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	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Health and Rehabilitation Center	801 Greenhaven Drive Greensboro, NC 27406

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff, physician, family and law enforcement interviews, the facility failed to supervise a severely cognitively impaired resident from exiting the facility without supervision. On 08/05/25 at approximately 8:30 pm Resident #1 followed Dietary Aide #1 out of the employee exit door and exited the facility. Resident #1 did have a wanderguard bracelet (component of a wander management system) on his left ankle; however, the door Resident #1 exited did not have a transmitter sensor and the magnetic lock was released when Dietary Aide #1 entered a code on the door keypad. Dietary Aide #1 believed Resident #1 to be a visitor (because he was wearing street clothes, had a hat on, and was walking unassisted) and had directed him to exit through the front door and did not realize Resident #1 had followed him out the door until he saw him walking outside the building toward the front as he was driving away. On 08/05/25 Resident #1 was located by local law enforcement at 10:37 pm (approximately 1.0 mile away from the facility.) He was found lying in the road on a five-lane main street where the I-40 interstate east and west on and off ramps are located at the intersection of [NAME] Road and [NAME] Street. When law enforcement arrived, a bystander was trying to help Resident #1 get out of the street. It appeared to law enforcement that Resident #1 had fallen over the median and was lying face down on the pavement in the middle of the busy road. It was raining and he was shaking, cold, and wet. He was returned to the facility by the Director of Nursing and Medication Aide #1 in Medication Aide #1's private vehicle. Emergency Medical Services (EMS) personnel assessed Resident #1 at 11:41 pm on 08/05/25 at the facility. Resident #1's mental status was oriented to person only and EMS presumed Resident #1 had fallen. EMS left the resident with his family to transport him to the hospital at the family's request. The family took him directly to a regional hospital where he was diagnosed with a left 1 cm (centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose/beneath the eye), a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher-level trauma hospital for treatment. The Trauma Medical Center Physician stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed was too large for the other hospital to manage in accordance with their hospital protocol and the injuries Resident #1 presented with were life threatening. This was for 1 of 3 residents reviewed for accidents (Resident #1). Findings included:A history and physical assessment completed by Physician #1 on 05/28/25 for Resident #1 (when Resident #1 was previously admitted to the facility for a 5-day respite stay) was reviewed. Resident #1 was assessed to have severe chronic dementia. He required assistance with bathing and was continent of bowel and bladder. He was without untoward behaviors or overt agitation. He had a subtle anxious affect, with a tendency toward wandering.Resident #1 was admitted to the facility on [DATE] for respite care (temporary institutional care of a sick, elderly, or disabled person, providing relief for their usual caregiver). He entered the facility from home. Diagnoses included Alzheimer's disease, low back pain, chronic kidney (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	disease stage 1, Type 2 Diabetes Mellitus, major depressive disorder, hypothyroidism, and essential hypertension.A Nursing Admission/Re-entry Evaluation assessment completed by Nurse #2 on 08/04/25 was reviewed. Resident #1 needed setup or clean-up assistance with dressing and personal hygiene. He needed moderate assistance with showering. He was independent with eating. He was independent with mobility, transferring, and ambulation. He did not use any assistive devices for mobility. He could communicate with some difficulty. He wore glasses. He had no falls within the past 30 days of admission. He had a serious intellectual mental health diagnosis. His admission to the facility was for short-term placement.A Wandering Risk Evaluation completed by Nurse #2 on 08/04/25 was reviewed. Nurse #2 documented Resident #1 had no known history of attempts to leave home or facility or wander. His mood and behavior was complacent. He was ambulatory and/or self-mobile. He had a diagnosis of Alzheimer's dementia or severe cognitive impairment. He never or rarely made decisions. He rarely/never understood or was understood when communicating. He made verbal statements of a desire or intent to leave the facility. Resident #1 scored 13 on the assessment (a resident who scores greater than 5 is at risk for wandering.) A progress note written on 08/04/25 at 4:25 pm documented Resident #1 arrived at the facility on 08/04/25 at 12:00 noon from PACE (a program of all-inclusive care for the elderly) for Respite Care accompanied by family. He had a wanderguard on his left leg. Resident #1 was a participant in the PACE of the Triad program under the primary care of the PACE physician. In an interview with the Pace Program Physician on 08/11/25 at 9:49 am she stated Resident #1 had been a participant in the Pace program since 05/01/25. She explained he wandered and was often agitated. She stated he was not okay to be outside by himself. She noted PACE staff often calmed Resident #1 down by singing hymns to him. She reported that he acted out in non-violent ways and was resistant to care.Review of a skin assessment dated [DATE] at 6:07 pm by the Treatment Nurse was reviewed. Resident #1 had no abrasions or cuts on his body on admission.A progress note written on 08/04/25 Nurse #1 at 11:35 pm documented, in part, that on admission Resident #1's skin was dry and warm to touch with no lesions noted, that he was ambulatory, wandered around and needed frequent redirection.Review of the care plan for Resident #1 initiated on 08/04/25 revealed the following focus areas: Wandering and or at risk for unsupervised exits from facility related to cognitive impairment and at risk for falls characterized by a history of falls/actual falls, injury and multiple risk factors. The goals were: 1) The whereabouts will be known to staff as demonstrated by no events of leaving the facility unsupervised, 2) Will have no episodes of unsupervised exits from the facility, and 3) The resident will remain free of injury as evidenced by no falls or accidents through the next review. Interventions included to place familiar objects in resident surroundings, Wanderguard alarm bracelet to the resident's left ankle, have commonly used articles within easy reach, and keep the call light within reach and answer timely.The following physician orders were reviewed: WANDERGUARD-Verify location and expiration every day and night shift for Safety (start date 08/05/25); and Check Wander Device Transmitter to ensure proper functioning every day and night shift for Safety/Monitoring (start date 08/05/25).A telephone interview was conducted with Nurse Aide #1on 08/12/25 at 10:29 pm. She stated she had cared for Resident #1 on 08/04/25 and 08/05/25 on day shift. She recalled on 08/04/25 he had been looking for his mama and asked her where she was. She told him that his mama wasn't there. She remembered she had seen him walking up and down the hall several times but had not seen him pushing on any exit doors.An interview was conducted with Medication Aide #2 on 08/12/25 at 10:16 am. She started her shift at 5:00 pm on 08/05/25. She recalled Resident #1 was sitting in a chair on the 400 hall and did not appear to be upset and he was calm. He was still sitting in the chair when the dinner carts came to the hall at approximately 5:30 pm. She stated at approximately 6:30 pm she saw Resident #1 walking up and down the 300 and 400 halls. Medication Aide #2 recalled when she was providing care to another resident, Resident #1 approached her and asked her where the door was to get out. She stated she told him, No, and directed him to his room, but he replied, I already paid my money and I'm going to see my mother and father and he walked away.In a telephone interview with Nurse Aide #1 on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	family in the front lobby. During the interview she provided a copy of the notations she had made regarding the times mentioned above along with a screen shot of the phone record that indicated the time she reported to the DON that Resident #1 was missing.In an interview conducted with Medication Aide #2 on 08/12/25 at 10:16 am she recalled sometime around 9:00 pm on 08/05/25 an Agency Nurse Aide approached her and asked if she had seen Resident #1 and stated staff could not find him. She stated she began to look for him and had searched the salon, bathroom, and laundry room but was unable to find him. As she was looking for him another Nurse Aide told her she had seen him on the 300 hall pulling at the exit door, but she did not know the Nurse Aide's name. She explained she went to the 300 hall to search for him. She checked all the doors on the 300 hall, and they were all locked. She stated she had not heard any door alarms sound during her shift. The following written statement made by Nurse Aide #4 on 08/06/25 was reviewed. She had documented, in part, that she witnessed Resident #1 push the exit door handle on the 300 hall at approximately 8:00 pm on 08/05/25. She also documented that she had seen the resident around 8:45 pm. She had told him that the door was locked, and he walked back up the 300 hall towards the nursing station. She wrote that he stated he was looking for his mom and dad. An interview was conducted with Nurse Aide #4 on 8/12/25 at 3:11 pm. She stated that her written statement was not correct. She reported she thought her first interaction with the resident was at 8:00 pm on 08/05/25 but she had heard some other staff member say 8:45 so that's what she documented. She denied she had seen him push the door handle and had only heard him say he wanted to get out to see him mom and dad.In a telephone interview conducted with Nurse Aide #3 on 08/12/25 at 11:25 am she remembered that when she returned to the building after her break on 08/05/25 she was told that Resident #1 was missing. She stated she really wasn't sure what time she returned to the building. She noted she joined in the search for the resident and recalled some staff members used their personal cars to search in surroundings neighborhoods. She stated when she punched out around 11:05 pm the resident had not been found.The law enforcement Incident/Investigation Report was reviewed. The date and time of the report was 08/05/25 at10:37 pm. The location of the incident was 2501 [NAME] Road and [NAME] Street. The victim was Resident #1. A second police officer assisted the responding officer on the scene. The responding law enforcement officer documented: On 08/05/2025 at 2237 (10:37 pm) hours, I responded to [NAME] Rd. and [NAME] St. in reference to a suspicious activity. The investigation is ongoing at this time.A return telephone call from the responding Law Enforcement Officer was received on 08/12/25 at 10:20 pm. He explained he had responded to a call at the location of [NAME] Road and [NAME] Street on 08/05/25 for an incident of simple physical assault. He stated when he arrived a bystander was standing over the resident trying to get him up and out of the street. Two young ladies had pulled over after exiting the I-40 ramp and were yelling aggressively at the bystander who was trying to help Resident #1. He stated when he interviewed the 2 young ladies they told him they thought the bystander was assaulting the resident but had never seen him or anyone hit the resident. The bystander explained to him that he had been walking by with his girlfriend, saw the resident lying in the middle of the road and was trying to help him. The responding Law Enforcement Officer stated the traffic on [NAME] was heavy that night on the 5-lane road. He reiterated that no one was seen beating up the resident. He commented that it was a very busy area and if someone was getting beat up there would have been more than one call to 911. He concluded it appeared that Resident #1 had fallen over the median and was lying face down on the pavement in the middle of the busy road and the bystander was trying to help him get out of the road. The responding Law Enforcement Officer concluded that the investigation was ongoing.Weather conditions reported by customweather.com for the Greensboro area on 08/05/25 documented the outside temperature to be between 66 degrees Fahrenheit at 7:54 pm and 63 degrees Fahrenheit at 10:54 pm. The conditions were mostly cloudy with light rain and fog.A telephone interview was conducted with Nurse Aide #2 on 08/12/25 at 4:39 pm. She stated it was about 10:40 pm on 08/05/25 when she and the DON went in her personal car to pick up Resident #1 from where he had been found by the police. She recalled Resident #1 was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on 08/05/25 at the facility. The EMS report documented Resident #1 had a blood pressure of 136/100 millimeters of mercury, a heart rate of 100 beats per minute, a respiratory rate of 18, and an oxygen saturation reading of 96% on room air. He had a right facial cheek laceration approximately 2.5 inches long with controlled bleeding. He had band aids on his knees placed by Nurse #1 during first aid care. Resident #1's mental status was oriented to person only. EMS presumed Resident #1 had fallen and they informed the family of the risks of an intracranial hemorrhage after a fall and the risks of transporting the resident themselves. EMS left the resident with his family to transport him to the hospital at their request and advised the family to call 911 for any changes.In an interview with a family member on 08/11/25 at 4:08 pm she stated the family took Resident #1 straight to the regional hospital after removing him from the facility. The regional hospital then sent him to the trauma center in [NAME]-Salem for treatment of a brain bleed. She stated Resident #1 was doing better but that the hospital was keeping him for a couple extra days in a regular room to keep an eye on the brain bleed to make sure there were no further complications.An interview was conducted with the Maintenance Director on 08/13/25 at 12:30 pm. He stated on the night of 08/05/24 he was called back to the facility to check the doors after Resident #1 had exited the building without staff supervision. He explained that only the front exit was alarmed for the wanderguard system, and all other doors had a keypad. Each door that had a keypad had its own unique key sequence to unlock the door. He stated all doors at the facility including keypads and the front entrance were checked daily and logged in the maintenance electronic computer system.An observation of the employee exit door was made on 08/12/25 at 10:10 am. The door was equipped with a keypad to enter a specifically assigned code for that door. When left ajar, the door did sound a faint alarm. The door was not equipped with a wanderguard alarm.An observation of the routes Resident #1 may have taken was conducted by the survey team by driving both routes on 08/12/25 beginning at 8:15 pm. Whether the resident turned left or right when leaving the facility driveway, the location where he was found by police was measured by driving the routes as 1.0 miles either way. The road where the resident was found (the intersection of [NAME] Road and [NAME] Street) had 5 lanes and was the hub for the on and off ramps for Interstate 40. Traffic was steady during the observation. There were streetlights that came on if the resident had turned right (Creek Ridge) but to the left the street was a dark industrial side road ([NAME] Street). Both routes were observed to be heavily wooded. A 35 mile per hour speed limit sign was observed on [NAME] road where Resident #1 was found.Hospital records dated 08/06/25 at 1:01 am were reviewed. Resident #1 was diagnosed with a left 1 cm (centimeter) subdural hematoma (brain bleed), a right 7 mm (millimeter) subdural hematoma (brain bleed), a 3 mm midline shift of the ventricle (when the brain moves past it's center line) due to the subdural hematoma (brain bleed), a right maxillary sinus fracture (beside the nose/beneath the eye),a right orbit fracture (bone around the eye), and a right zygomatic arch fracture (cheek). He was transferred to a higher level trauma medical center for treatment. A telephone interview with the Hospital physician was conducted on 08/15/25 at 4:09 pm. He stated Resident #1 was not able to tell him what had happened due to his advanced dementia but that the injuries he had to his face were caused from blunt force trauma and could have been the result of a fall. He reported that he thought the subdural hematomas he currently had could be a mix of an old subarachnoid brain bleed from January 2025 but that two of the subdural hematomas were acute meaning they had occurred within the last 24 hours. He explained he did not have anything else to offer, that Resident #1 had been transferred to a trauma hospital and the family was happy with the care Resident #1 had received at the Regional Medical Center.A telephone interview was conducted with the Trauma Medical Center Physician on 08/21/25 at 10:30 am. He stated Resident #1 had been transferred to their trauma unit from an affiliated regional medical center because the size of his brain bleed on 08/06/25 was too large for the other hospital to manage in accordance with their hospital protocol. He stated the injuries Resident #1 presented with were life threatening and very reasonably were caused from a fall. He stated he examined the brain scan results and noted both the subdural hematomas were new and had occurred within the previous 12 (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hours. The Trauma Center physician explained that Resident #1 had a previous brain bleed in January 2025 which he reviewed and noted that the previous brain bleed was a very different type of bleed than the current subdural hematomas. The comparison showed the January 2025 brain bleed was from a different area of the brain and only had trace bleeding-unlike the current subdural hematomas that had a large amount of bleeding. He also noted that the January 2025 test results showed no facial fractures. He stated all of the facial fractures were also from this episode. He stated that Resident #1 was fortunate to be in stable condition. He noted it was a shame this had happened when the family had only placed Resident #1 for respite care to free up their time to hold a birthday party for Resident #1's wife. At the end of the interview the Trauma Center Physician reported that the resident had returned home with his family.The Administrator was notified of Immediate Jeopardy on 08/12/25 at 5:35 pm.The facility provided the following corrective action plan:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 is alert but not oriented, with a Brief Interview for Mental Status (BIMS) of 3. Diagnoses included Alzheimer's dementia and major depressive disorder. He was admitted to the facility on [DATE] for respite care. On August 5, 2025, at approximately 8:15 pm, Dietary Employee #1 observed an unknown gentleman (Resident #1), presumed to be a visitor, walking down the service hallway of the facility. The employee redirected the individual toward the front entrance, assuming he was unfamiliar with the building layout and attempting to exit. Upon the dietary employee exiting the facility via the service hall door, the gentleman followed behind him and proceeded to walk around to the front of the building. The dietary employee ensured the service hall door was secured and then proceeded to leave the facility with his transportation, believing the gentleman who came out behind him was walking around the front to meet his own ride.At approximately 8:30 pm, Medication Aide #1 attempted to administer Resident #1's, evening medications but was unable to locate him. Medication Aide #1 notified Nurse #1 that Resident #1 could not be located. A facility-wide search was immediately initiated, and a code orange (code used to notify all staff of a missing resident) was announced by Nurse #1. The Director of Nursing (DON) and Administrator were notified that resident #1 could not be located. Staff continued to search for resident #1 inside the facility and in the surrounding areas in their vehicles. At approximately 9:49 pm, the Administrator notified law enforcement that Resident #1 could not be located. At approximately 10:00 pm, local law enforcement arrived onsite to begin searching for Resident #1. At approximately 10:36 pm, the Administrator notified the Resident Representative (resident's daughter) that resident #1 could not be located. At approximately 10:45 pm, the police department notified the Administrator that the resident was located 0.9 miles away from the facility. The Director of Nursing and a Nursing Assistant #1 went to the location of the resident. The resident was uncooperative with EMS, so the family was contacted by the DON and made the decision for the resident to be brought back to the facility. Resident #1 was brought back to the facility via the staff's private vehicle, where the family was onsite at arrival. The Director of Nursing discussed with the resident's family the need for the resident to be sent to the emergency room (ER). The family agreed, and EMS was notified. An assessment was completed by the assigned hall nurse and revealed a laceration approximately one inch to the right cheek and a 3/4 inch abrasion above both knees. Treatment was provided to the areas along with resident care. EMS arrived to evaluate the resident and found the resident to be stable. The family decided to discharge the resident Against Medical Advice (AMA) and take the resident to the ER via their private vehicle. At approximately 11:32 pm, the physician services were notified by the DON of the incident and the family's decision to discharge the resident AMA. At approximately 12:00 pm, the resident left AMA with family.On 8/6/25, the Administrator completed a root cause analysis for Resident #1's unsupervised exit. The investigation identified the root cause to be that Resident #1 walked out behind a dietary aide, and the dietary aide did not intervene to prevent an unsupervised exit, thinking he was a visitor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On 8/5/25, t[TRUNCATE