment as well as upon any changin resident's condition to include skin status when appropriate.	on hat each		
	reviewed and updated assessments are con	d when the MDS			The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements	nat cted		
					The Director of Nursing will audit reside care plans to ensure that care plan reviews and revisions have been completed and the care plan is accurat related to skin status. Five resident car plans will be audited weekly x 12 week This audit will be documented on the F657 audit tool.	te re		

PRINTED: 08/07/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING				22/2018
NAME OF PI	ROVIDER OR SUPPLIER	0.0.02		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	22/2010
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GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657 SS=E	S483.24(a)(2) A resid out activities of daily I services to maintain opersonal and oral hyo This REQUIREMENT by: Based on observatio and resident interview provide incontinence (Resident #1 and Res (Activities of Daily Liv Findings include:	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ans, record review, and staff ws, the facility failed to care for 2 out of 4 residents sident #2) reviewed for ADLs		6577	The monthly QI committee will review the results of the F657 audit tool monthly for months for identification of trends, action taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction. An acceptable plan of correction must contain the following elements: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The procedure for implementing the acceptable plan of correction for the specific deficiency cited;	or 3 ons ng, he he	7/20/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			1	C 22/2018
NAME OF P	ROVIDER OR SUPPLIER	-		S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				80	1 GREENHAVEN DRIVE		
GREENHA	VEN HEALTH AND RE	HABILITATION CENTER		G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	ge 34	F6	677			
	right and left hands, unspecified open we encounter, and type A review of Residen	ses of contractures of the unsteadiness on feet, bund left lower leg initial e 2 diabetes mellitus.			 The monitoring procedure to ensure that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible incorrection of the person responsible incorrection. 	nd e	
	assessment and wa was coded with no of Resident #2's functi needing 2 plus pers mobility, dressing, b hygiene.	was coded as a quarterly as dated 4/12/18. The resident cognitive impairment. onal status was coded as on assistance with bed eathing, toileting, and personal			implementing the acceptable plan of correction. Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent that the summary of findings is factually		
	included that the res decline in ADLs rela	at #2's care plan dated 4/20/18 sident was at risk for further ted to impaired mobility. made on 6/18/18 at 9:20am			correct and in order to maintain compliance with applicable rules and provisions of quality of care of resident The Plan of Correction is submitted as written allegation of compliance.		
	Care Assistant) #1. An observation GCA #1 as they pro care to Resident #2	sistant) #9 and GCA (Geriatric was made of NA #9 and vided a bath and incontinence The resident had a bowel #9 cleaned up the resident's	Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation				
	5:30pm on 6/17/18. 6/11/18 he pushed to because he had had reported a NA (nurshold him that she would help her. Resident to her in the room until 11: nurse arrived to per leg. The resident retold him she would legate to help her.	Resident #2 was conducted at Resident #2 stated that on the call bell at 8:30am d a bowel movement. He ing assistant) came in and ould have to find someone to the reported no one came back 30am when the treatment form his wound care to his left ported the treatment nurse et the staff know to come and ent #2 reported at 12:00pm no			Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or lega proceeding. F677 The plan of correcting the specific deficiency		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345132	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	343132		STREET ADDRESS, CITY, STATE, ZIP C		6/22/2018
NAME OF FI	NOVIDER OR SUFFLIER				ODE	
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		801 GREENHAVEN DRIVE		
				GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From page	e 35	F 6	777		
F 677	one had shown up to call bell again. He rehim it would have to hot find anyone to he #2 reported at 1:45pr changed and he rang reported the DON (ditreatment nurse arrive cleaned him and changesident #2 reported assigned to him would then had to find some and that would take at An interview was conge: 20am on 6/20/18. Sto Resident #2's call off or was notified but to provide incontinent was the only NA on the wait until she could find with incontinence car. An interview was conge:	change him so he rang his aported a NA arrived and told be after lunch as she could alp her change him. Resident in he still had not been in his call bell again. He rector of nursing) and the rector of nursing) and the red in his room and they inged him at that time. It that a lot of times the NA in dianswer the call bell but recone to help with the care in long time. Inducted with NA #9 at the she had to have assistance are care. She reported if she in hall she would have to indicate another NA to assist her rectant to Resident #2's room the told her he needed and had a bowel movement. The NA assigned to Resident be changed. The treatment she arrived back in the copy he had not been and he had not been and he had not been and the resident.	F 6	The position of Greenhaver rehabilitation center regard that lead to this deficiency-provide incontinence care was to follow established proced. Resident # 1 was provided incontinent care during the survey by the certified nurs. Resident # 1 refused a show that was offered by the certified nurs. Resident #2 was provided in care by facility certified nurs. On 6/18/18 at 920am. The procedure for implement acceptable plan of corrections specific deficiency cited. On 7/13/18, the social work interviewing all interviewab. This interview consisted of including 1. Are you provide assistance timely, and with Have you been yelled at by during adl care? Interviews complete by 7/20/18. Any refindings will be addressed in the sw. Beginning on 7/12/18, the fit reatment nurse and/or direct observed non-interviewable ensure dignity was provided care, including no yelling. Owere completed on 7/13/18	ing the process failure to was staff failure dure. with complaint ing assistant. wer on 6/20/18 tified nursing incontinent sing assistant. enting the on for the confort the staff will be negative mmediately by facility ector of nursing eresidents to d during adl observations.	
	reported it was his ex	ence care in a timely manner.		negative findings. On 7/13/18, the Director of		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	. ,	(X3) DATE SURVEY COMPLETED		
		345132	B. WING			C 6/22/2018		
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	10115211 011 001 1 2.2.11			801 GREENHAVEN DRIVE				
GREENHA	VEN HEALTH AND REH	IABILITATION CENTER		GREENSBORO, NC 27406				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	N OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE	COMPLETION DATE		
F 677	Continued From page	e 36	F 6	77				
	. •			reviewed residents in fa	acility for showers			
	2. Resident # 1 was a	admitted to the facility on		given in the last 7 days	-			
	August 2, 2016 with			showers were not giver				
		and right legs below the		needs, and showers we				
	knee, hypertension a	nd diabetes mellitus.		resident preference (pla	an of care).			
				All nursing staff, includi	ng agency will be			
		um Data Set dated May 5,		in-serviced by 7/20/18 b	_			
	2018 revealed Resident # 1 was cognitively			nursing, or Administrate				
		equired extensive assistance		choice including resider				
	_	transfer with two person		shower preferences, an	•			
		motion on/off unit, dressing,		showers based on their nursing staff will be allo				
	toilet use and person	with one person physical		7/20/18 until in-service				
		was incontinent of bladder		in-service will be added	•			
	and bowel.	was mosminent of bladder		process for all new nurs				
				agency.	onig etan, meraanig			
	During an interview v	vith Resident # 1 on June 17,		All nursing staff, includi	ng agency, will be			
	_	e revealed that she had not		in-serviced by 7/20/18 b				
	had a shower in two	months". Resident #1		nursing, or Administrate	or on promoting			
		days were Monday and		dignity during adl care,	-			
	-	t #1 indicated she was a		yelling at residents, time				
		ed her showers weekly so		care, and residents mus				
	she would not have a			table at a time. No nurs				
	_	nted a shower this would " Resident #1 also indicated		allowed to work after 7/				
				in-service completed. T				
		ft for 2 hours lying in her d not think she was wet		be added to the orienta new nursing staff, include	•			
	enough to be change			The monitoring procedu				
	chough to be change			the plan of correction is				
	A review of her care	plan dated May 5, 2018		specific deficiency cited				
		interventions about Activities		and/or in compliance w				
		ident #1 for staff to provide		requirements	- •			
	assistant with all ADL	s care but just set up help						
	for eating.			The director of nursing,				
				and/or minimum data se				
		ne daily shower sheet was		10 residents weekly for				
		18 at 10am revealed that on		ensure showers were g				
		lays Room 104 A and B		choice, and adl care, in				
	receives shower duri	ng 2rd shift.		care, has been provided	d. This audit will be			

Facility ID: 923238

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER		-1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
ODEENIU	VEN HEALTH AND DEH	A DIL ITATION CENTED		80	1 GREENHAVEN DRIVE		
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		GI	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	3pm until 7:15pm, revenot received a shower During an interview was 2018 at 9:30am, Resenot received her show her about taking a shower about taking a shower about taking a shower about taking as the During an interview was Member (FM) on Jung an interview was Member (FM) on Jung revealed that on seven Resident #1 indicated shower. FM also indicated an odor and FM had with the previous admitted buring an interview was (DON) on June 20, 20 each resident's needs are expected to be do bases. An interview was con administrator on 6/21	n on June 19, 2018 from realed that Resident ##1 did r. with Resident # 1 on June 20, ident #1 indicated she did ver nor did anyone asked ower. with Nursing Aide (NA) # 1 on a she revealed that resident er. with Resident #1's Family the 20,2018 at 3:30pm that she had not had cated that Resident #1, at that she had not had cated that Resident #1 had discussed all the concerns ininistrator who according to g for my Aunt". with the Director of Nursing 2018 at 4:15pm, she revealed a and activities of daily living one and given on a daily ducted with the acting	F6	677	documented on the F677 audit tool. The monthly QI committee will review to results of the F677 audit tool for 3 monfor identification of trends, actions take and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrate and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive QI committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible filmplementing the acceptable plan of correction.	ths n, d for or nd A s	
F 725 SS=E	Sufficient Nursing Sta CFR(s): 483.35(a)(1) §483.35(a) Sufficient	(2)	F 7	'25			7/20/18
	,	Ç					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	ATE SURVEY DMPLETED	
		345132	B. WING _			C 06/22/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406		00/22/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 725	provide nursing and resident safety and practicable physical well-being of each resident assessme and considering the diagnoses of the falaccordance with that §483.70(e). §483.35(a)(1) The by sufficient number types of personnel nursing care to all resident care plans (i) Except when was this section, license (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour This REQUIREMED by: Based on observating interviews the facilial nursing staffing to plimely manner for 2 (Resident #1 and Forovide 1 of 4 resident #1) and for the condition of the condi	mpetencies and skills sets to direlated services to assure attain or maintain the highest all, mental, and psychosocial resident, as determined by ints and individual plans of care enumber, acuity and cility's resident population in e facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with the cived under paragraph (e) of ed nurses; and ersonnel, including but not essection, the facility must ed nurse to serve as a charge	F 7	An acceptable plan of correct contain the following elements The plan of correcting the deficiency. The plan should ac processes that lead to the deficited; The procedure for implem acceptable plan of correction is specific deficiency cited; The monitoring procedure that the plan of correction is eithat specific deficiency cited re	e specific ddress the dciency henting the for the eto ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345132	B. WING_			C 06/22/2018		
NAME OF PE	ROVIDER OR SUPPLIER	0.0.02	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/22/2010	
TO THE OT THE	TO VIDER OR OUT FEEL		801 GREENHAVEN DRIVE					
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			REENSBORO, NC 27406			
04.0.1=	CLIMMADY CT	ATEMENT OF DEFICIENCIES			<u> </u>		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page	e 39	F 7	725				
	(Resident #2)				corrected and/or in compliance with the	Э		
	Findings Included:	,			regulatory requirements; The title of the person responsible implementing the acceptable plan of	for		
	This tag was cross-re	eferred to			correction.			
	F-550 - Based on observations, record review, and staff and resident interviews, the facility staff failed to treat the resident with dignity by yelling at the resident when she came in to assist him with ADL (Activities of Daily Living) care, failed to provide care for 2 of 5 dependent residents (Resident #1 and Resident #2). The facility further failed to serve residents meal trays at the same time all table mates were served for 1 out of 3 residents (Resident #11). F-561 Based on observation, staff and resident interviews the facility failed to honor a resident's choice of having weekly showers for 1 of 3				Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent tha the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of resident The Plan of Correction is submitted as written allegation of compliance. Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor	es at s. a		
	F-600-Based on obsestaff and resident interfailed to provide income two hours respectfully two different staff that needed assistance in (Resident #2).	ased on observations, record review, and resident interviews, the facility staff provide incontinence care for one and is respectfully for a resident that advised rent staff that he/she was soiled and assistance in 1 of 3 dependent residents at #2).			does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.			
	F -677 - Based on observations, record review, and staff and resident interviews, the facility failed to provide incontinence care for 2 out of 4 residents (Resident #1 and Resident #2) reviewed for ADLs (Activities of Daily Living). An interview with Resident #1 on 6/17/18 at 4:45				F725 The plan of correcting the specific deficiency			
	•	had several issues with staff Il bell in a timely manner.			The position of Greenhaven Health and Rehabilitation center regarding the	d		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345132	B. WING		C		
NAME OF DE	ROVIDER OR SUPPLIER	0-10102		STREET ADDRESS, CITY, STATE, ZIP CODE	06/22/2018		
NAIVIE OF FI	NOVIDER OR SUFFLIER						
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		801 GREENHAVEN DRIVE			
				GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 725	Continued From page	2 40	F 72	5			
	Resident #1 reported	issues on 4/2/2018 when		process that lead to this deficiency-fa	iled		
		r 2 hours waiting to be		to provide nursing staff of sufficient			
		iff told her she was not wet		quantity to provide timely incontinent	care.		
	_	d. She added this had been		and provide showers per resident	,		
	_	ident #1 stated she had filed		preference and as scheduled- was a			
		s and nothing had been		communication deficit.			
	done. Resident #1 sta	ated in May 2018 (exact day					
	not known) she waited three hours for staff to change her. She added this would always be a problem until the facility got more staff. Resident #1 revealed she had not had a shower in two months. She added her shower days were			During the complaint survey, resident	#1		
				and resident #2 were provided ADL c	are		
				to promote quality of life, including wit			
				yelling, by a certified nursing assistan			
				On 6/20/18, resident #1 refused a sho			
		ays. She explained she was		that was offered by the certified nursi	ng		
		eeded her showers weekly		assistant.			
	so she would not hav	e an odor.		On 6/11/18 resident #2 was provided			
				incontinent care at 145pm by the dire			
		sident #2 was conducted at Resident #2 stated that on		of nursing (DON) and treatment nurse	9.		
	6/11/18 he pushed the			Throughout the duration of the survey	<i>'</i> ,		
	because he had had	a bowel movement. He		resident # 2 received ADL Care per			
	reported a NA (nursin	ig assistant) came in and		resident preference.			
		ld have to find someone to					
		reported no one came back					
		0am when the treatment					
		rm his wound care to his left					
		orted the treatment nurse		The procedure for implementing the			
		t the staff know to come and		acceptable plan of correction for the			
		t #2 reported at 12:00pm no		specific deficiency cited			
	•	change him so he rang his		D 4440440 H 6 334 L 1 1			
	_	ported a NA arrived and told		By 4/13/18, the facility had signed a			
		be after lunch as she could		contract with a staffing agency to prov	/ide		
	_	lp her change him. Resident		sufficient nursing staffing.			
		n he still had not been		Dy 4/12/19 the facility began effective	oign		
		his call bell again. He rector of nursing) and the		By 4/13/18, the facility began offering			
		· · · · · · · · · · · · · · · · · · ·		on a sign on bonus for certified nursir	-		
		ed in his room and they		assistants, licensed practical nurses,	anu		
	cleaned him and char	that a lot of times the NA		registered nurses.			
		d answer the call bell but		On 7/13/18, the social worker (SW) be	egan		
	assigned to min would	u answer the can bell but		On 11 13/10, the Social Worker (SW) b	-yan		

NAME OF PROVIDER OR SUPPLIER GREENHAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406 (EACH CORRECTION SHOULD BE PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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REENHAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPANY OF CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) (BOTH COMPANY OF LSC IDENTIFYING INFORMATION) (BOTH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1 00/2	22/2016
GREENHAVEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE								
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	GREENHA	AVEN HEALTH AND REF	IABILITATION CENTER					
DEFICIENCY)	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI)		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
then had to find someone to help with the care and that would take a long time. An interview on 6/19/18 at 4:00 pm with Nursing Assistant (NA) #1 revealed she had provided care for Resident #1. She stated she always answered her call bells within 10 to 15 minutes, but it was hard to do this when there were times she had 15 to 20 residents to care for on her assignment. An interview was conducted with NA #9 at 9:20am on 6/20/18. She reported she responded to Resident #2's call bell as soon as she saw it go off or was notified but she had to have assistance to provide incontinence care. She reported if she was the only NA on the hall she would have to wait until she could find another NA to assist her with incontinence care. She reported that on 6/11/18 she went into Resident #2's room around 11:30am and he told her he needed changing due to having had a bowel movement. She stated she told the NA assigned to Resident #2's room around 11:30am and he told her he needed changing due to having had a bowel movement so she and the DON changed the resident. An interview on 6/21/18 at 10:01 am with the Administrator revealed it was his expectation that the nursing staff met the needs of the residents in a timely manner.	F 725	then had to find some and that would take a An interview on 6/19. Assistant (NA) #1 review for Resident #1. She her call bells within 1 hard to do this when to 20 residents to car. An interview was cor. 9:20am on 6/20/18. Sto Resident #2's call off or was notified but to provide incontinent was the only NA on twait until she could fi with incontinence car. An interview was cor. 11:40am with the treat that on 6/11/18 she waround 11:30am and changing due to having She stated she told to the state of the nurse reported when resident's room at 2:1 changed from a more and the DON change. An interview on 6/21. Administrator reveals the nursing staff met.	eone to help with the care a long time. /18 at 4:00 pm with Nursing vealed she had provided care stated she always answered 0 to 15 minutes, but it was there were times she had 15 re for on her assignment. Inducted with NA #9 at She reported she responded bell as soon as she saw it go t she had to have assistance ace care. She reported if she he hall she would have to and another NA to assist her re. Inducted on 6/20/18 at attement nurse. She reported went into Resident #2's room he told her he needed and had a bowel movement. The NA assigned to Resident be changed. The treatment she arrived back in the cooping bowel movement so she ad the resident.	F 7	inter This inclu assis Have durir com findii the s Begi nurs non- digni inclu com findii On 7 revie give shov need resid nega On 7 the c stafff shov incol proc The the p sped and/ requ The	viewing all interviewable residents interview consisted of questions ading 1. Are you provided with adlastance timely, and with dignity? are you been yelled at by the staffing adl care? Interviews will be plete by 7/20/18. Any negative ngs will be addressed immediately sw. Inning on 7/12/18 the facility treatre and/or director of nursing observinterviewable residents to ensure ity is provided during adl care, ading no yelling. Observations were pleted on 7/13/18 with no negative ngs. 7/13/18, the Director of Nursing ewed residents in facility for shower in the last 7 days to ensure nowers were not given due to equipmeds, and showers were given per dent preference (plan of care). No active findings noted. 7/2/18, the administrator in-serviced director of nursing, and scheduler ing expectations including ensuring vers are completed per policy, and nutinent care is provided timely per edure. In monitoring procedure to ensure the blan of correction is effective and the correction of compliance with the regulated of in compliance with the regulated or administrator will audit daily or administrator will audit daily	y by ment ved ee ers nent ed on ng d that ected ory	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		801	REET ADDRESS, CITY, STATE, ZIP CODE 1 GREENHAVEN DRIVE REENSBORO, NC 27406	001	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	S483.35(g) Nurse Sta §483.35(g) Nurse Sta §483.35(g)(1) Data re must post the followir basis: (i) Facility name. (ii) The current date. (iii) The total number by the following category unlicensed nursing sta resident care per shift (A) Registered nurses (B) Licensed practica	g Information (4) Iffing Information. Equirements. The facility Information on a daily and the actual hours worked Increased and Incre		725	monitoring tool. The monthly QI committee will review to results of the F725 audit tool for 3 monitor identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrational and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive QC committee for further recommendations and oversight The title of the person responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	ths n, l for or nd	7/20/18

PRINTED: 08/07/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED		
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F 732	specified in paragraphically basis at the begin daily basis at the begin in Data must be possible. An observation on 6.	g requirements. post the nurse staffing data oh (g)(1) of this section on a ginning of each shift. sted as follows: ble format. dace readily accessible to s. caccess to posted nurse dicility must, upon oral or e nurse staffing data dic for review at a cost not to dity standard. y data retention acility must maintain the taffing data for a minimum of quired by State law, whichever T is not met as evidenced ons, record reviews and staff y failed to post daily nurse during one (1) of four (5) failed to post the correct the daily nurse staffing 1) of four (5) days during the	F 7	An acceptable plan of correcticontain the following elements The plan of correcting the deficiency. The plan should acprocesses that lead to the deficited; The procedure for implem acceptable plan of correction fine specific deficiency cited; The monitoring procedure that the plan of correction is effective.	specific dress the ciency senting the for the sto ensure fective and		
	6/15/2018 was poste	urse staffing information for ed in the facility's front lobby fing information was not 3.		that specific deficiency cited recorrected and/or in compliance regulatory requirements; The title of the person res	e with the		

Facility ID: 923238

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00//	22/2010
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PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
daily nurse staffing infor facility's front lobby and The facility's resident ce there were 53 on 6/18/2 An interview with the Di 6/19/2018 at 3:10 PM re was 52 on 6/18/2018. Shere on the weekend to staffing sheets and she posting was wrong on 6 An interview with the Ac	/2018 at 10 AM revealed rmation was posted in was dated 6/18/2018. ensus sheet revealed 2018. rector of Nursing on evealed that the census she stated that no one was the post the daily nurse was not aware the 6/18/2018. dministrator on 6/20/2018 at it was his expectation raffing be correct and	F	732	implementing the acceptable plan of correction. Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose 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 resident The Plan of Correction is submitted as written allegation of compliance. Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F732 The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failing promote to post daily nursing staffing, a post correct resident census on one daily post correct post daily post correct resident census on one daily post correct post daily post correct post daily post correct resident census on one daily post correct post daily post correc	s. a nt y of	

\ '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00/22/2010	
				801 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		GREENSBORO, NC 27406			
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F 732	Continued From page	e 45	F 7:	nursing staffing posting- was knowledge. On 6/19/18 and 7/9/18, the nursing staffing posting was present with census. This was verified by the of Nursing. The procedure for implementing acceptable plan of correction for specific deficiency cited. On 7/2/18, the Director of Nursing in-serviced by the Administrator daily nursing staffing posting, in correct census. By 7/16/18, all prinvolved with scheduling will be in-serviced by the Administrator Director of Nursing on completic posting information. This in-serviced by the Administrator Director of Nursing on completic posting information. This in-serviced by the Administrator Director of Nursing on completic posting information. This in-serviced by the orientation process newly hired staff involved with some the plan of correction is effectively specific deficiency cited remains and/or in compliance with the result of the plan of correction is effectively specific deficiency cited remains and/or in compliance with the result of the plan of correction is effectively specific deficiency cited remains and/or in compliance with the result of the plan of correction is effectively specific deficiency cited remains and/or in compliance with the results of the formal will be docured to the plan of correction of trends, action and to determine the need for a frequency of continued monitoric make recommendations for more deficiency.	sing th correct the Director g the or the sing was or on the including people or or on of staff ervice will as for all scheduling. Issure that the and that the scorrected regulatory tor of sing tor		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			01 GREENHAVEN DRIVE REENSBORO, NC 27406		
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F 732		redures/Pharmacist/Records		732 755	continued compliance. The administrat and/or DON will present the findings ar recommendations of the monthly QI committee to the quarterly executive Q committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	nd A	7/20/18
SS=D	drugs and biologicals them under an agreet §483.70(g). The facil personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accuration dispensing, and administration biologicals) to meet the service of the serv	ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed er drugs if State law er the general supervision of es. A facility must provide es (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident.					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION IILDING			(X3) DATE SURVEY COMPLETED	
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				801	GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		GR	EENSBORO, NC 27406			
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F 755	Continued From page	e 47	F7	755				
	receipt and disposition sufficient detail to enapter the conciliation; and							
	§483.45(b)(3) Detern order and that an acc is maintained and pe This REQUIREMENT by:							
	Based on observation interviews, the facility instead of a licensed prescription ointment	ns, record review, and staff rallowed a nursing assistant nurse to administer a to 1 out of 3 residents ed for skin conditions.			An acceptable plan of correction must contain the following elements: • The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency cited;	e		
	Findings included:				 The procedure for implementing the acceptable plan of correction for the 	ie		
	1/18/17 with diagnose	nitted to the facility on es of unsteadiness on feet, n wound left lower leg initial			specific deficiency cited; The monitoring procedure to ensure that the plan of correction is effective a that specific deficiency cited remains corrected and/or in compliance with the	nd		
	(Minimum Data Set) assessment and was was coded with no conceed the Resident #2's MDS was coded with most of Resident #2's MDS was coded with MDS was coded with	#2's most recent MDS was coded as a quarterly dated 4/12/18. The resident ognitive impairment. vas coded as no pressure DS coded the resident as			regulatory requirements; The title of the person responsible implementing the acceptable plan of correction.	for		
		nd to left lower leg that was n.			Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and propose this Plan of Correction to the extent tha			
	revealed a physician'	s order written on 2/8/18 that tment 1% to left flank area			the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of resident			
	A review of Resident	#2's treatment record for			The Plan of Correction is submitted as			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE				
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OKLEMI	WENTILALITIAND I	REHABIEHATION GENTER		GI	REENSBORO, NC 27406				
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F 755	Continued From p	nage 48	[755					
	1	-	' '	, 55	witter allegation of compliance				
		ed Triamcilone ointment had not			written allegation of compliance.				
	June.	d as being applied any day in			Greenhaven Heath and Rehabilitation				
	Julie.				Center response to this Statement of				
	An observation of	Resident #2 receiving personal			Deficiencies does not denote agreement	ent .			
		rsing Assistant) #9 and GCA			with the Statement of Deficiencies nor				
	,	ssistant) #1 was conducted on			does it constitute an admission that ar				
		n. The DON (director of			deficiency is accurate. Further,	,			
	nursing) was pres	sent during the observation. The			Greenhaven Health and Rehabilitation	1			
	observation revea	aled NA #9 applying Triamcilone			Center reserves the right to refute any	of			
		resident's back and sacral area			the deficiencies on this Statement of				
	_	dent #2 instructed NA #9 where			Deficiencies through Informal Dispute				
		ncilone ointment during ADL			Resolution, formal appeal procedure				
		Living). NA # 9 obtained the			and/or any other administrative or lega	al			
		ent from the closet in the			proceeding.				
	resident's room.				F755				
	An interview with	the treatment nurse was			F755				
		8/18 at 5:00pm. She reported			The plan of correcting the specific				
		for Triamcilone ointment but			deficiency				
		sed to let the treatment nurse			deficiency				
		at as he preferred it applied after			The position of Greenhaven Health ar	ıd			
		atment nurse revealed the nurse			Rehabilitation center regarding the	_			
	who had Residen	t #2 was to apply the			process that lead to this				
		ent and document on the			deficiency-allowing s nursing assistan	t to			
	treatment record	when she applied it. She			administer a prescription ointment- wa				
	reported because	Triamcilone ointment is a			knowledge deficit.				
	prescription medi-	cation, only a nurse not a NA							
	should be applyin	g the ointment.			On 7/13/18, resident #2's skin was				
					checked by the facility treatment nurse	غ ,			
		conducted on 6/19/18 at			with no negative findings.				
		OON. She reported any			The procedure for implementing the				
		cations including ointments are			acceptable plan of correction for the				
		nurse not a NA. She reported			specific deficiency cited				
	she is not sure why NA# 9 applied Triamcilone ointment to Resident #2's back.	•			On 7/12/19 the facility treatment are	•			
	Onlinent to Resid	CIII #2 S DACK.			On 7/13/18, the facility treatment nurs started an audit of all resident rooms t				
	An interview was	conducted on 6/20/18 at			ensure no prescription creams or	J			
		She reported she "does what			ointments are present. This audit will be	20			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		345132	B. WING			l '	22/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	L	80	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GREENHAVEN DRIVE REENSBORO, NC 27406	0011	22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755	reported she put the Resident #2's back "verported she is not suprescription ointment she did not know Triat prescription medicationly cared for Reside and had applied the coback with each bath the she was supposed. An interview was considerationally nurses can admit ointments. He reported all prescription ointments by the nurses not the An interview was considerationally the nurses not the pharmacist reports ointment is a steroidal strength than over the and creams. She reprince ased strength strength a prescription.	a me to do" when she hare on the resident. She Triamcilone ointment on where it itches." NA # 9 apposed to apply any is to residents. She reported amcilone ointment was a con. NA #9 stated she had not #2 for the past 2 weeks continuent to the resident's because Resident #2 told individual to apply the ointment. I ducted with the acting inster prescription and it is his expectation that ents were to be administered in nursing assistants. I ducted on 6/22/18 at a continuent with an increased a counter steroidal ointments orted because it is an eroid, it can only be obtained the reported not allowed to apply a	F	755	completed by 7/20/18. Any negative findings will be addressed immediately the auditor. On 7/13/18, the Administrator started a in-service for all nursing staff, including agency, on application of prescription creams and ointments. This in-service includes that nursing assistants cannot apply prescription creams or ointments In-service will be completed by 7/20/18 No staff will be allowed to work after 7/20/18 until in-service is completed. The in-service will be part of the orientation new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The administrator, director of nursing, social worker and/or staff development coordinator will audit 10 rooms weekly 12 weeks to ensure no prescription creams or ointments are present in the resident room. This audit will be documented on the F755 audit tool. The monthly QI committee will review the results of the F755 audit tool for 3 monitor identification of trends, actions taken and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrate and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QL committee for further recommendations and oversight.	n his for at atted y x he ths n, for or ad		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	COMPLETED		
		345132	B. WING		C 06/22/2018			
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	1 00.22.2010			
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F 755	Continued From page	e 50	F 7	The title of the person responsite implementing the acceptable place correction. The director of nursing is responsite implementing the acceptable place correction.	an of nsible for			
F 760 SS=D	CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT	f Significant Med Errors ure that its- nts are free of any significant is not met as evidenced	F 7		7/20/18			
	resident and staff into administer scheduled residents (Resident # Resident #9) that were medications on 6/19/Findings include: a. A review of Reside Administration Record to 5:00pm, the reside tablet for diabetes, Gofor chronic pain, and preventing blood clots given with no explanatine medications were Resident's medical redocumentation as to not given on 6/19/18 b. A review of Reside on 6/19/18 at 5:00pm 0.5mg tablet for anxiet for chronic pain were	nt #2's MAR (Medication d) revealed that on 6/19/18 nt's Metformin HCL 1000mg abapentin 300mg capsule Pradaxa 150mg capsule for s were documented as not ation on the MAR as to why not given. A review of cord showed no why the medications were		An acceptable plan of correction contain the following elements: The plan of correcting the sideficiency. The plan should addrocesses that lead to the deficiencited; The procedure for implement acceptable plan of correction for specific deficiency cited; The monitoring procedure that the plan of correction is effet that specific deficiency cited remote regulatory requirements; The title of the person respimplementing the acceptable placorrection. Greenhaven Health and Rehab Center acknowledges receipt of Statement of Deficiencies and pthis Plan of Correction to the exthe summary of findings is factorized.	specific dress the diency enting the r the do ensure ective and mains with the onsible for an of dilitation f the oroposes tent that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345132	B. WING _		06/22/2018	
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				801 GREENHAVEN DRIVE		
GREENHA	VEN HEALTH AND F	REHABILITATION CENTER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE	1
F 760	Continued From p	age 51	F 7	760		
	review of Residen no documentation receive her 5:00 p 6/19/18. c. A review of Resident on 6/19/18 at 5:00 60mg tablet for he not given with the "late start to med An interview was 9:14am with the Dreported that she Resident #2, Resident #2	given as late on med pass." A t #3's medical record revealed as to why the resident did not m Oxybutynin medication on ident #9's MAR revealed that typm the resident's Furosemide eart failure were documented as explanation on the MAR as pass." conducted on 6/21/18 at PON (director of nursing). She thought Nurse #7 assigned to dent #3, and Resident #9's hall ond shift had an emergency on 9/18 and left suddenly. The e does not know how long the t or if the nurse gave any evening. The DON reported she any medication doses were		correct and in order to mal compliance with applicable provisions of quality of car The Plan of Correction is swritten allegation of compl Greenhaven Heath and Recenter response to this St Deficiencies does not denwith the Statement of Deficiency is accurate. Fur Greenhaven Health and Recenter reserves the right to the deficiencies on this Statement of Deficiencies through Information Resolution, formal appeal and/or any other administr proceeding.	e rules and e of residents. submitted as a iance. ehabilitation atement of ote agreement ciencies nor ssion that any ther, lehabilitation o refute any of atement of mal Dispute procedure	
	who took over Number 1971. An interview was 6/21/18 at 9:30 am Data Set) dated 5 no cognitive impair told on the evening was not given her because the facility nurse." She stated medications that 6 Resident #3 stated doses of her medianxious and nervo An interview was 11:47 am with Medication 6/19/18 she	stated she was not aware of ree #7's cart and hall when she conducted with Resident #3 on a. Her quarterly MDS (Minimum /18/18 coded the resident with rment. She reported she was g of 6/19/18 that the reason she 5:00pm medications was by was "having trouble with the dishe was not given any evening until around 8:30pm. In the was not to miss any cations as she could get ous without her medications. Conducted on 6/21/18 at lication Aide #1. She reported we was assigned as a CNA assistant) on the 100 hall for		F760 The plan of correcting the deficiency The position of Greenhave Rehabilitation center regal process that lead to this do to administer medications was the staff failure to follo administration of medication of knowledge. Resident #2, #3, and #9 which by the Director of Nursing any adverse effects from remedication doses on 6/19/16 findings noted.	en Health and rding the eficiency-failed as ordered- ow policies for ons due to lack ere assessed on 7/13/18 for nissed	

OLIVILIY	OT OIL MEDIO, ILL G	· · · · · · · · · · · · · · · · · · ·					7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345132	B. WING			06/	22/2018
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		80	01 GREENHAVEN DRIVE		
				G	REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	400 hall at 7:20pm or medication aide becahad to leave suddenly back in an hour. The she was put on the m She reported she did 5:00pm medications had been documented on nurse never came bareported she did not missed medications and that is the nurse? An interview was con 11:50am with Nurse the nurse assigned to on 6/19/18 during the she came to work on emergency and had the arrived for work. Nursemember if she gave evening of 6/19/18. Sonly for one resident. leave, she gave her keto handle the medicaremember who she great to work that ever An interview with the conducted on 6/21/18 administrator reporter medications are to be	orted she was pulled to the 6/19/18 to serve as use she was told the nurse of and was supposed to be Medication Aide reported redication cart at 7:30pm. The not give the residents their operations are she was not sure if the been given as nothing had the MAR. She stated the color of the col	F	760	The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/13/18, a Quality assurance nurse audited the last 14 days of medication administration records to ensure medications were administered as ordered. No negative trends noted. All licensed nurses, including agency, be in-serviced by 7/20/18 by the direct of nursing(DON), on administration on medication administration, including medications must be administered as ordered. No licensed nurse will be allow to work after 7/20/18 until in-service is completed. This in-service will be part the orientation of new licensed nurses including agency. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The DON, treatment nurse, and or minimum data set nurse will audit 10 residents' medication administration records weekly x 12 weeks to ensure medications are given as ordered. This audit will be documented on F760 audit tool. The pharmacy consultant will review 25 of residents medication administration records during monthly pharmacy consultant reviews. The monthly QI committee will review the results of the F760 tool monthly for 3	will or wed of at teted by the state of the	
					The monthly QI committee will review t		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345132	B. WING				C 22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 01 GREENHAVEN DRIVE BREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	appropriate competer out the functions of the taking into considerate individual plans of call and diagnoses of the in accordance with the required at §483.70(e). This includes: §483.60(a)(1) A quality	If (2) loy sufficient staff with the noies and skills sets to carry the food and nutrition service, ion resident assessments, are and the number, acuity facility's resident population e facility assessment e) fied dietitian or other		760	taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing the acceptable plan of correction.	he the	7/20/18
	full-time, part-time, or qualified dietitian or o nutrition professional (i) Holds a bachelor's a regionally accredite	rition professional either on a consultant basis. A ther clinically qualified is one who-or higher degree granted by d college or university in the equivalent foreign degree)					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 801 GREENHAVEN DRIVE GREENSBORO, NC 27406		00,22,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 801	a program in nutrition an appropriate nation recognized for this program in nutrition an appropriate nation recognized for this procession of a regiprofessional. (iii) Is licensed or contrition professional services are perform provide for licensure will be deemed to have or she is recognized the Commission on successor organizate requirements of parathis section. (iv) For dietitians hir November 28, 2016 no later than 5 years as required by state §483.60(a)(2) If a que clinically qualified nuemployed full-time, the section of the complex of the comple	ne academic requirements of n or dietetics accredited by nal accreditation organization ourpose. It least 900 hours of practice under the astered dietitian or nutrition rtified as a dietitian or nutrition as a "registered dietitian" by Dietetic Registration or its ion, or meets the agraphs (a)(1)(i) and (ii) of red or contracted with prior to number these requirements after November 28, 2016 or law. Italified dietitian or other utrition professional is not the facility must designate a	F	301		
	nutrition services wh (i) For designations meets the following years after Novembe year after Novembe after November 28, (A) A certified dietar (B) A certified food s (C) Has similar nation	prior to November 28, 2016, requirements no later than 5 er 28, 2016, or no later than 1 r 28, 2016 for designations 2016, is: y manager; or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345132	B. WING_			C 06/22/2018		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 801	service management course study include management, from a higher learning; and (ii) In States that hav food service managemeets State requirer managers or dietary (iii) Receives frequer from a qualified dietit qualified nutrition pro This REQUIREMENT by: Based on observation facility failed to employ and nutrition services skills required to carr services. This was explanned menu for 2 of failure to provide food	s or higher degree in food for in hospitality, if the s food service or restaurant an accredited institution of e established standards for rs or dietary managers, nents for food service managers, and attly scheduled consultations ian or other clinically fessional. I is not met as evidenced ans and staff interviews the by a qualified director of food as with the competencies and by out food and nutrition by out food and nutrition by a qual observations, d that was palatable for 1 of and failure to understand the	F8	Greenhaven Health and Reha Center acknowledges receipt of Statement of Deficiencies and this Plan of Correction to the ethe summary of findings is fact correct and in order to maintai compliance with applicable rul provisions of quality of care of The Plan of Correction is submixitien allegation of compliance Greenhaven Heath and Rehat	of the proposes extent that tually n es and residents. nitted as a se.			
	staff interviews the far planned menu, failed substitutions and failed substitutions that we the planned menu ite 2 meal observations. F804 - Based on observationt and staff interviews the farmed menu ite 2 meal observations.	ervations, record review and acility failed to follow the to document menued to provide menure of similar nutritive value of ems. This was evident in 2 of		Center response to this Stater Deficiencies does not denote a with the Statement of Deficien does it constitute an admission deficiency is accurate. Further Greenhaven Health and Reha Center reserves the right to re the deficiencies on this Statem Deficiencies through Informal Resolution, formal appeal prod and/or any other administrative proceeding.	ment of agreement cies nor n that any ; bilitation fute any of nent of Dispute cedure			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING				C 22/2018	
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				80	01 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		G	GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)			(X5) COMPLETION DATE	
F 801	Continued From page	= 56	F	801				
	observations.							
					F801			
		#1 on 6/19/18 at 2:08 pm						
		ed a diet order for a clear			The plan of correcting the specific			
	T	serve chicken broth and s. She added she would			deficiency			
	serve the crackers if t				The position of Greenhaven Health and	1		
		ated she was not sure what			Rehabilitations center regarding the	-		
	-	served on a clear liquid diet.			process that led to the deficiency of fail	ing		
	T	verages that were identified			to employ a certified dietary manager v			
	on the resident 's meal card would be served				the competencies and skills to carry ou			
	such as tea, water an	such as tea, water and milk.			food and nutrition services was a dietal	ſy		
	A nhana intantiaw wit	h the Degistered Distition			manager who has not completed the			
		h the Registered Dietitian 16 pm revealed Dietary			certified dietary manager training.			
		s not a certified dietary			On 6/20/2018 the facility began employ	/ina		
	,	DM #1 was in the course to			a certified dietary manager.	9		
	_	tion. The RD added she			, 0			
		RD preceptor for DM #1 's						
		t recall having reviewed any			The procedure for implementing the			
		nts for the course yet. She			acceptable plan of correction for the			
	stated she had provid				specific deficiency cited			
	education to DM #1 a	nter the last annual hich resulted in multiple			On 6/19/18 the meal was observed by			
	·	The RD stated she was at			Certified Dietary Manager and the mea	ıl		
	the facility once a wee				was served according to the posted	•		
	,				menu, with substitutes available with			
	An interview with DM	#1 on 6/20/18 at 2:53 pm			comparable nutritional value. The meal	i		
		d her start date at the facility			was palatable (served at the correct			
	-	of 2017. She stated she			temperature).			
		ertified Dietary Managers			The comment distant			
		is after she was hired. DM			The current dietary manger was	aad		
		mpleted approximately half thought she would be			in-serviced on 6/20/18 by the District F Service Director related to following the			
		ourse by November 2018			established menu, nutritional value of	•		
		ike the certified dietary			substitutes, and correct temperatures of	of		
		stated the RD consultant			food. This in-service will be provided to			
	was her preceptor for				any new dietary manger.			
					The certified dietary manager was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	0-0102	1	STREET ADDRESS, CITY, STATE, ZIP C	:ODE	1 06/	22/2018	
TO AVIL OF T	NOVIDER OR COLL FIER			801 GREENHAVEN DRIVE	ODL			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER	GREENSBORO, NC 27406					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE	
F 801	3:30 pm revealed DM company. He confirm the facility was 6/28/1 requirements as a Ce	Administrator on 6/20/18 at I #1 worked for a contract ed her actual start date at I 8 and she had not meet the ertified Dietary Manager. Administrator on 6/21/18 at expected the DM to be the guidelines when	F	in-serviced on 7/18/18 by the Service Director on clear like in-service will be provided dietary manger. The current dietary manage Dietary Manager. The monitoring procedure the plan of correction is effective specific deficiency cited reand/or in compliance with the requirements. The payroll clerk and/or advalidate every two weeks from the plan of a certified of (CDM) in the kitchen. The be accomplished through resubmission and supporting credentials. The dietary manager, or accobserve 5 meals weekly x	quid diets. To any new er is a Certification ensure the ective and the regulator ministrator wor 3 months dietary mana validation weview of pay CDM	inis ied at nat cted ry will the ager rill yroll		
				ensure meals are provided temperature, meal served a planned menu, and appropriate substitutes are available. Toccur on random days, at times. This audit will be do the F803 audit tool. The dietary manager, or ac observe 5 meals weekly x ensure meals are provided temperature and food is paraudit will occur on random different meal times. This adocumented on the F804 at Contracted Dietician will remonthly during monthly factors.	at acceptable according to priate this audit will different measuremented or the at acceptable alatable. This days, at audit will be audit tool. view audit to	ole I al n will ole		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345132	B. WING				C /22/2018
NAME OF PR	ROVIDER OR SUPPLIER	1.0.02		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010
GREENHA	VEN HEALTH AND REH	ARII ITATION CENTER	801		01 GREENHAVEN DRIVE		
GKLLINIA	VENTICALITI AND INCI.	ABILITATION CENTER		G	REENSBORO, NC 27406		
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F 801 F 803 SS=E	CFR(s): 483.60(c)(1)- §483.60(c) Menus an Menus must-	t Nds/Prep in Adv/Followed -(7) d nutritional adequacy.		801	The monthly QI committee will review to status of the CDM position monthly for months for the need of continued monitoring and make recommendations. The administrator will present the finding and recommendations of the monthly Committee to the quarterly executive quality assurance (QA) committee for further recommendations and oversigh. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	3 s. ngs มี	7/20/18
	residents in accordant guidelines.; §483.60(c)(2) Be prep §483.60(c)(3) Be follo	owed;					
		e religious, cultural and esident population, as well as esidents and resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CDEENIL	VEN HEALTH AND REH	ARII ITATION CENTER		80	1 GREENHAVEN DRIVE			
GREENHA	WEN HEALTH AND KEN	ABILITATION CENTER		GI	REENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 803	Continued From page	e 59	F 8	303				
	§483.60(c)(6) Be revi							
		cally qualified nutrition						
	professional for nutrit							
		g in this paragraph should be						
		resident's right to make						
	personal dietary choic							
	by:	is not met as evidenced						
	,	ns, record review and staff			An acceptable plan of correction must			
		failed to follow the planned			contain the following elements:			
		nent menu substitutions and			The plan of correcting the specific			
	failed to provide men	u substitutions that were of			deficiency. The plan should address th			
	similar nutritive value	of the planned menu items.			processes that lead to the deficiency			
	This was evident in 2	of 2 meal observations.			cited;			
					The procedure for implementing the control of	ıe		
	Findings included:				acceptable plan of correction for the			
	An observation of the	supper meal on 6/18/18			specific deficiency cited;The monitoring procedure to ensure	ro		
		s were served pork chops,			that the plan of correction is effective a			
	white rice, lima beans				that specific deficiency cited remains	110		
	chocolate chip cookie				corrected and/or in compliance with the	e		
		wich and potato chips.			regulatory requirements;			
					The title of the person responsible	for		
	Review of the planne				implementing the acceptable plan of			
	_	018" week 2 provided by			correction.			
		planned supper meal for						
		caroni casserole, capri			Greenhaven Health and Rehabilitation			
		dinner roll and chilled pears.			Center acknowledges receipt of the			
	sandwich, potato chip	e meal was a grilled cheese			Statement of Deficiencies and propose this Plan of Correction to the extent that			
	Sandwich, polato chip	os and green peas.			the summary of findings is factually			
	An observation of the	lunch meal on 6/19/18			correct and in order to maintain			
		s were served diced chicken			compliance with applicable rules and			
		d sour sauce, white rice,			provisions of quality of care of resident	s.		
	broccoli, a dinner roll				The Plan of Correction is submitted as			
	alternate meal availal potato chips.	ble was a sandwich and			written allegation of compliance.			
	,				Greenhaven Heath and Rehabilitation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245420	D WING			С		
		345132	B. WING		•	06/22/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE			
GREENHA	VEN HEALTH AND REI	ABILITATION CENTER		801 GREENHAVEN DRIVE				
OKELINIA	WENTILALITI AND INCI	IABIENATION SENTER		GREENSBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 803	Continued From page 60		F 80	03				
	DM #1 revealed the 6/19/18 was fried fish squash with onions, fruit cup. The planner swedish meatballs, repeas. An interview with Corevealed DM #1 told make the diced chick sauce for the 6/19/18	2018" week 2 provided by planned lunch meal for h fillet, pinto beans, yellow cornbread and summer fresh d alternate meal was mashed potatoes and green ok #1 on 6/19/18 at 1:00 pm her yesterday afternoon to ken with sweet and sour 8 lunch meal because there		Center response to this State Deficiencies does not denote with the Statement of Deficie does it constitute an admissideficiency is accurate. Further Greenhaven Health and Reh Center reserves the right to respond to the deficiencies on this State Deficiencies through Informat Resolution, formal appeal presend/or any other administration proceeding.	e agreement incies nor on that any er, abilitation refute any of ment of I Dispute ocedure			
	was no ground beef available to make the beef macaroni casserole. She stated on average the menu on her shift was changed twice a week because the planned food items were not available. Cook #1 added this typically occurred the days before their food delivery came in, which was on Tuesdays. An interview with DM #1 on 6/19/18 at 2:00 pm revealed the lunch menu served today was changed due to a resident choice meal. She stated when menu substitutions were made they were supposed to be recorded on a menu substitution record and approved by the Registered Dietitian (RD). DM #1 explained she was not able to find the substitution log. She stated the menu substitution for the 6/18/18 supper meal was because she didn't have any spinach available and she changed the vegetable to lima beans. She acknowledged that lima beans were not a correct substitute for spinach. DM#1 stated she didn't realize the residents were served white rice for 2 consecutive meals. She added she was not sure why the additional substitutions were made and she had not documented the menu substitutions routinely.			F803 The plan of correcting the sp deficiency	ecific			
				The position of Greenhaven Rehabilitation center regarding process that lead to this defict to follow the planned menu a substitutions provided were routritional value as the plann	ng the ciency-failed and the food not of similar			
				On 6/21/18 the Certified Diet observed the lunch menu wh served according to menu, w substitutes of similar nutritive available. The procedure for implement acceptable plan of correction specific deficiency cited On 6/19/18, the District Food Director in-serviced the dieta on 1. Following the approved needed following the substitu	ich was rith value ting the for the Service ry manager I menu, 2. If			

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GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			REENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 803	pm revealed she had menu substitutions exchicken for pork in the recipe. She stated the not appropriate. The supposed to approve they were supposed to substitution log. An interview on 6/20/#4 revealed she didn' facility including the added her family had she kept in the nouris she would have the k to eat. A phone interview on facility Ombudsman reconcerns from the reschoices. She stated realternate meal was all chips or cheese puffs this information had be Administrator. An interview with the 8:45 am revealed the or grievances for the alternate meal sandwich with chips of the alternate meal sandwich with chips of the alternate meal sandwich with the sandwich with th	th the RD on 6/18/18 at 3:16 not been made aware of the keept for the change of the except for the except for the menu substitutions and the precorded on the menu substitutions and the precorded on the menu for the except for the following the following for the except	F	303	(ensuring nutritive value). This in-service will be provided to any new certified dietary manager. On 6/19/18, the District Food Service Director in-serviced the dietary staff on Following the approved menu, 2. If substitutions are needed the correct process, to ensure similar nutritive valuations in-service will be complete by 7/20/18. The in-service will be part of the orientation process for all newly hired dietary staff. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The dietary manager, or administrator observe 5 meals weekly x 12 weeks to ensure meals are provided according to approved menu. This audit will occur or random days, at different meal times. It audit will be documented on the F803 audit tool. The monthly QI committee will review the results of the F803 audit tool monthly from months for identification of trends, active taken, and to determine the need for and/or frequency of continued monitoriand make recommendations for monitoring for continued compliance. The monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	1. I.e. I.	
		RD on 6/21/18 at 9:37 am					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				C 22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804 SS=E	followed, including sealternate menus. She should be of similar noriginally planned me An interview on 6/21/Administrator reveale were served their me menu and if a menu swould be correct and Nutritive Value/Appea CFR(s): 483.60(d)(1) §483.60(d) Food and Each resident receive §483.60(d)(2) Food a attractive, and at a satemperature. This REQUIREMENT by: Based on observation and staff interviews the food that was palatable observations. Findings Included An observation of the conducted related to resident) regarding for Manager (DM) #1 too calibrated thermomet steam table. The tem	ervice of the planned added menu substitutions autritive value as the enu item. 18 at 10:01 am with the add he expected residents als according to the planned substitution was made it approved by the RD. ar, Palatable/Prefer Temp (2) drink es and the facility provides- arepared by methods that ue, flavor, and appearance; and drink that is palatable, afe and appetizing is not met as evidenced an, record review, resident the facility failed to provide	F8	304	An acceptable plan of correction. The administrator is responsible for mplementing the acceptable plan of correction. The administrator is responsible for mplementing the acceptable plan of correction. An acceptable plan of correction must contain the following elements: The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The monitoring procedure to ensure that the plan of correction is effective at that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;	e ne re nd	7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345132	B. WING			1	22/2018
NAME OF D	ROVIDER OR SUPPLIER	0.0.02	<u> </u>	٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010
NAME OF T	TOVIDER OR SOLT EIER						
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER			01 GREENHAVEN DRIVE		
				G	REENSBORO, NC 27406		
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F 804	Continued From page	e 63	F 804				
	mashed potatoes 199 degrees F, rice 205 degrees F, broccoli 200 degrees F, pureed broccoli 196 degrees F and pureed chicken 202 degrees F.				The title of the person responsible implementing the acceptable plan of correction.	for	
	A test tray was prepa main dining room with 12:00 pm. Six of the redelivered to residents and the other 4 resident the 100 hall. The term were taken by the DN thermometer at 12:20 were diced chicken 1 degrees F and rice 14 tasted warm. The broappearance and taste and sour chicken was small amount of sweet The chicken tasted gr. An interview with DM revealed she had charand sour chicken, rice the regular diets and were both getting the	ts on the 400 hall and then peratures of the test tray of the using a calibrated of pm. The temperatures 41 degrees F, broccoli 145 degrees F. The food accoli was light green, gray in the degree of the diced chicken with a set and sour sauce over it.			The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-faile to serve food that was palatable and at acceptable temperature- was knowledge deficit: the dietary manager at the time survey, and dietary staff were not able consistently verbalize correct food serve temperatures, placing food on the stead table appropriately to maintain temperatures, how to correctly cook vegetables, and that recipes must always be followed. On 6/21/18, the Certified Dietary Manages observed the lunch meal which was served according to menu, and the last tray was served to hall at time and resident reported his food was warm and	ed an ge of to ing m	
	An interview with Respm revealed she had broccoli for lunch. Shalternate meal (a san was always "nasty ar #1 added the broccol	sident #1 on 6/19/18 at 12:43 received a sandwich and e stated she choose the dwich) because the food and had no flavor". Resident i was very mushy and she			tasted good. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 6/19/18, the District Food Service Director in-serviced the dietary manage on 1. The process for placing food onto the steam table to maintain food)	
	wasn't going to eat it.				temperatures, and 2. Trays will be serv at the appropriate temperature. Any ne		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	L	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.			
				80	1 GREENHAVEN DRIVE				
GREENHA	WEN HEALTH AND REF	ABILITATION CENTER		GI	REENSBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 804	F 804 Continued From page 64 An interview with Resident #7 on 6/19/18 at 12:50		F 8	304	dietary manger will receive in-service				
					dietary manger will receive in-service during orientation. On 7/18/18, the District Food Service Director in-serviced the dietary manager on proper cooking of vegetables, and that recipes must be followed. Any new dietary manager will receive in-service during orientation. On 6/19/18, the District Food Service Director in-serviced the dietary staff on 1. The process for placing food on the steam table to maintain temperature, 2. The need temperatures for each food type, and 3. Trays must be served timely and according to the established meal schedule. This in-service will be complete by 7/20/18. The in-service will be part of the orientation process for all newly hired dietary staff. On 7/18/18, the dietary manager began an in-service with the dietary staff on proper cooking of vegetables, and that recipes must be followed. This in-service will be completed by 7/20/18. This in-service will be part of the orientation process for newly hired dietary staff member. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected				
					requirements The dietary manager, or administrator observe 5 meals weekly x 12 weeks to ensure meals are provided at acceptable temperature and food is palatable. This audit will occur on random days, at	ole			

PRINTED: 08/07/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345132	B. WING _				C 22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		801	EET ADDRESS, CITY, STATE, ZIP CODE GREENHAVEN DRIVE EENSBORO, NC 27406		
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F 842 SS=D	CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of except to the extent the to do so. §483.70(i) Medical re- §483.70(i)(1) In accor professional standard	dentifiable Information 483.70(i)(1)-(5) Int-identifiable information. Belease information that is to the public. Belease information that is of an agent only in Intract under which the agent disclose the information The facility itself is permitted			different meal times. This audit will be documented on the F804 audit tool. The monthly QI committee will review the results of the F804 audit tool monthly for months for identification of trends, action taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The administrator is responsible for implementing the acceptable plan of correction.	or 3 ons ng, the	7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345132	B. WING _			06/2	22/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406		, 00/-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE
F 842	all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research properations threat to he by and in compliance §483.70(i)(3) The fact record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under States	ented; e; and ganized ility must keep confidential ned in the resident's records, n or storage method of the release is- retheir resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, boses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when int in State law; or ars after a resident reaches	F8	342			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		345132	B. WING _			C 06/22/2018		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	DDE	VV:===================================		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE		
F 842	2 Continued From page 67 (i) Sufficient information to identify the resident;		F 8	342				
	(ii) A record of the re (iii) The comprehens provided; (iv) The results of an and resident review determinations cond (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as rathis REQUIREMEN' by: Based on record reviacility failed to main record that included health condition after This was evident for reviewed for dialysis. Findings included: Resident #6 was add 3/24/18 and diagnost disease with hemodical A care plan dated 3/2 he had end stage refor complications due Interventions included Wednesdays and Fridialysis center as incresident's care or tree resident upon return notify the physician of	sident's assessments; live plan of care and services by preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and blogy and other diagnostic equired under §483.50. T is not met as evidenced view and staff interviews the tain a complete medical assessment of a resident's receiving dialysis treatment. 1 of 1 resident that was (Resident #6). mitted to the facility on es included end stage renal alysis. 26/18 for Resident #6 stated hal disease and was at risk		An acceptable plan of correcontain the following element of the plan of correcting the deficiency. The plan should processes that lead to the decited; The procedure for implicance ptable plan of corrections pecific deficiency cited; The monitoring proceduthat the plan of correction is that specific deficiency cited corrected and/or in compliant regulatory requirements; The title of the person mimplementing the acceptable correction. Greenhaven Health and Recenter acknowledges receip Statement of Deficiencies a this Plan of Correction to the the summary of findings is forrect and in order to main	ents: the specific address the leficiency ementing the en for the ure to ensure effective and dremains ence with the responsible for e plan of habilitation pt of the end proposes e extent that factually			
	3/31/18 for Resident received dialysis. Th	#6 did not identify that he e MDS revealed the		compliance with applicable provisions of quality of care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		345132	B. WING _		06/22/	2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•			
				801 GREENHAVEN DRIVE				
GREENHA	VEN HEALTH AND I	REHABILITATION CENTER		GREENSBORO, NC 27406				
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)		
PREFIX TAG		IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	OMPLETION DATE		
F 842	Continued From p	page 68	F8	42				
	resident's cognition	on was intact.		The Plan of Correction is s	ubmitted as a			
				written allegation of complia	ance.			
		progress notes for Resident #6						
		n 3/24/18 through discharge on		Greenhaven Heath and Re				
		one entry dated 4/21/18 that		Center response to this Sta				
		sidents condition upon return		Deficiencies does not deno				
	from dialysis.			with the Statement of Defic				
	Daview of the Me	rah 2010. April 2010 and May		does it constitute an admis	•			
		rch 2018, April 2018 and May administration records (MARs)		deficiency is accurate. Furt Greenhaven Health and Re				
		ministration records (MARS) for		Center reserves the right to				
		aled there was no assessment		the deficiencies on this Sta	•			
		condition upon return from		Deficiencies through Inform				
	dialysis.			Resolution, formal appeal p				
				and/or any other administra				
	An interview on 6	/19/18 at 10:12 am with Nurse		proceeding.				
		vas the first shift (7:00 am to						
		or Resident #6. She stated the						
		dialysis on Mondays,		F842				
		Fridays and left the facility		-				
		. Nurse #5 added the nurse on		The plan of correcting the s	specific			
	him upon return fi	vould be responsible to assess		deficiency				
		om darysis.		The position of Greenhave	n Health and			
	An interview on 6	/19/18 at 3:29 pm with Nurse #6		Rehabilitation center regard				
		the second shift (3:00 pm to		process that lead to this de				
		for Resident #6. She stated the		to maintain a complete med	•			
		from dialysis around dinner time		including assessment of re-				
	and she would ch	eck his vital signs and for		dialysis- was knowledge de	eficit.			
		ng around his dialysis site.						
		she was supposed to document		Resident #6 was discharge				
		the electronic medical record		The procedure for impleme				
	but she would for	get to do this at times.		acceptable plan of correction specific deficiency cited	on for the			
	An interview on 6	/20/18 at 3:14 pm with the						
		g (DON) revealed residents that		On 7/13/18, the Director of	• ,			
		were supposed to have a		completed auditing the last	-			
		orm with their vital signs on it		dialysis residents progress				
	sent with them to	dialysis. She stated when the		ensure documentation of re	esident status			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X3) DATE SURVEY COMPLETED		
	345132	B. WING		C		
NAME OF PROVIDER OR CURRULER	343132	B: Willo _		06/22/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENHAVEN HEALTH AND REHABIL	ITATION CENTER		801 GREENHAVEN DRIVE			
			GREENSBORO, NC 27406			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 842 Continued From page 69		F 8	42			
resident returned from dia supposed to check their vonto be documented in the ercord. An interview on 6/21/18 and Administrator revealed hereceived dialysis were associated per their plans.	ital signs, bruit and thrill. mation was supposed electronic medical t 10:01 am with the expected residents that sessed and this was		is present post-dialysis. Negative finding were be addressed immediately by the DON by completing an assessment of resident status. All licensed nurses, including agency, be in-serviced by 7/20/18 by the Direct of Nursing on documentation of resides status post dialysis in the medical reconverse of No licensed nurse will be allowed to waster 7/20/18 until in-service is comple. This in-service will be part of the orientation of new licensed nurses including agency. The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correction in compliance with the regulator requirements. The DON, social worker, administrator and/or facility consultant will audit 10% dialysis residents' medical record weed 12 weeks to ensure post dialysis statut documented in the medical record. The audit will be documented on the F842 audit tool. The monthly QI committee will review results of the F842 audit tool monthly the months for identification of trends, actitaken, and to determine the need for and/or frequency of continued monitor and make recommendations for monitoring for continued compliance. administrator and/or DON will present findings and recommendations of the monthly QI committee to the quarterly executive QA committee to the quarterly executive QA committee for further recommendations and oversight.	will tor nt ord. ork ted. at hat cted ry , of kly x s is s the or 3 ons ing, The		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY MPLETED
		345132	B. WING _		0	C 6/22/2018
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	0/22/2010
GREENHA	VEN HEALTH AND REH	ARII ITATION CENTER		801 GREENHAVEN DRIVE		
OKLEMIA	WENTIEAETH AND KEN	ADIENATION SERVER		GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From page	e 70	F 8	The title of the person responsimplementing the acceptable correction. The Director of nursing is reimplementing the acceptable correction.	e plan of sponsible for	
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F8	67		7/20/18
	§483.75(g) Quality assessment and assurance.					
	§483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the Annual Recertification and complaint survey of 2/18/18. This was for 5 recited deficiencies which was originally cited during the annual recertification and complaint 2/18/18, were subsequently cited again during the complaint survey of 6/22/18. The repeat deficiencies were in the areas of F641 accuracy coding, F 656 Care Plan development, F657 Update care plans, F677 Activities of daily living, and F804 Palatable foods. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included:			An acceptable plan of correctontain the following elemer The plan of correcting the deficiency. The plan should processes that lead to the dicted; The procedure for imples acceptable plan of correction specific deficiency cited; The monitoring proceduthat the plan of correction is that specific deficiency cited corrected and/or in compliar regulatory requirements; The title of the person reimplementing the acceptable correction. Greenhaven Health and Rel Center acknowledges receipt Statement of Deficiencies and	he specific address the eficiency ementing the n for the ure to ensure effective and remains nee with the esponsible for e plan of the habilitation of of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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GREENHA	VEN HEALTH AND REF	ABILITATION CENTER		G	REENSBORO, NC 27406		
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F 867	67 Continued From page 71		F 8	367			
	This tag is cross refermed 1.F641 Based on reconstruction interviews, the facility the MDS (Minimum Interested Interviews and Interviews and Interviewed Interviewed Interviews and Interviewed Interviews the facility to address behaviors	cord review and staff (railed to accurately code, Data Set) on 1 out 3 (railed to accurately code, Data Set) on 1 out 3 (railed to accurately code, Data Set) on 1 out 3 (railed to code Date Set (MDS) for 1 Of For dialysis (Resident #6). Ition and complaint survey If acility was cited for F 641 Dy code the MDS (Minimum If 5 residents (Resident #36 De include special treatments			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 resident The Plan of Correction is submitted as written allegation of compliance. Greenhaven Heath and Rehabilitation Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor does it constitute an admission that an deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	s. a nt y	
	#6. This was evident for 1 of 1 resident that was reviewed for dialysis. During the recertification and complaint survey dated 2/18/2018 the facility was cited for F 656 for failed to develop and implement a comprehensive care plan on 1 out of 1 resident (resident #36) who was on dialysis to monitor the graft access site and remove the dressing to site nightly. 3. F 657 Based on record review, observations and staff interviews the facility failed to update the care plan on 1 out of 3 residents (resident #7) reviewed for pressure ulcers. During the recertification and complaint survey dated 2/18/2018 the facility was cited for F 657			F 867 QAPI Committee The plan of correcting the specific deficiency The position of Greenhaven Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI by the Administrator. No policies were amended, re-training to current procedures were implemented.			

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345132 B. WING		C 06/22/2018				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE			
BILITATION CENTER		GI	REENSBORO, NC 27406			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		REFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
867 Continued From page 72		867				
t transferred for 1 of 5			The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 7/2/18, the facility (Quality Assurantial)	ce)		
residents reviewed for Activities of Daily Living (Resident #20). 4. F677 Based on observations, record review, and staff and resident interviews, the facility failed to provide incontinence care for 2 out of 4 residents (Resident #1 and Resident #2) reviewed for ADLs (Activities of Daily Living). During the recertification and complaint survey dated 2/18/2018 the facility was cited F 677 for failed to provide incontinence care to 1 of 5 resident's reviewed for activities of daily living (Resident #20). 2/14/2018 5. F 804 Based on observation, record review, resident and staff interviews the facility failed to provide food that was palatable for 1 of 2 meal observation. During the recertification and complaint survey dated 2/18/2018 the facility was cited for F804 for failed to serve food that was palatable and at temperatures acceptable to the residents that resided in the facility. This was evident in 1 of 1 meal observed. During an interview with the Administrator on June 22, 2018 at 10:15am. The administrator reported it was his expectation that the facility continue to change the Quality Improvement system to prevent recurrent issues.			QA Committee held a meeting to review the purpose and function of the QA committee and review on-going compliance issues. This meeting was conducted by the Administrator. Committee Members trained include: T director of nursing (DON), maintenance director, Social Worker, Activity Director Therapy manager, Accounts Receivable Director, Payroll Manager, Admissions Director, Medical Director, Certified Dietary Manager, Treatment Nurse, an housekeeping supervisor. These committee members will attend QA Committee Meetings on an ongoing bate and will assign additional team member as appropriate. On 7/13/18, the vice president (VP) of Operations in-serviced the administrator related to the appropriate functioning of the QA Committee to include identify issues an correct repeat deficiencies related to F641, F656, F657, F677, and F804. On 7/13/18, the administrator in-service the department heads related to the appropriate functioning of the QA Committee and the purpose of the	The eport, le dississers		
	BILITATION CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 72 resident's care plan to at transferred for 1 of 5 Activities of Daily Living ervations, record review, interviews, the facility failed ac care for 2 out of 4 and Resident #2) tivities of Daily Living). on and complaint survey icility was cited F 677 for inence care to 1 of 5 activities of daily living 018 servation, record review, views the facility failed to palatable for 1 of 2 meal on and complaint survey icility was cited for F804 for at was palatable and at on and complaints that This was evident in 1 of 1 the Administrator on fam. The administrator inectation that the facility acquality Improvement	A BUILDI 345132 B. WING BILITATION CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 72 Tesident's care plan to at transferred for 1 of 5 Activities of Daily Living Pervations, record review, interviews, the facility failed are care for 2 out of 4 and Resident #2) tivities of Daily Living). On and complaint survey acility was cited F 677 for inence care to 1 of 5 activities of daily living 018 Pervation, record review, views the facility failed to palatable for 1 of 2 meal On and complaint survey acility was cited for F804 for at was palatable and at one to the residents that This was evident in 1 of 1 A BUILDI B. WING B. WING ID PREFI TAG TAG F 3 TO TAG TAG	BILITATION CENTER BILITATION CENTER BILITATION CENTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TO president's care plan to the transferred for 1 of 5 Activities of Daily Living Envations, record review, interviews, the facility failed are care for 2 out of 4 and Resident #2) tivities of Daily Living). On and complaint survey interviews of daily living on and complaint su	BILITATION CENTER BROOD BRO	A BUILDING 345132 BILITATION CENTER BILITATION CENTER BELITATION CENTER BILITATION CENTER BELITATION CENTER BILITATION CENTER BOROWSERS PERENBORO, NC 27406 The provolute FALIVION SCHAME CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRACED TO NEHOULD BE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345132 B.		B. WING _	B. WING		C 06/22/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 00//	LL/LUIU	
				801 GREEN	HAVEN DRIVE			
GREENHA	VEN HEALTH AND REH	ABILITATION CENTER		GREENSB	ORO, NC 27406			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 867	Continued From page	÷73	F8	As of 7 facility other a QA review Medica council concert and review minimum Quality Improvation a minimum develotion plans of concert identifity F657, The mathematical specific and/or required the exception of the exception o	7/13/18, after the in-service, the QA Committee will begin identificate of quality concern through view process, for example: reviews tools, review of work orders, of Point Click Care (Electronic al Record), review of resident ill minutes, review of resident rologs, review of pharmacy repoview of regional facility consultatementations. acility QA Committee will meet at um of monthly and Executive y Assurance Performance were present (QAPI) committee meeting mum of quarterly to identify issued to quality assessment and ance activities as needed and will perform an enditor of action for identified facility rms. Active action has been taken for the field concerns related to F641, F6 F677, and F804. Conitoring procedure to ensure the enditor of correction is effective and the concerns related to F641, F6 ferometric in compliance with the regulator ements. Executive QAPI committee will use to meet at a minimum of early, and QA committee monthly ght by a corporate staff member.	the w of orts, ort		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345132	B. WING		C 06/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 GREENHAVEN DRIVE GREENSBORO, NC 27406	00/22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 867	Training for Feeding A		F 86	The Executive QAPI Committee, include the Medical Director, will review quarter compiled QA report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan correction.	rly / e e c
	the facility as a paid findividual has succes State-approved traini assistants, as specific This REQUIREMENT by: Based on staff intervifacility failed to ensur assistants completed	e any individual working in eeding assistant unless that sfully completed a ng program for feeding ed in §483.160. This is not met as evidenced liews and record review, the e that paid feeding the state approved training esting residents with feeding		An acceptable plan of correction must contain the following elements: The plan of correcting the specific deficiency. The plan should address th processes that lead to the deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345132	B. WING _			C 6/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	•	0/22/2010	
				801 GREENHAVEN DRIVE			
GREENHA	VEN HEALTH AND REF	HABILITATION CENTER		GREENSBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 948	Continued From pag	ne 75	F 9	48			
	The findings included			cited; • The procedure for impler acceptable plan of correction	-		
		el file of GCA (Geriatric Care		specific deficiency cited;			
	•	led that the GCA was hired had not completed the state		The monitoring procedur that the plan of correction is a			
		nad not completed the state ogram for paid feeding		that the plan of correction is e that specific deficiency cited r			
	assistants when she			corrected and/or in compliance			
	assistants when she	was filled		regulatory requirements;	oc with the		
	An interview was cor	nducted on 6/19/18 at		The title of the person re	sponsible for		
		#1. She reported her duties		implementing the acceptable	•		
	included making beds, filling up ice pitchers,			correction.			
	taking residents to the dining room, and assisting						
	_	nts. She reported she was		Greenhaven Health and Reha	abilitation		
	hired in February 20	18 and at the time of her hire		Center acknowledges receipt	of the		
	she had not complet	ed the state approved		Statement of Deficiencies and	d proposes		
	training for assisting	residents with feeding at		this Plan of Correction to the	extent that		
		he when she was hired she		the summary of findings is fac	ctually		
		ome a nursing assistant and		correct and in order to mainta			
	•	nce she would be taking the		compliance with applicable ru			
		chool she did not need to take		provisions of quality of care o			
		cility. She reported she		The Plan of Correction is sub			
	•	ents within the first 2 weeks at the facility. She stated		written allegation of complian	ce.		
		e the feeding of resident		Greenhaven Heath and Reha	abilitation		
	training in school unt	til May 2018 and has not		Center response to this State	ment of		
	provided the facility a	a copy of the completed		Deficiencies does not denote	agreement		
	training.			with the Statement of Deficier	ncies nor		
				does it constitute an admission	•		
		nducted with the DON		deficiency is accurate. Further			
		on 6/19/18 at 1:30 pm. She		Greenhaven Health and Reha			
	· · · · · · · · · · · · · · · · · · ·	t aware if GCA #1 had		Center reserves the right to re	•		
		approved training for paid		the deficiencies on this State			
	feeding assistants.			Deficiencies through Informal	•		
	An intensionaries	aduated on 6/24/49 at 44:55		Resolution, formal appeal pro			
		nducted on 6/21/18 at 11:55		and/or any other administrative	ve or iegai		
	am with the acting ac			proceeding.			
	· ·	sultant. They both reported ectation that all staff who were					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345132	B. WING			C 06/22/2018	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENHA	VEN HEALTH AND RE	HABILITATION CENTER		801 GREENHAVEN DRIVE			
				GREENSBORO, NC 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 948 Continued From page 76 hired to assist with feeding residents completed the state approved training for paid feeding assistants prior to feeding any residents. The		F 94	F948 The plan of correcting the speci	fic			
	corporate nurse cor responsibility of the	nsultant stated it is the administrator and the DON to		deficiency			
	responsibility of the administrator and the DON to assure newly hired GCAs completed the state training.			The position of Greenhaven Hea Rehabilitation center regarding a process that lead to this deficient to ensure that paid feeding assist completed the state approved tr program- was knowledge deficit Administrative nurses not educate GCA staff having to pass the state approved training program prior residents On 6/19/18 the Administrator sut the GCA #1 until verification contrained to work on 6/22/18. The procedure for implementing	the ncy-failed stants raining t. ated on the ate to feeding aspended mpletion of gram was d the state 1/21/18 and	g f	
				acceptable plan of correction for specific deficiency cited On 6/19/18, the Administrator saudit of all GCAs on staff to ens state approved training program feeding assistants has been cor Those who have not completed will be contacted and will not be assist in the meal process. On 7/2/18, the Administrator stain-service for all nursing staff, in agency, on the role of GCAs in assistance and that the state ap training program must be complete assistance being provided. T	started an sure the n for paid mpleted. course e allowed to arted an including meal oproved leted prior		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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345132 B.			B. WING _	NG			06/22/2018	
NAME OF PROVIDE	R OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
GREENHAVEN I	IFALTH AND REH	ABILITATION CENTER		801	1 GREENHAVEN DRIVE			
OKEE!!!!!!		ASILIPATION CLATER		GF	REENSBORO, NC 27406			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 948 Cont	inued From page	÷77	FS	948	in-service will be part of the orientation new nursing staff, including agency. The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements The director of nursing, treatment nurse social worker, and/or administrator will observe 5 meals weekly x 12 weeks to ensure any GCAs providing assistance have completed the state approved training course. This audit will occur on random days, at different meal times. It audit will be documented on the F948 audit tool The monthly QI committee will review the results of the F948 audit tool for 3 mon for identification of trends, actions take and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring continued compliance. The administrational and/or DON will present the findings are recommendations of the monthly QI committee to the quarterly executive QI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The director of nursing is responsible for implementing the acceptable plan of correction.	at nat nat ted y e, This he ths n, for or nd A		