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 05/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DR 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on Physician Assistant (PA) and Director of Nursing (DON) interviews and medical record reviews the facility failed to act upon the consultant pharmacist's recommendations for a gradual dose reduction of an antidepressant (Zoloft) over a six month period for one (1) of eleven (11) sampled residents (Resident # 15). The findings include: Resident # 15 was admitted to the facility on 02/26/2010 with diagnoses which included dementia, Alzheimer's disease, and depression. A review of the resident's medical record revealed the resident's medications included - Zoloft 50 milligrams (mg), one every day (to treat the resident's depression). A review of the resident's Minimum Data Set (MDS) dated 03/14/2013 indicated the resident to be severely cognitively impaired. The MDS also documented the resident had diagnoses which included dementia, Alzheimer's disease, and depression. The MDS indicated the resident was being administered an	F 428	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. Greenhaven Health and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation Center reserves the right to refuse on this statement of deficiencies through dispute resolution, formal appeal procedure and /or any other administrative or legal proceeding. The facility ensures that services provide or arranged by the facility meet professional standards of quality and that pharmacy drug regimen review recommendations are followed. F; 428: Drug Regimen Review, Report Irregular 1. Resident # 15 was seen by the Nurse Practitioner on 5/17/13 for gradual dose reduction of an antidepressant (Zoloft).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Pittman | TITLE: Administrator | (X6) DATE: 5-17-13

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 428	Continued From page 1 antidepressant. The resident's Care Plan dated 03/25/2013 indicated the resident had feelings of sadness and depression and was receiving medication for the depression and the nursing staff had interventions in place to assist with the depression. A review of the consultant pharmacist's monthly Medication Regimen Reviews (MRRs) for the preceding twelve months was made. The consultant pharmacist documented a recommendation via consult to the physician on 11/02/2012 for a gradual dose reduction (GDR) of resident # 15's proscribed Zoloft. The recommendation by the pharmacist was to reduce the resident's Zoloft dosage from 50mg to 25mg. There was no documentation by the consultant pharmacist concerning the recommendation in the December 2012 MRR monthly note. The consultant pharmacist documented on the 01/04/2013 MRR note a request for the Director of Nursing (DON) to issue a second consult to the physician for the recommended Zoloft GDR. In the 02/05/2013 MRR note the consultant pharmacist documented the recommendation of the Zoloft GDR had not been acted on and wrote - "Zoloft Consult?" The consultant pharmacist's MRR note dated 03/07/2013 documented - "MD - reissue Zoloft consult x3." The consultant pharmacist documented in the 04/10/2013 MRR note -"Zoloft GDR." There was no other information in the paper (hard) chart or the electronic chart to indicate the physician or DON had acted on the consultant pharmacist's recommendation to reduce the resident's Zoloft dose (conduct a GDR) over the preceding six months.	F 428	Resident #15 received order to decrease Zoloft to 25 mg daily. This order will continue until the attending physician discontinues or changes the order. 2. A 100 % chart audit for all current residents was started on 5/16/13 will be completed by 5/17/13 to ensure all Drug Regimen Recommendations from the consulting pharmacist's. April reports have been reviewed as appropriate. 3. The nurse consultant in-serviced the Director of Nursing and QI nurse on 5/15/13. The in-service covered the electronic Pharmacy Policy and Procedure Manuel to include carrying out pharmacy drug regimen recommendations from the consulting pharmacist. The nurse consultant also in-service MDS nurses on 5/17/13. The in-service included the proper procedure for carrying out recommendations from the consulting pharmacist.	5-18-13

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F 428	Continued From page 2 A review of the resident # 15's Medication Administration Records (MARs) for 12/2012 - 05/02/2013 was conducted. The review revealed there were no changes made in the strength of the resident's Zoloft during the six month period. A review of the physician's telephone/verbal order sheets for the same six 6 month period revealed there was no telephone/verbal order found to indicate a GDR or change in the resident's Zoloft dosage was ordered or made. A review of the physician's progress notes from August 2012 prior to the consultant pharmacist's recommendation through May 2, 2013 was conducted. The physician documented the same information in each month's (August 2012 through May 2, 2013) progress note, "Depressive disorder, patient's depression remains stable, will not change medication, continue to monitor for complications." There was no documentation in the physician's progress notes or elsewhere in the resident's paper and electronic chart to indicate the physician had seen, reviewed, or acted on the consultant pharmacist's recommendation for the Zoloft GDR. On 05/08/2013 at 11:20 a.m. a return call was received from the facility's Physician Assistant (PA) concerning the consultant pharmacist's 11/02/2012 GDR recommendation for resident # 15. The PA indicated she reviewed all of the consultant pharmacist's recommendations every month as this was one of her assigned tasks by the physician. The PA indicated the 1st time she became aware of the consultant pharmacist's GDR recommendation for resident # 15 was in March 2013 when she reviewed the consultant pharmacist's 03/07/2013 MRR recommendation.	F 428	4. The Director of Nursing, and or QI/MDS nurses will perform a monthly audit to validate resolution to issues identified in the Pharmacy Consultant Review Recommendation reports. A monthly audit will be completed once per month for three months then quarterly on-going. The Quality Improvement Committee will make recommendations for follow -up and monitoring frequency. The audit results will be reviewed by Administrator. The Administrator will forward the results of the audits to the Quality Improvement Committee monthly for 3 months. The Quality Improvement Committee will make the recommendations for follow-up and monitoring frequency.	

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F 428	Continued From page 3 The PA indicated she wrote on the consult recommendation that it was OK to conduct the GDR. The PA stated, "When I write that information on the consult recommendation - that is the order (my order) for the facility to conduct the GDR. I don't know why they did not initiate the GDR for Resident # 15. I know there was a lot of miscommunication at that time concerning pharmacy recommendation consults. Between June 2012 and March 2013 I was reviewing the pharmacy recommendation consults, writing my orders and comments on them and giving them directly to the DON. At the end of April, during your visit, I was told to start giving them to the Quality Assurance nurse." The PA indicated she had reviewed the April 2013 pharmacy recommendation information (facility MRR sheet) from the Neil Medical Group pharmacy indicating the pharmacist had been recommending the Zoloft GRD for resident # 15 since November 2012 and their information it had not been addressed. The PA indicated she thought the GDR had been initiated by the facility per her order on the 03/07/2013 consult recommendation form. The PA indicated she was unaware the GDR order had not been initiated or acted on by the facility after she had reviewed and signed the pharmacist's recommendation consult indicating it was OK to initiate. An interview was conducted with the DON on 05/02/2013 at 9:05 a.m. concerning the consultant pharmacist's MRR recommendations for resident # 15 covering the past 6 months and finding no information in the chart or electronic record indicating the recommendation was acted on by the DON or the facility's physician. The DON instructed the medical records staff member	F 428		

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F 428	Continued From page 4 to review the chart. The medical records staff member could not find any consult documentation to show the physician or DON acted on the consultant pharmacist's recommendations during the past 6 months. At 10:20 a.m. on 05/02/2013 the DON provided a copy of a consult form signed by the consultant pharmacist dated 03/07/2013. The consult documented the consultant pharmacist's same recommendation to the physician as in the November 2012 consult for resident # 15's Zoloft GDR. The DON indicated she had a binder in her office she kept copies of the pharmacy consult recommendations in. The consult copy had the physician's assistant (PA) signature on it as being reviewed. The PA documented on the consult she was in agreement with the recommendation for the Zoloft GDR as - "OK to do (triangle symbol indicating - change)." The DON was asked if the GDR had been initiated or conducted per the pharmacist's recommendation and the PA's acknowledgement/agreement on the March 2013 consult. The DON stated, "No," and indicated an order was never obtained and/or written to do the recommended Zoloft GDR. The DON provided a copy of a second document dated 04/10/2013 entitled -MRR recommendations from 04/01-10/2013 Neil Medical Group. The DON indicated the document was from the Neil Medical Group, the facility's contracted pharmacy. The Pharmacy's MRR document read in part: Antidepressant Therapy Recommendation, priority - normal, this resident has had an order for Zoloft 50mg QD since August 2010. She is due for an evaluation for GDR (Zoloft) per the Centers for Medicaid and	F 428		

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F 428	Continued From page 5 Medicare (CMS) guidelines. Is she a candidate for a dosage reduction to 25mg every day (QD) at this time? DON-This consult was issued in November and does not appear to have been addressed. The DON was asked if she or the facility could provide any information or documentation to show the consultant pharmacist's recommendations from November 2012 through May 2, 2013 for resident # 15 were acted on. The DON indicated she had nothing to show the facility acted on the consultant pharmacist's GDR recommendations between November 2012 and March 2013 and had not initiated and/or acted on the recommendation after the physician's assistant reviewed and agreed with the GDR between March 2013 and the survey end date of May 2, 2013.	F 428		
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F: 431: 483.60 B Drug Records Label/Store Drugs & Biologicals 1. A 100% audit for expired medications and supplies was initiated on 5/01/13 and repeated on 5/17/13. The audits were performed by the Director of Nursing, QI, Staff facilitator and MDS nurses. The audit included search in the medication room, medication refrigerators, medication carts, crash cart, treatment carts, treatment storage area, and supply room. Expired medications and supplies were discarded and re-ordered as needed.	

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F 431	Continued From page 6 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and facility staff interviews the facility failed to ensure expired medications were removed from use for 2 of 7 medication storage areas. The findings include: 1. On 04/30/2013 at 5:30 p.m. an observation of the facility's wound care treatment and storage room was conducted with the facility's DON. The following item (injectable medication) was observed to be expired: 1 - 10cc syringe, 0.9% sodium chloride for injection, unopened on shelf for use. Lot # 8108706 Expiration date - 04/2011	F 431	2. The Director of Nursing received guidance and mentoring, from the facility consultant, on 4/29/13 followed by re-training starting 5/15/13 through 5/17/13. The re-training included review of the electronic Pharmacy Policy and Procedure Manual. The Director of Nursing will be responsible for will in-servicing nurses on proper procedure on expired medication. In-service started on 5/16/13 to be completed by 5/18/13. 3. An audit tool titled" Expired Medication" will be used by the Director of Nursing, QI nurse, MDS nurses and staff Facilitator to audit for expired medications and supplies. The tool will be completed 5 days a week for 1 month then monthly there after. Any expired medication of supplies or supplies will be and removed discarded as appropriate. 4. The Administrator will review the audit results and forward the results of the audits to the Quality Improvement Committee during the next 3 months for review, for follow up as necessary, and to determine the continuing need for and frequency of monitoring.	5/18/13

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F 431	Continued From page 7 On 05/01/2013 at 1:35 p.m. an interview was conducted with the facility's DON concerning her expectations for removing expired medications from use. The DON indicated the facility nurses were supposed to check their medication and treatment carts and rooms daily for expired medications. If expired medications were found they were to be removed from service and discarded or returned to the pharmacy for exchange/destruction. 2. On 05/01/2013 at 10:40 a.m. an observation of the 300 hall's medication cart was conducted with the 300 hall medication nurse. The following items were observed to be expired: Located in the 3rd drawer of the medication cart were 10 packages of individual use nutritional supplement (to promote wound healing). 4 of the packages (Arginaid 4.5gm/package) were observed to be expired. The Arginaid package label documented - Medical food intended for use under medical supervision. Lot # 1286500717; Expiration date - 04/10/2013 On 05/01/2013 at 10:45 a.m. an interview was conducted with the 300 hall's medication nurse. The nurse indicated she had several residents on the 300 hall that the physician had ordered to receive the Arginaid nutritional supplement during her medication passes to promote their wound healing. The nurse indicated she did not know the Arginaid had an expiration date and had never checked for one. On 05/01/2013 at 1:35 p.m. an interview was conducted with the facility's DON concerning her	F 431		

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F 431	Continued From page 8 expectations for removing expired medications from use. The DON indicated the facility nurses were supposed to check their medication and treatment carts and rooms daily for expired medications. If expired medications were found they were to be removed from service and discarded or returned to the pharmacy for exchange/destruction.	F 431		

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	345132	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/21/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	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.	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/21/13 at approximately noon the following egress illumination was observed as non-compliant, specific findings include the following rooms would leave the patient in darkness. a. Activities room b. Dining room	K 045	• K045 NFPA 101 Life Safe Safety Code Standard 1) Corrective action will be accomplished for the alleged deficient practice by June 28, 2013. An authorized vendor will install a single lighting fixture (bulb) in the Activities and Dining room so no area is left in darkness. 2) The maintenance supervisor will visually inspect the Activities and Dining room to ensure proper placement and operation of the lighting fixtures. 3) The maintenance supervisor will inspect the lighting fixtures in the Activities and Dining room 5 days a week for one month for Proper placement and operation and then weekly. 4) The maintenance supervisor will provide the results of the inspection to the Executive QA Committee for review on a monthly basis for three months to identify any trends and or patterns corrections to determine the durations of the inspections	6/28/13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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

Greg Pilmon | administrator | 6-7-13

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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K 130	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/21/13 at approximately noon the following was observed as non-compliant, specific findings include insulation in the above dryer compartment was being pulled away from the dryer wall and sucked into the gas fired compartment. The dryer was shut down. Far right dryer in the laundry room.	K 130	K130 NFPA 101 Life Safety Code Standard 1) a. The maintenance supervisor removed the insulation in the above dryer compartment on 5-21-13. 2) The maintenance supervisor inspected all dryers compartments to ensure they are free from insulation and lint 3) The maintenance supervisor will inspect the dryers' compartments 5 days a week for one month. Then weekly to ensure the compartments are free from insulation and lint. 4) The maintenance supervisor will provide the results of the inspections to the Executive QA Committee for review to identify any trends and or patterns.	5/21/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/21/13 at approximately noon the following NFPA item was observed as non-compliant, specific findings include the beauty shop ground fault circuit interrupter, GFCI, could not be verified and required labeling on the devise.	K 147		

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K 130	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/21/13 at approximately noon the following was observed as non-compliant, specific findings include insulation in the above dryer compartment was being pulled away from the dryer wall and sucked into the gas fired compartment. The dryer was shut down. Far right dryer in the laundry room.	K 130	• K147 NFPA 101 Life Safety Code Standard 1) The facility maintenance supervisor purchased and installed a ground fault circuit interrupter in the beauty shop on 5-22-13. 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 weekly for proper installation and placement of ground fault circuit interrupter during regular rounds for two months. 4) The maintenance supervisor will provide the results of the inspections to the Executive QA Committee for review to identify any trends and or patterns to determine the durations of the inspections	5/22/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/21/13 at approximately noon the following NFPA item was observed as non-compliant, specific findings include the beauty shop ground fault circuit interrupter, GFCI, could not be verified and required labeling on the devise.	K 147		