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	07/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council, resolve repeat grievances, and communicate the facility's efforts to address grievances voiced during Resident Council meetings for 4 of 4 consecutive months: March 2025, April 2025, May 2025, and June 2025.The findings included:A review of the grievance policy that was revised on 10/12/2020 indicated that Resident Council concerns that are voiced through Resident Council are recorded on the Facility Concern/ Grievance Form and are handled in a similar manner to individually voiced concerns., complaints and grievances. The Administrator is informed that the concern is referred to a department head, investigated and resolved, and the Resident Council is informed of the progress of the resolution. a. A review of the Resident Council minutes completed on 3/19/25 had no stated author and revealed the following grievances were expressed: Shower room floor needs to be cleaned more, want better access to the phone, call bells are not being answered for 45 minutes, and staffing at night and weekends were not available. A review of the grievances for the month of March 2025 revealed no Resident Council grievances were submitted. b. A review of the Resident Council minutes completed by the Activities Director dated 4/8/25 revealed the following grievances were expressed: resident food had been stolen from the nutritional room, cigarettes and lighters are getting missing, call bells not answered for 30 minutes, laundry is getting missing, nursing assistants have attitudes when residents ask for assistance after 6 pm, sandwiches are hard. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of April 2025 revealed no Resident Council grievances were submitted. c. A review of the Resident Council minutes completed by the Activities Director dated 5/6/25 revealed the following grievances were expressed: third shift staff are not assisting residents, call lights are not answered for 30 minutes, lack of sheets, staff are asleep at 4:00 AM, residents did not get baths and staff made racist comments during 2nd shift. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of May 2025 revealed a Resident Council grievance was submitted on 5/6/25. The grievance indicated resident concerns regarding 3rd shift call light response times, sheets, staff on phones/sleeping. The only noted action taken was that nursing will follow up with 3rd shift staff. d. A review of the Resident Council minutes completed by the Activities Director dated 6/4/25 revealed no new grievances for this month. There was no documented discussion or resolution of the previous month's grievances noted in the minutes. A Resident Council meeting was held on 7/2/25 at 3:3P PM with Residents #2, # 8, 28, #53 and #55. During the meeting, Resident #8, the resident council president, expressed that the Resident Council has made repeated grievances month after month which had not been fully addressed or resolved. Resident #53 stated the resident council's complaints were not resolved and the residents were never provided follow up to their stated grievances. An interview with the Activities Director on 7/3/25 at 10:12M revealed that she completes the resident council minutes and then provides a copy of the minutes to the Administrator. She further indicated that she did not fill out grievance forms for Resident Council grievances nor did she provide follow-up to the Resident Council members at the next meeting because she did not know that she needed to do it. An interview with the Administrator on 7/3/25 at 1:35 PM revealed that Resident Council grievances were reviewed in morning meetings by the Administrator but neither he nor the Activities Director documented any actions taken to address the grievances and did not communicate the facility's efforts to address the grievances. He further indicated that these actions should have been taken and felt this was an oversight.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of a narcotic medication (oxycodone-acetaminophen) prescribed to treat pain for 1 of 1 resident reviewed for misappropriation of property (Resident #56). The findings included:Resident #56 was admitted to the facility on [DATE].A review of Resident #56's quarterly Minimum Data Set assessment, dated 04/26/25, indicated his cognition was intact.Resident #56 had an order dated 5/25/23 for oxycodone-acetaminophen 5-325 milligrams (mg) two times a day every Tuesday, Thursday, Saturday, Sunday, for pain. The second oxycodone-acetaminophen 5-325 mg order dated 6/25/25 for oxycodone-acetaminophen 5-325 milligrams (mg) every 6 hours as needed for pain on hemodialysis days on Monday, Wednesday, and Friday.a. A review of Resident #56's June 2024 Medication Administration Record (MAR) revealed the resident received oxycodone -acetaminophen 5-325 mg administered as ordered.A review of the investigative report dated 6/25/24 read in part, a narcotic card of oxycodone-acetaminophen with 30 pills was missing from the medication cart. On 6/20/24 during shift change the narcotic card count sheet indicated 21 cards (a card is a bubble pack used for storage of medications) total during shift change at 07:00 PM. On 06/24/24 on the morning of shift change the unit coordinator (Director of Nursing) counted and took keys from the night shift nurse (Nurse #8) due to first shift nurse (Nurse #3) running late and the narcotic card count resulted in 23 total cards, which included 2 additional cards delivered on 06/21/24. At about 7:30 AM the first shift nurse (Nurse #3) came in and the unit coordinator (Director of Nursing) handed over the keys to the medication cart to the first shift nurse without counting the narcotics, including the number of cards, due to the unit coordinator (Director of Nursing) just holding the keys and not opening the cart after she counted with the night shift nurse (Nurse #8). The first shift nurse worked the cart until 3:00 PM when another nurse (Nurse #9) came in to relieve her. During the count the incoming nurse (Nurse #9) counted 22 narcotic cards, and the first shift nurse (Nurse #3) brought it to her attention there were supposed to be 23 cards based on what was written. The incoming nurse (Nurse #9) recounted again while the first shift nurse (Nurse #3) flipped the sheets to confirm, and there were 22 cards. The first shift nurse (Nurse #3) assumed it was probably a miscount. On 06/25/24 at approximately 7:00 AM the outgoing nurse counted off 22 cards and sheets with oncoming nurse. Resident #1 requested a pain pill, and the oncoming nurse administered the medication. The oncoming nurse mentioned to Resident #56 there was only 1 oxycodone-acetaminophen left, and she would have to notify the hospice physician to receive a script to order a refill. Resident #56 informed the oncoming nurse (Nurse #3) he was told on the day before that he had another full card of the medication. The oncoming nurse (Nurse #3) called hospice to get a script and was informed they had sent 44 tablets of the oxycodone-acetaminophen on 06/21/24. The oncoming nurse (Nurse #3) informed management of her findings, and an investigation was initiated into the missing medication.A review of the Pharmacy delivery manifest sheet dated 06/21/24 revealed 44 oxycodone-acetaminophen tablets delivered to the facility.A review of the controlled substance count sheet record dated 06/21/24 indicated 1 of 2 cards for 30 of 44 tablets revealed 14 oxycodone-acetaminophen tablets signed for on the record. There were 14 tablets signed out from 06/22/24 through 06/25/24.An interview was conducted on 07/02/25 at 11:30 am with the Director of Nursing (DON) (who was the Unit Manager during the timeframe of the missing medications that counted narcotics with Nurse #8 at 07:00 AM. The DON indicated she counted the narcotic sheets with Nurse #8 and the narcotic cards and sheets they counted matched. She stated she did not open the medication cart again until Nurse #3 came in at approximately 7:30 AM on 06/24/24 and she didn't recall if they counted the cards and the sheets, but she did know she did not go back in the cart after counting with Nurse #8.On 07/02/25 at 4:05 PM an interview was conducted with Nurse # 3, and she indicated she was called in to work on her day off due to a call out on 06/24/24. She stated when she arrived at work she counted the narcotic cards with the Unit Manager, however she did not count the narcotic cards. She indicated at 3:00 PM at the end of her shift Nurse #9 counted the cards and she was counting the pages, and they noticed the cards and the narcotic sheets were not matching. Nurse #3 indicated she thought it was a mistake and she and Nurse #9 corrected the narcotic count sheet with the narcotic cards. She stated she thought someone forgot to put the right number of cards on the sheet. Nurse #3 indicated she received a call at home the following day about the missing narcotics, and she was informed she had been suspended pending an investigation. She stated when the investigation

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of vision for 1 of 1 resident reviewed for communication (Resident #57). The findings included:Resident #57 was admitted to the facility on [DATE] with a diagnosis of cardiac arrythmia, dementia, and essential hypertension. A review of Resident #57's electronic medical record (EMR) included an ophthalmology consultation note dated 11/19/24. The assessment revealed a medical condition of cataracts in both eyes and related blurred vision. The consultation note further indicated that cataract surgery was recommended and had been scheduled on 3/26/25 for the left eye and 4/30/35 for the right eye. A review of Resident # 57's Significant Change in Status MDS assessment dated [DATE] was completed by MDS Nurse #2 and revealed the resident had severely impaired cognition , adequate vision and had corrective lenses. Resident #57's most recent Minimum Data Set (MDS) assessment dated [DATE] was completed by MDS Nurse #1 and revealed the resident had severely impaired cognition ,adequate vision, and had corrective lenses. Resident #57's care plan revised on 5/15/25 by MDS Nurse #1 did not include any identified problems or interventions related to visual impairment. An interview and observation was conducted with Resident #57 on 6/30/25 at 10:21 AM. Resident #57 indicated that she was waiting for cataract surgery for her eyes and that she had difficulty seeing her food. An interview was conducted with the scheduler for appointments and transportation on 7/1/25 at 3:01 PM. She indicated that Resident #57's cataract surgeries were delayed due to a hospital stay in March of 2025 prior to her scheduled surgery. She further revealed that a follow-up appointment was scheduled for 7/24/25. An interview was conducted with MDS Nurse #1 on 7/1/25 at 3:05 PM. She revealed that she completed the quarterly assessment of 5/15/25, and she was not aware of any blurred vision or that Resident #57 had bilateral cataracts. MDS Nurse #1 then indicated that Resident #57 should have been coded for visual impairment. An interview was conducted with MDS #2 on 7/2/25 at 11:22 AM. She indicated she was the interim MDS nurse and completed Resident #57's Significant Change in Status Assessment of 3/19/25. She further revealed that she was not aware of an ophthalmology consultation note that indicated bilateral cataracts and blurred vision and if she had seen the report, she would have coded Resident #57 to have visual impairment and cataracts. An interview on 7/3/25 at 1:38 PM with the Administrator revealed that Resident #57's MDS assessments should have been coded to accurately reflect the resident's medical condition.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews, the facility failed to provide a copy of the baseline care plan to the responsible party for 1 of 23 residents reviewed for baseline care plans (Resident #57).Findings included:Resident #57 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, in part, non-traumatic intracerebral hemorrhage in the hemisphere (bleeding within the brain tissue of one cerebral hemisphere, occurring without any known trauma or injury). A review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #57 was severely cognitively impaired.A review of the medical record revealed a baseline care plan was completed by Unit Manager #1 3/13/25.A review of the medical record revealed Resident #57 listed a family member as her own responsible party. A review of the medical record revealed no documented evidence that a copy of the baseline care plan was given to the resident or the responsible party. Multiple attempts were made to interview the responsible party, but attempts were not successful. An interview was conducted with Resident #57's admitting Nurse, Nurse # 7. She indicated she did not complete the baseline care plan and did not provide a summary of the baseline care plan. Multiple attempts were made to interview Unit Manager #1, but attempts were not successful. On 7/2/25 at 11:03 AM an interview was completed with Unit Manager #2. He stated that typically the unit managers develop the baseline care plan for new or readmitted residents and reviewed it with the resident and/or responsible party within 48 hours of admission.On 7/2/25 at 11:03 AM an interview was completed with the Director of Nursing (DON). She stated the baseline care plan was initiated and completed 3/13/25 by Unit Manager #1. She said she expected the baseline care plan to be developed within 48 hours of admission, and a copy provided to the resident or resident representative. The DON further stated she could not confirm that Resident #57's t baseline care plan summary was ever provided to the resident or responsible party. An interview was conducted with the Administrator on 7/3/25 at 1:30 PM and he indicated that he expected the resident and/ or the responsible party to receive a written summary of the baseline care plan within 48 hours of their admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff and record reviews, the facility failed to clarify the dosage of aspirin to administer to 1 of 5 residents reviewed for unnecessary medications (Resident #66). The findings included: Resident #66 admitted to the facility on [DATE] with diagnoses including dementia, cerebral stroke syndrome, and cerebrovascular disease. Resident #66's quarterly Minimum Data Set (MDS) dated [DATE] documented she had severe cognitive impairment. The MDS noted she had a history of a stroke and she received antiplatelet medications (prevents the accumulation of platelets to prevent blood clots). Resident #66's Medication Administration Records (MAR) from January 2025-July 2025 were reviewed and included an order for staff to administer aspirin once every other day. The MAR did not have a dosage listed on the entry. In an interview on 7/03/25 at 3:30 PM, Nurse #12 stated she was the regular nurse on Resident #66's hallway and routinely gave her the aspirin. She stated she gave Resident #66 an 81 milligram (mg) every other day out of the facility stock of over-the-counter medications because she thought that was what was ordered. She stated she was not aware there was no dosage in the original order but stated she believed there was a standing order for aspirin for all residents of aspirin 81 mg if needed. Resident #66's standing physician's orders did not include an order for aspirin. In an interview on 7/03/25 at 9:27 AM, the Director of Nurses (DON) stated she had been at the facility since the end of 2024 and stated she was not aware there was no dosage listed for the aspirin until surveyor intervention. She stated all medications orders should have the strength of the medication to be given. She stated there were two dosages of aspirin in the over-the-counter facility stock, 81 mg and 325 mg. She stated Resident #66 should have received 81 mg of aspirin which was the usual dosage for residents with a history of stroke and the order should have been clarified. Resident #66's physician was unable to be interviewed during the survey.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to arrange or coordinate podiatry care for 1 of 5 dependent residents reviewed for assistance with activities of daily living (ADL) (Resident #31). The findings included:Resident #31 was admitted to the facility on [DATE] with diagnoses which included cellulitis of left lower limb, chronic kidney disease and congestive heart failure.Resident #31's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and was dependent on staff for personal hygiene. The MDS further revealed the resident was coded for not being ambulatory. Resident #31 s care plan, revised 6/6/25, revealed the resident had a focus area of activities of daily living/personal care. The goal was for Resident #31 to have staff complete activities of daily living as appropriate to maintain the highest practical level of functioning through the next review. There was no documentation in the medical record the resident had been seen by podiatry. An interview and observation with Resident #31 on 6/30/25 at 10:30 AM revealed the resident's great toenails on both feet to be extending beyond the end of her toes, and were thick, and yellow in color. Resident #31 indicated that she felt the nursing staff would not be able to cut her toenails and has not been offered a podiatry consult and would like to have a podiatry visit from the facility onsite provider. Resident #31 stated she was not in pain from the length of her toenails as she did not walk or wear shoes.An interview was conducted with Nursing Assistant (NA) #7 on 7/1/25 at 2:15 PM. She indicated that she was assigned to Resident #31 on 7/1/25 and that she completed personal hygiene care which included nail care. NA #7 indicated that she observed Resident # 31's toenails to be long, hard and overgrown and did not feel she was able to trim the toenails therefore she notified Nurse #7 of the status of her toenails and that she was in need of a podiatry consult. An interview conducted with Nurse #7 on 7/1/25 at 2:31 PM revealed she was not aware Resident #31 needed a podiatry consult and that NA #7 did not report this issue to her. An interview was conducted with the Director of Nursing (DON) on 7/1/25 at 3:05 PM. She indicated toenail care was to be provided by the nursing staff and if the nurses were not successful with trimming a resident's toenails, then the resident was offered a podiatry consult to the resident's toenails needs. The DON indicated the in-house podiatrist visited the facility quarterly. The DON reported the facility attempted to trim Resident #31's toenails in May of 2025, but she declined. The DON further revealed Resident #31 was not offered a podiatry consult at that time and should have been referred to the podiatrist for services in May when she declined to let staff trim her toenails.

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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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to lock the brakes on a resident's wheelchair before leaving her unattended on the facility's front patio. Nurse Aide (NA) #5 positioned Resident #102 on the front patio and then walked away from the resident without securing the wheelchair brakes. Due to the brakes not being locked, and the resident's inability to stop the wheelchair when it began to roll due to weakness in all of her extremities, Resident #102 rolled approximately 10 feet across a circle drive and then struck her head on a brick wall which resulted in two lacerations to Resident #102's forehead that required sutures to repair. In addition, the facility also failed to provide care in a safe manner when Resident #310 rolled off the bed while NA #6 was providing a bed bath. This deficient practice occurred for 2 of 10 residents reviewed for accidents (Resident #102 and Resident #310). The findings included:1. Resident #102 was admitted to the facility on [DATE] with diagnoses including quadriparesis (weakness in all four limbs) and chronic dislocation of right shoulder. Resident #102 was discharged from the facility on 4/24/25.Resident #102's most recent quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #102 was cognitively intact, used a manual wheelchair, and was dependent on staff for all activities of daily living.The care plan last reviewed on 3/18/25 showed Resident #102 was care planned for falls and required assistance with activities of daily living due to chronic health conditions and weakness in extremities. The interventions included the use of a manual wheelchair for mobility. Review of physician orders showed Resident #102 was not on any blood thinners.An incident report dated 3/28/25 at 3:30 PM completed by the Director of Nursing (DON) revealed NA #5 transported Resident #102 out to the front patio of the facility. The report read that Resident #102 had lost control of her wheelchair and had rolled into the wall. The report further read that staff assisted immediately to complete a head-to-toe assessment, including vital signs, and applied pressure to stop bleeding. The emergency contact and the Nurse Practitioner were notified. Resident #102 was sent to the hospital for evaluation and treatment. During an interview with NA #5 on 7/1/25 at 2:17 PM, she stated she had pushed Resident #102 outside to the front patio in the afternoon of 3/28/25. NA #5 stated Resident #102 liked to sit in the sun, so she had pushed to her usual spot which was all the way across the patio and beside the circular drive. NA #5 also reported Resident #102 naturally leaned slightly forward in her wheelchair and did not have the strength to propel or stop herself in a wheelchair. NA #5 indicated she always locked the brakes on the wheelchair and couldn't explain why she didn't that day other than she just forgot. NA #5 stated she had just walked back into the building when she turned and saw Resident #102 slowly rolling across the circular drive. NA #5 reported she didn't reach her fast enough and Resident #102 struck her forehead on the brick retaining wall. NA#5 stated Resident #102 did not fall out of her chair and she didn't lose consciousness. NA #5 further stated that Resident #102 told her she was trying to get into the sun more and couldn't stop the wheelchair from rolling. NA #5 stated she didn't remember calling for any assistance, but other staff members then appeared to assist with getting Resident #102 back into the building to assess her and address her wound on her head that was bleeding. During an interview with the DON on 7/1/25 at 3:34 PM, she stated that she was up front on 3/28/25 when the incident with Resident #102 occurred. The DON stated she heard a staff member (unable to recall whom) say a resident just had an accident outside. The DON stated she responded immediately and performed an assessment on Resident #102. The DON reported Resident #102 did not fall out of her wheelchair, did not lose consciousness, and was complaining of minimal to moderate pain around the wound on her forehead. The DON stated Resident #102 told her she was trying to move further into the sun and couldn't stop the chair from rolling. The DON stated she contacted the emergency contact and NP #1 who provided the order to send Resident #102 to the hospital to assess her wound. The DON stated her vital signs were normal and Resident #102 was verbally responding in her normal manner.Review of the Emergency Medical Service note showed they arrived on 3/28/25 at 3:31 PM to the facility and found Resident #102 sitting upright in her wheelchair in the lobby. The note further read Resident had free rolled several feet across the drive into a brick wall. The resident had two small lacerations on her forehead. Bleeding was controlled, the area was cleaned and bandaged by staff .Resident is not on blood thinners and did not lose consciousness. Resident requested transport to a specific hospital for treatment. Alert and oriented, vital signs normal. No complaints of dizziness, only some pain around laceration. Resident is a non-emergency transport today.Review of the emergency department note dated 3/28/25 at 4:09 PM showed Resident #102 sustained two lacerations- a 4

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with staff and record reviews, the facility failed to address discrepancies identified by the facility consultant pharmacist when a recommendation was made to clarify the dosage of aspirin ordered for 1 of 5 residents (Resident #66) reviewed for unnecessary medications. The findings included: Resident #66 admitted to the facility on [DATE] with diagnoses including dementia, cerebral stroke syndrome, and cerebrovascular disease. Resident #66's quarterly Minimum Data Set (MDS) dated [DATE] documented she had severe cognitive impairment and had no behaviors or refusals of care. The MDS noted she had a history of a stroke and she received antiplatelet medications (prevents the accumulation of platelets to prevent blood clots). Resident #66's Medication Administration Records (MAR)s from January 2025-July 2025 were reviewed and included an order for aspirin once every other day. The MAR did not have a strength listed on the entries. Resident #66's monthly consultant pharmacist reviews dated 2/27/25, 4/30/25, and 6/27/25 noted she had an order for aspirin but there was no strength in the order, either 81 milligrams (mg) or 325 mg. There was no documentation of the facility addressing the recommendations. In an interview on 7/03/25 at 3:30 PM, Nurse #12 stated she was the regular nurse on Resident #66's hallway. She stated she gave Resident #66 aspirin 81 mg every other day out of the facility stock of over-the-counter medications because she thought that's what was ordered. She stated she believed there was a standing order for aspirin for all residents. Resident #66's standing physician's orders did not include an order for aspirin. In an interview on 7/03/25 at 9:27 AM, the Director of Nurses (DON) stated she had been at the facility since the end of 2024 and stated when she looked for the recommendations at the surveyor's request, she found there were several pharmacy recommendations that were not completed by the former DON and former Assistant Director of Nursing (ADON). She stated she was not aware of the missing dosage until surveyor intervention. She stated the recommendations should have been reviewed and the order clarified within a few days of receiving the recommendation.

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	07/08/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to offer the opportunity to be vaccinated with the Pneumococcal 20-valent Conjugate Vaccine (PCV20) for 3 of 5 residents reviewed for pneumococcal immunizations (Resident #52, #74, and #66).Findings include:The Center for Disease Control and the Advisory Committee on Immunization Practices (ACIP), last reviewed on 10/26/24, recommends routine vaccination against pneumococcal infection for all adults aged 65 years or older and 19-64 with certain underlying medical conditions. Beginning June 8, 2021, for persons aged 65 years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, they should receive 1 dose of PCV15 [Pneumococcal 15-valent Conjugate Vaccine] or 1 dose of PCV20. Review of the facility's immunization policy last reviewed 3/4/2024 stated that all residents would be offered a pneumococcal vaccine PCV13 (Pneumococcal 13-valent Conjugate Vaccine) or PPSV23 (pneumococcal polysaccharide vaccine) upon admission.A. Record review revealed Resident #52 was admitted to the facility on [DATE].Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #52 declined a pneumococcal vaccine on 8/11/21. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine. There was no documentation the resident was offered or received a pneumococcal 20-valent conjugate vaccine since the last recertification on 3/14/24. There was no documentation the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility.B. Record review revealed Resident #74 was admitted to the facility on [DATE].Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #74 declined to receive a pneumococcal polysaccharide 23 vaccine and a pneumococcal conjugate 13 vaccine on 7/14/23. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine since 7/14/23. There was no documentation that the resident received a pneumococcal 20-valent conjugate vaccine prior to admission or since the last recertification on 3/14/24. There was no documentation that the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility.C. Record review revealed Resident #56 was admitted to the facility on [DATE]. Review of the pneumococcal immunization records for the residents, provided by the facility, indicated Resident #56 declined to receive a pneumococcal polysaccharide 23 vaccine and a pneumococcal conjugate 13 vaccine on 3/18/24. There was no documentation on the declination form that the resident had specifically been offered a pneumococcal 20-valent conjugate vaccine since the last recertification on 3/14/24. There was no documentation that the resident declined or received pneumococcal 20-valent conjugate vaccine prior to admission to the facility.During an interview with the Director of Nursing (DON)/Infection Preventionist (IP) on 7/2/25 at 8:52 AM, she stated this was her first DON position and she had been with the facility since April 2025. The DON reported she was aware the facility offered pneumococcal polysaccharide 23 vaccine and to all pneumococcal conjugate 13 residents and was unaware they needed to also offer pneumococcal 20-valent conjugate vaccine. The DON indicated she would be setting up a vaccine clinic as soon as possible with an outside vendor who would be offering and providing the necessary vaccines, including pneumococcal 20-valent conjugate vaccine.