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	345132	A. BUILDING ______ B. WING ______	C 04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments The survey team entered the facility on 04/05/21 to conduct a Recertification survey. The survey team was onsite 04/05/21 to 04/08/21. Additional information was obtained offsite on 04/09/21 to 04/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MMF111.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 04/05/21 to conduct a recertification survey and complaint investigation. The survey team was on site 04/05/21 to 04/08/21. Additional information was obtained offsite on 04/09/21 to 04/12/21. therefore, the exit date was 04/12/21. Event ID #MMF111. 1 of 40 complaint allegation were substantiated resulting in deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		5/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/03/2021

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.

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F 585	Continued From page 1 accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 585		

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F 585	Continued From page 2 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and	F 585	This timeline investigation and plan of	

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F 585	Continued From page 3 staff interviews, the facility failed to initiate a written grievance summary for grievances verbally reported for one of one resident reviewed for grievances (Resident #38). Findings included: Resident #38 was discharged from Facility X on 1/26/21 following treatment for coronavirus and readmitted to the facility. A quarterly assessment of the Minimum Data Set dated 2/2/21 revealed Resident #38 had moderately impaired cognition Interview with Resident #38 ' s family member on 4/7/20201 at 9:20 am revealed he was concerned about Resident #38 ' s belongings that were missing from Facility X. An interview was conducted on 4/7/21 at 11:40 AM with Social Worker (SW) and she stated she had spoken to Resident #38 ' s family member when Resident #38 returned from Facility X on 1/26/21 concerning the resident ' s missing items, which included a cell phone, reading glasses, and some clothing. She stated the items did not return with resident Facility X and she tried to contact Facility X to locate the items and was unable to get in contact with anyone from the facility. She stated resident ' s family member stated he also attempted to contact Facility X, however, did not get a response. She stated she had not initiated a grievance at the time because it was a busy time for the facility due to the COVID-19 outbreak. A grievance log from March 2020 to April 2021 revealed no concerns identified for Resident #38.	F 585	correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove substantial noncompliance. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Resident affected: Resident #38 was discharged from Facility X on 1/26/21 following treatment for coronavirus and readmitted to the facility. Resident #38 belongings was not returned from Facility X. A grievance was filled out on 4/7/21, eyeglasses was found, cell phone and clothes were replaced by facility. Residents with potential to be affected: Social Services completed a 100% audit on 4/30/21 for all residents that was discharged from Facility X and readmitted to the facility. Audit identified issues and were followed up through the grievance process. Social Services completed 100% audit on all resident concerns were followed up by 5/11/21. Plan-systemic changes:	

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F 585	Continued From page 4 On 4/07/21 at 3:35 pm an interview with the Administrator was conducted and she stated she expected a grievance to have been filed, so the facility would have been able to follow-up with the family member. She stated it was a busy time in the facility due to the COVID-19 outbreak and was probably what contributed to the missed documentation of the grievance in the facility. She stated they would be contacting the family member and resolving the issue of missing items.	F 585	Administrator initiated in service on grievance process on 4/15/2021. All new hires will be educated on the grievance process during orientation. Monitoring: Beginning 4/19/21 during Cardinal IDT meeting all readmits from another facility will be addressed to ensure all items were returned and all resident concerns will be reviewed on a Grievance log audit tool and will be monitored as follows: 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks. Monitoring will be done by the Director of Nursing and Administrator to ensure grievances are resolved. Results of the monitoring, with tracking and trending, will be reported by Administrator to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvements and changes.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		5/11/21

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F 656	Continued From page 5 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an individualized and person-centered care plan that addressed Resident discharge for 1 of 2 residents (Resident #126) reviewed for discharged.	F 656	Resident affected: Resident #126 was discharged on 1/21/21 and no longer in the facility. Residents with potential to be affected:	

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F 656	Continued From page 6 Findings included: Resident #126 was admitted to the facility on 12/18/20 with diagnoses of Cancer, malignant neoplasm of left breast and anemia. A review of Resident #126's admission Minimum Date Set (MDS) dated 12/23/20 revealed Resident #126's was able to make her needs known to staff. However Resident #126 need extensive assistance with bed mobility and transfer with two plus persons with physical assistance. Resident #126 needed extensive assistance with dressing, toilet use, person hygiene and bathing with one-person physical assistance. Resident #126 was able to feed herself with set up help only. Section Q indicated no referral needed. A review of Resident #311's care plan dated 01/06/21 did not include a discharge care plan. During an interview with the MDS Coordinator on 04/06/21 at 3:00 PM, the MDS Nurse stated that the Social Worker was responsible for developing the discharge care plan. During an interview with the Social Worker (SW) on 04/07/21 at 8:45am, the SW indicated that she worked with Resident #126. SW indicated that she believed it was an oversight on her part. She indicated it was her responsibility to care plan discharge for this resident. Resident #126 discharge plan was to return home. During an interview with the Administrator on 04/07/21 10:30 am, she indicated that it was her expectation for staff to develop a discharge care plan timely.	F 656	Social Services completed a 100% audit on all resident�s discharge care plan. Care plans have been updated to reflect resident discharge status as of 5/3/21. Plan-systemic changes: Education was done on 4/26/2021 by the DON for MDS and Social Worker Director on discharge care plans. Social Services Director or nurse management will use day of admission audit for new admissions or readmission to ensure a discharge care plan is implemented. On 5/3/2021 initiated day of admission audit tool by Social Services Director or nurse management will be reviewed during Cardinal IDT meeting for 3 months Monitoring: Monitoring will be done by the MDS, Director of Nursing, and Administrator to ensure a discharge plan of care is included in the Comprehensive Care Plan. Continued monitoring will occur for three months. Results of the monitoring with tracking and trending will be reported by the Director of Nursing monthly to the Quality Assurance Performance Improvement committee for recommendations and suggestions for improvement and changes.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		5/11/21

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F 880	Continued From page 8 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review staff interview and physician interview, the facility failed to implement their infection control policies and procedures for personal protective equipment (PPE) and hand hygiene when 1 of 2 staff members (Nursing Assistant #1) failed to perform hand hygiene before exiting the room for 2 of 5 residents (Resident #229 and Resident #227) on enhanced droplet isolation who were observed for infection control practices. This failure occurred during the COVID19 pandemic.	F 880	The position of Greenhaven Health and Rehabilitation is that the center has established and does maintain an infection prevention and control program that is designed to provide a safe, sanitary and comfortable environment. The infection prevention and control program is designed to help prevent the development and transmission of communicable diseases and infections.	

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F 880

Continued From page 9

Findings included:

Review of the facility's "guidelines for initiation of Precautions" policy and procedure dated 3-10-20 revealed in part; wash hands after touching contaminated items, wash hands immediately after gloves are removed, wear gloves when touching contaminated items, wear eye protection and wear a gown during procedures and resident care.

Review of the facility's "Guidelines Related to Dedicated Isolation units" policy and procedure dated 4-18-20 revealed in part; all personnel entering a resident room on isolation should use face mask, eye protection, gown and gloves.

A continuous observation of hall 200 (quarantine unit for new admissions) occurred on 4-7-21 at 8:35am. NA #1 was observed in Resident #229's room, who had an enhanced droplet isolation sign on the door, doffing his gown and gloves by the door. After removing his gown and gloves, he picked up Resident #229's breakfast tray without gloves on and proceeded to the meal cart in the hallway where he opened the meal cart door with his bare hands and placed the tray inside. NA #1 was not observed performing hand hygiene after he removed his gloves and before exiting Resident #229's room. NA #1 was then observed to enter Resident #227's room, who had an enhanced droplet isolation sign on the door, wearing a gown, mask, eye protection and gloves, retrieving the residents breakfast tray, walking back to the resident's door, placing the meal tray on a table by the door where the NA doffed his gown and gloves, then walked back across the room to Resident #227, handed the

F 880

Resident #229 and Resident #227 as well as all residents residing on 200 hall have the potential of being affected by the alleged deficient practice. All residents residing on 200 hall have been monitored for any signs and symptoms of infection and have remained unaffected as of 5/3/21. The facility will continue to monitor.

On 4/15/21 an in-service was initiated by the Administrator and Director of Nursing regarding infection control procedures and hand hygiene during meal service. All clinical staff will be educated by the DON/Infection Preventionist on infection control procedures and hand hygiene during meal service. The education will be completed as of 5/11/21. All newly hired staff and agency staff will be in- serviced regarding infection control procedures and hand hygiene while passing trays during new employee orientation.

The Nurse management team will conduct visual audits on 10 residents per week for 4 weeks, then 8 residents per week for 4 weeks, then 5 residents per week for four weeks. The visual audit on 200 hall will focus on appropriate infection control practices and hand hygiene during meal service utilizing the infection control audit tool. Start date for audits will begin 5/4/21.

The monthly QI committee will review the results of the infection control audits for identification of trends, actions taken and to determine the need for continued

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F 880	Continued From page 10 resident his call bell and adjusted the residents tray table, retrieved the meal tray by the door and proceeded down the hall where he opened the meal cart door with his bare hands and placed the meal tray in the cart. NA #1 was not observed performing hand hygiene after he removed his gloves and before he exited Resident #227's room. NA #1 was interviewed on 4-7-21 at 8:40am. The NA explained he was in a hurry to get the breakfast trays picked up. He also stated he worked for an agency and had not received training on infection control, isolation precautions or hand washing from the agency or the facility. The NA stated, "I have not had any training since I was in school about a year ago." During an interview with the Infection Control Nurse on 4-8-21 at 10:00am, the Infection Control Nurse stated agency staff were educated by the facility prior to working and the education consisted of; use of PPE, don/doffing PPE and hand hygiene. The Infection Control Nurse presented an education form signed by NA #1 that included education on wearing a mask, gown, gloves and eye protection when entering an isolation room, doffing the gown and gloves prior to exiting the isolation room and performing hand hygiene before entering and after leaving an isolation room. The Administrator was interviewed on 4-8-21 at 5:30pm. The Administrator stated staff should be following basic standard precautions for all the residents and if staff was working with a resident on enhanced droplet isolation, then the staff needed to follow the correct procedures.	F 880	monitoring for ninety days or as needed.	

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F 880	Continued From page 11 The facility's medical director was interviewed by telephone on 4-12-21 at 11:38am. The Physician discussed the need for staff to have training and refresher trainings and she stated the staff needed to be diligent to keep the virus from spreading.	F 880		