STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 05/18/2017

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

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F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to turn and reposition and to assist with hydration for 1 of 5 sampled residents reviewed for activities of daily living (ADL) care, Resident #16. Findings included: Resident #16 was admitted to the facility on 11/28/16 with diagnoses which included: cerebral palsy, contractures, and urinary tract infection. The review of the quarterly minimum data set (MDS) dated 3/8/17 indicated Resident #16 was cognitively intact, required extensive assistance with bed mobility, transfers, and hygiene, was totally dependent on two staff for bathing, and the resident had range of motion impairment on both of her upper and lower extremities. The last Care Plan Review completed on 3/16/17 revealed Resident #16 was at risk for skin breakdown, falls, and required assistance with activities of daily living (ADLs) related to impaired mobility, muscle weakness, and status post catheter placement. Interventions included: assisting the resident during transfer and mobility, encouraging the resident to change positions (out of bed daily, boosting resident up while in the wheelchair), and limiting the amount of time the head of the bed was elevated.	F 312	On 05/18/17, the nursing assistant (NA) turned and repositioned Resident #16. On 05/18/17, the NA assisted Resident #16 with hydration. On 6/14/17, a 100% audit of the electronic health record (POC) of all residents, to include Resident #16, was initiated by the director of nursing (DON) to ensure all residents requiring staff assistance were turned and repositioned and assisted with hydration. This audit was completed on 6/15/17. The audit revealed no identified areas of concerns requiring physician notification. Any areas of documentation concerns were immediately addressed by the DON. On 06/05/17, the DON initiated a 100% in-service for all NAs on their responsibility to turn and reposition and to assist residents with hydration as outlined in the major duties and responsibilities of the Nursing Assistant I job description. The in-service was completed on 06/12/17 by the DON. No NA is allowed to work until the in-service is completed. All newly hired NAs, to include agency NAs, will be in-serviced during orientation by the Staff Facilitator (SF) on the responsibility to turn and reposition and to	6/26/17

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

Electronically Signed | 06/12/2017

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F 312	Continued From page 1 During an interview on 5/18/17 at 8:46 a.m., nursing assistant (NA#1) revealed Resident #16 was usually out of bed and dressed between 7:30 a.m. and 9:00 a.m. NA#1 stated that the resident required total assistance with bathing and dressing; and the assistance of two staff for transferring to and from her motorized wheelchair. During an interview on 5/18/17 at 8:59 a.m., Resident #16 revealed that on the night of 5/13/17 she initiated her call light because she needed to be repositioned in her bed and she wanted a drink of water. Both of the resident's hands were noted to be contracted. The resident stated that her call light remained unanswered from 9:00 p.m. to 11:00 p.m. Resident #16 stated that her call light request was finally answered by a nursing assistant (no name given) at the beginning of third shift (11:00 p.m.) The resident stated that she needed her care because she had to be up early the next morning at 7:00 a.m. for church services and was uncomfortable for most of the night, receiving very little sleep. During an interview on 5/18/17 at 9:14 a.m., NA#2 indicated Resident #16 was alert and oriented, and was able to verbalize her needs. NA#2 revealed the resident required the assistance of two staff for transfers and repositioning. Review of the ADL sheet revealed "NA #4" provided ADL care (personal hygiene and dressing) to Resident #16 at approximately 9:20 p.m. on 5/13/17. However, a review of the Daily Assignment Sheet for 5/13/17 revealed "NA #4" was not on duty during first, second, or third shift.	F 312	assist residents with hydration. On 06/12/17, the DON, SF, Quality Improvement (QI) nurse, Minimum Data Set (MDS) nurse and/ or the treatment nurse began monitoring documentation in the electronic medical records (POC) for hydration and turning and repositioning for 50% of residents, to include Resident #16 for 4 weeks, 25% of residents for 4 weeks, and 10% of residents for 4 weeks to ensure turning and repositioning and hydration was received utilizing the NA Assignment Tool for all shifts including weekends. Any areas of concern noted will be immediately addressed by the DON, SF, QI nurse, MDS nurse, and/or treatment nurse. The administrator will review and initial the NA Assignment Tool weekly for 12 weeks for completion and to ensure all areas of concern are addressed. The administrator and/or DON will present the findings of the NA Assignment Tool audits to the QI committee monthly for 3 months and to the Quality Assessment and Assurance committee for one quarter and address any issues, concerns, and/or make additional recommendations for monitoring and continued compliance. Identified areas of noncompliance may result in extended monitoring.	

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F 312	Continued From page 2 The Assignment Sheet indicated NA#3's resident assignment included Resident #16 on 5/13/17 from 7:00 a.m. to 11:00 p.m. On 5/18/17 at 5:08 p.m. an unsuccessful attempt was made to conduct a telephone interview with the nurse who was on duty on Resident #16's hall on 5/13/17 during the 3:00 p.m. to 11:00 p.m. shift. During an interview accompanied by the DON (Director of Nursing) on 5/18/17 at 6:58 p.m., NA#3 confirmed she worked on 5/13/17 from 7:00 a.m. to 9:30 p.m. on the 400 residents' hall. NA#3 revealed she was the only nursing assistant assigned to the 400 hall (location of Resident #16's room). NA#3 stated that when she documented ADL care into the computer she initialed another NA's initials instead of using her own due to a problem with the computer system. NA#3 acknowledged that she reported to the Nurse that she was leaving the facility for the night. NA#3 said she did not know who provided ADL care to the residents on the 400 hall from 9:30 p.m. to 11:00 p.m. The DON was unable to confirm that "NA #4" was an employee of the facility, and the facility was unable to provide information that showed there was nursing assistant coverage for the 400 hall after NA #3 left at 9:30 p.m. on 5/13/17.	F 312		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 353		6/26/17

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F 353	Continued From page 3	F 353		

provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to

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F 353	Continued From page 4 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff to provide dressing changes for 2 of 3 residents reviewed for pressure ulcers and failed to provide assistance with Activities of Daily Living (ADL) for 1 of 5 residents reviewed for ADL care. Resident #8, Resident #35 and Resident #16. This tag is cross referenced to tags F 314 and F 312. Findings included: 1. F 314: Based on record review and staff interviews, the facility failed to perform dressing changes as ordered to prevent pressure ulcers for 2 of 3 resident reviewed for wound care (Resident #8, Resident #35). 2. F312: Based on record reviews, resident and staff interviews, the facility failed to turn and reposition and to assist with hydration for 1 of 5 sampled residents reviewed for activities of daily living (ADL) care, Resident #16. During an interview on 5/18/17 at 6:17 p.m., the Director of Nursing (DON) revealed the facility had a total of seven floor nurses (2-registered nurses and 5-licensed practical nurses) and also routinely covered the remaining shifts with 5-6 nurse agency nurses. An interview was conducted on 5/18/17 at 7:10 PM with the facility's Administrator regarding the	F 353	Greenhaven Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greenhaven Health and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 5/17/17, the Treatment Nurse administered all treatments as ordered by the physician to 100% residents with pressure ulcers to include Resident #8 and Resident #35. On 06/06/17 the Physician was notified by Hall Nurse of all missing documentation of pressure ulcer treatments 05/01/17-05/31/17 to include	

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F 353	Continued From page 5 corrective action taken for the provision of sufficient nursing staff to meet the residents' care needs. During the interview, the Administrator reported the facility was currently utilizing, "a lot of Agency (temporary) staff" to meet its staffing requirements. The Administrator stated the residents' care was monitored on a daily basis and she indicated no concerns had been identified to date.	F 353	Resident #8 and Resident #35. No new orders were received by the physician for all affected residents to include Resident #8 and Resident #35. On 05/18/17, the nursing assistant (NA) turned and repositioned Resident #16. On 05/18/17, the NA assisted Resident #16 with hydration. On 06/05/17 the Regional Vice President trained the administrator on the need for sufficient staff to provide the needs of the residents. On 06/05/2017 the Administrator notified the Regional Vice President (RVP) of current facility staffing needs to provide the needs of the residents. On 06/05/2017 the administrator trained the DON and staff scheduler on the need for sufficient staff to provide the needs of the residents. On 06/06/17 the administrator reviewed all staffing schedules for the past 30 days to identify areas of concern with staffing patterns. The results revealed that at times adequate staff was not supplied to provide the needs of the residents. On 06/06/2017, the Administrator and Director of Nursing (DON) reviewed the current schedule of staffing to ensure sufficient numbers of staff to provide the need of the residents for the next 3 days. To ensure the problem of insufficient staffing does not reoccur the facility has: 1) created a quality action team committee on staffing/recruitment/retention, 2) instituted a NA/nurse mentorship program for all new hires, 3) expanded recruiting efforts	

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F 353	Continued From page 6	F 353	for nursing staff by extending the facility advertising range to include adjacent metropolitan areas, 4) utilized vendor resources to send email blasts about job openings to nurses located within the facility□s city, and 5) initiated the use of an revised daily staff assignment sheet which identifies how many staff are working and the division of assignments. On 06/12/17, the administrator and DON initiated the Staffing Assignment Tool to ensure appropriate staffing and identify staffing needs on all shifts to include weekends. The goal of the Staffing Assignment Tool is to ensure sufficient staff are listed on the daily assignment sheet for the number of residents and ensure the staff working are given appropriate assignments to meet the needs of the residents, to include administration of all pressure ulcer treatments as ordered by the physician, turning and repositioning and hydration. The DON will utilize the Staffing Assignment Tool 5 times weekly for 4 weeks, twice weekly for 4 weeks, and weekly x 4 weeks. Any identified areas of concerns will be addressed immediately by the DON. Any identified areas of concerns will be addressed immediately by the Administrator or DON. The Regional Vice President (RVP) will review and initial the audit tool weekly x 3 months for completion and to ensure all areas of concern have been addressed. Beginning 06/12/2017, the Administrator will monitor the staffing assignment tool to ensure proper completion and to ensure	

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F 353	Continued From page 7	F 353	all areas of concern have been addressed. The Administrator will and/ or DON will meet with the Quality Improvement Committee monthly for 3 months and with the Quality Assessment and Assurance Committee quarterly for 1 quarter to review the results of the staffing assignment tool and address any issues, concerns, and/or make additional recommendations for monitoring and continued compliance. Identified areas of noncompliance may result in extended monitoring.	