DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346132	A. BUILDING _____ B. WING _____	C 05/24/2012

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

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, facility failed to obtain/provide psychiatric services as ordered by the physician for 1 of 3 sampled residents with behaviors. (Resident #28). Findings included: Resident #28 was admitted to the facility on 01/20/12 with diagnoses which included: psychosis; bipolar disorder with references to schizophrenia; vascular dementia with delirium; late effects of cerebravascular accident; anxiety state; insomnia; muscle weakness; diabetes mellitus; dysarthria; dysphagia; abnormal posture; and, multiple contractures. The Admission Assessment (1/27/12) indicated the resident was cognitively intact, but had verbal and wandering behaviors. The most recent Assessment (4/22/12) indicated the resident's cognition was severely impaired, but with no behaviors. Review of the Care Plan initiated 1/20/12 and updated 4/12/12, revealed the resident received	F 309	Greenhaven Health & Rehab acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. The facility ensures that services provide or arranged by the facility meet professional standards of quality and that physicians' orders as followed 1. Resident # 28 obtain consent form and was seen by Paradigm Health Services and results had no negative outcome 2. Physician order reconciliation of identified resident(s) A 100% of all current Physician orders to ensure that physician psychiatric services referrals have been carried through to completion. 3. In-service social worker and admission director on procedure for physician psychiatric service referrals. 4. 5 times a week review of new orders (pink slips) and verification that new orders new physician's psychiatric services referrals orders are followed through properly	5-25-12 5-31-12 5-31-12 5-25-12 STARTED 5-25-12 ONGOING

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Pittman — TITLE: Administrator — (X6) DATE: 6-7-12

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

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F 309	Continued From page 2	F 309		

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

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

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

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

During an interview on 5/23/12 at 4:30pm, the DON (Director of Nursing) revealed that she was informed by the facility's SW that the consent form for psychiatric services was faxed to Resident #28's Guardian on 4/27/12, but had not received a response. The DON revealed her

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F 309	Continued From page 3 expectation was that the SW would have followed up with a certified letter to the resident's Guardian within two business days. Also, to ensure continuity of care, the SW should have informed her (DON) of any works in progress when she had the family emergency. On 5/24/12 at 10:00am, Resident #28 was observed in his wheelchair in the dining room calmly drinking a cup coffee at table, alone. During an interview on 5/24/12 at 10:14am, NA#1 (Nursing Assistant) revealed Resident #28 would often become resistive and combative when staff attempted to shave, or check him for incontinence (the resident hated to lie down during first shift, even when his adult diaper needed changing). NA#1 stated she observed the resident kick another staff; slap a staff nurse in the face when she was giving him his medication; calling out profanities and slanderous names to staff; and, using profanities to other residents when he would accidentally run into them with his wheelchair. These episodes usually only lasted approximately five minutes, then the resident would forget and requests a cup of coffee which he really enjoyed. NA#1 revealed that whenever a resident was verbally or physically abusive, the nursing assistants report the behavior to a nurse and record it on the POC (Point of Care) Behavior Record. During an interview on 5/24/12 at 10:41am, the DON stated that when residents had behaviors that were deemed socially inappropriate, the resident would be referred to the physician, who would conduct an assessment then refer, accordingly. A copy of the physician's order would	F 309		

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F 309	Continued From page 4 be given to the SW and if the resident had a completed Consent form in his/her clinical record, then the SW would complete a "Referral Fax" form to the Intake department of the Psychiatric Services. If there was no completed consent form in the resident's record, then SW was to contact and obtain written consent from the resident's Responsible Party or Guardian.	F 309		

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted: 1) The corridor door to the Employee Break room was missing the latching hardware and the door was split in the center and not in good condition. 42 CFR 483.70(a)	K 018	Greenhaven Health & Rehabilitation acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of finding is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. This plan of correction is submitted as a written allegation of compliance. K018 NFPA 101 Life Safety Code Standard 1) Facility purchased and will install latching type hardware. Employee break room door has been ordered. The break room door and latching hardware to be installed ASAP when door arrives 2) The maintenance supervisor will do a walk through of the building to identify any others and remove upon finding and correct. 3) The maintenance supervisor will monitor via facility weekly inspections of doors during regular rounds for three months. 4) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections	7-2-12 6-14-12 7-2-12
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Patterson — TITLE: Administrator — (X6) DATE: 6-25-12

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K 025	Continued From page 1 accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted: 1) On the 200 hall the smoke wall above the corridor door has holes and penetrations that were not properly sealed. There are also pipe penetrations in the smoke wall equipped with foam insulation that was cut back and sealed around pipe penetration on all halls. 42 CFR 483.70(a)	K 025	K025 NFPA 101 Life Safe Safety Code Standard 1) Corrective action has been accomplished for the alleged deficient practice by removal of the foam sealant and Application of an approve fire rated sealant in the holes in the ceiling located on the 200 hall. 2) The maintenance supervisor will visually check all of the attic area to identify any other areas of concern and repair these areas as identify with fire barrier sealant. 3) The maintenance supervisor will inspect monthly for the next three months for proper sealing of any holes with fire barrier sealant. 4) The maintenance supervisor will provide the results of the inspection to the Executive Committee for review on a monthly basic for three months to identify any trends and or patterns corrective to determine the durations of the inspections	6-12-12 6-12-12 7-2-12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K029 NFPA 101 Life Safety Code Standard 1) a. The maintenance supervisor installed a self-closer on the kitchen corridor door. 2) The maintenance supervisor inspected all doors that required a closer to ensure they are fully operational and in place.	6-12-12 6-12-12

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K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted: 1) The corridor door to the kitchen was not self-closing. 42 CFR 483.70(a)	K 029	3) The maintenance supervisor will inspect doors monthly for three months to ensure all closing devices are in place and working proper during via facility inspections. 4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections	7-2-12
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted: 1) Based upon observation at the time of the survey the kitchen was experiencing a sever negative pressure. One of two exhaust fans for the hood were not operational and the make-up air hood for the kitchen was not operational at the time of the survey. NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air. - " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa). " 42 CFR 483.70(a)	K 069	K069 101 life Safety Code Standard 1. The facility maintenance supervisor restored power to the exhaust fan for the hood in the kitchen. The facility ordered and will replace the make -up -air hood for the kitchen ASAP upon arrival. 2. The maintenance supervisor will inspect the exhaust fans for the hood in the kitchen to ensure proper function. The maintenance supervisor will inspect the new make up-air hood for proper function 3.) The maintenance supervisor will inspect the exhaust fans for the hood, and the make-up-air hood in the kitchen 5 days a week for one month for proper function.	6-7-12 6-26-12 6-26-12 7-2-12

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	Continue 0169			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD Is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted: 1) The generator annunciator panel was missing in the facility. The generator annunciator panel was removed when the area was remolded and not replaced. 42 CFR 483.70(a)	K 144	4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections K146 NFPA 101 Life Safety Code Standard 1.) The exhaust fan in the laundry room was replaced. 2.) The maintenance supervisor will inspected the exhaust fan in the laundry room to ensure it is operational. 3.) The maintenance supervisor will inspect the exhaust fan in the laundry room 5 days a week for one month for proper function.	6-7-12 7-2-12
K 146 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1 This STANDARD Is not met as evidenced by: Based on observation on Wednesday 6/6/12 at approximately 10:00 AM onward the following was noted:	K 146	4.) The maintenance supervisor will provide the results of the inspections to results of the inspections to the Executive Committee for review to identify any trends and or patterns corrective to determine the durations of the inspections	

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K 146	Continued From page 4 1) The exhaust fan in the laundry room was not operational at the time of the survey. 2) The exhaust hood and make-up air fan for the kitchen, and the dishmachine exhaust hood did not have intermediate switches to turn the unit on and off. Staff turned the units on and off at the breaker panel. 42 CFR 483.70(a)	K 146	K146 NFPA 101 Life Safety Code Standard 1.) Intermediated switches to the Exhaust hood and make-up-air fan for the kitchen, and the dish machine were installed to turn units on and off separated from the breaker panel. 2.) The maintenance supervisor will inspect the intermediate switches to the exhaust hood and make up air fan and dish machine exhaust hood in the kitchen to ensure it is operational and working proper. 3.) The maintenance supervisor will inspect the intermediated switches to the exhaust hood, make up air fan and dish machine exhaust fan in the kitchen 5 days a week for one month for proper function. 4.) The maintenance supervisor will provide the results of the inspections to the Executive Committee for review to identify any trends and or patterns to determine the durations of the inspections	6-16-12 7-2-12